

High Risk Infants Service Quality Initiatives Project

*Parenting Assessment and
Skill Development Program:*

Evaluation

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Parenting Assessment and Skill Development Program: Evaluation

This report was prepared by Dr Lynda Campbell, Professor Alun C Jackson, Serena Smith and Nadine Cameron for the Victorian Department of Human Services, Child Protection Service

By
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July 2001

This document has been prepared by the Royal Children’s Hospital/University of Melbourne Social Work Practice Research Unit and the Children, Young People and Families Research Unit, School of Social Work, The University of Melbourne. Its purpose is to provide advice and information to the Child Protection and Juvenile Justice Branch of the Victorian Department of Human Services concerning the implementation of the Parenting Assessment and Skill Development Services component of the *High Risk Infants Service Quality Improvement Initiatives*.

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Citation:

Campbell, L., Jackson, A.C., Smith, S., Cameron, N (2001) *High Risk Infants Service Quality Initiative Evaluation: Implementation of the Parent Assessment and Skill Development Program*, Melbourne: Victorian Department of Human Services.

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ISBN 0 7311 6162 9

May 2002

(1080302)

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The Parenting Assessment and Skill Development Services (PASDS) constitute one of several quality improvement initiatives by the Child Protection and Juvenile Justice Branch of the Victorian Department of Human Services, as part of the High Risk Infants Service Quality Improvement Project (HRI Project.) Phase One of the PASDS evaluation is a review of the utilisation of PASDS in their first year of operation. PASDS. This is reported in the *High Risk Infants Service Quality Improvement Initiatives Final Evaluation Report*, provided to the Child Protection and Juvenile Justice Branch of the Department of Human Services in November 2000. The pattern of service utilisation has not changed significantly in the program’s second year.

This report of Phase Two of the PASDS evaluation critically reviews the implementation data. It also examines early information about the impact of the PASDS initiative on the basis of further program consultations and document analysis, analysis of a sample of completed PASDS episodes from multiple perspectives, and limited direct and indirect client feedback from parents who have used PASDS.

The use of PASDS is carefully regulated by High Risk Infant (HRI) managers within the Child Protection Service (CPS). PASDS **assessment** places are reserved for those infants where the CPS has already assessed the infant’s situation as one of **high risk**, but where there remains some doubt about whether the parents have adequate knowledge and skills to meet the baby’s needs and the capacity to do so over a sustained period despite other risk factors. This tends to be referred to as the assessment of ‘parenting capacity’. PASDS **skill development** places are used to address gaps in parenting capacity or performance as revealed by the PASDS assessment or other assessments.

The duration and intensity of PASDS delivery has been varied since the implementation of the program. The duration, in most cases, has been extended and the amount of time spent with a family at any time is largely determined by the needs of the family and the skills being developed.

This report outlines in some detail the way PASDS have been organised and how they operate in practice. The key features of the PASDS services described are:

- **Multiple delivery sites: residential, day-stay, in-home.**
- **The integration of maternal and child health and child and family welfare practice approaches within the in-home program.**
- **Voluntary involvement by families.**
- **Practice models that highlight strengths and stress a collaborative approach to working with clients.**
- **Assessment models that are transparent and evidence-based.**

The uses of the different components of PASDS have been based on several criteria, which are outlined below. Of the criteria listed, the key considerations are the need for supervision of the infant and the willingness of the parent to participate in the program.

The design of PASDS has occurred within limits. No service has been established from scratch; rather, service delivery models have been grafted on to existing suitable service delivery frameworks. The PASDS established are considered to be of high quality by major stakeholders. The PASDS seem to be fulfilling the aims of their establishment and are contributing to better quality assessment practice within the child protection system. Although the PASDS in each Region differ, stakeholders across regions presented similar comments. Child Protection Services staff were generally positive about the quality of PASDS delivery.

The research undertaken for this evaluation report has not been able to clearly establish patterns of intervention that have produced successful results. Given the critical nature of the question of what works for whom, it is a key recommendation of this report that more uniform data collection systems are established, to allow for more systematic research to explore the factors influencing outcomes in the practice of PASDS. Anecdotally, the establishment of a trusting relationship with clients was presented as a key factor in success by a number of PASDS providers.

The impact of the implementation of PASDS on practice with high risk infants within the Victorian child protection system has been variable. HRI teams within CPS report that PASDS have increased Child Protection Workers knowledge of the issues affecting early childhood development and have made them more sensitive to the indicators of ‘adequate care’. The PASDS have plugged a gap that existed in parenting services and in many ways extended the network of

1. Evaluation of Parenting Assessment and Skills Development Services

services available for families whose infants are at high risk of abuse and/or neglect.

On the basis of the responses provided by the major stakeholders, the establishment of PASDS has contributed to the following aspects of service delivery to infants within protective services.

- **Improved risk and need assessment**
The observational nature of the PASDS assessment process has enhanced the quality of the overall risk assessments provided by the child protection system. They help disentangle issues of knowledge and skill from those of personality and circumstance in parenting performance.
- **Case planning and decision making**
As already mentioned, the evidence-based assessments provided by PASDS provide compelling evidence for case planning and decision making. They assist in highlighting the issues involved in the parenting practices of families and the sort of skill development and ongoing support required to ensure adequate care of infants.
- **Court outcomes**
All participants indicated a positive relationship between PASDS and the Children’s Court. PASDS reports are well received and rarely contested on those occasions when they do proceed to court. PASDS reports are usually agreed to by all parties involved in a child protection case.
- **Inter-agency collaboration**
The relationship between the Child Protection Service and the PASDS within a Region are close and are nurtured by the HRI manager in each Region. The success of the establishment of PASDS has been due, in large part, to the close collaboration between CPS and PASDS providers. The establishment of PASDS has reinforced the importance of Maternal and Child Health Nursing practice to child welfare work with infants.
- **Innovative service arrangements**
The establishment of PASDS has provided some enhancement to service delivery within the agencies providing them. This has varied from working with staff around their preconceptions when working with child protection clients, to

developing and refining assessment practices within the agency. Given the establishment of PASDS within already existing parent/child or family support services, innovation has been limited to some extent. Western Region has attempted some new approaches to PASDS delivery, such as delivering a PASDS through a drug and alcohol agency and the establishment of a day-stay program aimed specifically at providing a bridge into other PASDS for hostile and/or reluctant clients.

The establishment of PASDS has provided many lessons for the development of future programs. The key lessons have been the importance to the Child Protection Services of being able to achieve an independent assessment of parenting practices and being able to provide families with the concrete skills needed they need to adequately care for an infant. The commonalities and variations between PASDS programs also raise central questions about how ‘parenting’ is conceptualised, and the implications of this for further conceptualisation and development of the PASDS initiative are discussed.

Recommendations regarding the development of PASDS are made at the end of this report. They focus on key areas of funding and targets, service provision, inter-disciplinary collaboration and future research. These recommendations provide a direction for the further development of PASDS.

PASDS were established as part of an initiative undertaken by the Department of Human Services Child Protection Service and aimed at providing better services to infants at risk of child abuse or neglect. The core goals of the HRI Project were to produce more cautious practice with infants known to the Child Protection Service by enabling:

- Improved risk and need assessment.
- Better informed case decision making.
- Improved protective services performance at court.
- Improved inter-agency and inter-disciplinary communication and coordination.
- Service and practice innovation.

The implementation of these initiatives has been underway since July 1997 with most services becoming operational from 1998 (see Appendix A).

PASDS were established with the following aim:

To improve Child Protection Services’ risk assessment and management plans for high risk infants through improved access to timely, comprehensive, research based assessment of parenting capacity and ongoing skill development and support. (*High Risk Infants Service Quality Initiatives Project*, Department of Human Services 1999)

PASDS were to be characterised by the following key features:

- Timely, comprehensive, evidence-based assessment.
- Individually tailored skill development and support.
- Flexible delivery modes.
- Priority access for Child Protection Services clients.

PASDS were established to provide assessment of parenting competence and/or parenting skills development in residential, day-stay and/or home settings. The target group of the initiative is infants (usually defined as children up to 24 months) at high risk of abuse and/or neglect and known to the Child Protection Service, and their parents. (See Appendix B for a detailed service and regional profile of the PASDS.)

1.1 Evaluation Methodology

The PASDS evaluation process involved two phases. The first phase aimed at establishing the service delivery models in operation, the initial use of PASDS

by the Child Protection Service and issues raised in the implementation of PASDS. This phase was reported in the evaluation team’s report to the Department of Human Services in September November 2000.

The second phase of the evaluation, and the focus of this report, centered on a critical review of the implementation data and development of some understanding of the impact of the establishment of PASDS programs. It was not within the scope of this brief to provide an outcome evaluation.

1.1.1 Stakeholder Interviews

During the PASDS evaluation, a series of stakeholder interviews were held. The aim of these interviews was to receive feedback from PASDS providers and stakeholders within the Child Protection Service, including personnel from Partnerships and Service Planning (PSP), HRI managers and Specialist Infant Protection Workers (SIPWs).

Two sets of interviews were conducted. The first were a number of telephone interviews conducted with PASDS providers and personnel from Partnerships and Service Planning and the HRI manager within each Department of Human Services Region. The outcomes of these **Phase One** interviews are reported in the High Risk Infants Service Quality Improvement Initiatives Final Evaluation Report, provided to the Child Protection and Juvenile Justice Branch of the Department of Human Services in November 2000. (For a summary of these Phase One comments see Appendix C.)

The second series of interviews was conducted on site with PASDS providers and the HRI team within each Department of Human Services Region. In the second phase of the evaluation, at individual and group interviews across 11 sites, 33 PASDS personnel put forward their views on the operation of the service. Two additional PASDS providers fed comments into the interview process via fax. HRI workers within the Child Protection Service were also interviewed on site within each Department of Human Services Region except Loddon Mallee (which had not at that stage implemented a PASDS), with 18 staff putting their views forward in group interviews and an additional two HRI managers providing written responses. In this second phase of consultations, the primary

interest of the evaluation team was to establish:

- If PASDS arrangements have been implemented and sustained.
- How PASDS were organised and operated in practice.
- How PASDS were utilised across their first year of operation.
- The pattern of use of PASDS by the Department.
- The appropriateness of PASDS design and the quality of PASDS provision.
- Patterns of intervention that stakeholders believe to have produced successful results.
- The impact of PASDS on practice with high risk infants within the Child Protection Services and other infant and family service providers.
- Overall, if PASDS have contributed to improved risk and need assessment, case planning and decision making, court outcomes, inter-agency collaboration and innovative service arrangements.
- Lessons for further modification and development of PASDS.

See Appendix D for a detailed summary of stakeholder interview comments on PASDS provision.

A prepared list of questions was sent to PASDS providers and HRI workers within the Child Protection Service prior to the interview. These lists are provided as appendices E and F.

1.1.2 Document Review

PASDS providers were also asked to provide examples of documents they use to guide service provision, particularly any assessment tools used, and to provide a profile of the staff working with PASDS families. The request for this information was sent to the provider prior to the on-site interview and was to be made available to the evaluator at the interview. The items requested are noted in appendices G and H. These items were then reviewed in the light of the interview data, the program expectations and prior HRI project research.

1.1.3 Retrospective Case Analysis

In an effort to examine a sample of episodes of PASDS (approximately 20 per cent annual cases—estimated to be 70 cases in all), Regional HRI managers were asked to complete a questionnaire (see Appendix I) for each of a designated number of cases referred to a PASDS between 1 July 1999 and 31 December 1999. Cases

were to be identified simply from the chronological record of referrals, without selectivity, for example, the first 10 cases referred. For each of these returned questionnaires, a corresponding questionnaire was sent to the most recent Child Protection Service case manager or team leader responsible for the case (see Appendix J), where available, and another was sent to the PASDS provider (see Appendix K). From these questionnaires, it was hoped that a triangulated picture of the case would emerge, comprising:

- The HRI manager's view of the basic features of the family and child's situation, and the needs of the Child Protection Service with respect to the referral and other program implications.
- The Child Protection Service case manager's account of the utility of the program for the family and for the Child Protection Service, and information about subsequent use of services and the outcome for the infant.
- The PASDS provider's view of the nature of the actual service given, and issues arising in its delivery.

Of the HRI managers' questionnaires, seven Regions returned forms for a total of 51 cases. Two were contracted to a non-government agency for case management and were excluded from the Department of Human Services case manager questionnaire sample, and questionnaires were not sent to either the case manager or the PASDS in the still sensitive case of an infant who had subsequently died. Two cases were taken no further because the PASDS referral had not eventuated, according to the case manager. (This case was discussed verbally with the HRI manager.) Twelve questionnaires were returned by Child Protection Service case managers, allowing a picture of the longer-term case outcomes in only a small group of cases. Forty-three PASDS questionnaires were returned, for 47 children.

1.1.4 Client Feedback

The evaluation team also hoped to obtain feedback from approximately 20 per cent of an annual intake of PASDS users and, in an effort to secure this, PASDS agencies were asked to forward an invitation to participate in the evaluation to all families who had used the service between 1 January 2000 and 30 June 2000. It is believed that approximately 200 invitations with consent forms were sent. The cumbersome third party recruitment that had been designed to minimise

breaches of privacy (to ensure the evaluation team did not know where families lived) and ensure free choice to participate, and to secure ethical clearance, resulted in only two families responding to the invitation. It is understood that many families may have moved in the 6–11 months since case closure and may not even have received the invitation. It is also possible that the provision for signed consent may also have deterred some families from replying, as might the late time of year, approaching the holiday season.

The case managers' questionnaires included provision for them to relay what families had told them about what they had found helpful and unhelpful about the PASDS. While this is a second best, it does give some glimpse of client response to the services, separate from the views of the PASDS providers.

1.2 Establishment of PASDS

The notion of a set of PASDS was developed centrally by the Child Protection and Juvenile Justice Branches of the then Youth and Family Services Division (now Community Care) of the Department of Human Services Victoria in 1997–1998.

It was evident from Regional consultations that there could be no one model of service delivery. The Department's regionalised system of service planning and delivery recognises local differences and had led to a unique service system configuration in each Region. Since the monies available for PASDS were designed to enhance the existing capacity of these service systems to meet the needs of infants and their families, it was inevitable that PASDS arrangements would vary between Regions. Even the timing of the establishment of PASDS has varied between Regions.

At the time of the interviews, all Regions described the status of their service agreements with PASDS as 'interim'. A number of factors have influenced this, most notably, a change of government in Victoria in 1999. This change has resulted in a hold being placed on the existing and developing arrangements between the Regional Child Protection Services and PASDS, although this moratorium was not specifically directed by Department of Human Services. Some Regions were waiting for the completion of the PASDS evaluation, to ensure they are funding 'best practice' frameworks for service delivery.

Notwithstanding the interim nature of these arrangements, all Regions except one have been operating some form of PASDS since 1999. A number of Regions have developed a service delivery system that they are confident of and wish to continue, others are in the process of redeveloping appropriate service delivery systems and one Region is in the establishment phase.

1.3 The Use of PASDS by the Child Protection Service

1.3.1 Who Is Referred into a PASDS?

Not all high risk infant referrals that come into the Child Protection Service are then referred on to a PASDS. It depends on the issues present in the case. In all Regions the HRI manager and SIPWs are responsible for gate-keeping and establishing the suitability of families for referral to a PASDS. Not all infants are at high risk because of deficits in parenting capacity but rather because of external factors, such as a housing crisis, drug and alcohol use or family violence. The following criteria were given concerning suitability and the terms of the referral.

Indicators for referral at this time

- Was parenting capacity an issue in the case? That is, were there concerns regarding the parents' ability to provide direct care for their infants?
- The receptiveness of the family, that is, will they agree to enter the service?

Cautionary considerations for referral at this time

- The level of violence present within the family, that is, will PASDS workers be at risk?
- The level of current drug and/or alcohol use, that is, will this interfere with the learning process?
- The need for other assessments prior to referral, such as cognitive assessments or mental health assessments, to clarify potential impediments to PASDS participation.
- Other issues involved that may make learning difficult, for example, immediate housing crisis, relationship breakdown, drug withdrawal, psychotic episode.

These latter criteria do not necessarily imply exclusion, but yield information to help shape the way the PASDS constructs the assessment and/or skill

development process. PASDS are used in a range of cases across Regions. HRI staff identified a range of uses from early intervention with young mothers or intellectually disabled parents, immediate post-birth service provision, to the ‘last ditch’ effort with families who have experienced multiple protective interventions across a number of years. While PASDS are used with a range of clients, the key factor used to establish suitability is apparent deficits in the parent’s ability to directly care for and demonstrate positive attachment to the child.

The Retrospective Sample

According to the HRI managers, 51 returned questionnaires on the sample of PASDS referrals between July and December 1999, the following factors were relevant:

Age

The emphasis was clearly on younger children, but with a spread across the first year of life.

N = 53 infants (51 families—one family had three infants)		
0–2 months	3–6 months	7–12 months
14	12	13
13–18 months	19–24 months	Over 24 months
8	4	2

Parental Conditions/Risk Factors

Conditions identified explicitly as posing risks to infant care included:	
• Domestic violence	23 families
• Substance abuse	22 families
• Previous child removal or death	8 families
• Mental illness	14 families
• Adolescent parent’s high risk lifestyle	13 families
• Homelessness-transience	8 families
• Intellectual disability	6 families
• Parent’s self-harm	4 families

Protective Concerns

Kinds of harm concerning to Child Protection Services included:	
• Neglect and/or developmental harm	24 families
• Known or likely abuse	15 families
• Medical issues	13 families
• Attachment difficulties	7 families

Protective Status

Thirty-seven of the families were referred during the ‘protective intervention’ phase, post-substantiation of a concern, while 13 were still in the initial investigation stage. At referral, 14 infants were on no Court Order; ten were on Interim Accommodation Orders, nine on Supervision Orders and nine on Custody to Secretary Orders. Six children were on Interim Protection Orders, one of these also being on an interim Accommodation Order. No data were provided regarding the legal status of the others, but it might be presumed that they were part of the ‘no Order’ group.

Purpose of PASDS Referral

The purpose of the referral is related to the substantial number of infants on temporary orders or longer-term custodial orders. Of the 53 infants, 21 were referred for assistance with family reunification and 19 for placement prevention. The remainder was referred for ‘other’ reasons (seven for unspecified reasons) and one was explicitly referred for help in reaching a permanent care decision, while no data were entered for the remainder. Grampians and Barwon South Western Region cases were strongly represented in the reunification cases.

In summary, cases referred to PASDS, as represented by this sample, were weighted toward younger infants in the first year of life, on no court orders or interim orders only, from families, which usually had two to four serious family risk factors (especially substance abuse and domestic violence). Neglect and concerns about medical and developmental wellbeing were more likely than suspected active child abuse, and slightly more infants were referred for assistance with decision making about reunification than about placement prevention. Inasmuch as these cases involved decisions being made regarding parent competence, they were appropriate referrals.

These data are echoed in the two-year analysis of PASDS referrals provided separately by Southern Metropolitan Region HRI manager, and in the information provided by the internal evaluator of the Uniting Care Connections (UCC) PASDS to the Eastern Region and the earlier interim service to the Northern Region.

1.3.2 Differential Usage of Assessment and Skills Development Components of the PASDS

Decisions regarding the differential use of PASDS components of assessment and skills development vary a little across Regions. The majority of clients who enter into a PASDS program receive an assessment of their parenting capacity. Not all these families then go on to receive skills development, although a low intensity skills development process occurs during the assessment period. The referral data provided by the HRI managers for the 51 cases in the retrospective sample suggest that referrals rarely distinguished assessment from skills development, in that 47 families were referred for both assessment and skills development.

Some PASDS providers and HRI staff reported that they expected there to be a greater number of families moving through both an assessment phase and a skills development program than appears to be the case to date. *In the retrospective sample* of 51 cases, while 41 cases were said to have completed the PASDS episode of service, this does not mean all successfully completed a skills development component. Indeed, there were 14 cases in which assessment was used as a decision point to establish that the parent was unable to provide safe or adequate care. These cases mostly resulted in placement of the child with relatives or in other formal care, rather than developing into a skills development service to the parents.

Reasons Provided for Families Receiving Only an Assessment and Not Skills Development

- During the consultations with PASDS and HRI staff, some of the reasons provided for *families receiving only an assessment and not skills development* by a designated PASDS were:
- Parenting capacity was assessed as adequate, even though there might be other issues to address.
 - Parenting capacity was assessed as inadequate and the infant was subsequently removed from the parents’ care.
 - The assessment process was disrupted by, for example, a housing crisis, re-commencement of drug use, or the parent leaving the service.
 - The family was found to need social support rather than parenting skills development.
 - A number of other services were involved in the family’s life and able to proceed with skills development.

- The PASDS was provided to assess parenting capacity in cases of reunification, and found the parent/s able to care appropriately.

There is a minority of cases in which families could be said to receive the skill development component without the assessment component of the PASDS. This may occur if the Child Protection Service assessment is thorough and especially if it has been augmented by independent assessments and reports from clinicians contracted through the use of HRI Flexible Budget brokerage or from other services that have been able to identify specific areas of needed skills development. This latter approach has been favoured by Western Region in recent times.

Reasons for Deciding Whether the Assessment Is Undertaken within the Home or within a Residential Setting

- Stakeholders reported that the decision regarding *whether the assessment is undertaken within the home or within a residential setting* also varies according to a number of factors:
- The residential setting has been preferred when there is a need to reduce external distractions for the client during the parenting assessment process, and where there is a need for 24-hour professional supervision of the child and the child’s care.
 - Willingness of clients to participate in the residential setting is an important determinant.
 - If there are siblings who cannot attend the residential setting, then a home-based or day-stay service is preferred.
 - Reunification assessments may require a day-stay or residential setting to provide a transition between the substitute care placement and home.

Referrals for Combinations of Service Location

In the retrospective sample, there were some referrals for combinations of service location. For the 51 families, there were 30 residential PASDS referrals, 25 in-home and six day-stay (in Grampians, Gippsland, Hume and Western Metropolitan Regions). Ten of the families had received a PASDS prior to the referral captured in the sample time period, usually a recent residential service leading up to the home-based referral covered in the sample period. Similarly, 12 families had a further PASDS episode after the referral that was the focus of the questionnaire. Again, these additional

episodes were usually additional in-home services after a residential or initial in-home service, to continue skill development, with respect to the same infant. In two cases, the additional PASDS was given to another carer (father in one case; grandmother in the other) after an earlier period with the mother of the same infant. In all, approximately half of the sample had more than one PASD service episode with the same infant, though these were usually continuous or closely linked.

In order to provide a flexible service response to families, the combination of components used is decided on a case by case basis. High Risk Infant staff in all regions considered this variety of service delivery modes and the flexibility with which they could be ‘wrapped around’ the family, a great strength of PASDS.

1.4 Service Delivery Frameworks

The first full year of service operation for most PASDS was 1999–2000. The Department of Human Services established a number of program parameters and funding levels for the provision of PASDS. This provided a basic framework for the establishment and implementation of PASDS in each Region. The funding agreements with PASDS providers define a number of key output measures. These are:

- Provision of a PASDS to a nominated number of families across a year.
- An assessment report on all families commencing the service within 21 days.
- A skill development service and an individual skill development plan for a nominated number of families.

A call for tenders was made for the provision of PASDS and a number of tenders from *existing* parent/child services were received. The Child Protection Service was interested in building on the existing knowledge and experience of services delivering parenting programs. This would have two key outcomes: the ability of the agency to work with these high need/high risk families would be enhanced and this often extremely isolated population could be integrated into the mainstream service system. Additional benefits from using existing mainstream services to deliver PASDS were the ability to establish the services quickly; and that mainstreaming would lessen the stigma associated with being involved with

child protection and would enable child protection client families to come into contact with other families around the experience of parenting.

The PASDS funding has been used in two ways by these existing services— to augment existing service delivery, making the service suitable to meet the needs of the client group; and to establish new programs within an existing service delivery system.

Since the establishment of PASDS a number of broad service delivery frameworks have emerged:

- **Residential PASDS**

Three metropolitan-based Early Parenting Centres provide a residential PASDS within their existing residential parenting services. The Queen Elizabeth Centre (QEC) and Tweddle Child and Family Health Service provide an assessment process across ten continuous days with 24-hour supervision, to a number of Regions. O’Connell Family Centre also provides a residential PASDS exclusively for the Eastern Region, but is able to provide only a five-day continuous residential service Monday to Friday, given its limited funding. While it is unable to provide the service across the weekend, most PASDS families are provided with two periods of five-day assessment.

A regionally-specific relationship has been established between Barwon PASDS and Geelong Hospital to provide a residential style PASDS where 24-hour supervision of the infant is needed.

- **Centre-based day-stay PASDS**

This program is also assessment-focussed and is best developed in the Grampians and Barwon Regions. These PASDS have been established in agencies with existing day-stay facilities, which can be utilized for PASDS. The day-stay PASDS assessment usually occurs across a two-week period, with up to 12 hours of assessment in each week. Day-stay is primarily used in cases where home life is not conducive to learning or when supervised parent-child access is necessary in cases of potential reunification of a placed child with his or her parent/s.

In Western Region, a specialist day-stay program has been developed to act as a bridge into a

residential or home-based PASDS. Within this model families receive six episodes of contact at a venue of their choice, unless there are some requirements regarding parental access to the infant.

- **In-home assessment and skills development service**

The way PASDS are delivered to families within their home is the most varied aspect of service delivery. The following list indicates the range of arrangements in operation:

Lead Early Parenting Centre (QEC) alongside a consortium of local family support agencies, providing in-home assessment and skills development. (Southern Region)

The Queen Elizabeth Centre delivers an outreach service at a locally-based Maternal and Child Health centre, providing assessment and skills development. (Northern, Gippsland, Hume)

Community-based family preservation/support agencies deliver the assessment and skills development service. (Eastern, Hume, Western (*skills development only*), Grampians)

Local Government based family services deliver the assessment and skills development service. (Barwon South West)

Despite this variety in service delivery frameworks and sites, the actual components and overall service delivery process are similar between services, as will be shown in the discussion of the service delivery process. Some of the differences between PASDS simply reflect the differences in the type of agency delivering the PASDS. The selection of these services was regionally driven and this is consistent with the need for the program to reflect regional priorities.

2. Funding and Targets

Since services started at different times, and some have experienced changes, it is not possible to compare them all in terms of targets and performance since inception. The following table, for one year only, provides an indication of the variations in targets and configurations referred to above.

Table 1: Funding Levels and Placement Targets for PASDS July 1999–June 2000

Region	Funding Level (\$)	Residential	In-Home Support	Annual Target*	Agencies Used To Deliver PASDS
Eastern	392,700	30 places	20 places	50 places	Canterbury Family Centre** O'Connell Family Services
Northern	523,500	30 places	54 places	84 places	Queen Elizabeth Centre QEC†† Outreach Canterbury Family Centre (until Sept'99)
Southern	618,600	60 places	70 places	130 places	Queen Elizabeth Centre QEC Consortium Anglicare, Southern Family Life, City of Port Phillip, Windermere Child & Family Services.
Western	430,200	35 places	29 places	50 places	Tweddle, QEC, 'Connell, Anglicare, Abercare, Centacare, MacKillop
Barwon South West	234,200	10 places	20 places	30 places	City of Greater Geelong Warrnambool City Council
Hume	195,000	12 places	20 places	32 places	QEC Wangaratta Goulburn Valley Family Care
Gippsland	204,900	12 places	32 places	44 places	Queen Elizabeth Centre QEC Outreach
Grampians	159,300	N/A †	N/A	40 places	Ballarat Child & Family Service QEC
Loddon Mallee	Fully funded for 2000–2001			Currently case by case	Queen Elizabeth Centre

*Some families receive more than one unit of service.
** Canterbury Family Centre is now known as Uniting Care Connections.
†N/A = Not Available
†† QEC = Queen Elizabeth Centre

Table 1 indicates the degree of regional latitude in designing PASDS as enhancements to existing services, given that the PASDS initiative was a new idea and agencies were invited to submit their own designs for such a service. On the raw targets, the anticipated average price per case varied from approximately \$3800 to \$8600, depending on existing agency infrastructure (some of which was already funded from other sources within the Department of Human Services), expensive residential costs, and other components. The Child Protection and Juvenile Justice Branch is undertaking a separate costing exercise in an effort to gain more clarity about actual costs and comparability in the process of resource allocation. That costing process will need to factor in the status of the funding as service enhancement monies, rather than funds for full new program development, and by the variable models of service delivery, staffing and so on, which will be discussed throughout this report.

The present evaluation report does not attempt to do this costing work, but the evaluation team recognises that further clarity about cost and price is as necessary a prelude to any cost-benefit analysis as the program descriptive analysis presented here.

In discussion with PASDS providers it became apparent that the funding available for PASDS did not always cover all the costs involved in running these services. One provider stated that the only reason the current funding covered the costs of running the PASDS was because the program did not meet its targets. There may be some mismatch of expectations over the purpose of funding, given that PASDS providers express such concern while Department personnel suggest that a fully funded new service was never the Department’s intention.

Given the insecurity of the current funding within a number of Regions (funding is being provided to services for a maximum of six months at a time), and the interim nature of funding arrangements, many provider agencies expressed doubt about the viability of continuing to provide a PASDS. It should be noted that funding is secure to the Regions. The insecurity is in Regional funding to the specific services. The provider agencies argued that the delivery of a PASDS requires a considerable amount of expertise, which, in turn, involved additional staff training and, in some cases, a culture shift within agencies not familiar with working with child protection clients.

In a series of interviews conducted with the HRI teams within the Child Protection Service, one Region identified the throughput achieved by PASDS as a minor concern. The number of families receiving a PASDS in most Regions was consistent with, or slightly below, the targets established. HRI managers were asked to provide additional information on the gap between funding targets and actual referrals. At this stage only two Regions responded to the request for additional information, so it is difficult to draw any definite conclusions regarding throughput from this data. At present, most Regions that are not fulfilling targets do not identify this as a particular problem. Rather they reported it to be part of the adjustments necessary in implementing such a complex program that is also intended to be flexible and tailored to client needs.

Recommendations:

That the reasons for the gap between targets and referrals are explored in more detail and adjustments made to the annual targets set in the funding agreements with PASDS providers, where appropriate.

That any formula for funding PASDS ensures flexible delivery alongside stable service structures and encourages service development.

That PASDS funding occurs across a longer-term cycle than at present, enabling proper recruitment, training and retention of staff within programs and the development of ‘best practice’ service delivery models.

2.1 PASDS Delivery Models

2.1.1 Residential

As noted previously, the establishment of residential PASDS has been taken up by existing agencies that provide services for families experiencing difficulties with parenting. There are three agencies that provide residential PASDS in the metropolitan area. These are the Queen Elizabeth Centre (QEC), O’Connell Family Services and Tweddle Child and Family Health Service. The focus of the residential PASDS is to provide an assessment of parenting capacity. Low intensity skills development occurs as part of identifying the ability of parent/s to learn and maintain knowledge regarding parenting skills. Western Region is in the process of establishing a specialist residential service within a local drug and

alcohol service for assessment of parents with drug and alcohol problems.

The duration for which the residential PASDS is offered depends on the capacity of the PASDS provider. The residential assessment provided by the QEC and Tweddle occurs for 24 hours, across ten continuous days, whereas O’Connell Family Services can only operate a residential 24-hour service across five days, Monday–Friday, because the service closes on the weekend. In order to provide a comprehensive parenting assessment, most clients who attend O’Connell require two weeks of service provision, making it a ten-day program. Care arrangements have to be organised across the weekend period for these families, creating a break that can often disrupt the learning process, although O’Connell’s partnership with Uniting Care Connections makes intensive weekend support and supervision possible in Uniting Care Connections’ own facilities.

A regionally-specific residential program has been developed by Barwon PASDS based at the City of Greater Geelong and the Geelong Hospital. The City of Greater Geelong feeds most of its residential PASDS through a unit within the Geelong Hospital and stays at the unit usually last between five to ten days. The Barwon PASDS coordinator works with local paediatricians to gain access to a bed within a special parent-child unit at the hospital. This residential facility is used only when the work involves a newborn infant and there is need for 24-hour supervision.

QEC is used by a number of Department of Human Service Regions including Southern, Hume, Northern and Gippsland. Tweddle is used primarily by Western Region, although it is hoping to extend its reach into other Regions. O’Connell Family Centre is used exclusively by Eastern Region. In principle, Uniting Care Connections also has the capacity to provide a residential service but the staffing model does not at this stage allow for routine 24-hour supervision. Western, Eastern and the Grampians Regions have used QEC to absorb any overflow of referrals within the Region. Brokerage funds are used to purchase these additional places.

The QEC and Tweddle residential models are similar. They include 24-hour stay across a minimum of five days and maximum of ten days. Most clients, unless

they leave the program, receive a ten-day program. The ten-day program is provided only to PASDS clients and provides the time necessary to carefully observe parenting practice, assess areas of strength and greatest need, implement a small scale skills development plan and assess the progress of the parenting practices of the families. The Department of Human Services is provided with a comprehensive assessment report within 21 days of the client receiving the service.

The format used in the assessments undertaken by QEC is the **Queen Elizabeth Centre Parenting Competencies Assessment Instrument (QECPCAI)**. Assessments developed using this instrument explore parenting competence across four dimensions: physical health and wellbeing; emotional development; cognitive or intellectual development; and social development and environmental awareness. Tweddle has developed an instrument that is based on the QEC model and assesses parenting across the same domains. A more comprehensive description of assessment tools is provided in a later section of this report.

At Tweddle, QEC and O’Connell, the ratio of PASDS clients to other families is kept at 20–25 per cent. This has been established as a reasonable balance to ensure an appropriate level of care for non-PASDS families using the facilities. This ratio also provides the opportunity for a normalised experience for PASDS clients whilst in the program, encouraging them to interact with other families, rather than isolating them. PASDS families usually receive a higher level of one-to-one care from the staff, and efforts are made to ensure that each family has continuous relationships with particular staff to facilitate the development of trust, to focus the transmission of learning, and to provide reliable and systematic observation for assessment purposes.

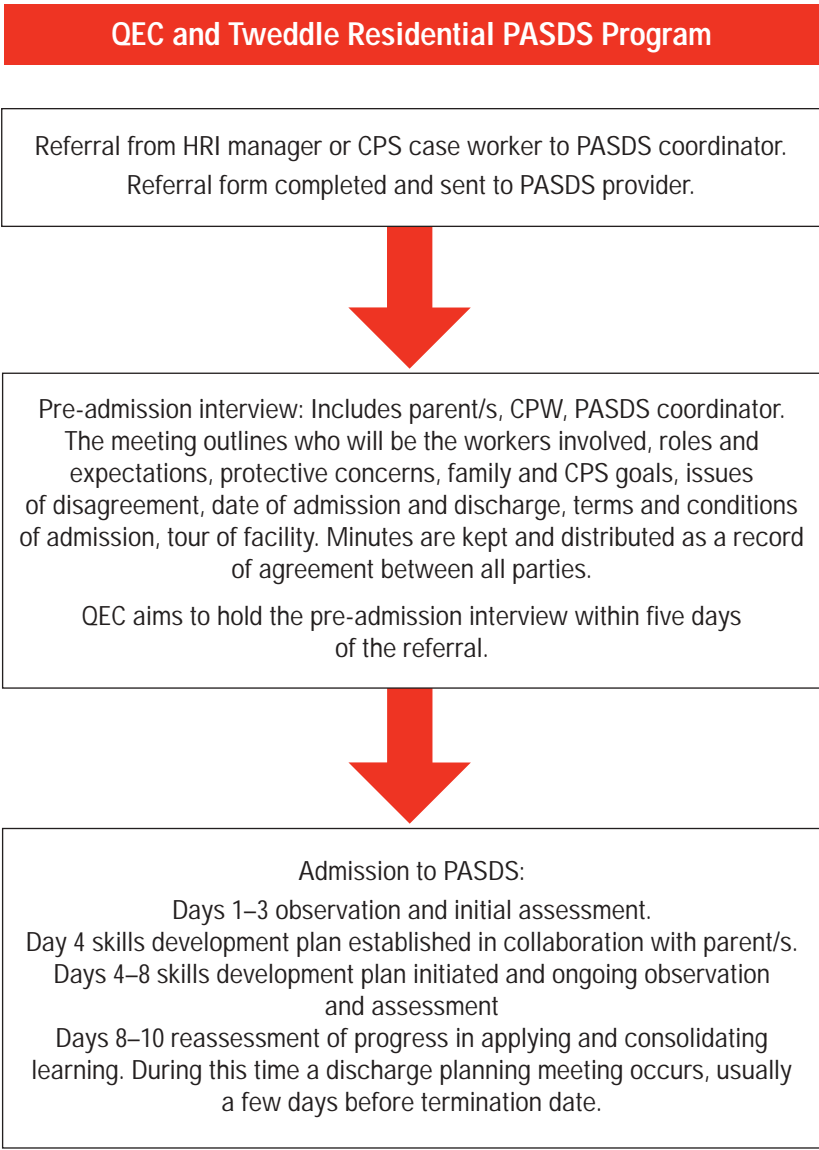
The residential services combine private family space and public spaces, allowing for private interventions with families (for example, feeding and settling the baby) and shared interventions, such as play sessions, peer discussions and formal and informal information giving. PASDS families are encouraged to participate in some of the group activities undertaken with other parents. While residential settings simulate the home and allow for intensive observation and skills practice in the simulated environment, families are relieved of

many everyday home care responsibilities in order to focus on the parent-infant interaction.

At Tweddle, QEC and O’Connell, eligibility/suitability criteria apply to families entering the program. Agencies require participants to be drug and alcohol free during the period of residency, insist that the

actions/behaviour of PASDS parents must not threaten the wellbeing of residents or staff and that families agree to participate fully in the program whilst they are at the Centre.

The typical pathway of families through the residential programs is as follows.



Recommendation:

That it is recognised that practice experience indicates the need for a ten-day residential program. Some time and resources need to go into establishing the rationale of the need for the ten-day PASDS, developing a best practice model and implementing this across delivery sites.

2.1.2 Day-Stay

Day-stay PASDS are most consistently used in the Barwon and Grampians Regions, though the Hume Region arrangements with Goulburn Valley Family Care allow for some use of day-stay. This development is the result of the PASDS providers in those Regions having established day-stay facilities and programs that can be used for PASDS clients. Day-stay is used by PASDS primarily for assessment purposes and usually with cases involving reunification or where the home environment is too chaotic for effective learning to take place. In discussion with these providers they identified the program as being a ‘holding place’ and were eager to transfer clients back to their home environment as soon as possible, believing that the gains were more realistic if achieved in the client’s natural environment. If a family were to go on and receive skills development with either of these providers, they would be transferred to the home environment. The assessment undertaken during the day-stay PASDS usually occurs across a two to three week period, with up to 12 hours of contact each week.

It appears from the limited information available with respect to the sample of PASDS cases studied retrospectively for this evaluation, and from Regional consultations for the earlier HRI Evaluation, that rural Regions may resort to placing high risk infants in substitute care because of problems in providing supervision during the early stages of intervention. Rural Regions, therefore, appear to use PASDS slightly more often for reunification than metropolitan Regions (11/23 for rural Regions compared with 10/28 for metropolitan, in the retrospective sample). In this context, day-stay centre-based services offer an important option for rural Regions.

The Western Region Child Protection Service and Tweddle have developed a specific day-stay PASDS program with a focus on providing a bridge into the usual PASDS. At Tweddle, the day-stay program

targets parents who are negative about receiving a PASDS, with the aim of assisting in the transition of these families into an existing PASDS program. The Tweddle model allows for six episodes of contact and these may be for any length of time.

Centre-based day-stay programs also have the capacity for families to interact with, and learn alongside, other families where this is seen as desirable, such as in situations where it is important for a parent to learn that others face similar challenges.

Recommendation:

It is suggested the potential of the day-stay programs may be underdeveloped. Some time and effort needs to go into establishing the relative benefits of existing residential or in-home modes of delivery, against the comparable benefits of a day-stay mode of delivery.

2.1.3 In-Home Assessment and Skills Development

In-home PASDS are provided by a range of agencies across the State. The establishment of in-home PASDS has been regionally driven. A competitive tendering process was entered into within most Regions and the services currently delivering in-home PASDS were the successful applicants. For this reason, and because the funding was designed to enhance the capacity of existing services to meet the needs of high risk infants and their families rather than to create new services, there are differences in the configuration of these services. Each service tends to reflect the dominant theory base, practice approach and service arrangements of its host service. Despite these differences, most services use a similar model of service provision, by providing in-home skills development for a period of hours across a number of weeks. The actual formula used at the different PASDS will be provided in more detail in the following section.

The basic in-home PASDS delivery arrangements are as follows:

- Lead Early Parenting Centre (QEC) alongside a consortium of local family support agencies, providing assessment and skills development. (Southern Region)
- Lead Early Parenting Centre (QEC) agency delivering outreach services via locally based MCH centres, providing assessment and skills development. (Northern, Gippsland, Hume)

- Community-based family support agencies delivering the assessment and skills development service. (Eastern, Hume, Western—skills development only, Grampians)
- Local government based family services delivering the assessment and skills development service. (Barwon South Western)

Although there are some interesting differences between the approaches of the various PASDS providers, the basic structure of the program is similar across Regions and services. All Regions except Western (which arranges its assessments in a variety of ways) currently provide in-home assessment as well as skills development. The assessment component of the in-home PASDS usually takes place within the first weeks of service delivery. This usually involves three to five days of contact across a one to two week period at varying times in the day. The assessment period is largely a time of observation with some low intensity, incidental skills development.

Each program also provides skills development packages that occur across at least 12 weeks. The regularity and intensity of service delivery will depend on the family’s needs and the number and range of skill areas being developed. The range of contact mentioned in interviews with PASDS providers was anything from one hour a week with a family to four or five hours spread across the week. It was usually suggested that family contact is more intensive in the early stages, and tails off over time as skills are consolidated. It should be noted that in rural Regions the hours spent on a family include time travelling to and from the family.

- The key features of the in-home PASDS are:
- Careful monitoring of referrals into the program by HRI managers and the PASDS. Only families about which there exist clear questions regarding **parenting capacity** will be referred into the program.
 - Most agencies have developed service delivery models that integrate early childhood and family welfare approaches. This is reflected in the assessment frameworks used and staffing of in-home PASDS, which draw on bodies of knowledge from MCH nursing and child care and development as well as social work-influenced family preservation and family support.

- Program frameworks that are flexible, with the intensity and duration of service delivery determined according to family needs.
- An assessment process that is based on careful observation, is transparent, strengths-based and emphasises meeting the needs of the infant as primary.
- The implementation of a collaborative approach to goal setting with families.

As with residential services, not all families who undertake an assessment service receive skills development.

2.2. Process of PASDS Delivery

In-home PASDS program development and design varies between Regions. The following profile provides an overview of the programs provided by the selected agencies within each Region.

2.2.1 Referral Process—Regional Maps

Referrals into the PASDS program are regionally determined. The referral maps below each regional design profile provide an outline of referral pathways across each Region. There are two levels of gate-keeping that occur before families enter PASDS. First, within the Child Protection Service the HRI manager or SIPW is responsible for assessing the suitability of a family to receive a PASDS. The primary criterion used in this judgement is the presence of questions regarding a family’s competence to parent a child. The PASDS provider also applies its’ own eligibility criteria.

Although there is regional variation in who contacts the PASDS provider, all referrals have been checked or discussed with the Child Protection Service HRI team. Some Child Protection Service units have SIPWs working directly with these families and others use them in a more consultative and coordinating capacity where they are checking and guiding the work of generalist protective workers with high risk infant cases. (See *HRI Final Evaluation Report, November 2000.*)

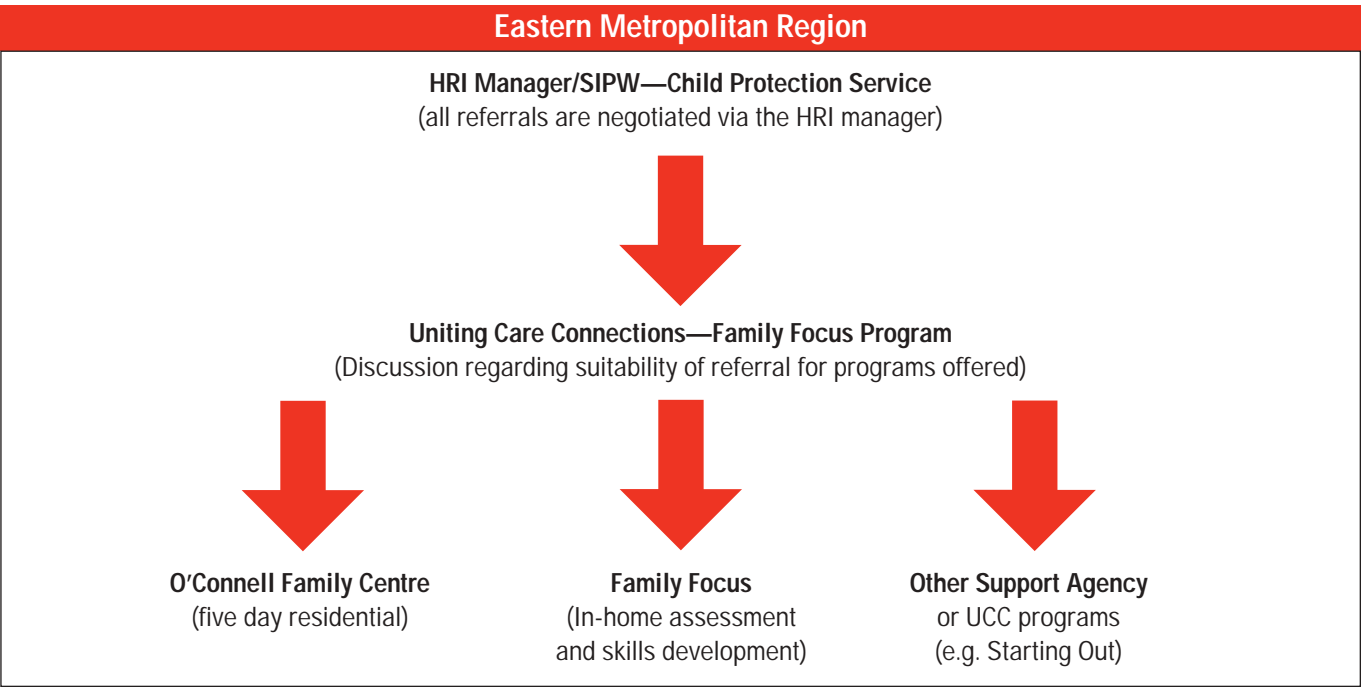
Eastern Metropolitan Region

The in-home PASDS is delivered by Uniting Care Connections–Family Focus program.

In-home PASDS are delivered by a caseworker and a family care worker within the Family Focus program. This program has a history of intensive therapeutic and practical assistance to high-needs child protection clients within a family preservation services conceptual framework, using a team approach and very low caseloads. The workers delivering the in-home PASDS, both assessment and skills development, are the same workers who normally deliver the family preservation service within the agency. The PASDS can provide up to 30 days assessment and 30 days skills development.

The frequency of visits across the 30 days depends on the needs of the family and the level of supervision required. Not all families receive the skills development component of the program.

The program is staffed by case workers who have been trained in social work and/or welfare studies and by experienced trained family care/child care workers with a variety of post-qualifying training. If a specialist infant health assessment is needed, a Maternal and Child Health Nurse is accessed via brokerage to provide an assessment of infant health, and staff consult with the nurse as necessary.

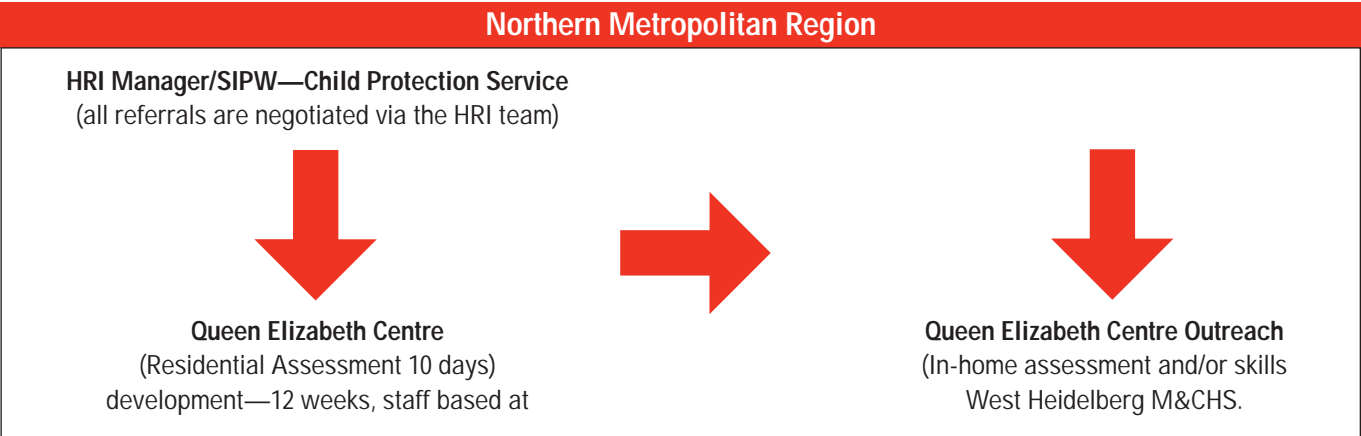


Northern Metropolitan Region

The in-home PASDS is delivered by a QEC outreach team based at West Heidelberg MCH Centre. A team of two Maternal and Child Health Nurses and two early childhood workers (previously known as mother craft nurses) staff the program. The assessment and skills development plan is undertaken by the Maternal and Child Health Nurses with early childhood workers providing observations for the assessment and being

responsible for the implementation of the skills development plan.

The PASDS program is normally delivered across 12 weeks. The intensity of service delivery varies depending on each family’s needs. Ten to 12 families are worked with at any one time. This is the equivalent of one referral each week from the Region. This number of clients is consistent with the regional targets.



Southern Metropolitan Region

A consortium of agencies provides the in-home PASDS in the Southern Region and it is coordinated by two part-time Maternal and Child Health Nurses located at QEC. QEC acts as the lead agency in the consortium. Agencies providing family support programs to various parts of the Region have been included as partners in the consortium. These agencies are City of Port Phillip Child and Family Services, Southern Family Life, Anglicare Frankston, Windermere Child and Family Services.

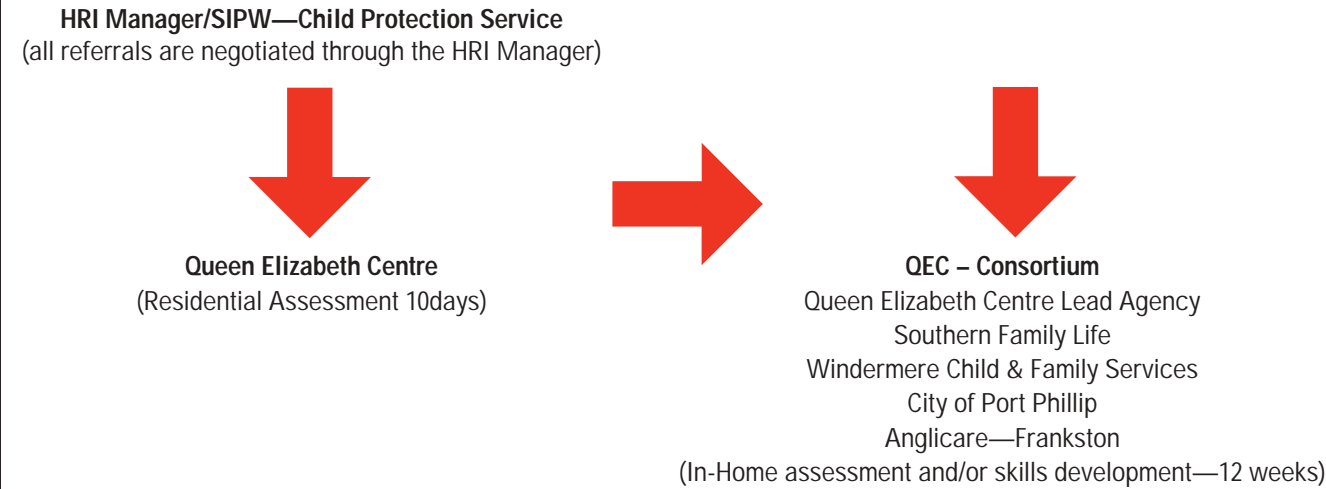
Within the consortium model, parenting assessment is undertaken by the QEC based coordinators and early childhood workers. If families go on to receive skills development, early childhood workers and family support workers from the consortium agencies provide ongoing support. There is a possibility for the family to receive ongoing support from a family support program within the consortium agencies. The need for this is established and organised towards the end of the PASDS program.

Typically the program runs across 12 weeks. Approximately four weeks are used for assessment and the establishment of a skills development plan for the family. The assessment process is intense for the first weeks with workers visiting clients four to five times in the week. During this period the family is introduced to the family support worker and early childhood worker who will be responsible for the implementation of the skills development plan. A formal review of the work with the family occurs at week ten and the PASDS is normally completed by week 12. The length of the program often varies from the 12 weeks; it is either interrupted or can be extended if the need is present and all parties agree.

The staffing of these PASDS integrates the Maternal and Child Health Nurses and early childhood workers based at QEC with welfare trained workers, in the family support teams, at the consortium agencies. This is a complex staffing framework.

QEC, the HRI team in Child Protection and the consortium agencies have put time into developing a set of protocols and service delivery standards, in order to ensure equity in standards of service delivery is maintained across the range of agencies.

Southern Metropolitan Region



Western Metropolitan Region

The Western Metropolitan Region uses Abercare Family Services and Anglicare (Werribee) to deliver in-home PASDS. These services provide in-home skills development only to PASDS clients, although they have both assessment and intervention roles with other families referred by Child Protection Service or through other channels. Both organisations have a program coordinator and team of in-home support workers who provide family support and family preservation services within the agencies. PASDS referrals are given priority into the existing family support service. In-home PASDS are currently purchased from these agencies in blocks of eight to ten families.

The skills development program at both services runs across 12 weeks with up to 20 hours of service delivery time for each client in any one week, although this does include travelling and administration time. Given that the services are requested to provide only skills development, they do not provide a routine formal parenting assessment, although both services undertake an assessment of family needs to guide their work with the family.

These services are staffed by workers trained in social work, welfare studies or family support.

Western Metropolitan Region

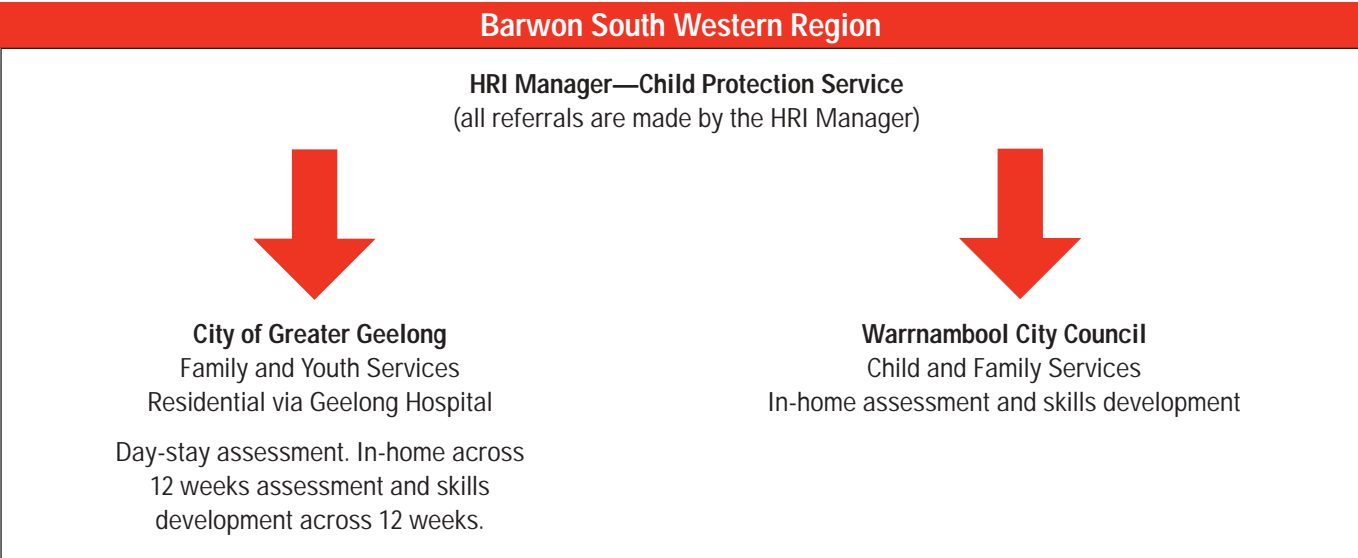


Barwon South Western Region

A tender process was undertaken in Barwon and the City of Greater Geelong (COGG) and Warrnambool City Council (WCC) were the successful applicants. Separate PASDS were developed in both regional centres, under the auspices of the local council family services. Warrnambool did not commence taking PASDS referrals until November 1999 and has incorporated many of the systems and processes developed and implemented by the Geelong PASDS. COGG can offer residential, in-home or day-stay assessment. All skills development is undertaken in the home. Warrnambool PASDS is only set up to deliver in-home assessment and skills development.

The PASDS program provided by both services occurs across 12 weeks. The first three weeks are spent assessing the family and the following nine weeks are spent implementing the skills development plan. The intensity of service provision across this 12-week period depends on the family and their needs, and the travel time involved in reaching more remote parts of the Region.

The PASDS coordinators are trained Maternal and Child Health Nurses; other program workers have early childhood worker training.

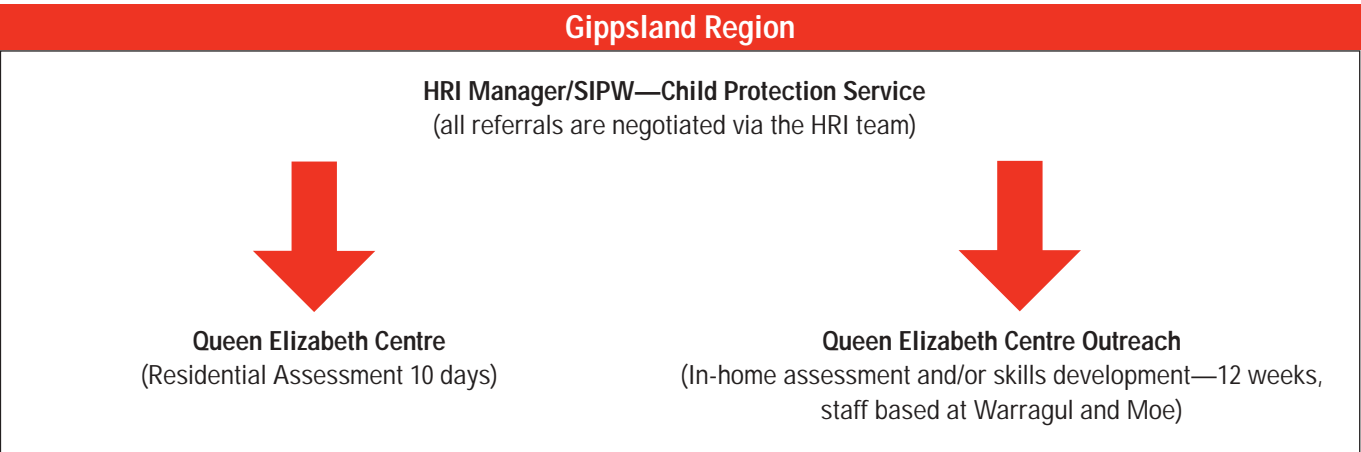


Gippsland Region

The model of in-home PASDS implemented in Gippsland is a QEC - outreach model.

QEC manages the program with outreach teams based at regional MCH centres in Warragul and Moe. The service is staffed by two coordinators and early childhood workers and these four part-time workers service the region. The coordinators are trained Maternal and Child Health Nurses with Early Childhood Workers providing much of the hands on work with families.

The PASDS offers a 12-week program with a varying intensity of contact across the 12 weeks. The assessment component of the service is undertaken in the first few weeks of contact. The intensity of service delivery is based on consideration of the families’ needs and the travelling necessary to reach more remote clients.



Hume Region

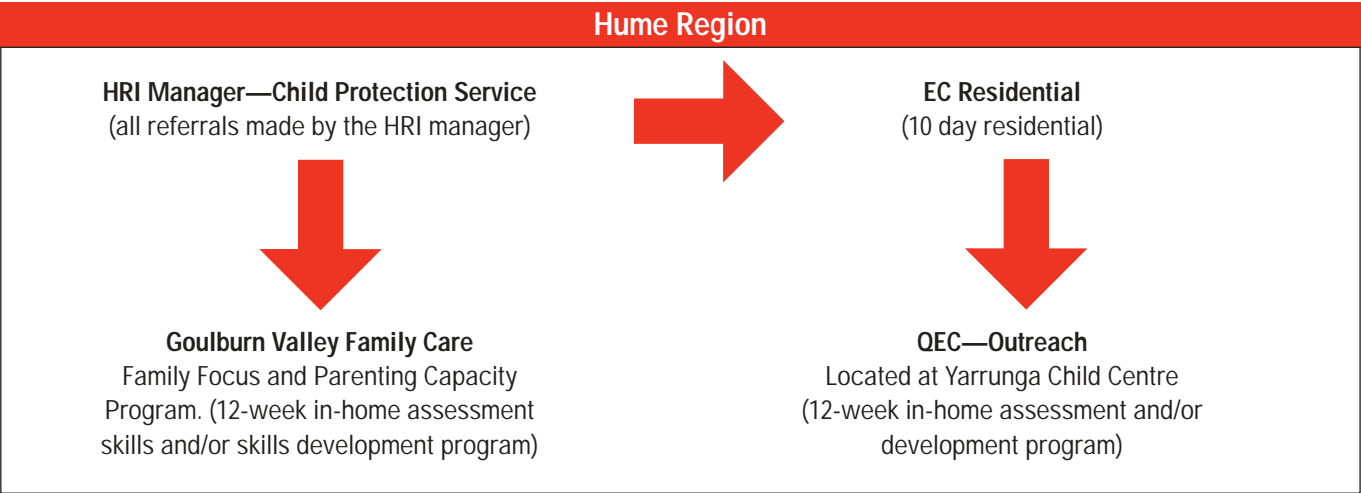
Hume Region is organised around two geographical areas, with quite distinct agencies delivering the PASDS in each area.

In the east of the Region, a QEC outreach model is in place, with the coordinator based in Wangaratta, working with two other Early Childhood Workers. The coordinator is a trained Maternal and Child Health Nurse and her work is supported by two Early Childhood Workers. The model in operation is similar to other QEC outreach services—a 12-week program with varying intensity of contact across the 12 weeks and assessment occurring in the first weeks of contact.

Goulburn Valley Family Care (GVFC) serves the western part of the Region. GVFC has an integrated model of MCH and family support working from within their Family First and Parent/Child programs. The Families First preservation program targets child protection service clients, while the parent/child

program is a more widely accessible day-stay parenting service. The integration of PASDS clients into these programs has provided these clients with access to a 24-hour, on call service and telephone counselling service. The PASDS provides a combination of a three-week assessment program and, if appropriate, a 12-week skills development program. GVFC receives additional funding from the psychiatric and disability sectors to provide a PASD-like service to infants and families referred directly from those other services systems, rather than via the Child Protection Service HRI program. We would suggest that Department of Human Services investigate the feasibility of transfer of this service funding approach.

Workers within the Family First program are primarily welfare trained with the parent/child program coordinator being a trained Maternal and Child Health Nurse. They may work with a family either simultaneously or sequentially depending on the needs and circumstances of the case.

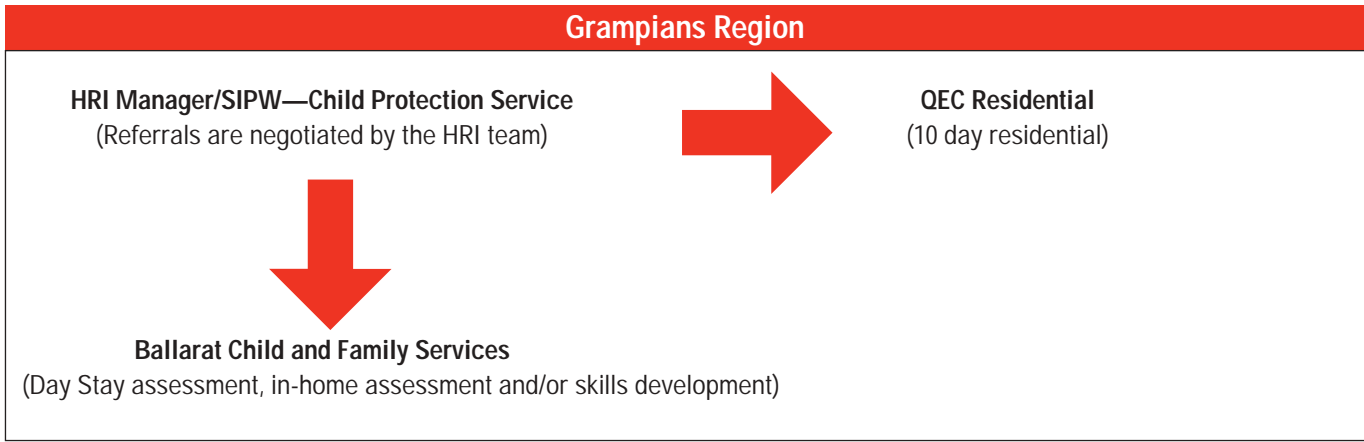


Grampians Region

The PASDS in the Grampians Region is provided by Ballarat Child and Family Services (BC&FS), an agency that has a broad protective and community client base. The program is run from the day-stay facility belonging to BC&FS. The service is staffed by a PASDS coordinator and two Early Childhood Workers.

Parenting assessments usually occur across the first six sessions. Skills development can occur across a 13–20 week period with varying intensity.

The workers employed by the service are trained as Maternal and Child Health Nurse, primary teacher and probationary psychologist.



2.2.2 Timing of Referrals

The point in the protective process where families are referred to a PASDS varies. Some Regions use the PASDS to provide early intervention, including immediate postnatal service provision. This normally occurs with women who have had previous involvement with Child Protection Services or where a family is identified as having a number of risk factors present at the time of notification.

Most assessments conducted by the PASDS, particularly residential assessments, are provided within the period of 90 days allowed the Child Protection Service for investigation and case resolution without Court action. These assessments are used to inform Child Protection Service of the level of parenting capacity and the ability of the family to care adequately for the infant. The recommendations are then used to inform any Protection Application the Child Protection Service makes to the Children’s Court. The skills development component of the PASDS is primarily accessed for preventive purposes, to provide support to families to keep their children at home and increase their parenting capacity. PASDS skills development is used only after parenting has been assessed generally as adequate, but there may be

some specific areas of skills development required to keep the baby safe. All skills development programs are delivered in-home.

Families can also be referred to PASDS in cases of reunification of an infant with his/her parents after placement. A family may be receiving either an assessment or skills development service in these cases, although it would be unlikely that this PASDS would be provided in-home, since the aim of the service is to facilitate a cautious transfer from one environment to the other.

PASDS providers identified that the best time to deliver the service is when the family is willing and ready to receive it.

Some referrals are court-directed when the magistrate is of the view that a PASDS would inform the court or would be an appropriate response to the infant’s needs.

2.2.3 Accessibility of PASDS

The experience of most Regions, is that access to PASDS places has not been a significant problem. PASDS clients are given priority access into programs. There have been delays of up to a few weeks but this

is more the exception than the rule. Longer waiting periods for in-home PASDS are more likely in remote rural areas. Most Regions experience an unpredictable pattern of service demand, which sometimes results in some juggling of places or waiting times of up to a few weeks. This is also affected by the limits of the PASDS provider regarding taking on new referrals and the preference of the family. For example, Northern Region finds most of its clients prefer to receive the in-home PASDS and, while there may be some residential places available, families would prefer to wait and receive PASDS in-home.

In summary, we believe that the gate-keeping process is key to ensuring that families who are most suitable receive PASDS. This process is best brokered by the HRI manager or SIPW. Referral into the program and the timing of this is critical to successful interaction between PASDS and the family. The PASDS needs to be delivered when the family is open to learning and this is affected by family willingness and environmental pressures.

2.2.4 Pre-PASDS Interview

All PASDS, whether delivered residentially or in-home, involve a preliminary meeting between the family, the PASDS provider and the Child Protection Service. Typically, at this meeting the following matters are discussed and clarified:

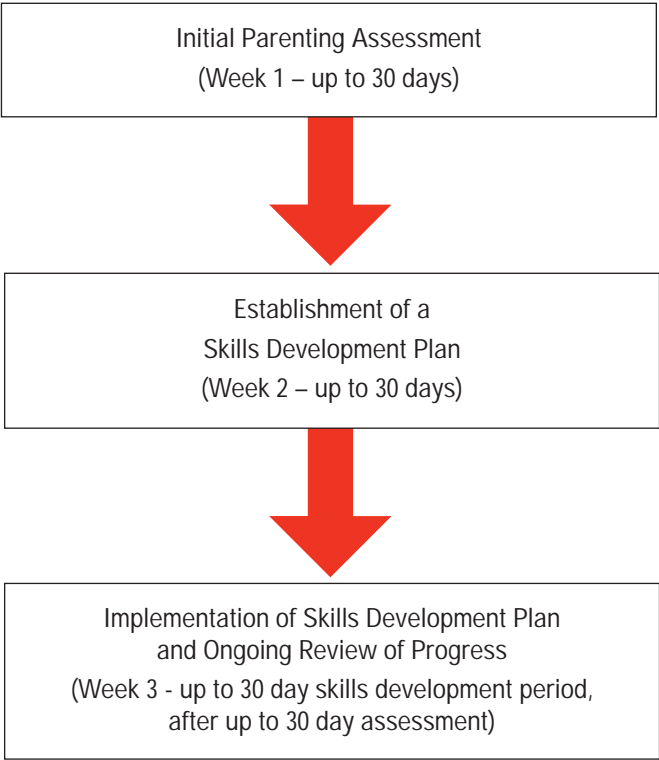
- The role of the PASDS.
- The protective concerns in the case.
- Support people or services who are involved with the client.
- Clarification of the goals for admission by various players.
- Issues of disagreement.
- Identification of any special conditions.
- Clarification of any legal orders applicable in the case.
- Date of entry into PASDS program or next visit.
- Explanation of conditions for service provision, if appropriate.
- Some services invite the client to sign a contract at this point.
- At residential services the client is taken for a tour of the facility.

Minutes of this meeting are taken and distributed to all players as a basis for the work to be undertaken and service provided. This meeting provides a critical

forum to outline the function of the PASDS as separate from the Child Protection Service. The pre-admission meeting or initial contact meeting is a key to PASDS providers gaining the confidence of the family and encouraging their use of PASDS.

2.2.5 Flow Chart of Service Delivery Components for In-Home PASDS

The following description summarises the dominant in-home PASDS model. The process that occurs in the residential PASDS has been described in a previous section.



The range of time across which assessment and skills development occurs varies considerably between and within agencies. The differences are the product of the following factors:

- Differences in agency type and philosophy.
- The needs of the particular families worked with.
- The structure of the PASDS program and its impact on the framework for service delivery.

Within all services, the goal setting with each family is undertaken in an open and collaborative manner. The assessment process is also transparent with the family

familiar with the assessments being made by the PASDS workers. Many PASDS providers believe that the acceptance of their reports at court, by all players, is the direct result of the transparency of the assessment process.

No information was available to determine if the length of an intervention influenced the outcomes for families. This, and the different interventions used by agencies, are important areas that need to be researched across the life of the PASDS.

Recommendation:

A careful study of the effectiveness of interventions be undertaken to establish the elements of service delivery important to the production of positive outcomes.

2.2.6 Assessment Frameworks and Tools

Although the formal documented assessment frameworks differ between agencies, the areas assessed are similar. The main tools used in the assessment of parenting competence, by all providers, are observation and direct questioning. In some cases this was supplemented by a specific test regarding a parent's cognitive ability or mental health. Brokerage funds were often accessed to provide these additional specialist assessments.

Across all assessment frameworks used by PASDS providers the following items are assessed. The *emphasis* placed on particular items varies depending on the philosophy and approach of the agency.

1. Physical Health and Wellbeing of the Child

- **Nutrition/feeding:**
The parent understands the nutritional needs of an infant and is able to feed the infant appropriately and adequately.
- **Hygiene:**
There is a 'reasonable' level of hygiene maintained for the infant and within the infant's environment.
- **Safety:**
The parent understands the safety issues appropriate for the age and developmental stage and the parent initiates safe practices with

the child. The parent shows recognition of the signs of the infant being unwell and responds appropriately.

- **Sleeping, resting and settling:**
The parent demonstrates an understanding of the appropriate sleep requirements of the child and can establish a manageable sleep routine for the child. The parent is able to demonstrate the ability to settle the child during the day.

2. Social and Emotional Development (Including Parent/Child Interaction)

- The parent demonstrates a caring and protective relationship with the infant.
- The parent demonstrates ease with close physical contact with the infant.
- The parent can initiate contact between the infant and other adults and/or children.
- The parent and child respond to each other in a way that indicates an attachment/bond has been developed.

3. Cognitive and Intellectual Development

- The parent talks appropriately with the child.
- The child has age-appropriate play and learning experiences.
- The parent demonstrates that she/he can identify inappropriate behaviour when it occurs and respond appropriately to it.
- The parent demonstrates that she/he can teach the child how to deal with and solve problems (older infant/toddler).

4. Environmental Awareness

- The parent demonstrates she/he can identify what is needed for taking a child on an outing.
- The parent can identify two sources of social support, one of which is available to assist the parent in crisis situations and after hours.

The fact that the assessment is based on careful observation of parenting alongside verbal accounts from parents has enhanced the objectivity of the tools used, although there is still a considerable level of interpretation involved in determining the "adequacy" of parenting practice. In most of the assessments, the above areas are assessed using specific indicators and judging the level of adequacy that the parent displays.

Defining 'Adequate' Parenting

Adequate' is defined in the following way by QEC and appears to be implicit in the assessment systems of other providers:

The parent demonstrates parenting competencies to a level that is equal to an 'average' parent's understanding and practice of parenting behaviours that ensures the child is nurtured, protected from preventable injury and illness and that normal developmental progress is enabled.

The extent to which the concept of adequacy is standardised varies between staff within agencies, but all agencies rely heavily on the clinical judgement of staff, drawn from their experiences in both generalist and specialist roles. Maternal and Child Health Nurses, in particular, base the confidence of this clinical judgement in their professional standards and (usually) in their exposure to a wide range of families in the universal MCH service.

Additional Assessment Foci

Other information gathered by some PASDS providers includes:

- Any immediate risks to the child.
- The learning ability of the parent, any impairment.
- The mental health status of the parent.
- Family relationships and significant relationships outside the family; how they function and how they can assist in supporting the family.
- The history of abuse or neglect in the parent's family.
- Cultural influences on the family.
- Any traumatic events in the family's life that impact on ability to parent.
- Linkages the family has into their immediate community and the broader social service sector.

Comparison of Use of Assessment Tools and Frameworks

The variation between the documented assessment frameworks and tools is substantial. The evaluation team compared the materials provided by the major providers who undertake assessment—QEC, O'Connell, Tweddle residential services, Barwon South West, Uniting Care Connections and BC&FS as examples of services providing assessments in home and in centre-based and residential settings in some

instances). The comparison exercise found great variation in layout and how items were grouped.

A review of categories against the framework proposed by Littlefield et al. in the *High Risk Infants Parenting Assessment and Skill Development Research Project* (1999: 48) shows how the programs share the basic parenting skills assessment framework, but differ in the level of specificity with which those areas are documented and performance is 'measured' or rated according to level of adequacy. Even though all agencies base their assessments on intensive observation, the programs with the strongest MCH nursing presence are those with the strongest attention to detailed observational records of actual parenting practices, reflecting the profession's commitment to evidence-based practice. Assessments by agencies with a strong Maternal and Child Health Nurse presence produce strong reports about actual parenting practices in given circumstances and the extent to which parenting competence is demonstrated over a series of repeated observations.

The programs also vary in the level of attention their PASDS assessment frameworks pay to the dynamic and contextual variables that influence the development and application of those parenting-child care skills. The programs coming from the mother-baby residential tradition tend to have more focussed and formal skills ratings. Those with a stronger in-home responsibility and/or located in more general family service agencies with a wider mix of staffing qualifications and experience (see the section "Staffing PASDS's" below), tend to include a wider range of variables in their assessments, though they may be less routine in the way these are documented. They also appear to draw on a range of frameworks and tools according to the case and the circumstances of the request for assessment, and appear (given their 'in-home' role) to pay a little more attention to house-keeping/material provision for the baby.

The Grampians Region BC&FS program assessment framework appears to have a strong orientation to learning and the application of learning in the daily environment, integrated into the assessment framework. The Uniting Care Connections framework emphasises both the social and physical environment of the family, and the dynamic interactions between parent/s and infant and between parent/s and other key family members. It also attends to the quality of engagement between the parents and the workers.

These emphases are not, however, routinely integrated into a single assessment tool. The City of Greater Geelong reporting integrates the skills assessment observations into a picture framed by parental and contextual information.

A major strength of the frameworks is their routine attention to core parent-child interactions and day-to-day parenting responsibilities, providing for what is essentially a parent-infant interactional health and behavioural assessment in the maternal and child health/early childhood intervention tradition.

An important feature of the assessment practices is that, in most instances, the whole framework is followed, rather than the focus being on named problems only. This ensures that families and the Child Protection Service receive feedback about good parenting practices as well as about knowledge and skill gaps and problematic behaviour. The PASDS staff consulted talked of being committed to this strengths perspective. A number of Child Protection Service staff responses to the retrospective case sample study noted that the PASDS assessments were able to identify areas of good parenting practices, and that this was both an aid to decision making and sometimes an important contribution to parental motivation and self-esteem. All PASDS providers identified the need to assess the parent's capacity to learn and retain information as this is critical for the transferability of skills and the ability of the parent to maintain any new learning. This was so even if their assessment frameworks did not contain specific items relating to learning abilities and retention.

None of the frameworks used have been validated across a range of research environments, and none covers all the areas named as desirable components of parenting assessment in the PASDS research commissioned by the HRI project (Littlefield et al., 1999.) Littlefield et al. recommended a framework (1999: 48) that covered most areas that the PASD agencies attended to, but this comparison found that in practice the agencies paid more detailed attention to sleeping and feeding than the recommended framework suggested. The recommended PASDS framework named two areas that were not found in the PASDS documentation:—whether the infant was pre-term; and 'parenting style'. The latter may not be so amenable to specification. It also lacked specific

mention of several factors that more than one PASDS agency routinely includes, notably the parent/s' stress and frustration management approaches, access to social support, the parent-parent relationship, maternal self-awareness (regarding parenting), and the parent's learning style/capacity.

Additional Brokerage Funding

Brokerage money is used by all Regions and services to purchase assessments and services not deliverable from existing services, that is, specialist psychological testing and assessment and anger management classes. HRI managers reported that this was so for seven of the 51 cases in the retrospective case sample, the assessments purchased being psychological, neuro-psychological, drug and alcohol, medical and paediatric. For PASDS programs, if psychological assessments are made *before* the family enters the service, they may assist PASDS staff to tailor the assessment and skills development processes to the parent's cognitive limitations, learning style or personality characteristics. It is unclear at this stage how often this occurs or under which circumstances it is most appropriate, other than in situations of a parent's previously untested apparent intellectual disability or suspected but undiagnosed mental illness.

Some Regions have used brokerage money to purchase emergency residential places for families if there is not space available in services with existing agreements. Access to this flexible brokerage fund to support the work of PASDS by providing additional assessment was considered by almost all stakeholders to be a key component of the success of the program and should continue as a part of the overall HRI funding initiative.

Ready access to smaller amounts of brokerage was also seen as important to the work of in-home PASDS workers, who may need to assist families with practical needs at short notice. A number of issues arise from consideration of the use of brokerage funds. These include:

- The need to be aware that a saturation point may be reached with families in terms of the number of specialists involved.
- The need to be aware in each case of the extent to which change is achievable by parents, and the need to adequately assess capacity to learn as well as absolute levels of attainment.

Recommendations:

That a framework for assessment be standardised rather than a single assessment tool established.

That the assessment process includes items that can evaluate a parent's capacity to learn, maintain information and learning and apply these differentially.

That there be further consideration of where the responsibility lies for integrating motivational and situational assessments into a full biopsychosocial assessment that can contextualise and interpret parenting difficulties and inform planning for work on developing and sustaining parenting improvement.

That brokerage funding is continued as it is key to ensuring flexible service delivery responsive to family needs.

2.2.7 Tools and Processes Used in Skills Development

In the transfer of learning undertaken in the skills development phase the most commonly used technique was demonstration and modelling. In addition to tools drawn from other program areas in agencies (for example, the crisis cards, scaling techniques or strengths cards used in family support and preservation work), PASDS specific techniques used included visual prompts for parents with literacy issues (for example, laminated cards of instructions for bottle preparation and feeding) and some video learning materials. Other processes included conscious self-esteem building in parents through reinforcement. A number of PASDS are involved in ongoing review and adjustment to the skills development process.

All PASDS providers indicated that the success of the education process depends on the establishment of a trusting relationship between the worker and the client. They spoke of the need for honesty and openness in the processes of assessment and skills development, and of the importance of a clear focus on the infant's needs and the skills of child care early in the infant's life, to enable a 'good start' for the family, or at least for this infant in the family. They suggested that with experience they were finding themselves more confident of making a positive difference with those families whose infants were still very young,

before patterns of parenting had become established. Five of the 12 case managers' replies to the retrospective case sample study supported the assessment that trust is important, linking parents' reports that they liked or felt supported by the PASDS workers with their confidence that they had learned new skills.

PASDS workers indicated that a major strength of the service is the flexibility and intensity that allows for different 'windows' on to the family's life at different times of day across several weeks. They work to maximise their impact on key moments in the family's daily life, such as mealtimes and bedtimes. (One HRI manager reported, however, some difficulties in home-based PASDS being able to offer much evening and out-of hours work, for a variety of reasons, including funding, security, and the lifestyles of the workers themselves, who often have their own family commitments.)

A range of other issues was noted by PASDS workers in relation to skills development, derived from their experience with the retrospective case sample. The issues included:

- Difficulty in not crossing over into family support work, exacerbated in situations where, for example, skill development is related to changing and feeding the infant and the parents need assistance to obtain nappies and food from a material aid agency.
- Impact on acquisition of skills or utilisation of skills developed in the program by recurrence or persistence of behaviours and states affecting parenting capacity, such as alcohol and other drug abuse, acute psychiatric episodes, domestic violence or conflict between the parents, unstable housing, and medical needs of the infant.
- Usefulness of sequencing types of skill development, for example, in one case, usefulness of a home-based assessment following residential skill development for one of the parents; followed by home-based skill development for both parents, later supplemented by day-stay assessment and skill development for the mother.
- Ability of parents to self-refer to PASDS for residential admission with siblings of the infant when in difficulty after skill development sessions, due to positive regard for staff and positive perception of gains made.

- Consolidation of gains made in skill acquisition by effective post-PASDS referral and backup. For example, in the case of a single, adolescent mother in a rural area, referral to the Maternal and Child Health Nurse, young mothers group, provision of respite care for the infant, sexual assault counselling and housing.

Agency Accounts of Skills Development

The interplay of parenting skills development interventions and other personal and family interventions is most apparent in the limited detailed case presentations we have from in-home PASDS.

Uniting Care Connections

Uniting Care Connections has also made available to the evaluation team some of their own internal evaluative material. A quotation from the internal evaluator's intensive cross-section of case studies—in the Uniting Care Connections Northern Region PASD prior to the transfer of PASD responsibility to QEC (6 families), and in the Eastern Region Uniting Care Connections PASDS (9 families)—helps illustrate the skills development process in infant work.

Careful infant and infant-mother observations were conducted in every case, and considerable time spent throughout the whole day, so that all daily routines were assessed. In addition to observation, the workers engaged in modelling and teaching around all areas of baby care—feeding, changing and bathing; picking up and responding to the baby's cues in every area of life; play; settling and bedtime routines. Workers also spent considerable time speaking with the child's or baby's voice, helping the parent to see and understand the cues and needs of the baby, thus building attachment of the child to the parent and strengthening the attachment of the parent to the child. In some cases (where the child had not been in the care of the parents) this involved building the attachment of the parent to the child and the child to the parent almost from scratch.

A great deal of careful, intricate teaching and modelling occurred, with the worker showing the parent how to feed, bath, play with and settle the baby. This part of the intervention was focussed on the minutiae of parenting - in a very practical, hands-on way. Through such teaching and

modelling the workers could also assess the parent's ability to learn and enact changes in their care of the baby. Families were assessed and helped by their local Maternal and Child Health Nurse, with Canterbury liaising with the Nurse. Together the social worker, family care worker and nurse combined formal assessment with hands-on teaching and considerable observation of both infant and parent/infant which fed back into the assessment loop. Particular attention was given to the child's development, whether developmental milestones were being achieved, attachment and bonding assessment, assessment of the child's emotional security and parent/infant interaction throughout the day, and covering all aspects of parenting. (Mitchell, 2001)

In this work, the workers used tools such as videotapes of the parents' own good parenting, photographs, play and creating pleasurable mealtimes. In addition to this infant-focussed parent-child work, in the Eastern Region Uniting Care Connections, the internal evaluator found the following interventions with the nine case study families:

- Linking the family to the local Maternal and Child Health Nurse (4 families).
- Referrals for paediatric specialist assessment (2 families).
- Work on the relationship between the parents (5 families).
- Work on the parents' relationships with their extended families (4 families).
- Specific work to link the families into the service system, including ongoing family support services (3 families).
- Intervention to reduce chaotic lifestyles (3 families).
- Financial counselling (3 families).
- Help with housing, with material aid, liaison with drug and alcohol services and work on domestic violence (each given to 2 families).
- Individual adult work with one parent, individual adult work with both parents, crisis management, and grief counselling (each with one family).

In the sample of Northern Region cases, the ancillary work was quite extensive, as these families had multiple problems and serious impediments to responsible parenting. This ancillary work included trying to establish some engagement between the parents and older children in the family; trying to develop the motivation to parent; work on the effect of

the environment on the mother's violence; work on decreasing the mothers' working hours due to prostitution (mothers were tired and unavailable to the infants); modifying behaviour associated with parental mental illnesses (self-harm, bulimia); and moderation of drinking.

Queen Elizabeth Centre Partnerships

Similarly, the Southern Region has made material available through papers prepared for the QEC Conference 'The Early Years' in late 2000. In one paper, Kyrios (the Southern Region HRI Manager) and Nagorcka (the QEC PASDS manager), outlined a case example of a QEC residential assessment, followed by a home-based PASDS from QEC and one of its consortium partners. This involved working on deficient parenting skills identified in the residential assessment: 'nutrition, safety, distribution of medications and difficulty in managing challenging situations and appropriate methods of responding to unacceptable behaviour'. The focus was maintained on parental skill development over a 16-week period of service, while the consortium agency allocated family support worker time to address housing issues and relieve financial anxieties that were undermining the parents' interactions with each other and the child. This account did not detail the use of learning or therapeutic aids and processes.

One interviewee, a working partner, however, spoke of the important distinction between QEC workers' interventions, and the family support-oriented PASDS workers' interventions. The former were described as health-centred and very focussed on infant care, while the latter were described as 'far broader', and included:

- Helping families practice their newly learned skills (for families commonly reported and demonstrated that they had learnt a lot from QEC staff) on a daily basis.
- Rewarding and reinforcing this learning, and building parental confidence and self-esteem.
- Assisting families to structure the rhythm of the week, in what are typically chaotic lives.
- Making connections with community resources, such as toy libraries and child care, through taking parents to the services, assisting them in decision making, and coaching them in relating to staff of these services.

- Encouraging parents to continue learning about child development through direct discussion, commenting on observations, showing and discussing videos, reinforcing parents' own discoveries and learning, providing written materials and illustrations.
- Working with parents to develop informal as well as formal support.
- Engaging the fathers' or mothers' partners and finding out more about the sources and amenability to change of apparent violence or anger problems.

Recommendations:

That suitable learning aids for PASDS providers be made available, such as videos, visual cue cards, games; in addition to a training strategy for their implementation.

That the amount of time agencies have to spend developing their own tools be minimised.

2.2.8 Review and Reporting

For cases involving *assessment only*, whether undertaken in a residential or in-home environment, one report was provided to the Child Protection Service by the PASDS as soon as possible after the completion of the assessment. The actual time varied according to the need for the report. Most reports were written within 21 days of commencing the program. Training and assistance in court report writing has been provided by Child Protection Service to PASDS. Report structures are typically based on the areas of parenting assessed and worked on, with additional information supplied about the duration and intensity of the PASDS involvement with the family. Some programs also provide recommendations with respect to each parenting skill area, but they tend to avoid making more general recommendations, such as whether or not the infant should stay in the care of the parent/s, since these are statutory clients and such decisions rest with the Child Protection Service.

For cases where assessment and skills development has been undertaken by the PASDS provider, the Child Protection Service would receive an initial assessment report and a second report at the completion of the skills development program.

In addition to these formal reports, the initial meeting with the client and the Child Protection Service is

always minuted and acts as a record of agreement between the PASDS and the client. As mentioned earlier, there are also discharge meetings prior to the termination of the service.

Within all the Regions there is regular contact and supervision between workers and coordinators within the PASDS program. The contact between PASDS providers and case workers is more variable with most PASDS providers satisfied with the level of contact, although there were some serious concerns expressed by one provider regarding the lack of responsiveness of some case managers within the Region. PASDS providers shared the view that case managers needed to remain actively involved in cases referred to a PASDS. PASD staff consulted for the evaluation also mentioned their disappointment at the lack of feedback about outcomes for the families they serve. This is not simply a matter of personal satisfaction, but the lack of feedback loops also has ramifications for program modification and improvement.

Child Protection Service use of the PASDS Assessments

The PASDS assessment and/or skills development report is integrated into the Child Protection Services overall assessment of risks and needs, which in principle includes the Child Protection Worker’s environmental observations and biopsychosocial history. The Child Protection Worker, however, is unlikely to have seen the parent interacting with the infant so often or for such protracted periods as the PASDS worker, nor with such an eye trained to detect the nuances of infant care-giving. This is likely to mean that, even if the PASDS does not make explicit recommendations, the findings of the assessment and skills development processes conveyed in the PASDS reports are likely to be very influential in Child Protection Service decision making. The PASDS reports are usually appended if a Protection Application is taken to the Children’s Court after an infant has been involved with a PASDS. The relationship between these reports, and the reasoning and inferences that link them, are important areas for further consideration.

Of the 12 questionnaires returned from Child Protection Service’s case managers in the retrospective case sample, 10 recorded satisfaction with the PASDS report (the other two did not respond to this question),

with the workers commenting on the reports being comprehensive, thorough, clear and useful to the case manager. One case manager was generally pleased with the service of a residential PASD agency but believed the assessment would have been more useful had it included attention to the mother’s motivation to care for the child, and the influence of her substance use and family situation on the dynamics of the mother-infant relationships and the provision of infant care. The HRI managers also commented favourably on the impact of PASDS reports for the 16 families in which there were subsequent court appearances. Typical comments included: ‘Impartial report demonstrated unsafe parenting and insufficient change’; ‘assisted in obtaining supervision order’; ‘well accepted by Court’; ‘considered by magistrate and influenced the conditions on the Order’. It was evident that the signed and dated observational form of the QEC-style assessments was particularly useful when evidence of inadequate infant care was required.

Recommendation:

That a mechanism for consistent feedback to the PASDS provider on the outcome of a case be developed and implemented by Child Protection Services.

2.2.9 Outcomes

The focus of this evaluation has been on documenting program design features, implementation and initial impact, rather than on case level outcomes. The PASDS and regional staff consulted reported that there were no clear patterns apparent relating specific interventions to successful outcomes. *This is confirmed by the analysis reported later in this section.* This finding relates in part to the wide range of family circumstances and protective queries dealt with by the PASDS, and the expectation that the PASDS will respond flexibly in ways tailored to the family-defined and Department of Human Services-defined needs, and their own analysis of need. PASDS providers did, however, suggest that families who receive both assessment and skills development gain better outcomes. This is most probably a reflection of the in-home skills development component only being undertaken by families who were already assessed as able to maintain children in their care, and were therefore likely to do well. Those families who receive assessment only include those who are found unable to care safely for their child, and whose child is removed

after the PASDS. The perceived link between positive outcomes and the use of both the assessment and skills development components of the PASDS may also reflect PASDS staff satisfaction with the skills development work. From the Child Protection Service perspective, however, a parenting assessment that dispels concerns about parenting competence is also a positive outcome, even if the family is not then referred on to a skills development phase. The outcomes for these infants and families may remain invisible to the Child Protection Service and the PASDS once the case is closed.

This perception of service type having differential effects is obviously a core question for resolution in any follow- up outcome evaluation of the PASDS.

Largely as a result of workload and logistics, most regional HRI teams have not been able to maintain systematic outcome data in relation to PASDS referrals, nor to regularly analyse and disseminate such data as

is available. Renotifications and re-investigations of cases previously dealt with are not routinely identified and analysed. The evaluation sought a preliminary understanding of outcomes through the retrospective study of 20 per cent of PASDS referrals for 1999, but conclusions are limited by the incomplete return rate, especially from Child Protection Service case managers, who would be in the best position to identify and discuss outcomes. The evaluation team attributes the low response rate largely to staff workloads and the low priority given research in contrast to pressing case and court demands, to staff turnover in the Child Protection Service, and to undertaking the evaluation over the November–January period.

From the data available, however, some statements can be made. HRI managers were asked to comment on the status and placement of the child at the end of the PASD intervention. The following profile emerged.

	Type of PASD Referral									
Outcome	Residential			In-Home			Centre-Based / Day-Stay			Total
	A	A/SD	SD	A	A/SD	SD	A	A/SD	SD	
Parenting adequate – stayed with parent	1	15	0	1	10	0	0	0	0	27
Parenting inadequate – infant placed with other parent	0	1	0	1	1	0	0	0	0	3
Parenting inadequate – infant placed with relative	0	0	1	0	4	0	0	1	0	6
Parenting inadequate – infant placed in other placement	0	4	0	1	1	0	0	1	2	9
Ongoing	0	0	0	0	2	0	0	0	0	2
Not known	0	0	0	0	3	0	0	1	0	4
Total	1	20	1	3	21	0	0	3	2	51

A = Assessment
A/SD = Assessment and Skill Development
SD = Skill Development

Where the HRI manager recorded the case as being referred for more than one form of PASDS, the case has been classified as the least restrictive form for this table. Where there were multiple forms of PASDS delivery, the results were:

- Two cases, one a reunification, involving both residential and in-home resulted in the infant going to relatives.
- One reunification case used both in-home and day-stay resulting in the child moving from mother to father.
- One residential and day-stay reunification attempt left the infant still with a relative but closer to reunification with the parent.
- Two ongoing cases involved a combination of residential and in-home service.
- One residential assessment was curtailed by parental illness, and a further in-home service resulted in the infant going to the other parent.
- A successful reunification involved both in-home and day-stay.

Of the 20 completed referrals for assistance with reunification with a parent of an infant already in placement, ten resulted in successful returns to that parent; two were resolved with the infant going to the other parent; three went to or remained with relatives; and five were placed or remained elsewhere.

While the PASDS episodes appear to have assisted with the successful resolution of slightly more placement prevention than reunification placements, overall the infants were more likely to be at home with the same parent in whose care they had been before the service.

Given the paucity of Child Protection Service case manager returns, it is not possible to draw conclusions about the extent to which this exit information held true over time, and whether parents were able to sustain adequate parenting.

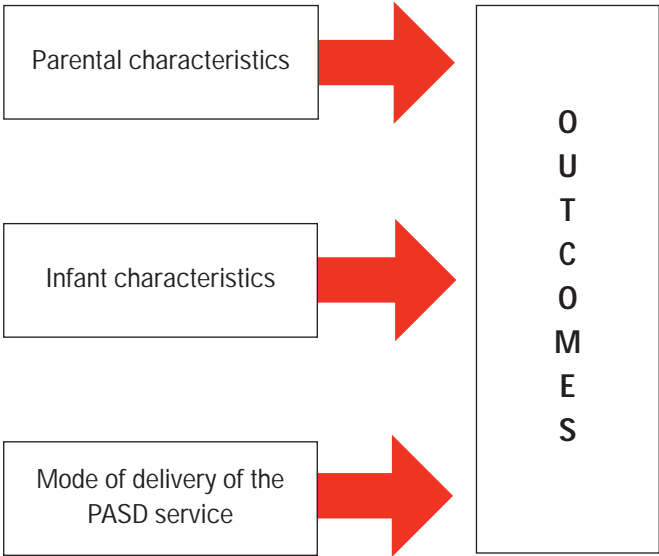
Information provided by the Southern Metropolitan Region’s HRI manager suggests that in that Region recent (late 2000) follow-up of 1998–99 and 1999–2000 PASDS cases indicates that approximately one-third have remained at home as closed cases with no renotification to Child Protection Services one-third are still open as child protection clients, and one-third has been renotified. One in-home PASDS provider in the Region commented on families’ appreciation of both

the QEC and the community agency input, and families’ almost universal requests for more service at the end of the PASDS experience. There is, however, little more specific information as yet to guide an analysis of such trends.

In the returns from case managers and HRI managers, six families were noted as receiving services post-PASDS. These included parents receiving ongoing counselling from the PASD agency; utilisation of a playgroup; involvement of Families First (both pre and post PASDS) and use of MCH services and General Practitioners (GPs).

Predictors of Outcomes for the PASDS

The following diagram shows the possible predictors of outcomes within the PASDS program. It is asserted in this model that outcomes may be influenced by parental characteristics, the characteristics of the infant and their presenting problems and/or the mode of delivery of the PASDS, that is, whether it is primarily a day-stay, residential or home-based PASDS.



Using multivariate modelling procedures, such as discriminant function analysis, it is possible to directly compare the contributions of each of these sets of characteristics to variability in outcomes for the individual cases. This type of analysis does not assume *a priori*, for example, that the mode of delivery of the service (for example in-home, day-stay, residential) is a more potent predictor of outcomes

than, for example, parental characteristics. This is a much more powerful method of analysis than, for example, conventional group comparisons.

That said, it must be stated that multivariate methods, such as discriminant function analysis, require reasonably large numbers of cases for the analysis to be robust. The numbers of cases available to the present analysis are satisfactory for exploratory purposes, however, in that we are examining preliminary outcome data in the context of an implementation evaluation. We would suggest that this

discriminant function analysis is repeated with a large validation sample of at least 200 cases, in an outcome evaluation proper.

Before we present the discriminant function analysis, univariate analyses are presented so that the characteristics of the data that are to be fed into the discriminant function analysis are fully understood.

The following charts show the percentages of mothers and fathers with various types of problems including drugs, alcohol, intellectual disability, mental illness, domestic violence, abuse, housing/homelessness.

Figure 1: Percentage of Mothers with Problems

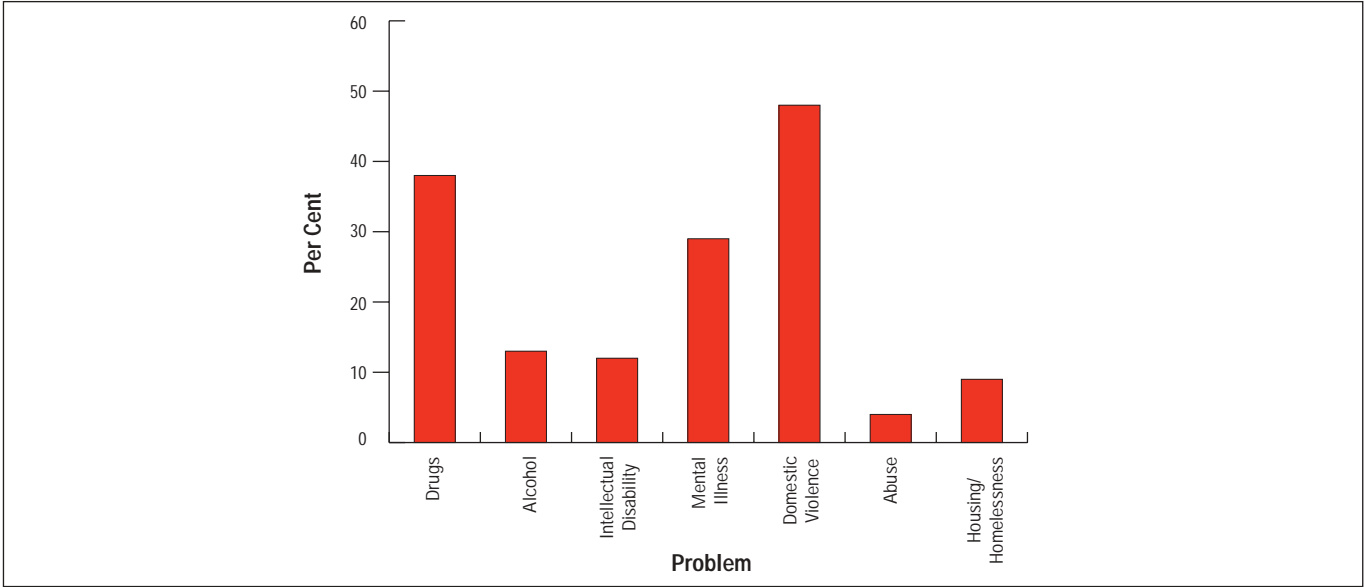
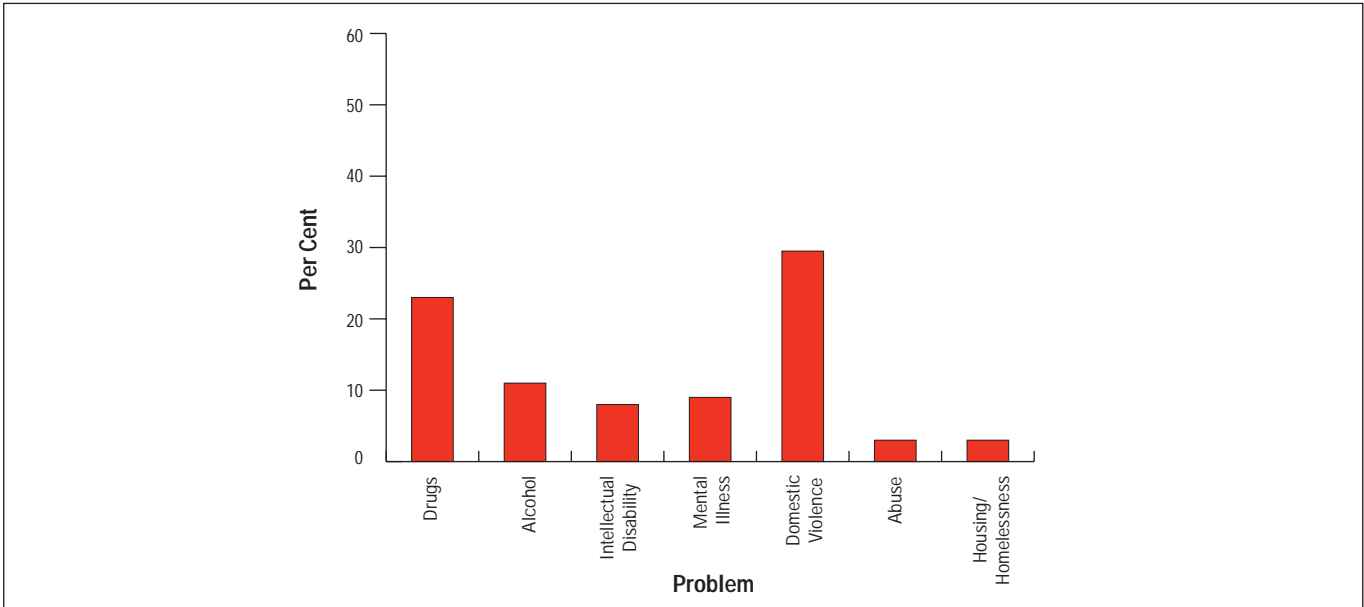


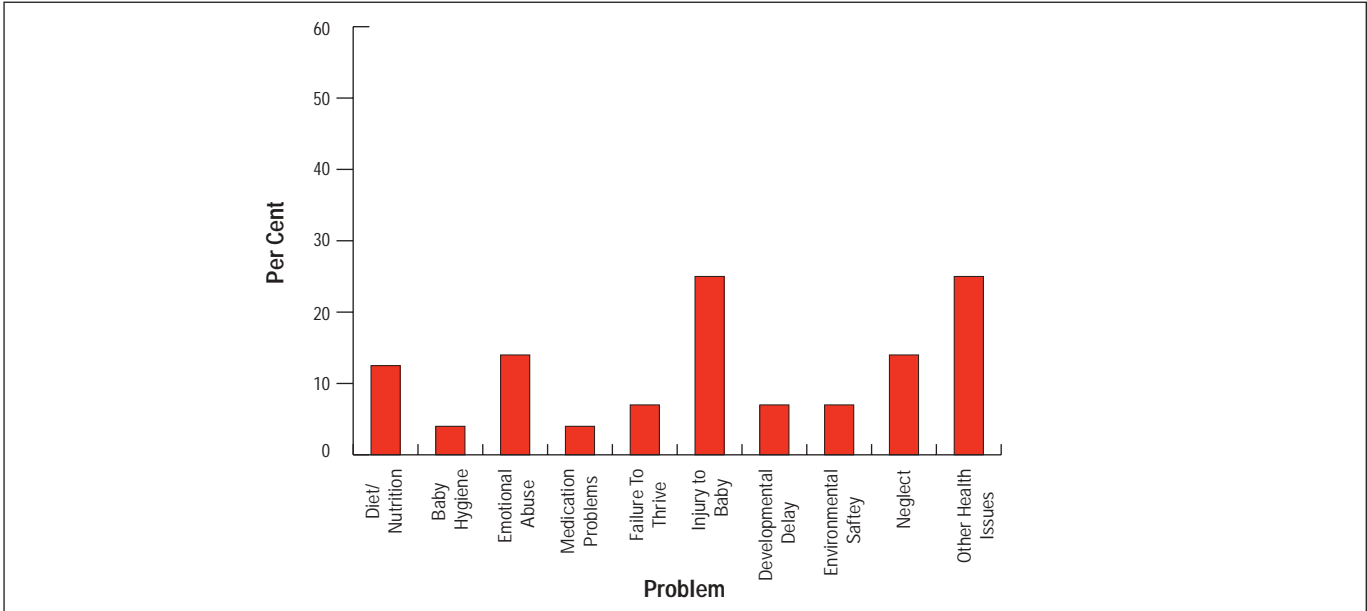
Figure 2: Percentage of Fathers with Problems



Almost all parents (N=74) about whom data were recorded in the PASDS worker questionnaire had multiple problems:

- In the 32 cases where problems were named in the referral for both parents, the mean number of problems for mothers was 2.9. One-fifth of the mothers had only one problem identified. This was typically a ‘global’ issue such as ‘parent unable to explain serious injury to child’, or ‘mother unable to address the child’s needs before her own’. The highest number of problems recorded for a mother was six, and one-third of the mothers were noted as having four or more problems.
- In these 32 cases, the mean number of problems for fathers was slightly less than for the mothers, at 2.4 (range 1 to 6). In only four cases were fathers deemed to have more problems than the mothers.

Figure 3: Percentage of Infants with Problems



The most common problems listed were actual injury to the infant, emotional abuse and other health issues. As might be expected, infants were less likely to be identified as having multiple problems, compared with their parents, although nearly half of the infants referred to in the retrospective case analysis had two or more problems noted. Typical of the single problem group were notations such as, ‘child sustained non-accidental injuries; exposure to domestic violence involving drug using parents’. In one-quarter of the cases, no specific problem relating to the infant was identified, rather, reference was made to the

- In 10 other cases, mothers only were involved in the PASDS program. For this group of mothers, the mean number of problems was higher than for the ‘couple’ mothers, at 3.3 (range 1 to 6), with a range from 1 to 6, as with the other group of mothers.
- For both mothers and fathers, living in situations of domestic violence and drug use are the most frequently reported characteristics, with almost half of the mothers being subjected to domestic violence.

The following chart shows the percentages of infants nominated as having a range of problems as identified by Child Protection Service workers and the PASDS workers.

consequences for the infant of parent-related problems. For example, lack of a safe environment for the infant was noted in five cases.

The number and type of problems were correlated with the rated outcome measure for both mothers and fathers using contingency tables analyses (the procedure CROSSTABS on SPSS), as reported in the table below. ‘Rated outcome’ is the PASDS worker response to the question:

From your perspective as a service provider to the infant and family, *on balance*, was there improvement in the parent’s performance over the course of the PASD intervention?

This is minimised to a large extent, however, by the use of explicit intervention plans with their specification of measurable goals for the intervention. Self-report, in this case, does not equate to mere subjectivity, with its potential to overestimate program effects.

The PASDS workers could indicate whether they thought the parenting performance had either improved; not improved, but stayed much the same; or deteriorated. An obvious limitation of the analysis that follows is the self-report nature of these responses.

Table 2: Correlation between Parent and Infant Characteristics and Rated Outcome for PASDS Cases

Characteristics	x ²	Df	p
Mother drug use	2.2	2	ns
Mother alcohol use	1.4	2	ns
Mother intellectual disability	1.9	2	ns
Mother mental illness	3.1	2	ns
Mother victim of domestic violence	2.1	2	ns
Mother abuse of infant	8.2	2	p<.02
Mother housing/homeless	2.5	2	ns
Young mother	1.04	2	ns
Father drug use	4.09	2	ns
Father alcohol	3.2	2	ns
Father intellectual disability	1.0	2	ns
Father mental illness	1.1	2	ns
Father perpetrator of domestic violence	4.9	2	p<.05
Father abuse of infant	0.2	2	ns
Father housing/homeless	0.236	2	ns
Infant diet/nutrition	5.0	2	p<.1
Infant hygiene	0.7	2	ns
Infant subjected to emotional abuse	1.9	2	ns
Infant needing high level of medication	0.7	2	ns
Infant failure to thrive	5.0	2	p<.1
Infant sustaining injury	0.1	2	ns
Infant developmental delay	4.3	2	ns
Infant environmental safety	1.1	2	ns
Infant neglect	1.0	2	ns
Other infant health issues	4.0	2	ns
Mode of PASDS delivery	1.6	2	ns

The above table shows that most parent and infant characteristics on their own were not associated with outcomes for the PASDS.

The ones that showed some association were:

- Mother abuse of infant
- Father perpetrator of domestic violence
- Infant diet/nutrition
- Infant failure to thrive.

These could be considered to be risk factors associated with poorer outcomes for the cases.

No association was found between Mode of PASDS delivery and case outcome.

It is recognised, in making this statement, that ‘mode of service delivery’ as a variable is not absolute in its distinction between types of service. This is because the service types are not clearly distinguished by intervention method, staffing profile and focus. In this sense, the analysis should be taken as indicative of trends, and used to formulate tight outcome evaluation questions to be asked in the next phase of evaluation research.

The next set of analyses investigated the multivariate associations between the above predictor sets and outcomes. Multivariate analysis essentially partials out the complex sets of interactions between predictors, such as parental, infant and mode of delivery variables, and enables us to see overall whether it is possible to predict outcome by knowing the values on these variables for individual cases. That is, it tells us which characteristics best predict outcomes.

If it were the case that mode of service delivery were found to be a strong predictor of outcome in this type of analysis, then this tells us that some types of service delivery are inherently more effective than others. On the other hand, if it were found that parental characteristics were found to be stronger predictors, then there would be a case for identifying the characteristics in risk assessments or screening tools so that these cases may be targeted for more intensive or different interventions. Let us consider the outcomes of the analysis.

When single step discriminant function analysis was applied to the data, 96.3 per cent of the cases were correctly classified using the discriminant function to predict the value of the outcome variable. This corresponded to a canonical correlation of .917, which achieves statistical significance at the level of $p < .01$. The variables that were found to be most discriminating or predictive of negative outcome, as

defined earlier, were as follows:

- Mother involved in drug use
- Father as perpetrator of domestic violence
- Mother with an intellectual disability.

The relationship between interventions and outcomes within PASDS needs to be monitored across the next two years, to provide an overview of the work undertaken with various families and the success of this. A longitudinal study of a sample of families recruited at the point of referral into the program (preferably at least 200 in number, as noted previously) would be an appropriate methodology for this research. Comparison of the PASDS intervention with other similar interventions (for example, Families First) might be of value, but the funding of PASDS as enhancements to existing services makes it difficult to find contrasting pure models of different service types. There are a number of issues to be considered in attempting to obtain and interpret data about post-PASDS case trajectories, including:

- What level of follow-up post-PASDS can be justified ethically, especially for those families whose CPS case is closed?
- How long might one reasonably expect the benefits of a PASD skill development intervention to ‘stick’? This has a number of dimensions including the persistence of non externally-reinforced intervention effects.
- Is it reasonable to take the absence of a re-notification to Child Protection Services as a good outcome?
- How might data be obtained about whether the parents are able to transfer learning from one developmental crisis to the next (for example, infant enters new phase of development; mother has second child)?
- How can the contribution of the PASDS be distinguished from the other case inputs from other professionals and agencies?

Recommendation:

That research frameworks be developed to assist PASDS providers identify intervention and outcome linkages and document these for future service development.

2.2.10 Staffing the PASDS Program

Each service has its own unique staffing profile, reflecting the orientation of the program and the its historical employment patterns, as well as its active efforts to accommodate the goals of the HRI initiatives. Most services responded to the request to provide staff qualifications and experience data. These reports illustrate the range and depth of staff preparation for the PASDS intervention. They also show some differences in emphasis between the two main types of service: those oriented to the ‘early parenting centre’ concept, influenced by the Maternal and Child Health Nursing discipline; and those oriented to the ‘intensive family support/preservation’ concept, influenced by the social work discipline.

Maternal and Child Health and Development Orientation

QEC requires its PASDS coordinators to have a degree or diploma in Maternal and Child Health Nursing (an advanced nursing qualification), and looks for additional qualifications in business/health management, psychology or other related areas. Team members (early childhood workers/mothercraft nurses) have a Diploma in Community Studies (Child Care). Staff participate in an in-house four-day per year training program and Southern Region staff have an additional training program. All staff members attended a ‘Working with Families Affected by Drug and Alcohol Issues’ program in 2000, and some are pursuing additional studies. Their prior employment has been in a wide range of specialist and generalist maternal and infant health and support programs in the community. Southern Family Life coordinates the PASD training for the Region, and this is seen to be working well.

O’Connell similarly uses a registered nurse (MCH and/or midwifery trained), with MCH and early parenting centre experience, as the primary care worker for a family, and a preschool/mothercraft nurse, with early parenting centre and child care centre experience, as the secondary worker. Staff have also undertaken staff development and training around issues of family violence and drug and alcohol use.

Tweddle is staffed by Maternal and Child Health Nurses and early childhood mothercraft nurses, with the PASDS coordinated by a Maternal and Child

Health Nurse with social work qualifications as well. Additional qualifications and training include lactation consultant, mental health, family counselling. Positive Parenting Program levels 2–5 and chemical dependency. The staff bring to the PASDS experience in MCH centres, family support, community health, child care, and chemical dependency services. There is a similar profile in Barwon South West, where the Geelong coordinator has graduate qualifications in public health and family therapy in addition to MCH nursing, while the Warrnambool PASDS worker has 20 years of wide-ranging community nursing experience.

Social Work/Family Preservation Orientation

In the Eastern Metropolitan Region, Uniting Care Connection’s PASDS staff is a mix of case workers and direct family care workers, who have qualifications that include Master of Social Work; Bachelor of Social Work (some with progress toward MSW, one combined with Law/Arts); probationary psychologist; Certificate of Child Development; Bachelor of Human Services; Associate Diploma of Welfare Studies; Associate Diploma of Human Services; Graduate Diploma of Addiction Studies; and BA (Social Sciences.) Staff also reported having undertaken a variety of relevant advanced studies: one-year infant observation training; family therapy; Keys to Caregiving; attachment and bonding in infants and preschoolers; Certificate course in child development; Certificate of trauma counselling and therapy; neuro-developmental impact of childhood abuse and trauma; neglect, abuse, brain adaptation and development; domestic violence and impact on infants; risk management; and high risk infants training. Their prior employment has been chiefly in intensive family services and child protection.

The Anglicare Werribee program employs both social workers and family support workers, with a mix of family support, child protection and other social work experience. Staff variously reported post-qualifying training in Positive Parenting Program, drug and alcohol, family therapy, working with young children, and working with families in crisis.

Hybrid Model

An interesting variation is provided by BC&FS, where the agency has experience with offering family preservation services to child protection client families, and where the PASDS brings together a Maternal and

Child Health Nurse, a teacher with studies and experience in work with the intellectually disabled, and a probationary psychologist/welfare worker with experience in schools, crisis care and with high risk adolescents. Similarly, the western Hume PASDS, auspiced by Goulburn Valley, combines family preservation and early childhood orientations.

The differences in PASDS delivery design reflect variations in the existing regional service constellation, particularly the relationship of the Child Protection Service to family support/family preservation services or early childhood agencies. This variation in models is consistent with the PASDS program goal of reflecting regional priorities. It is also important to note that this program design decision is reinforced by the finding in this report that no one method of service delivery predicted to positive outcome better than any other method of service delivery. That is, each service type is as likely to produce positive outcomes as the others.

Within the in-home PASDS, on detailed inspection of the cases in the retrospective sample, there appeared to be no clear evidence of particular patterns of intervention providing differential outcomes for families. Successful outcomes, as is consistent with our finding on overall service delivery frameworks, seem more dependent on the issues confronting the family and some key family characteristics than on particular interventions. Factors impeding parenting improvements include inability of parents to sustain a drug-free lifestyle; inability of mother to sustain improvements due to ill health; continuing relationship and domestic violence issues; and continuing psychiatric illness in mother.

The importance of establishing good rapport and a trusting relationship with the family was highlighted by PASDS workers as a key factor in the success of the work. Although no clear patterns of intervention and outcome are currently evident with the data available, it is important to monitor the emergence of any patterns, as noted earlier, and subsequently to develop service delivery models on the basis of these findings.

Recommendation:

That intervention/outcome data be maintained on PASDS families to provide insight into the factors that have an impact on service delivery and program outcomes.

That best practice models be established through rigorous evaluation and research of practice activities.

That, where possible, an integrated model and/or strong links to family support agencies be maintained.

2.3 Department of Human Services Stakeholder Views Regarding Service Use and Design

2.3.1 Is the Program Being Used in the Ways Intended Originally?

Most regional HRI and Partnerships and Service Planning staff members consulted for the evaluation were satisfied with the PASDS arrangement they have in place and feel the flexible nature of service delivery has been an essential and continuing part of the program's development. One region noted that they were surprised there was not more frequent movement between the assessment and skills development phases of the program.

2.3.2 Issues Raised by Child Protection Service Regarding PASDS Delivery

Commendations:

- The referral process has been carefully developed. The process of gate-keeping and referral into the PASDS program works most of the time and should be maintained.
- The strongest features of the program are its flexibility, ability to tailor the service delivery to client needs, and the combining of MCH expertise with child and family social work expertise. The PASDS program begins to bridge these two disciplines and fields of practice.
- The clients perceive a separation between the Child Protection Service and PASDS, and this encourages their use of PASDS.
- The quality of the assessments provided by PASDS to the Child Protection Service is high. PASDS reports are rarely contested by parents in court and

are most likely to be accepted by all parties involved in a child protection matter. In a number of cases, magistrates explicitly refer to the reports as an aid to decision making.

- The integration of PASDS into mainstream parent/child services has been effective and valuable for clients, although it has taken a number of PASDS workers time to become comfortable with the more challenging behaviours of this client group.

Concerns and Queries:

- PASDS provider 'eligibility' criteria can be too restrictive and limit the availability of places for potential families, which reduces the throughput of the PASDS. This is particularly relevant in relation to substance abusing parents. As we have argued that substance abuse in mothers is a significant predictor of poor case outcome, this is an area that needs a high level of attention paid to it, both in terms of access of these parents to the programs, and the effectiveness of interventions once they are in.
- The use of PASDS in cases of reunification needs to be carefully thought through. The standard PASDS delivery framework does not fit well into the reunification process, which involves a gradual transfer of responsibility between carers, often in a neutral venue, with preparation, active transfer, and after-care phases. Reunification decisions are often a matter of timing and involve more than establishing that the parent has the requisite skills. A positive parenting assessment by a PASDS may raise expectations that cannot be met for other reasons.

Suggestions:

- Within the Department it is important that the time allocated to HRI managers to work with PASDS is protected and remains focussed on the development of the initiative and is not diluted by using HRI manager time on other Departmental initiatives.
- The residential PASDS program is working well, but there is a need to focus attention on the development of home-based PASDS in terms of comparative effectiveness.
- More work needs to go into building linkages with related service systems, such as intellectual disability, domestic violence, mental health and drug and alcohol services.

Other Observations:

- There is a demonstrated need for the residential assessment program to be a ten-day, continuous and 24-hour program, to allow for supervision of potentially unsafe care arrangements, a protracted assessment, and the opportunity to test learning.
- There are no clear patterns of intervention and successful outcomes, although most clients receiving both assessment and skills development are successful in maintaining their child at home.
- The quality of the communication between the PASDS provider and the Child Protection Worker involved in a case is critical to the PASDS process working well.
- Some rural Regions have found their own unique solutions to providing a residential PASDS. Given the size of a number of rural Regions, it is often difficult to offer a local effective PASDS in remote parts of Regions.

2.4 PASDS and Department of Human Services Stakeholder Views on the Impact of PASDS

2.4.1 Impact on the Child Protection Service

- The Department staff consulted often claimed that the PASDS have enhanced their service delivery to families by providing an essential assessment service that is seen as separate from the Child Protection Service.
- They believed that the PASDS have enhanced the evidence-based assessment process as applied to infants in contact with the child protection system. This has, in turn, enhanced the relationship between the Child Protection Service and the Children's Court. Many case managers note that they are now incorporating more of the areas covered in PASDS assessments in their own initial investigations.
- In one Region, a non-government provider commented that Child Protection Service workers have become more 'gentle, patient and realistic' about parents of high risk infants. This was attributed to the PASDS 'spreading the responsibility for the protection of the child', so that Child Protection Workers are aware that there are several other professionals closely involved in the case, and able to support each other.

2.4.2 Impact on Other Infant and Family Services

- The early childhood services delivering PASDS have become much more sensitive to the difficult and complex job undertaken by the Child Protection Workers.
- The contact between the Child Protection Service and MCH service network has been strengthened as the result of the establishment of PASDS.
- PASDS monies becoming available have resulted in the continuation of some mother-baby services that were under threat of closure, particularly in rural Regions.
- PASDS have increased the link between MCH services and family support services.
- PASDS providers have become more skilled in working with the often difficult client group referred from the CPS and, in some cases, PASDS work has made them more attentive to the needs of infants as the primary concern within families.
- The agencies providing PASDS have increased their linkages with disability, drug and alcohol and mental health services. There is still, however, a need for stronger relationships to be developed between the PASDS programs and these service systems. This is especially so, given the finding of this study that mothers’ involvement in drugs, mothers’ intellectual disability and fathers as perpetrators of domestic violence are the strongest predictors of negative case outcomes.
- Families’ needs have been exposed and it has become apparent that there is insufficient funding for longer-term family support work appropriate to and sought by these client families.

Recommendation:

That resources are made available to facilitate stronger linkages, including integration, between PASDS providers and key intellectual disability, domestic violence, drug and alcohol, mental health and family support agencies.

2.5 PASDS Staff Views of the Lessons Learned from the Establishment of PASDS

2.5.1 Regarding the Establishment of Parenting Skill Development Programs

- Rather contrary to expectations, there has not always been a flow from assessment to skills development within PASDS. The skills development component of PASDS only occurs in cases where parenting has been assessed as adequate for the child to remain at home.
- That a comprehensive and evidence-based assessment of parenting competence within a residential setting requires at least ten days of continuous monitoring to observe the durability of behaviour and the take-up of new learning.
- The amount of time required to adequately assess parenting competence within the home varies between five days and 30 days. This variability reflects the differing needs of families and different approaches used by PASDS providers, including the duration and frequency of home visits.
- Many of the families referred to the program are socially isolated and building social support networks with these families is an essential part of the work undertaken by in-home PASDS. Skills development—when conceptualised more broadly to include the parents’ competence in sustaining the family as an operational unit, able to make use of and join with the community within which the family lives—often requires more than 10-12 weeks of service, and transfer of engagement to new service providers may severely disrupt the family’s development.
- Families need to be relatively stable in terms of internal dynamics and environment in order to benefit and learn from the PASDS.
- PASDS providers identify the relationship developed with the family across the life of the PASDS to be the crucial factor in the transmission of knowledge and skills enhancement with families.
- Testing the transferability of parenting skills from residential PASDS setting to home-based settings is essential to the successful maintenance of gains.

- There is a difficulty in working effectively with clients who have a chronic involvement with the Child Protection Service. Sometimes PASDS providers feel they are used to confirm the failure of these families to ensure removal of children, as the courts are more likely to accept their recommendations. Providers feel this is not an appropriate use of their resources.
- In order to look after families appropriately, Child Protection Workers need to be actively involved with families during the life of the PASDS, leaving PASDS workers to concentrate on the development of parenting competencies.
- The program has administrative costs that have not been adequately identified and funded.

2.5.2 Regarding the Future Development of PASDS

- The development and expansion of the program has been inhibited by the ‘interim’ nature of the funding from Regions to the agencies. Agencies cannot maintain experienced staff and develop service networks without secure longer term (up to three years) funding.
- As part of the development of the PASDS program, there should be a greater exchange of knowledge and ideas between the Child Protection Service and PASDS. This could be in the form of training or secondary consultation. Respondents suggested that PASDS staff might offer training to Child Protection Service around infant development and needs. Child Protection Services could offer the PASDS training on working with aggressive or uncooperative clients.
- PASDS providers consider they can make a difference to families if referrals are made as early as possible in a child’s life, before patterns of parenting become entrenched.
- There is a need for more communication and idea sharing between PASDS providers.
- There is a clear need for ongoing support around parenting issues for families with high needs as each development milestone in early childhood brings with it new challenges in parenting.

2.5.3 PASDS Staff Views of Systemic Issues Arising from the Operation of the PASDS

Forty-two PASDS workers were surveyed on a range of systemic issues arising from their practice. These related to what requirements they believed needed to

be met for the PASDS to have been more successful; the working arrangements between the PASDS and Child Protection Service, and their perception of any policy and service gaps raised by the cases. The comments they made on systemic issues derived from their specific experiences in working with the cases included in the retrospective case analysis, and are not generalisations in the same way that comments relating to other aspects of the program’s operations, reported above, are.

2.5.4 Regarding Requirements To Be Met for the PASDS To Have Been More Successful

Eighteen staff had views on what may have made PASDS intervention more successful, although a number of workers took the opportunity that posing this question afforded, to affirm a number of the features of the PASDS program found to be particularly useful. On what may have made the intervention more successful, staff identified the following training gaps:

- Engaging difficult and resistant families.
- Working with people involved in drug and alcohol abuse.
- Working with families where psychiatric illness present.
- Working with domestic violence.
- Working with anger.

Other inhibitors of effective practice noted were a number of client-oriented and resource issues, namely:

- Having a client not ready to move from abusive relationship and substance abuse.
- Clients to have undertaken anger management prior to coming into residential program.
- Having more experience in working with adolescents.
- Not having enough travel time in large rural Region.
- Not having access to intensive family support.
- Difficulty at times in not merging PASDS work into family support work, and not having a budget to do this.

Features of the operation of the PASDS program which were affirmed as being particularly useful were:

- The need for assessments to be made immediately following birth.
- Usefulness of the PASDS worker being a Maternal and Child Health Nurse, given the high level of medical needs in a case.

- Reinforcement that parents can learn parenting skills but must be supported in other areas of their lives to ensure that this learning translates into longer term positive outcomes.
- Access to panel of experts on issues such as drug and alcohol and psychiatric issues.
- Confirmation of the usefulness of the admission criteria to a residential program that families need to be in a position physically, mentally and socially to be able to participate and learn.
- Demonstration of the usefulness of psychological assessments of parents.

2.5.5 Regarding the Working Arrangements between the PASDS and Child Protection Service

Seventeen PASDS staff noted a range of issues relating to the working relationship between Child Protection Services and PASDS. These included a number of negative aspects such as:

- Delays in reporting and case take-up where the case is transferred from Response Team to Long Term team in Child Protection Services or where there was change of worker in Child Protection Services, with, in one case, no notification to the PASDS worker or parents.
- Difficulty in communication where the case worker from Department of Human Services was not a member of the HRI team.
- The need for greater clarification of roles between Child Protection Service worker and PASDS worker.
- The need for a Child Protection Service worker to liaise more closely with a rural PASD worker to ensure family compliance with visits.
- The difficulty of dealing, in the PASDS program, with clients who were coping with adverse (as parents perceived them) Child Protection Service decisions on, for example, fostering.
- For one service, a domestic violence incident in first 24 hours of parents' attendance at the program raised the issue of whether Child Protection Services had given enough information to the PASDS.

A range of positives was also highlighted by PASDS workers considering the nature of the working relationship with Department of Human Services. These included:

- High levels of positive communication.
- Department of Human Services flexibility in, for example, extending stay in residential setting.

- Strong case management by Department of Human Services.
- The importance of having access to the Region's panel of experts.

2.5.6 Regarding Policy and Service Gaps Raised by the Cases Worked With

Fifteen PASDS workers took the opportunity to comment on broader issues of policy and service gaps. Some of these related to gaps in service delivery in their own organisations or challenges to agency policy and protocols, such as:

- The issue of a father not being able to participate in a residential PASD program, due to court order and later, work commitments.
- The issue of parents continuing to use drugs when in a residential program even though the contract for service specifies no use, but actually demonstrating growth in parenting capacity.
- The challenge to residential assessment where a family had a five year-old, and where the residential program excluded school-age children.
- The problem of residential assessment when parents work full-time.
- A discharge planning meeting being held too early, on day six of a ten-day program leading to mother losing motivation and leaving on day nine.

A number of broader issues were raised:

- The resource issue of travel in large rural Regions and costing this into program budgets.
- Lack of family support post-PASDS in rural areas.

As well, a number of issues relating to the policies of Child Protection Services and Department of Human Services were noted:

- The need for protective workers to be part of HRI team, managed by HRI manager and not 'generic' Child Protection Service workers.
- The need for a 'preventative assessment' process, for example, during antenatal visits, so that intervention such as modelling in high risk cases could be introduced earlier.

Finally, although not a policy issue in the sense of some of those noted above, the issue of worker safety was raised, in cases where there is a sole worker outside of mobile phone range, working with an isolated and unpredictable clientele.

2.6 Consumer Views of the PASDS

2.6.1 Direct Consumer Feedback

It was seen as crucial to the implementation evaluation process that feedback from former PASDS clients be sought. The initial aim of the evaluation team was to conduct interviews with approximately 20 per cent of previous clients (or 80 individuals). To increase the chances of securing interviews with such a high number of ex-service users, it was decided that a majority of parents who had received services from PASDS between January and July 2000 (originally estimated at around 250 individuals) should receive invitations to participate in the study. Those parents, who were still clients of PASDS, or currently subject to protective investigations, were to be excluded from invitation.

To satisfy both the Department of Human Services and University of Melbourne ethics committees to whom application was made for approval and in the interests of protecting clients' confidentiality, a third party recruitment process was chosen. PASDS agencies had agreed to address and send to parents, on behalf of the team, envelopes containing statements about the evaluation, interview consent forms and smaller, stamped envelopes addressed to the evaluation team. Clients were required to provide, on consent forms, only a first name and a contact telephone number. The numbers of envelopes sent to agencies was based on agencies' unit numbers for the first six months of 2000.

There are a number of explanations for why this mail out produced only two responses from clients and therefore two interviews. First, it is well documented, and reinforced in HRI managers and case managers questionnaire returns, that a high proportion of those individuals who become involved with child protection are transient. It is likely that a large number of clients moved subsequent to receiving services from PASDS and the letters were therefore sent to 'wrong' addresses. Second, it is possible that some clients, since attending a PASDS, have made significant improvements in their lives and are uninterested in reflecting on times when they were experiencing difficulty. Conversely, some clients may be currently in hardship and unable to cope with requests such as made by this project. Fourth, some clients have a fear of, or natural resistance to, participating in activities that are managed by large institutions. Finally, it must

be considered that a number of ex-service users may be illiterate and either unable to, or uninterested in, having the letters sent explained to them.

Interestingly, the two interviews conducted—both interviewees had attended residential assessments, but at different agencies—yielded markedly different responses, with one being uniformly positive and the other quite negative. The interviewees differed in terms of both their recollections about, and their attitudes towards, the PASDS. The one point of similarity between the interviewees was that both had believed, prior to attending the PASDS, that what they would receive during their assessments would be parenting advice. Neither interviewee could recall having had any other expectation in regard to their PASDS attendance.

Both interviewees were asked whether they would use services again, like the PASDS that they had attended. The first client said that in the circumstance that she had another baby and was having trouble with parenting she would use a PASDS again. When asked, she said she would recommend the service to other parents. The second interviewee said she would not attend a PASDS again and would not recommend the services to other parents.

2.6.2 Case Managers' Reports of Parent Feedback

To augment these two examples, we have some second-hand reports from the Child Protection Service case managers. In eleven of the case managers' returned questionnaires for the *retrospective case analysis*, they responded to a request to pass on any comments the families had made to them about their experience of the PASDS. Their replies covered the following areas. Eight noted positive reports of the helpfulness of the PASDS.

- Parents liked the worker and felt she advocated for them, and assisted them to have more flexible access to the child.
- Parents liked the workers, gained increased access to the child, and told their Child Protection Service case manager that they benefited from the education given.
- Parents appreciated the funds given for a new cot.
- The parents felt supported and reported that they learnt strategies they were able to implement on return home.

- While the worker believed the parents benefited, they did not see it as a benefit so much as a hurdle.
- The parents were pleased and had a good relationship with the PASDS staff, developed trust, ‘learned useful stuff’, and were amazed at how much they knew already. The service ‘confirmed they were good parents’.
- The mother gained some skills and the father gained a lot of skills. He could name these, and stated that he would continue to go the MCH Centre and ask questions.
- Useful feeding and changing tips.

Eight also reported comments regarding unhelpful aspects. These were:

- The recommendation from the PASDS that there be no reunification of the baby with the parents at that time.
- Parents not being able to do the residential component.
- The service was experienced as intrusive, and the father felt no need for it.
- The parents wanted more practical help—for workers to *do*, not *tell*.
- The parent felt watched, and that the service was intrusive, but did not report that any activities were unhelpful.
- The parent enjoyed the day-stay, but found the residential service draining and noisy.
- The parents saw nothing as helpful. They felt the service was intrusive, but agreed to it to prove their skills were OK.
- Parents felt watched, and believed that no good parenting episodes were recorded, only the not good behaviour.

These comments suggest that parents were able to balance positive and negative experiences. As is common with client feedback studies, they valued a pleasant working relationship with workers, and liked concrete activities that they could understand the purpose of. Given that there were cases in which the parenting assessment did indeed affirm parents’ areas of achievement, these comments add some small support to the use of PASDS to help dispel doubt, and the potential they have to lift the sense of parental self-worth and pride in parenting.

On the other hand, the very real discomfort with the observational process should not be discounted, and this echoes some similar discomfort on the part of PASDS staff. When the alternative might, however, be the removal of the child, this discomfort may be worth enduring, and may also have the benefit of enhancing parental skills. There is a clear tension between the purposes of child protection assessment, and the value of a PASDS, whether residential or home-based, being able to ‘seize the teachable moment’ and assist parents to learn at the very moment when they are ready and willing to learn. PASDS staff are clearly gaining a lot of experience in managing this tension productively, but the limited data to date suggests that this remains an area of confusion for some parents, perhaps inevitably.

Recommendation:

That in any outcome evaluation to be undertaken of the PASDS, a client survey be conducted not using the third party recruitment model used in this implementation evaluation, but using a method of client recruitment that respects confidentiality, but maximises client participation.

2.7 Summary of Findings

On the basis of the data provided by PASDS providers and relevant staff in the Child Protection Services and the regional PSP units, it is clear that PASDS are delivering services that meet the aims of the HRI initiatives. All PASDS providers deliver services that provide:

- Timely, comprehensive, evidence-based assessment.
- Individually tailored skills development and support.
- Flexible delivery modes.
- Priority access for child protection clients.

PASDS providers and the regionally based HRI teams within the Child Protection Service are to be commended for the success of the PASDS program implementation.

Notwithstanding the success of implementing PASDS, the process has highlighted a number of operational issues that require attention for the future development of PASDS delivery:

- The process of implementation obviously raises the issue of the general PASDS funding formula and frameworks for service delivery. Most regions have adjusted the intensity and frequency with which PASDS are delivered to clients. The relationship of these modifications to achievement of effective outcomes should be addressed in an outcome evaluation. Any findings should then be reflected, if appropriate, in future funding agreements and service specifications, with PASDS providers. These agreements need to also reflect legitimate regional variation in the way in which PASDS are delivered.
- There is a need for stronger integration between PASDS and specialist intellectual disability, drug and alcohol, domestic violence and mental health agencies. These issues affect the lives of many participating families and, as such, any service response needs to integrate the specialist impacts of this with general parenting skills development. This has implications for PASDS staff training.
- There is a need for better consultation between Regions regarding the establishment of models for PASDS. Although there is a need for regional variation in delivery modes, very little information and ‘know how’ is shared between Regions. Some areas of service delivery could be enhanced by a common approach across Regions, for example, assessment approaches used, various operational protocols.
- The quality and type of reporting used within agencies requires some standardisation. It is important in future program development to consider if a uniform framework can be found and to consider assessing the training implications of establishing such a framework.
- Problems emerge as the result of the irregularity and unpredictability of referrals coming from the Child Protection Service, and the implications of this for developing funding and staffing models for programs. Addressing the issue of targets and throughput is essential in the development of the PASDS as there appears to be a conflict between funding on a case by case basis and providing stable and well-structured programs.
- Within rural Regions there is a lack of locally-based services in remote areas and appropriate professional staff to deliver services. The issue of how best to deliver PASDS to rural Regions needs development.
- Resources need to be made available to ensure that the HRI teams within the Child Protection Service are able to fulfil a community development function, which would contribute significantly to the successful linkage of PASDS with other community-based family support agencies.

3. Discussion: ‘Parenting’ and the PASDS

3.1 Assessing Parenting

There are implicit assumptions embedded in PASD assessments about what ‘parenting’ is: that parenting is learned and teachable; that parenting can be assessed as a discrete entity outside the biopsychosocial assessment of the parent; that parenting behaviour is a proximal indicator of parenting capacity or competence.

While most PASDS demonstrate awareness of both parenting behaviour and the personal antecedents and social context of the behaviour, their frameworks do not all cover both equally. The PASDS that are strongly based in Maternal and Child Health Nurse practice tend to have more explicit documentation of the baby care assessment framework, and the social work/family preservation oriented programs tend to have the psychosocial framework better documented. Some frameworks appear to derive from, or share the basic understandings of, the QEC Parenting Competencies assessment framework, which is more oriented to the residential setting than the home. It is evident that in-home PASDS workers have access to in-depth real life observations of parenting in the home environment, and sometimes observations of the social conditions that influence this, and these have not (perhaps not yet) been systematically incorporated into the assessment frameworks supplied.

Assessment frameworks and tools are as strong as the conditions of their application. At their most helpful, they are used repeatedly over different times, places and circumstances, by staff with a clear understanding of the benchmarks for judgement of parenting performance. PASDS providers demonstrate awareness of this, and have chosen experienced and well-trained staff, and plan their assessments to ensure multiple observations over time and place. Arguably, the same instrument used for both in-home and residential assessments might produce more ecologically valid results in the family’s natural environment, but this depends on a range of factors and purposes. It is as yet unclear whether day-stay allows for a dilute form of residential assessment, with its various advantages and disadvantages, or whether it has its own distinctive assets.

3.1.1 Factors

Time is an important factor. The residential assessment allows for 24-hour supervision and hence many more small observational opportunities than is possible with limited home visits. In-home assessments, however, can be protracted over weeks, and address how behaviour is sustained and develops over time.

The **physical setting** of the residential service offers a clean, orderly, well-equipped and cheerful physical environment for infant care. One might expect this to enhance the opportunity for, and perception of, safe parenting in contrast with homes that Child Protection Workers frequently report to be chaotic.

The *social setting* of the residential assessment provides for multiple observers (even though families are usually assigned one main worker) whereas home-based PASDS usually have only one, or perhaps two, workers visiting the home. The residential setting introduces other families into the processes, allowing observation of the parents’ interactions with strangers albeit in a relatively intimate environment. There are, however, real social and personal stressors arising from a multiple staff/multiple family observational environment. The home-based setting is more likely to allow both incidental and planned observations of the family in interaction with kith and kin, both natural helpers and those who impede positive parenting. This has proven important in situations where parents have been misusing substances.

Other regulatory influences apply differentially in the residential and home settings. There may be extrinsic regulation, such as medical management of mental illness, access to drugs, restraints upon violence. The home-based assessment, however, may allow the parents themselves to regulate such affairs episodically to meet the requirements of the assessment visits.

3.1.2 Purposes

On the basis of the above factors, then, it can be hypothesised that the different settings may give the assessments different levels of trustworthiness for different purposes. The assessment frameworks described above may, when used in *residential* assessment, be most trustworthy as tools to assess whether parents possess *particular areas of knowledge and skill*, and the parents’ use of these in a well-resourced environment in which parenting is the

primary activity. It allows for close observation of how the parent's verbalised understanding of child development and infant care translates into many small and practical actions, both routinely and with sufficient flexibility to meet unexpected situations. It does not allow for inferences about the degree to which knowledge and skills will be applied under less well resourced and regulated conditions. There were a number of families referred to PASDS on the basis of observable conditions such as drug use who were found to be able parents using a residential assessment. Unfortunately, there has been insufficient data available at this stage to show whether those assessments endure outside the residential setting. Further follow-up work might be desirable. It is possible that a positive assessment under these conditions might stimulate parental motivation and provide a needed turning point in their lives, but this cannot be counted on.

Such residential assessment is also likely to suit the purpose of establishing biopsychosocial rhythms and patterns of parents (as individuals and couples) that influence infant care and the formation and maintenance of parent-infant attachment. This may be appropriate when it is unclear (for reasons of parental mental illness, disability or immaturity) whether the parent has the capacity to focus on the infant as an independent and needy entity, and to prioritise these needs. Because of the opportunity provided for many repeated micro-interventions, residential assessment using re-measures on a standard tool is also an aid to clarifying a parent's capacity to learn and retain new knowledge and behaviour and to adapt to changing demands.

Neither of these uses of residential PASDS assessment can answer the question of the transferability of knowledge and skill to the home environment, but they can give rich information to assist planning for the transition. Essentially, it is understood by the evaluation team that residential assessments offer an understanding of the adequacy of inherent parenting capacity at this time. The Child Protection Service has found this use to be especially helpful to their protective decision making and case planning.

Home-based assessments using the same framework provide a stronger basis for statements about the adequacy of parenting practices or performance under

(almost) real-life conditions. (This is within the constraints of periodic windows of observation, and depends on those windows being frequent, on different days and at different times of day, and ideally sometimes unannounced.) Home-based infant parenting assessment suits those situations in which it is unclear whether parents can and do use the knowledge and skills they possess in everyday life with the infant.

A major strength of the core PASDS assessment frameworks and tools is that they are essentially behavioural, focussing on acts of commission and omission, and yielding clear and specific information. It appears to be relatively easy for parents to understand the judgements made and the basis on which the judgments are made. PASDS behavioural assessments answer the 'what' questions about infant care, but do not intrinsically deal with the 'how' and 'why' questions. While the behavioural model may be particularly suited to parents with learning difficulties or particular knowledge and skill gaps, it does not necessarily provide an adequate basis for complex parenting assessment situations in which there are psychodynamic, motivational, interactional, and socio-economic sources of variability within the parent's care-giving performance and relationship with the infant.

Home-based assessments, in particular, potentially have much to add to an understanding of *how* environmental, motivational, situational and social factors inhibit or enhance effective parenting practices. This is a more *dynamic* assessment, yet most of the PASD frameworks as they stand focus on the parenting practices themselves, rather than on an analysis of the dynamics of the situational-personal-parenting practices interplay. In theory, at least, these kinds of assessments are within the scope of intensive family preservation services, informed as they are by both social work and psychology frames of reference, provided that they are also acutely infant-aware. For PASDS to meet this assessment purpose with more trustworthiness, it appears essential that the 'other factors' added to some assessment frameworks (see above) and the 'social/environmental' dimensions be further developed to assist in pin-pointing critical information for this dynamic analysis.

While it might be argued that this broader form of assessment is beyond the scope of the PASDS, and is a responsibility of the Child Protection Service, drawing on other reports PASDS have the face to face relationships and opportunities with the families, and may need to do this work to inform their subsequent skills development. There is a need for further work on how these issues are to be addressed. While one solution, often employed to date, is to 'buy in' additional psychological and other assessments to supplement the parenting assessment, neither this nor the assumption that the Child Protection Worker will complete the dynamic assessment may be the optimal solution.

At heart is the question of whether 'parenting' is an entity or a behavioural cluster that can be extracted from the rest of the personal and social functioning of the parent/s. Also, whether it can be extracted from the broader child rearing processes undertaken by parents assisted by other actors in the social and institutional environment, or whether this is to reify a construct. The argument is not merely academic, but has practical and legal ramifications, including:

- What is it that parents are consenting to when they agree to go to a PASDS or to have one come to them for a parenting assessment?
- How is the evidence of good or poor parenting performance presented to ensure that the constraints upon generalisability are understood and taken into account in decision making and case planning?
- On what basis can the PASDS assessment help the Child Protection Worker understand whether a family has changed or is likely to change in its parenting performance?

3.2 Developing Parenting Skills

The earlier research commissioned by the Department of Human Services gives some context to the HRI Project's efforts to help families care for their infants. *The High Risk Infants Known to Child Protection Literature Review* (Jackson et al., 1999) found that many programs for infants at high risk sought to intervene in time to divert the children from the child protection system but when the family already demonstrated major problems in such areas as substance abuse, mental illness, disability and poverty. That is, they were 'secondary prevention services' within a wide band,

some aligned with readily accessible primary services and some dealing with children already maltreated.

Most service models reviewed had a mix of components, including centre-based and in-home, with some including residential service. Most used a mix of volunteers and professionals from different disciplines, and emphasised skill in relationship formation as the key attribute. While services might explicitly target families with one salient risk factor, such as substance abuse, their response was multi-faceted, focussing on direct care skills, mother-child attachment, health care and often maternal employment and educational attainment. 'Models that address multiple levels of families' needs were found to be most successful'. (Jackson et al., 1999:34) The need for inter-agency collaboration tended to be taken for granted.

In the Victorian child and family services system, this mix of approaches is most likely to be found in family support or services usually auspiced by non-government agencies. These kinds of services have been developed since the early 1970s from in-home 'family aide' programs of varying duration and levels of depth, augmented by additions of different programs and funds over the years, including in some cases intensive family preservation programs modeled on the *Homebuilders* approach. They typically offer a mix of centre-based individual, family and group services, parent education and in-home support.

3.2.1 Differentiating PASD Interventions from Family Support Interventions

What differentiates in-home PASDS skill development from these other family support services or intensive family preservation services? Primarily, it is the clear focus on infant health and development, and a commitment to explicit evaluation and correction of inappropriate parenting behaviour, while rewarding parenting practices that nurture the infant in an age-appropriate way.

Most of the existing family support and family preservation services have worked closely with the Child Protection Services already, have existing expertise, and undertake some of the interventions found in the PASDS. Even so, they often lack several key components relevant to infants: infant and mother-infant expertise, on-site mental health and drug and alcohol treatment practitioners, and a residential

capacity. For the PASD component of the HRI initiatives, this residential capacity has been provided by a small handful of mother-baby services, mental health establishments, and intensive family-based services, but each of these types has historically worked to a different set of practice and program definitions. The mother-baby services have a maternal and baby health emphasis, with the Queen Elizabeth Centre, for example, still being a registered hospital.

Within Victoria, this history and service system configuration has led to the situation where none of the programs clustered under the HRI initiatives provides the full range of such services. The model is less one of self-contained holistic programs than it is one of service components linked together through Child Protection Service case management, guided by SIPWs and informed by expert practitioners of different disciplines.

In a consultation conducted for the *High Risk Infants Parenting Assessment and Skill Development Research Project: Phase One Research and Analysis* (Littlefield, et al. 1999), local practitioners nominated nursing, social work, psychology, psychiatry and paediatrics as the relevant disciplines for programs for high risk infants, acknowledging their different contributions. They did, however, call for a common assessment framework to help bring together this disparate set of service providers working to a new common purpose. In its search for possible contributors to a common tool, the *High Risk Infants Parenting Assessment and Skill Development Research Project: Phase One Research and Analysis* (Littlefield, et al. 1999) named the core parenting skills areas to be addressed as:

- Basic child care (infant handling, health, safety).
- Basic infant-parent interactions.
- Promoting attachment.
- Teaching new skills in managing challenging childhood behaviour.
- Adjunctive interventions (for example, managing stress, anger and relationship conflict; coping skills; partner support, communication, problem-solving and teamwork).

The limited data available from this implementation study of the PASDS, reported in previous sections of the present report, suggests that all PASDS routinely attend to the first four of these areas, often in great detail. Drawing on Maternal and Child Health models of child care and parenting advice, and on concepts

and processes from the field of infant mental health, they have been able to offer a more infant specific set of interventions than appears to have been the case in family support work.

Child Protection Workers and, as far as we can see through anecdotal evidence, parents, appreciate the core parenting skill development work. In particular, feeding and settling difficulties are often tackled, and improvement in these areas helps stabilise the babies' development, makes them less difficult to care for, and enhances parents' sense of mastery and competence. Not only do babies appear to benefit directly from improved daily care, but this work also offers parents, many of whom have been traumatised and/or demoralised by psychosocial stressors, the opportunity to experience joy in their parenting. This experience of joy appears to provide a powerful motivation for improved parenting, raising the credibility of the workers who facilitate it, and enhancing the process of making links to other relevant services. While not necessarily explicit in the formal PASD program materials, the 'joyful parenting' contribution of PASDS is evident in case discussions and in the reports of the satisfaction parents feel when their parenting is assessed as good, despite official doubts about this.

3.2.2 An Orientation to Competence

Pecora, Whittaker and Maluccio et al. (1992) argue that the concept of *competence* is critical for family-centred child welfare practice. Their use of competency theory incorporates a strengths perspective, which PASDS have also found to be important, but it goes further than the 'solution focussed' trend. Pecora et al.'s framework is immersed in theories of competency motivation, not just re-framing and choice-making, and attends to the innate desire for '*effectance*', and the self-feeding reward systems that come from effective behaviour. What we observe as 'competence' or 'competent parenting' is seen not as innate but as situational and motivational. The professional role is not simply to assess whether a parent is or is not competent, but to establish settings and relationships for learning that will capitalise on latent capacity and engage innate effectance – the desire to learn and master behaviour in the environment.

The accounts from the PASDS suggest that this ecological perspective on competence would provide a valuable lens for viewing the work of parenting skills

development with high risk parents. It articulates with the behaviourally oriented skills training programs, recognises the importance of setting and relationship, and links the question of motivation with the question of parenting capacity and adequacy.

A competency motivation approach might help with further exploration of what PASDS report to be the problem of 'readiness' for skills development. The approach encourages us to consider the impact of prolonged substance use, recurrent trauma and patterns of hurt and distrust, and of fear and survival behaviour (as evident in situations of domestic violence) on the parent's learned experiences of personal effectance and their sense of an internal locus of control (Campbell, 1998).

3.2.3 Interventions Beyond Infant Care

While all PASDS offer basic infant care interventions both as part of the assessment process and for those families who proceed to 'skills development' episodes, they differ in the attention they can and do give to the 'adjunctive interventions' mentioned by Littlefield et al. (1999). It tends to be those PASDS based within the broader family services that offer a wider range of parental and situational interventions. The argument for the wider range of interventions rests in part on the complexity of need and the degree to which those needs can be met elsewhere. It is very important to note the significant proportion of families with serious issues of substance abuse, violence and other family difficulties. Most PASDS are not organised to specifically tackle these issues, but are confronted with their effects on parenting. It is not always the case that these conditions do negatively affect immediate child care, as is shown by those families referred for assessment but found to be parenting adequately or well. These experiences have been important cautionary notes to the reliance on 'risk factors' as indicators of child wellbeing (Boyd, 1999).

There have been, however, many families whose complex needs negatively rebound on infant care. While substance abuse, domestic violence, and mental illness (the most common examples) might be viewed as contextual issues with regard to parenting, it is contended by the evaluation team that such concerns are deeply inter-twined with the business of child-rearing, practically, physically, emotionally, cognitively, socially and economically (see also Cleaver et al., 1999; Campbell, 1998).

From a competency perspective, risk factors relating to severe substance abuse, depression, domestic violence and similar personal challenges are not extrinsic to parenting capacity but part of the competence-motivation-opportunity cluster of circumstances. For successful parenting actions to generate the thrill of achievement and the desire for even more satisfying parent-child interactions, parents need a level of awareness of stimuli and an ability to focus on the interaction with the infant, free of pressing and competing psychic and social demands. The service system will need to assist the parents to remove the impediments to being fully with the infant; simple sequencing of personal and parenting interventions may not suffice. The 'adjunctive interventions' named by the *High Risk Infants Parenting Assessment and Skill Development Research Project* in 1999 become not so much 'adjunctive' as **core**, just as clinical and lifestyle interventions become not merely context but keys to parenting.

3.2.4 Coordinated or Integrated Service?

At this stage we lack the outcome data to know whether the more targeted infant care models of PASDS provide better or more lasting effects than the more holistic approaches., just as we lack sufficient evidence to draw strong conclusions about whether relevant additional expertise is best provided on site or elsewhere. In relation to parental substance abuse, for example, many writers have commented on the complex service needs of substance abusing parents (such as Barth et al., 1993; Berry, 1996; Cleaver, Unger and Aldgate, 1999.) Often they tend to focus on the multiple parallel needs, such as housing, health, material provision, mental health as well as parenting, and on referral and service coordination as critical intervention processes. Similar calls for coordination are now more routinely heard in relation to family violence and parental mental illness as well as substance abuse. (Department of Human Services, 2000; Gopfert et al., 1996; Cowling, 1999; Hampton et al., 1998.)

While service collaboration provides one route to meeting the varied needs, it may be necessary to consider much more integrated multidisciplinary efforts to address the interaction effects of parental conditions and infant care (Barth, 1993; Brooks and Rice, 1997; Campbell, 1998). It is difficult to know how we can validate the assertion that some parents are not

‘ready’ for PASD interventions, or lack motivation for parenting improvement, unless this challenge for more integrated models of intervention (by whatever service system arrangements) is seized, because we have not given families an opportunity to truly address the personal/parental interface issues. This would require a deeper analysis of and response to the particularities of their problems and the relationship of these to parenting practices. There is evidence of this more tailored approach by PASDS emerging with respect to parents with intellectual disabilities. However, there is a way to go before we meet the challenges posed by the specific concerns, contexts and meanings of the other major groups of problems and beginning to be discussed in a more differentiated way in the professional literature (for example, Boyd, 1999; Cowling, 1999; Mowbray et al., 2000; Hampton et al., 1998; Fleck-Henderson, 2000; Sun, 2000; Ray et al., 2000.)

In the internal evaluation of the Uniting Care Connections’ PASDS to the Northern and Eastern Metropolitan Regions, Mitchell asserts that there is evidence that, for some of these more troubled families, engagement with the service system is possible, but this rests on the capacity of the service to build the conditions of service. Motivation cannot be treated as a ‘given’, but may need to be built within the service. She also argues that this work takes time, and that the short-term model may not be appropriate for some families. This is a position also taken by a group of very experienced child welfare researchers in the US (McCartt Hess, McGowan, and Botsko, 2000). Mitchell draws particularly on Tierney’s notion of ‘excluded families’ to identify those PASDS clients for whom brief interventions may pose more risks than they solve, noting the need to be alert to such factors as:

- Lack of active relationships with family and friends.
- Focus on survival rather than developmental goals in family life.
- Closed to community help or unproductive relationships with service providers.
- Limited involvement in community life (early school failure, no employment history, marginal and illicit forms of income generation).
- Entrenched difficulties across a range of life tasks.

These families are challenging for PASDS because they have often already had children removed and/or it is difficult to argue from a brief period of service that the

infant can be safely cared for in the family. Yet their survival skills may be such that bare minimum goals are achieved and the protective case may be closed with referrals to community services, even while we might have little evidence from the history that these referrals are likely to be sustained. The development of the present and subsequent infants remains in jeopardy.

More follow-up research would be needed to see if such prophecies are fulfilled. Meanwhile, the assertions of the value of more holistic approaches from those PASDS that have developed or are developing links with other local longer-term and multi-faceted services should be taken seriously and consideration given to ‘best practice’ models of integrated rather than segmented care. Beginning work is occurring on these issues in the Southern Metropolitan Region consortium, Western Region’s experiments with the parenting service–women’s substance abuse service link, the Goulburn Valley program mix, and Uniting Care Connections’ theory-based practice research and evaluation.

3.2.5 The Need for a Social Network Orientation?

Extending the notion of an ecological view of competence, it could be argued that no infant protection program can work to its full potential without a social network orientation. To date there is little evidence from the PASDS implementation evaluation that the parenting skills development has encompassed the informal social network contribution to parenting competence. Stories of direct and creative interventions with family members, friends, or semi-visible partners were notable exceptions to the rule.

The dominant model of ‘parenting’ of infants as enacted by the PASDS remains essentially that parenting is a private and individualised set of activities by biological parents, in keeping with the dominant ideology of the legal framework, and the harsh reality that infants are most likely to be harmed by the actions of those having their most full-time care. This is a reasonable starting point, but should not be the end of the matter. Child Protection Workers may be more oriented to the social support dimension (though this has by no means been universal), than a focussed parenting skills development service can be.

PASDS assessment and reporting frameworks do tend to make a first step, in asking parents to name a small number of informal as well as formal sources of support who may be available in a crisis. For many high risk infants, however, there is a cast of players implicated in their care. Among the child protection clientele, parents with mental illness and those with intellectual difficulties appear to rely quite heavily on members of their extended families for crisis and long term child care, advice and multiple other forms of assistance. The infant’s wellbeing can be enhanced if these players are aware of and able to consistently reinforce or enact the practices and concepts conveyed in the parenting program.

Lindsay et al. (1999) in a small Western Australian study, have noted the high level of inter-connectedness of first-time adolescent mothers with their extended families and support network, when compared with their use of formal services. The Victorian HRI practitioners have reported considerable difficulties engaging and retaining engagement with some high-risk adolescent parents, in part because of the lifestyle volatility and mobility also noted by Lindsay. While some had histories of traumatic family life, and ‘extended family’ cannot be assumed to be an unambiguous source of support, effective skills development may require tighter connection to, and resourcing of, the young parents’ informal networks of advice and assistance, and less reliance on the formal service linkages that are part of child welfare’s tools of trade. An aspect of this, as Mitchell notes in her internal Uniting Care Connections’ evaluation, is that some of these young parents and infants have not yet formed a recognisable family unit, and the parents have not yet taken the parent role into their identity or lifestyle. In this context, links to parenting/family oriented services will be fragile.

Informal social networks may play an important part in setting, maintaining or eroding norms or standards for the physical home environment and the social arrangements for infant care (Sun, 2000.) It is in the informal world that expectations are conveyed about what is ‘good enough’ in terms of home care, baby-sitting arrangements, who the infant mixes with, and exposure to desirable and undesirable environments and experiences. While it is evident that there is a lot of work done on infant care in the PASDS, there is considerable variation in the degree of attention paid to improving the social and physical environment of infant care. The very positive reports from Southern and Hume Regions and from Uniting Care Connections about the value of integrating PASDS work with follow-up and more broadly conceptualised family support or intensive family services suggests that these approaches should be explored in more detail, but part of that exploration should be an examination of the service impact on the infant and parent’s physical and social world.

3.3 Parenting beyond the PASDS

A critical issue for these services is how gains made in parenting practices will be sustained once the service has ended. There are a number of pathways families can follow, and each pathway poses some questions to which the various practitioners must attend.

<p>Residential/Centre-Based Assessment</p> <p>Parenting inadequate</p> <p>Infant placed</p> <p><u>Question:</u></p> <p>Have the parent and significant others taken from the PASDS some information and positive attitudes to assist with later parent-child contact, possibly reunification, or with parenting a subsequent infant?</p> <p>Is it clear that the residential/centre-based conditions did not create the parenting difficulties?</p> <p>What has the agency learned about the family to aid future planning and parent-child contact?</p>	<p>In-Home Assessment</p> <p>Parenting inadequate</p> <p>Infant placed</p> <p><u>Question:</u></p> <p>Have the parent and significant others taken from the PASDS some information and positive attitudes to assist with later parent-child contact, possibly reunification, or with parenting a subsequent infant?</p> <p>What has the agency learned about the family to aid future planning and parent-child contact?</p>
<p>Residential Assessment or In-Home Assessment</p> <p>Parenting adequate</p> <p>Infant and parent return/stay home with no further services.</p> <p><u>Question:</u></p> <p>Have the parent and significant others taken from the PASDS some information and positive attitudes to assist with later stages of the infant's development or later family crises, or with parenting a subsequent infant?</p> <p>Is the parent connected with a source of competent and accessible information and support for the parenting role?</p> <p>Are there services in place to deal with psychosocial difficulties that are likely to precipitate further parenting crises or undermine parenting competence?</p>	
<p>Residential/Centre-Based Assessment</p> <p>Parenting marginally adequate and needing development ></p> <p>Refer to in-home additional assessment and/or skill development</p> <p><u>Question:</u></p> <p>What are the uncontrolled variables in the home environment that might invalidate the residential /centre-based assessment?</p> <p>Are there safety plans in place should these overwhelm parenting competencies?</p>	<p>In-Home Assessment</p> <p>Parenting marginally adequate and needing development ></p> <p>Refer to in-home additional assessment and/or skill development</p> <p><u>Question:</u></p> <p>What have been the impediments to parenting in this environment and what must change if further intervention is to yield more gains?</p>

<p>Centre-Based Skill Development and/or In-Home Skill Development</p> <p>Parenting adequate</p> <p>Infant and parent return/stay home with no further services</p> <p><u>Question:</u></p> <p>Have the parent and significant others taken from the PASDS some information and positive attitudes to assist with later stages of the infant's development or later family crises, or with parenting a subsequent infant?</p> <p>Is the parent connected with a source of competent and accessible information and support for the parenting role?</p> <p>Are there services in place to deal with psychosocial difficulties that are likely to precipitate further parenting crises or undermine parenting competence?</p>
<p>Centre-Based Skill Development and/or In-Home Skill Development</p> <p>Parenting adequate but ongoing support and services needed</p> <p>Family linked to new services</p> <p><u>Question:</u></p> <p>Have the new services been apprised (with client consent) of the particular strengths and vulnerabilities of the family, to guide their assistance?</p> <p>Is the family also supported by informal helpers (kith and kin) who share the values of the service system with respect to infant wellbeing and child development needs?</p> <p>Are there services in place to deal with psychosocial difficulties that are likely to precipitate further parenting crises or undermine parenting competence?</p>

4. Recommendations

4.1 Funding and Contracts

- Funding and service arrangements between Regions and PASDS providers be developed that provide secure, long term PASDS delivery but continue to enable a flexible service response.
- PASDS funding occurs across a longer-term cycle, enabling proper recruitment, training and retention of staff within programs and the development of 'best practice' service delivery models.
- Program target numbers need to be set on the basis of the numbers through the most recent past full year of service delivery. The target numbers need to be regularly reviewed and negotiated to reflect a realistic picture of PASDS provision.
- The continuation of brokerage funding is key to ensuring flexible service delivery responsive to family needs and, as such, it should be continued as an element of the HRI initiative.
- Resources need to be made available to facilitate stronger linkages between PASDS providers and key intellectual disability, drug and alcohol, mental health and family support agencies.

4.2 Program Infrastructure and Conceptualisation

- The establishment of regular, at least quarterly, meetings between PASDS providers with the aim of providing a forum to discuss referrals, service delivery frameworks, problems and solutions.
- A process of consultation with PASDS providers be commenced with the aim of establishing a broad framework for assessment based on current best practice and research.
- The potential of the day-stay programs may be underdeveloped. Some time and effort needs to go into establishing the relative benefits and niche or application of residential, day-stay and in-home modes of service delivery.
- Practice experience indicates the need for a ten-day residential PASDS program. Some time and resources need to go into establishing the rationale of the need for the ten-day PASDS, developing a best practice model and implementing this across delivery sites.

- A common **framework** for assessment rather than a single assessment tool should be developed, to include items that can evaluate a parent's capacity to learn, maintain information and learning and apply these differentially.
- Suitable learning aids for PASDS providers should be made available, such as videos, visual cue cards, games. The amount of time agencies have to spend developing their own tools should be minimised.
- A mechanism for feedback to PASDS providers on the protective outcome of cases they are involved in should be developed and implemented

4.3 Service Delivery

- The gate-keeping process should continue to be brokered by the HRI manager or SIPW as it is key to ensuring families most suitable receive a PASDS.
- The timing of referral into the program needs to be based on consideration of a number of factors that require clear articulation. These factors should include the family's openness to learning, willingness to participate and stability in personal environment. The program must remain voluntary.

4.4 Service System

- Service integration be developed between PASDS, HRI managers and specialist intellectual disability, drug and alcohol, and mental health service. The development of these relationships needs to include cross-fertilisation around the issues of referral, service delivery models and staff training.
- To maintain, where possible, an integrated model of service delivery by creating strong links to family support agencies.
- Providing families with services that can follow PASDS is essential for some families. Consideration needs to be given to the most appropriate post-PASDS arrangements for families. The funding of any follow on program needs to be shared between specialist departmental areas such as intellectual disability, psychiatric services and drug and alcohol services.

4.5 Research

- A major research project needs to be undertaken aimed at establishing ‘best practice’ models within PASDS. This research should involve assessing the outcomes of the various service models currently in operation. This research should include variables, such as the duration and intensity of the intervention, the type of intervention, tools used in the intervention, characteristics of families worked with and characteristics of the staff delivering the program.
- To establish a minimum common data set on need/intervention/outcome data on PASDS families to provide insight into the factors impacting service delivery and program outcomes.
- A careful study of the effectiveness of interventions needs to be undertaken to establish the elements of service delivery important to the production of positive outcomes.
- To continue to establish best practice models through rigorous evaluation and research of practice activities. PASDS providers need to be resourced adequately to take up this responsibility.

Glossary/Abbreviations

PASD Service or PASDS

Parenting Assessment and Skills Development Service:

A specific initiative, within the High Risk Infants Service Quality Improvement Initiatives of the Victorian Department of Human Services, Child Protection and Juvenile Justice Branch.

HRI

High Risk Infant:

A child under two years of age known to the Child Protection Services and judged to be of high risk according to the risk factors disseminated in program guidelines.

Child Protection Services:

The Victorian Child Protection Services operate under regional management, with reference to policies and standards set by the central Child Protection and Juvenile Justice Branch of the Department of Human Services.

CPW

Child Protection Worker:

Front-line employees of the Child Protection Services, usually trained at tertiary level in social work, welfare studies, psychology or other relevant disciplines, who undertake investigation, assessment, case planning, protective intervention and supervision of children and families under court orders.

SIPW

Specialist Infant Protective Worker:

A Child Protection Worker appointed and trained under the HRI Service Quality Improvement Initiatives to have designated responsibilities for monitoring high risk infants and consulting with child protection workers and others about their case planning.

ECW

Early Childhood Worker (previously known as Mother Craft Nurse):

Front-line staff in PASD and other child care services, trained in and responsible for direct care of children and assistance to parents with child care.

MCHN

Maternal and Child Health Nurse:

Nursing practitioners with further education in maternal and child health nursing, responsible for the assessment of infant health and wellbeing and advice and guidance to all parents.

Department of Human Services

Department of Human Services:

The Victorian State Government Department housing the Child Protection Services, and hence the HRI service quality initiatives, alongside a variety of other juvenile justice, health, mental health, disability and children’s services.

PSP

Partnerships and Service Planning:

The section of the Department of Human Services regional structure that manages contractual arrangements with non-government agencies providing services on behalf of Department of Human Services.

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Appendices: Appendix A—A Profile of PASDS Delivery across the First Twelve Months of Operation

Details of Regional PASDS Residential and In-Home Assessment and Skills Development Services Delivered across the First Twelve Months of Operation

ITEM	EMR	NMR		SMR		WMR #	BSW	GIPPS		GRAMPS	HUME QEC		LMR
Date funding commenced	Nov 1998	R July 1998	In H Mar 2000	R 1997/ 98	In H 1998 /99	July 1998	G Jan 99* W Aug 99*	R 6/98 case by case	In H 98/99	Not Available	R June 1998	In H 99/00	1999 (case by case, resi QEC only)
Date PASDS commenced	Dec 1998	R July 1998	In H Mar 2000	R July 1998	In H Aug 1999	Feb 1999– October 1999, interim currently	G Feb 99 W Oct 99 1999,	6/98	Sept 1999		6/98	8/00	Not yet formally established
Date of first referral	Dec 1998	R 13/7/98	In H 6/3/00	R 9/7/98	In H 4/8/99	15 Feb 1999	G 18/2/99 W15/11/99	18/6/98	14/9/99		18/6/98	2/8/00	14 Dec 1999
Number of residential referrals	10	29		61		20 (4 Anglicare, 16 Tweddle)	G 5 W 0	9			9		6
Number of in home referrals	9 (SD)	14 (only OEC 5 months)		47		26 A 23 SD	G 15 W 6	32			9		Not Applicable
Number referred for A & SD**	25	43		108		69	G 21 W 6	41			2A 16 SD		6
Number accepted for A & SD**	8	42		108		67	G 20 W 5	41			18		6
Number completing A & SD**	24 A 9 SD	33 complete 8 ongoing 2 withdraw		83 complete 13 ongoing 12 withdraw		19 resi 26 assess 23 sd	G 18 W 5	24 complete 12 ongoing 5 withdraw			15		5
Age breakdown	All under 2	Both R/IH 0–4wk (13) 4–13 wk (6) 3–12mth (9) 1–2 yr (35) 1–2 yr (35) 2–3 yr (9) > 3yr (10)		0–4wk (14) 4–13 wk (18) 3–12mth (48) 1–2yr (35) 2–3yr (22) > 3yr (9)		To come	0–4wk (2) 8–12wk (1) 3–6m (7) 6–12m (10) 1–2yr (8) 2–3yr (2) (inc sibs)	0–4wk (3) 4–13 wk (2) 3–12mth (19) 1–2 yr (15) 2–3 yr (18) > 3yr (13)			0–4wk (1) 4–13 wk (0) 3–12mth (9) 1–2 yr (6) 2–3 yr (7) > 3yr (1)		0–4wk (1) 4–13 wk (1) 3–12mth (2) 1–2 yr (2) 2–3 yr (1) > 3yr (2)
Cases involving PASDS staff in court	12	1		Resi 7 In Home 0		2	4	Nil			1		Nil

EMR Eastern Metropolitan Region
NMR Northern Metropolitan Region
SMR Southern Metropolitan Region
WMR Western Metropolitan Region

* G = City of Greater Geelong, W = City of Warrnambool
** A & SD = Assessment and Skills Development
Given the range of players within the WMR there is some additional data available on the numbers through each individual service.

Appendix B: Service and Regional Profile of PASDS

Table 1: Residential Assessment Services

Site	Queen Elizabeth Centre	Tweddle Child & Family Health Service	O'Connell Family Centre
Duration	10 days, 24-hour supervision	10 days, 24-hour supervision	5 days (Monday–Friday), 24-hour supervision
Schedule/Process	<ul style="list-style-type: none">Referral, pre-admission interview (overview of protective concerns and PASDS).Admission2–3 days initial assessment, care planning and intensive one to one teaching.Five days participation in group parenting skills program with other families. 2–3 days of reassessment of progress in applying and consolidating learning and future planning.The process is complete with a discharge planning meeting.	<ul style="list-style-type: none">Referral, pre-admission interview (overview of the protective concerns and PASDS).Admission3–4 days observation and assessment then individual goal setting occurs with the family and a skills development plan is established for the remaining time at the service. Plans are constantly reviewed and often areas of work have to be prioritised.The process is completed with a discharge planning meeting.	<ul style="list-style-type: none">Referral, admission meeting on each Wednesday, admission on Monday.Observation and assessment across period. Thursday discharge meeting.Some families find accommodation for the weekend and then return for a further 5 days.Discharge meetings are always held on Thursdays.
% of Client Group	4 PASDS out of 16—up to 25%	1–2 PASDS out of 10 families—up to 20%	1 PASDS out of 10 families—up to 10%
Goal Setting	At pre-admission interview with CPS and client. Goals are further developed with client once in PASDS.	At pre-admission interview with CPS and the PASDS. An overview of the protective concerns and the role of PASDS in addressing these are provided at the meeting. Tweddle has individual goal setting with the family once they are in residence.	Broad goals are set at an initial intake meeting attended by child protection worker and sometimes UCC.
Assessment Framework (described in detail in following section)	QEC – Parenting Competencies Assessment Instrument Parenting competency is assessed along a scale of adequacy, being defined as knowledge, skills and attitudes considered to be at least equal to those of parents in general population.	Tweddle has refined and developed an instrument based on the QEC model. Within this model, parenting capacity is defined in terms of adequacy, defined as <i>parenting competence to a level that is equal to an average parent's understanding and practice of</i>	Based on a child-centred, family-focused approach. Measuring the level of adequacy of parenting along the following categories: <ul style="list-style-type: none">HygieneNutritionSafetyHealth needs

Site	Queen Elizabeth Centre	Tweddle Child & Family Health Service	O'Connell Family Centre
Assessment Framework (described in detail in following section)..cont	<p>Categories assessed:</p> <ul style="list-style-type: none"> Physical health and well-being, including nutrition, hygiene, safety, health needs, sleep requirements. Emotional development, Cognitive or intellectual development. Social development and environmental awareness. <p>Focus on the strengths of the family is incorporated into the assessment process.</p>	<p><i>parenting behaviours that ensures the child is nurtured, protected from preventable injury and illness and that normal developmental progress is enabled.</i></p> <p>The categories assessed are:</p> <ul style="list-style-type: none"> Physical health Parent/child interaction, including social and emotional development Parent health and wellbeing. <p>Focus on the family's strengths is incorporated into the assessment process.</p>	<ul style="list-style-type: none"> Sleep requirements Parent-child interaction Cognitive or intellectual development Social development and environmental awareness Stress management. <p>Focus in the assessment is on the strengths as well as the deficits in the parenting practices of the family.</p>
Learning Tools	Demonstration, modelling, peer instruction via group work, videos, visual cues.	Demonstration, modelling, peer instruction, via group interaction.	Demonstration, modelling, peer instruction, via group interaction. Time and motion activities with ID clients.
Review and Reporting	<p>Review is ongoing across the ten days.</p> <p>A clear picture of what will be in the report is provided at the discharge meeting.</p> <p>A written report is provided to CPS as soon as possible after discharge.</p>	<p>Review is a constant part of the assessment process.</p> <p>If necessary, clients are asked to sign a statement saying they have been told what is in the assessment. A formal report is provided within days after discharge.</p>	<p>Review occurs continually across the stay.</p> <p>Clients are aware of the assessments being made. A formal report is provided two days after discharge.</p>
Staffing	Maternal & child health nurse coordinator, assisted by mothercraft nurse/early childhood workers	Maternal & child health nurse coordinator, assisted by mothercraft nurse/ early childhood workers	Maternal & child health nurse coordinator, assisted by mothercraft nurse/ early childhood workers
Outcomes	No clear patterns emerging.	No clear patterns emerging.	No clear patterns emerging.

- Key Features of Residential Assessment PASDS**
 - Goal setting is approached collaboratively.
 - The assessment process is completely transparent, with clients continually aware of the observations and assessments being made.

- Given a client’s ability to learn and retain knowledge is essential for the development of their parenting, skills development is an intrinsic part of the assessment process.
- It is important to establish the learning style suitable for the family.
- The assessment is observation and evidence based.

Table 2: In-Home Assessment and Skills Development Services—Metropolitan Regions

Metropolitan Region	Eastern	Northern	Southern	Western
Model	Uniting Care Connections (UCC)– Family Focus program	Queen Elizabeth Centre (QEC) – Outreach	Queen Elizabeth Centre – Consortium including: <ul style="list-style-type: none"> Port Phillip Child and Family Services Southern Family Life Anglicare Frankston Windemere Child & Family Services 	Abercare Family Services Anglicare – Werribee Family Services
Design	All inhome PASDS are delivered by two family support workers. Assessment and skills development can be provided by the same workers.	West Heidelberg Maternal & Child Health Centre is the site of the Northern PASD in home service. A team of 2 Maternal & Child Health Nurses and 2 Mother Craft Nurses staff the program. Assessment is undertaken by the Maternal & Child Health Nurse with Mother Craft Nurses implementing skills development plans.	Co-ordinated by two Maternal & Child Health Nurses located at QEC. In home parenting assessment is undertaken by the co-ordinators with some observations undertaken by Early Childhood Workers. If families go on to receive skills development early childhood workers and family support workers from the consortium agencies provide this ongoing support. Families have the possibility of receiving ongoing family support from the same agency once the PASD service is complete and this is decided towards the end of the program.	Presently these services provide inhome skills development only. The generalist staff of the program deliver PASD. Both agencies have a program co-ordinator and team of inhome support workers. PASD referrals are given priority into the existing family support service. Services are purchased from the agencies in blocks across the year.
Duration	Up to 30 days assessment and 30 days skills development. The frequency of the visits across the 30 days depends on the needs of the family and the level of supervision required.	The program runs across 12 weeks. The intensity of service delivery across this time depends on the needs of each family. Ten to twelve families are worked with at any one	The program runs across 12 weeks. The first two weeks are used for assessment and the establishment of a skills development plan for the family. The assessment process is intense for the first	The program offered at both services runs across 12 weeks with up to 20 hours of service delivery time for each client. This amount of time includes travelling and administration.

Metropolitan Region	Eastern	Northern	Southern	Western
	Not all families who are assessed through the in-home program go on to receive the additional skills development component of the program. Although some skills development work occurs during the assessment period.	time. This is the equivalent of one referral each week across the year.	weeks with workers visiting clients 4 – 5 times in the week. During this period, clients are introduced to the family support worker and early childhood worker who will be responsible for the implementation of the skills development plan. A formal review of the work occurs at week ten and the PASDS is closed at week 12. The length of the program can vary from the 12 weeks. It is either interrupted or can be extended if the need is present and all parties agree.	Given the services are requested to provide in-home skills development, there is not a formal assessment process. Both services undertake an assessment of families needs to guide their work with the family.
Schedule/process	Referral into the program comes via the HRI staff at CPS. At this point the needs of the family are carefully discussed and consideration is given to issues that may be impinging on the family. Once a client is referred into the program the coordinators and child protection worker involved meet with the client to discuss the program. The assessment process is outlined to clients. With inhome clients the engagement process can take a long time. The amount of time each day spent with a client varies according to needs and availability. Skills development	After a referral has been made from the CPS a pre intake meeting is held to clarify protective concerns, gain the families support and outline for the family the distinction between PASD and CPS, clarify what will be involved in the program and finally to establish a start date. At this stage it is also established whether the program is for assessment or skills development. The family also has an opportunity to state what they want at this meeting. The initial assessment period lasts daily for 5 visits usually around 8 to 12 hours in all. These visits are undertaken by	The referral process involves a response time of a week. Once a referral is determined to go ahead an intake interview occurs between the family, the PASD coordinator and CPS. At this meeting information is shared regarding the reason for the referral, the role of the PASD, the staff providing the service, the protective concerns in the case, the parenting difficulties as understood by players present at the meeting, what the family would like to achieve during PASD involvement and clarification of all legal and protective expectations.	Anglicare: The referral is taken by the home support coordinator. If the referral is suitable a referral form is completed by child protective worker and sent to Anglicare. An initial home visit is undertaken involving the protective worker, inhome family support coordinator and PASD worker. A period of intervention follows which includes: the identification of family goals, ongoing assessment of risk and skills development that includes parent modelling, life skills, education and information strategies, and review of

Metropolitan Region	Eastern	Northern	Southern	Western
	is an integral part of the assessment process particularly with home based PASD. A lot of information sharing and general support is provided to families by PASD workers.	the Maternal & Child Health Nurse. It is made clear at these meetings that the ongoing work with the family will be conducted by a Mother-Craft Nurse and they are introduced to this worker during the assessment period. The assessment period is used to identify the parenting strengths and deficits and a skills development plan is developed at the end of it. Although there are times when no skills development occurs because of the need to remove a child or the family no longer wants to work with the team. The frequency of contact with the family is important particularly in identifying how they manage in situations that occur in everyday life such as shopping, sleeping, feeding times, outings etc. In cases that go through to completion discussion about finishing and the gains they have made and how they will manage on their own, starts early in the work. With clients who are difficult to engage the time of service delivery has been extended.	Families sign a contract of participation at the end of this meeting and a record of the meeting is kept and provided to all present. Once the PASD is underway the initial phase involves assessment of parenting competency and the establishment of a skills development plan, is primarily done by the QEC workers. The skills development plan is then sent to the family support agency and is implemented between week 4–11 of the service. At termination families are assessed for their suitability to receive generic family support services. The family support agencies within the consortium provide clients with this ongoing family support, where possible the same worker is involved with the family. The skills development process is built on a based model where the focus is on the strengths the families have as well as the deficits that need attending to.	progress. Towards the end of the service delivery period progress towards goals are assessed and linkage into community support service for ongoing support occurs. A final meeting with the family is held which includes the PASD provider, CPS, future community support services and the family. A report is then provided to the CPS. Abercare: A referral is received from CPS and checked for its suitability with the inhome support coordinator. A referral form is completed by the Department and an initial meeting with the family and the child protection worker is organised at which goals are established and information regarding the role of the PASD and CPS are outlined. Initially the workers observe the situation within the family and assess how best to implement the skills development plan. The service uses a solution focused approach, which builds on strengths and develops the parents' confidence in their capacity to parent effectively. Clients are linked in to appropriate community support services for ongoing support towards the end of the PASDS process.

Metropolitan Region	Eastern	Northern	Southern	Western
Staffing	Workers involved in the PASDS program are social work or welfare studies trained. A Maternal and Child Health Nurse is used sessionally to advise on PASD service cases.	The team is entirely early childhood trained. Two Maternal and Child Health Nurses and two early childhood workers (previously known as mothercraft nurses). The nurses undertake the assessment phase with each family and the early childhood workers implement the skills development plan.	Workers involved in the delivery of the southern home based PASD are part of a multidisciplinary team. The QEC team comprises the co-ordinators who are Maternal and Child Health Nurses with the assistance of Early Childhood Workers. The consortium family support agencies employ a mix of social workers and welfare workers whose experience of child development is variable.	Anglicare: Workers involved in the delivery of the PASD are either trained social workers or family support workers. Abercare: They use an explicit model of social worker linked with family support worker. Families will have contact initially with both workers.
Goal Setting	The program is tailored to the needs of the families using it. Goal setting occurs collaboratively with clients and is reviewed across the life of involvement with the family.	Goal setting is undertaken with each family according to their particular needs and circumstances. The process is as transparent and collaborative as possible. There are no surprises for families. Goals are kept simple and involve specifying concrete indicators for improvement.	Goal setting commences at intake meetings and occurs throughout the life of the PASDS. The processes are always collaborative.	Anglicare: The goal setting process is a complex area. Often the CPS does not provide a clear indication of the goals they want addressed. The workers establish goals with the family in a collaborative way. Abercare: Goal setting involves the family at each stage And is always undertaken collaboratively.
Assessment frameworks	Uniting Care Connections use a framework that the agency developed across a number of years. The framework used explores the following areas of family experience. Presenting problem, family membership, engagement	The program uses the QEC Parenting Competencies Assessment Instrument. This instrument provides indicators of competence grouped according to children's needs with respect to their emotional development, physical health	The program uses the QEC Parenting Competencies Assessment Instrument. This is supplemented by a more ecologically focused assessment provided by family support services. These assessment focus more	Anglicare: The agency is currently in the process of developing an assessment tool based on the U.K. child in need model. But because assessment isn't the focus of the PASDS most time is spent establishing with the family their skills development needs.

Metropolitan Region	Eastern	Northern	Southern	Western
	issues, worker safety issues, current crisis, an assessment of individual family members, risk/needs assessment of children, specific protective concerns, family structure, family functioning, family development, family dynamics, interactions and communications, cultural dimensions, family and environment relationships.	and wellbeing, cognitive/intellectual development, social development and environmental awareness. Competency is assessed using a scale of adequacy defined skills, knowledge and attitudes are considered to be at least equal to those of parents in the general population. The assessment includes a focus on parental capacity to learn and put learning into practice.	strongly on the environmental influences affecting the family's capacity to parent.	These often turn out to be building social support networks. Abercare: Development of the skills plan involves the ongoing assessment between the worker and family of the learning needs of the family and the learning modes the family feels most comfortable with. Workers use their knowledge of risk assessment, attachment theory and learning theory as the base to the development of a skills plan.
Learning Tools	Use of the working alliance, observation, questioning, development of trust, modelling and information provision.	Observation, discussion and questioning. Demonstration and modelling. Spending time and building a trusting relationship.	Observation, discussion and questioning, demonstration and modelling.	Anglicare: Often these families have television as central to their lives so videos are used as teaching aids, mostly from the positive parenting series. Demonstration and modelling. Abercare: Workers use a mix of role modelling, information provision, observation and feedback with families to implement the skills development plan. With ID clients it is necessary to establish how they learn. With all clients it is important to establish what is inhibiting or able to enhance learning.

Metropolitan Region	Eastern	Northern	Southern	Western
Review & reporting	The time of the reporting is also established case by case. Weekly contact is had with the Child Protective Worker involved with informal reporting occurring. A formal assessment report is provided at the end of the assessment period, which can be up to 30 days.	The coordinator prepares the formal reports for the department. Records are kept for each family. These are used in producing the final report for the CPS. Informal debriefing with workers occurs after every visit and issues are carefully monitored across the life of a case. Once a week the team goes over the progress of all the families. Feedback more formally to families three weeks into the skill development process. The coordinator is in weekly contact with the HRI manager to discuss referrals and any issues arising with families.	Formal reporting occurs at the end of the assessment phase and the end of the PASDS program. There is ongoing informal contact between the coordinators and workers delivering the PASDS. There are formal bimonthly meetings between PASDS program staff. A protocol document exists which establishes certain standards of practice across agencies. This protocol document also provides an overview of the program model to assist workers establish how they need to approach the work. Formal training has been provided to all workers to establish some commonality of practice and processes across agencies.	Anglicare: The formal reporting process with the department occurs at the end of the program. Although there is weekly contact with protective workers regarding the case. Abercare: There is a formal report produced at the end of the skills development process. Although there is weekly contact with the CPS during the life of a case and monthly meetings of all professionals involved in the PASDS program.
Outcomes	There are no clear patterns of intervention though it is clear that clients have to want to learn and change for any meaningful work to be done. Clients who can focus on their baby's needs and put their own needs aside seem have the most successful outcomes.	The only clear patterns are most clients have CPS involvement when they were children. The physical care of children seems worse in cases of abuse. Clients that are more difficult to engage are most likely to be young mums or parents with lots of previous CPS involvement and have a lot of services involved in their lives.	No clear patterns have emerged, in terms of service delivery. Although it has become clear that family support is needed across the life of the PASDS and can occur concurrently with the assessment process. Most families finishing a PASDS go on to receive ongoing family support. Sometimes it can be difficult to engage clients so they only start getting benefits when it is time to finish.	Anglicare: The families that come to the program are varied with a range of needs and complex problems. They usually come within the statutory 90 days. There are always parenting issues involved but often link to social isolation and poverty. Abercare: There is a mix of clients using the PASDS and no clear patterns of service delivery are emerging.

Metropolitan Region	Eastern	Northern	Southern	Western
Key Features	The flexibility of the program and the ability to tailor an intervention to a family's particular needs. Transparency of the process, the value of delivering services in an open and empowering manner.	The flexibility of the program. That successful engagement relies on having complete honesty with families. Frequency and consistency of involvement is essential to successful assessment and planning. Having a consistent message being delivered to parents from all potential players including placement support workers, other family support services involved.	The flexibility of the program. The process being open and transparent to families is essential. Family support needs to be provided across the life of the PASDS. The link to family support services provides the opportunity for a fully integrated service delivery to these clients.	Anglicare: The program is flexible, strengths-based, and supportive of the families. The holistic family approach used at the agency provides a necessary supplement to the parenting focus. Abercare: Strong links intra-agency and inter-agency. The program is flexible and can meet the needs of clients.

Table 3: In-Home Assessment and Skills Development Service—Rural Regions

Metropolitan Region	Eastern	Northern	Southern	Western
Model	City of Greater Geelong (CGG) Warrnambool City Council (WCC)	Queen Elizabeth Centre (QEC) – Outreach	QEC – Outreach, Goulburn Valley Family Care (GVFC)	Ballarat Child & Family Services (BC&FS)
Design	Separate services developed in both regional centres, run through the local council Maternal and Child Health Services. Many of the process are similar as the WCC model built on the CGG model. CGG can offer either residential, inhome or daystay assessment. All skills development is undertaken inhome. WCC is only set up to deliver in-home assessment and skills development.	QEC manages the Gippsland service with local teams based at regional Maternal and Child Health Centres at Arrayal and Moe. time workers service the region. Two act as coordinators and they are supported by two early childhood workers.	QEC manages the service with a local coordinator based in Wangaratta working with other early childhood workers providing in-home assessment and skills development. GVFC integrated model of maternal and child health worker and family support worker working from within a Families First and Parent/Child program. This includes a hour on call service and access to a telephone counselling service.	As a discreet service within BC&FS. Run from the stay facility belonging to BC&FS. Coordinator and two parttime workers run the PASD.
Duration	The PASDS is provided by both agencies across 12 weeks. The first three weeks are spent assessing the family and then nine weeks are spent in skills development. The intensity of service provision across the period depends on the family, its location and needs.	The PASDS conducts a 12-week program with varying intensity of contact. Not all families will receive skills development at the end of the assessment period.	QEC: The model involves a 12-week program with varying intensity of contact. Not all families will receive skills development at the end of the assessment period. GVFC: A combination of a three-week assessment program and, if appropriate, a 12-week skills development program follows.	Assessment occurs across six sessions. Skills development can occur across 13 to 20 weeks with varying intensity.

Metropolitan Region	Eastern	Northern	Southern	Western
Schedule/ process	A referral comes to the service and the family's suitability for the program is established. Although there is contact between the PASDS and the child protection worker the initial meeting does not necessarily involve all three. The PASDS makes contact with the family and establishes its role and how the program is going to proceed. At the initial meeting with the client a contract of participation is signed. Then the assessment process commences. During this process it is important to observe and not advise as much as possible given the need to have a realistic picture of the parenting. Once the assessment is complete the skills development plan is established and implemented. Families can receive up to three months of PASDS delivery in Barwon/South West. At the end of the three month involvement a skills development report and final parenting skills competency table is submitted to the HRI manager.	The service delivery process is well documented in a protocol document between CPS and QEC. Referral from CPS is made and then an intake meeting is organised between the CPS worker, PASDS and family. At this meeting information is shared regarding the issues facing the family, protective concerns, what PASDS provides, the content of the assessment and what to expect. At this meeting the family will sign a contract with PASDS and an initial assessment visit will be organised. The assessment involves 45 visits and at the end of this process a report is produced. The assessment is discussed with the family and a skills development plan established with them. At the end of the skills development process the family is linked into any ongoing social support appropriate and available. A termination interview is held between the family, CPS and the client at the end of the PASD delivery process.	QEC: Referral from CPS is made and then an intake meeting is organised between the CPS worker, PASDS and family. At this meeting information is shared regarding the issues facing the family, protective concerns, what PASDS provides, the content of the assessment and what to expect. At this meeting the family will sign a contract with PASDS and an initial assessment visit will be organised. The assessment can occur in two ways either an intensive period across 10 working days (6 X 2hr visits at varying times in the day) or a less intensive number (45) of visits and at the end of this process an assessment report is produced. The assessment is discussed with the family and a skills development plan established around the indicators that were found to be less than adequate. At the end of the skills development process the family is linked into any ongoing social support appropriate and available. A final meeting is held in the last week of PASDS where clients are linked into services and the family's progress is reviewed. The meeting involves the family, CPS and the client.	A referral is forwarded from CPS. This is a formal process and the details of the client and their situation are forwarded to . An initial meeting is set up between all players and families sign a contract of participation with BC&FS. The assessment process occurs at home or in the day centre across 2–3 hours over a period of 4–6 weeks. The process of skills development usually involves the production of a skills development negotiated with the family and based on the assessment. he parenting competencies are established as well as the client's ability and willingness to learn. The length and intensity of this service depends on the individual needs of the family and these vary considerably.

Metropolitan Region	Eastern	Northern	Southern	Western
			GVFC: The PASDS involves both the Parent/Child Program and the Families First Program. All assessments are undertaken by the PCP. Gatekeeping occurs within the department as referrals come into the program and have an assessment five days across three weeks. An assessment report is then prepared. The report might be to receive skills development, to go to residential or to place child. If skills development, then PCP worker and Families First worker would provide the skills development training for families within the home across 12 weeks. The level of intensity depends on the family's needs.	
Staffing	The model in both agencies is for a coordinator who is a trained Maternal and Child Health Nurse with the support of one or two Early Childhood trained workers (previously known as Mothercraft Nurses).	The model employs two coordinators who are trained Maternal and Child Health Nurses and Early Childhood Workers.	QEC: The model employs a coordinator who is a trained Maternal and Child Health nurse and two early childhood workers. GVFC: The model employs Maternal and Child Health Nurses and Early Childhood Workers within the PCP and Social Workers and Welfare Workers within the Families First Program.	The model employs a coordinator who is a trained Maternal & Child Health Nurse and two workers who are trained as a primary teacher and as a welfare worker/probationary psychologist.

Metropolitan Region	Eastern	Northern	Southern	Western
Goal Setting	Goal setting occurs collaboratively with families across programs.	The goals for the skills development are developed collaboratively with the family.	QEC: The goal setting occurs collaboratively with the family. Having a comprehensive assessment process means what needs working on is fairly clear. GVFC: Goal setting is undertaken collaboratively with clients. Men are encouraged to be a part of the process.	The goal setting process is established collaboratively with clients.
Assessment Frameworks	The assessment format used is uniform across the region and was developed by the HRI manager and Barwon PASDS coordinator. The assessment covers indicators relating to the child's physical health and wellbeing, hygiene, safety, health needs, sleep requirements and routines, social and emotional development, cognitive/intellectual development and environmental awareness.	The QEC parenting competencies instrument is used to produce the assessment report and provides the basis for the skills development plan.	The QEC Parenting Competencies Instrument is used to produce the assessment report and inform the skills development process. GVFC: Maternal and child health development charts and worker knowledge are used in assessing parenting competence, based on Steiner & Gunner Developmental Milestones and the Victorian Risk Assessment Framework. The assessment is formulated with the input of the HRI manager.	The assessment format and skills development programs used by the service are based on a range of validated assessment instruments, where available, and are consistent with health and psychosocial frameworks that emphasise strengths-based, safety-oriented, family-centred approach. The assessment covers indicators relating to the child's physical health and wellbeing, emotional development, understanding age appropriate child development, safety and social development.
Learning Tools	The assessment is conducted primarily using observation and discussion. The skills development component occurs using demonstration and modelling techniques with parents.	The assessment is conducted using observation and discussion. The skills development component is conducted using primarily practical demonstration and modelling techniques.	QEC: The assessment is conducted using observation and discussion. The skills development component is conducted using primarily practical demonstration and modelling techniques.	The assessment is conducted using observation and discussion. The skills development components are developed using demonstration, visual

Metropolitan Region	Eastern	Northern	Southern	Western
			GVFC: Because of the integrated nature of the model, the assessment is conducted using a mix of observation and discussion, while the social support needs of the family are attended to by the Families First program. The skills development work uses a mix of modelling, practical assistance, demonstration and encouragement.	presentation of material, use of videos, modelling and information provision.
Review and Reporting	Reporting occurs formally with the preparation of the assessment, skills development plan and final skills development review. Contact between the PASDS coordinator and HRI manager would happen weekly, this occurs (fortnightly in the South West). Within the program there is ongoing contact between the coordinator and program staff.	Reviews within the program happen at the end of each visit where workers feed back to the coordinators. Contact with the HRI manager is usually frequent because the infants are at high risk.	QEC: Within the program, workers feedback to the coordinator after each home visit. The coordinator has ongoing contact with the HRI manager in the region. The assessment report is a formal reporting requirement and a report is produced at the end of the skills development phase where that has occurred. GVFC: Formal report writing occurs at the end of the assessment period and the end of the skills development phase. Daily contact is maintained between the CPS, HRI manager and the PCP coordinator.	The assessment process is reported on at completion. There is regular contact with HRI staff and ongoing discussion and debriefing between the program coordinator and workers.

Metropolitan Region	Eastern	Northern	Southern	Western
Outcomes	There is no clear pattern of outcome. Each family's needs are unique and varied and delivery reflects this uniqueness.	There is no clear pattern of outcomes emerging. Although with most of the clients the importance of play and the emotional development of children is little understood as is the need for loving interaction with children. Safety is a big area of concern as is emotional abuse. Clients need to be willing to do the work involved in the program for it to succeed.	QEC: There is no clear pattern of intervention and outcomes emerging. Most clients seem socially isolated and are not well linked in with the existing network of support services. The areas of parenting competence most deficient are emotional attachment with the child and safety. GVFC: There is no clear pattern of the link between intervention and outcomes. But in terms of the problems families present with it is clear that there are issues around breast feeding Shepparton has the lowest rate in Victoria, a lot of education around SIDS, safety and contraception education.	There is no clear pattern of intervention and outcome emerging. The varying needs of families make each case quite unique.
Key Features	The program is flexible and can be delivered from multiple sites.	Flexibility of the program. The ability to design the skills development around well assessed areas of need. Works extremely well with Koori families.	QEC: The flexibility of the program. It is tailored to the precise needs of families. That the service is successful for some clients and they maintain what they learn. Accepted by the Koori community in the area. GVFC: The integrated nature of the service works well for a rural community. Inclusion of men and working positively with men is a feature in the area.	The local base of the program is a real strength, as is its integration within the BC&FS service network. The existence of such a service for these clients is also an important strength.

Western	
Southern	<p>The program is working well with the local Aboriginal community.</p> <p>The ability to provide a 24-hour on call service to PASDS in-home clients means they can get a more comprehensive a total support package.</p>
Northern	
Eastern	
Metropolitan Region	

Appendix C: Implementation Issues from Phase One Report

Implementation Issues

As part of the evaluation process, PASDS providers were asked to identify the

strengths, achievements and weaknesses of the PASDS alongside the policy issues arising from the implementation process.

The following points provide a summary of the responses from PASDS providers and High Risk Infant, Child Protection Staff.

Program Strengths

The program strengths identified by PASDS stakeholders were:

- The opportunity to develop an agency assessment tools based on existing research and practice wisdom.
- PASDS delivery is informed by practical and manageable learning frameworks.
- PASDS are seen by families as supporting their efforts and, as such, there is a high level of client participation, completion and satisfaction with the service they receive.
- In most cases the presentation of expert assessment by PASDS staff is well received by the Children’s Court. This is improving the relationship between the CPS and court in cases involving high risk infants.
- On the whole, there is a positive impact on families receiving a PASDS as their parenting capacity is enhanced.
- The ability to tailor individual skills development plans for families.
- The work done by PASDS provides strong evidence from which long term cases plans can be developed within the Department.
- The establishment of PASDS has strengthened the relationship between the CPS and community-based family support agencies.
- The development of PASDS has strengthened the ability for universal parenting services to work with a difficult and high needs client population.

Program Weaknesses

The program weaknesses identified by PASDS stakeholders are:

- The interim nature of the funding has inhibited the development of new frameworks for the delivery of services. On the whole, service delivery has been integrated into existing programs.
- The lack of cross-regional planning and development in terms of design and delivery of PASDS.
- The lack of family support available to families receiving PASDS alongside their need for parenting skills development.
- Some families receiving PASDS are extremely deprived. These families need sustained longer term skills development and support if they are to successfully keep a child at home in their care. Currently this need is unmet by PASDS or existing family support agencies.
- A framework for dealing with case failures is underdeveloped within the program.
- The ability of PASDS to successfully deliver services to families with drug and alcohol issues or mental health issues is limited due to lack of appropriate infrastructure, lack of suitably trained staff and lack of strong linkages between PASDS providers and drug and alcohol and mental health agencies.
- There are difficulties created as the result of working for the Child Protection Service, particularly when conflicts arise regarding the ethics of information sharing and client involvement in decision making. Community-based PASDS require voluntary involvement by clients; but is this realistic when the Department is referring a case and often this is the families only chance of keeping the child at home?

Funding and Program Design Issues

- Most PASDS providers and the Department had difficulty developing and costing models of service delivery. The level of service use and appropriate service intensity was difficult to predict from the outset. The implementation process has produced a much clearer idea of the appropriate level of service delivery to families and the cost of this.
- The interim nature of much of the implementation funding has worked against the development of fully operational specialised service delivery systems.

- The tendering process worked against the establishment of a new service model.
- The stability and maturity of the program is severely diminished by the interim nature of the funding, requiring the employment of staff on short term contracts.
- The fixed nature of the budget will mean a reduction in the number of units offered to deal with increases in service provision costs.
- The targets established for funding have been arbitrarily set. Work needs to go into establishing sensible targets based on the first year of service operation and knowledge gained regarding the frequency and intensity of service provision to PASDS families.
- It has become apparent that there is a conflict between the wish for flexible funding (purchases places) and the need for a high quality predictable service response for HRI families. The latter requires stability of funding and targets negotiated with the PASDS provider to ensure the availability of appropriately staffed services and places. The former requires short term planning that reacts to need and relies on the goodwill of existing services to maintain the program when it isn't being used as the 'dip in' model.
- There is an established need for a number of families with high risk infants to receive both a residential PASDS and in-home skills development. This should be factored into future funding frameworks.
- The worker contact hours needed to successfully implement both residential and home-based PASDS are higher than initially expected.
- Continuity of case worker through the process of assessment and skills development is beneficial to clients.

Referral Networks

A number of PASDS providers and CPS staff identified several referral issues relevant to the implementation of PASDS.

Referral in

- The point of referral into a PASDS needs development and should be informed by research into the point in the process that interventions will be most effective for clients.

- In one agency, referrals made during the investigation stage have received better outcomes. This is consistent with literature on the impact of early intervention. It is important to avoid using PASDS to strengthen a Departmental case on its way to court. Families need to feel they have a real chance to demonstrate their parenting capacity if the voluntary nature of the program is to be maintained.
- Adequate and consistent referral protocols between the Child Protection Service and PASDS are essential to quality service provision.

Referral out

- There is a clear need for program links with family support agencies and some form of cross-referral. The competitive tendering process has, in some regions, damaged these relationships in a way that has created obstacles to effective post-PASDS planning.
- There is a need for case monitoring and crisis support to be available to these families on an ongoing basis.
- There is an established need across regions to strengthen the linkages between PASDS and drug and alcohol and mental health agencies. This community development work is essential to the implementation of an integrated service delivery system.
- There is a strong need in rural areas to inform and train workers in using PASDS and to train local services to be able to deliver PASDS.

Relationship between the CPS and PASD Service Provider

- There is an important need for a child protection case manager to remain involved in a case until the PASDS has been completed. This is particularly relevant for in-home skills development services. This means that a case should not be closed during the involvement of a PASDS as the final PASDS assessment should inform future planning for the case.
- There is a need to monitor parenting capacity and performance as intense services are reduced with a view to determining whether safe and effective parenting can be sustained. It is difficult to find a way to do this through the existing PASDS arrangements. This raises the question of who's responsible for the welfare of the child post-PASDS.

- All PASDS providers expressed concern at the lack of feedback they received from the CPS regarding the protective outcomes for the families they work with. They see this information as essential to the ongoing development of the program.
- There was also a need, in some instances, for debriefing to occur with Department staff and this was not always made possible.
- Sometimes due to the different expectations of PASDS from the Department and the family, conflict can arise over matters such as providing families with information about their progress and work within the program. This creates some ethical tensions for PASDS providers and the situation can become extreme in contested court cases. Secrecy and judging a person's parenting capacity is not a good basis for the establishment of a strong working relationship with the family, which is essential to achieving positive outcomes for clients.

- Good communication between the Department and PASDS is dependent on the HRI manager being available to attend to program needs as they arise. This can not occur and the strength of the specialist program gets diluted when specialist staff are used within the Department for other purposes.

Other Issues

- There can be a problem working with other agencies as they are involved in advocacy for the parent/s rather than the child, which is the PASDS responsibility.
- The framework and models used for providing parenting assessment and skills development at PASDS could be extended and used with non-protective clients, particularly with parents with intellectual disabilities and other more general parenting problem groups.

Appendix D: Summary of Comments Made During Stakeholder Interviews Regarding Aspects of PASDS Provision

D1: Summary of Comments regarding Access and Referral into PASDS, Made by Regional High Risk Infant—Child Protection Workers

Eastern Metropolitan Region

- The key to the process working is good communication between the Child Protection Workers in the HRI team and the PASDS providers.
- The eligibility requirements of the PASDS providers do limit access to the service. Issues of most concern to PASDS providers are violence and drug and alcohol use. This is difficult as a number of clients have issues related to this and so their access to the service is limited.
- There are some concerns regarding throughput. Ongoing discussions are being held with the PASDS provider.
- Some families need a greater intensity of service provision than others; therefore, there is a need to maintain the flexibility that enables this to happen.
- The five day stay available at O'Connell is a problem as it creates additional work if the child can't go home and can be disruptive to the family. The service also has a complex referral process that limits the use of places.

Northern Metropolitan Region

- More training is needed to ensure non-specialist child protection staff are able to identify more of the gaps in parenting competency and child development when they visit families.
- SIPWs are used as consultants by general case workers, but because of the lack of basic skills of workers, SIPWs end up carrying too much of the case load and get spread too thin as a result.

Western Metropolitan Region

- Very active control of all referrals into the program. How the PASDS is used is determined case by case by the HRI manager and team leader involved. Each case is carefully monitored regarding flow-through and quantity of service delivery.

Barwon South Western Region

- There is a gap in the provision of adequate psychological testing provided for clients, particularly around cognitive abilities. This should proceed any PASDS provision.
- An issue in the South West is the numbers that can be attended to. It takes a long time to get set up because of the travel time.

Grampians Region

- HRI worker time is often taken up by other duties making it difficult for them to attend fully to a family's needs.
- Need to be more aware of the funding available for brokerage so that when access is becoming difficult, alternative assessment can be purchased.
- Need to have some formal follow-up process for the families.

Southern Metropolitan Region

- Feel somewhat removed from the home-based PASDS and unsure as to how it is going. Some concerns regarding the time it takes to get access to a place if there is an influx of referrals.
- Unclear where PASDS is best used in cases of re-unification.
- The system works well in cases where CPS is clear about what they want.

Gippsland Region

- Of 187 cases referred to the HRI manager, 27 per cent have been referred onto PASDS. These are cases where parenting competence has clearly been an issue.

Hume Region

- Adolescent parents and parents with intellectual disability or low intellectual functioning figure strongly in the profile of clients receiving PASDS.

D2: Summary of Comments on the Quality of the PASDS by Regional High Risk Infant Child Protection Workers

Eastern Metropolitan Region

The program was contracted to be part of UCC's Family Focus program and they subcontract the residential component to O'Connell. This seems to work well except the O'Connell residential component can only provide a five day facility. UCC themselves doesn't have a 24-hour service they have an 'on call' system after 7.00 pm. Discussions were being held regarding the viability of providing a 24-hour service but because of organisational changes these discussions have been put on hold. There are some concerns about staffing levels and throughput and currently targets aren't being met. This seems to be exacerbated at present because of the organisational change at UCC. The UCC PASDS funding is still interim which makes it hard for UCC to commit fully to the development of the program.

A key element of the program design is the flexible and negotiated nature of each referral. The appropriateness of each referral is discussed between HRI team and family support co-ordinator; this is a key component of the service delivery process ensuring that an appropriate response for a family is provided.

It appears that some families require a greater intensity of service delivery than others and will receive up to three phases of service provision for up to 90 days.

There are some concerns regarding the service provision provided at O'Connell, the five day stay doesn't work well with most families needing at least ten days. This means plans have to be made for the infant's placement across a weekend, which can be disruptive to the assessment process and the family. A ten day assessment process would work better. O'Connell also runs an intake system where referrals have to be ready on a Monday and if someone drops out then the place is lost.

Families using PASDS are at the extreme end of protective clients, they are at serious risk of losing children. The PASDS is achieving some good results

with very difficult families by using the combination of the 30 day residential (not 24-hour supervision) and then in-home skills development PASDS.

No clear patterns are emerging regarding interventions producing good outcomes. Some families don't work well within the environment at O'Connell, which is very middle class. Every client referred to the PASDS receives an assessment unless they drop out, but not all go on to receive skills development. The PASDS provided at UCC are being used more for reunification through day-stay or in-home PASDS. There is a lot of confidence in the quality of UCC assessments.

If multiple agencies are involved in the client life, UCC workers identify if any of those services can take on the support role rather than adding another service to the list. They do this particularly with young mums who are part of their Starting Out program. Referral and linkage into appropriate programs is often done at the point of referral into the program. The PASDS has been used to provide secondary consultation to some other services such as Prahran Mission.

Northern Metropolitan Region

The Department was happy with the model presented by QEC, there was some discussion about the hours, but otherwise the model suited.

The HRI team and in-home PASDS team have a positive relationship. The PASDS coordinator is very competent, she had previously worked as a Maternal & Child Health Nurse at Olympic Village, so is used to working with clients involved with the CPS. The maternal and child health framework is critical to their strong observation-based assessments. Everyone trusts the PASDS workers' assessments. The approach used is very empowering for families as it is time-limited with clearly specified goals that are within the family's reach.

There can be a number of other services involved in the lives of these clients alongside PASDS, such as mental health, drug and alcohol, placement support workers, specialist children's services, intellectual disability services. The more services involved, the more the CPS worker becomes involved in appointment setting and feeling like the family's secretary.

The PASDS is being used everywhere across the life of a case. HRI teams want this flexibility in order to try and wrap the service around the family. The PASDS works best around meeting the direct care needs of families and identifying where other programs are needed; they are good at identifying gaps. The PASDS provides good evidence of parenting and helps identify strengths for families.

The model of observation-based assessment and recording provides a different but much needed approach. Protective has not been able to do this level of assessment for a range of reasons—lack of training, direction of child protection practice, the confidence of staff (this is in large part a product of the court treating staff so badly). Protective practice has become process driven—good at collecting information not analysing it. The recording process has exceeded the observing and workers have become overwhelmed with it.

The perceived separation between the PASDS and CPS is important for families. Everyone is very clear with the family regarding the role of the PASDS and this seems to work well.

The home-based PASDS is a strong program and needs to continue. The skills development component is working very well with generalisation and maintenance of gains across time, although it would be good to build in an automatic follow-up at three and six months. Most of our high risk families would prefer to receive PASDS in their own home.

The reporting of the PASDS is good; it is comprehensive and clear and is incorporated into the court report. The HRI team has contact with the home-based PASDS provider every two to three days.

Western Metropolitan Region

The use of PASDS is tailored to a family's needs. PASDS are utilised around cases with statutory orders. PASDS are not greatly utilised for early intervention, more where protective concerns can't be resolved via existing community-based responses. Thus a mix of chronic and urgent cases get referred to PASDS. Skills development cases have all been statutory clients with chronic poor parenting.

Families within the residential program have a range of problems, not just poor parenting, with domestic violence and need for 24-hour monitoring. The skills

development work is directed by CPS with areas of skills development established. At case planning the child protection worker identifies what the protective concerns are then these are worked on by the PASDS. There is a review process part way through the program. There is contact between workers regularly, usually weekly if child is at high risk.

Within the home-based skills development service there are issues around who the client is and where direction for the work comes from. With one service there has also been some debate regarding whom the report belongs to—families have been given copies of the report when that shouldn't have happened. The process can be open without the family being shown the report.

The residential program at Tweddle works well. A day-stay program is being developed but there are issues around how to staff that program.

The in-home assessment component hasn't been working and this is a limit in the West. There is also a gap for parents with psychiatric disabilities as it is difficult to access a place at Banksia [the only mother/baby unit for women with psychiatric conditions] and Banksia doesn't provide adequate parenting assessments. Tweddle is nervous about taking on clients with psychiatric conditions, which highlights some of the limits to a mainstream parent/child services taking on protective clients. Workers at Tweddle have been nervous about the impact of these clients on other service users.

The PASDS report gets integrated into the CPS case and issues that have an impact on the safety and parenting capacity are highlighted in these cases. The integration depends on where in the protective process the PASDS is delivered. If applying for court order, the report becomes a part of the total CPS assessment.

The program is running six months behind because of the tender debacle.

The day program was developed to assist in introducing the idea of PASDS to hostile or reluctant clients. It is has also been successfully used in cases of reunification.

Southern Metropolitan Region

One of the program's strengths is that it is provided as part of a generalist service. Families accessing PASDS have often been stigmatised enough through their involvement with the CPS. It is often important to the clients that they experience parenting as something that can be problematic for everyone. It also provides clients with the possibility of learning from other parents and their peers.

The in-home PASDS is structured so there is a multidisciplinary team supporting the family with specialist assessment by the Maternal and Child Health Nurses at QEC and psychologists. Then the skills development component is conducted by family support workers within locally-based agencies. Sometimes family support workers can be too focused on environmental issues rather than parenting competencies. Because of the distance between family support agencies and CPS, the HRI team is unsure about how specialised the skill development component is. Protective services input into the in-home program is minimal. QEC as the lead agency maintains the leadership role with the consortium. Protective workers in the HRI team would like more direct communication, input and review of the in-home PASDS. One of the problems in doing that is the negative view held by some family support workers towards the CPS. The family support workers seem more family/parent-centred than child-centred and protective workers worry about what may happen when the focus is taken off the child. The quality of the in-home PASDS differs across the region and can depend too much on the workers in the program. A set of protocols has been established as a quality control measure across agencies delivering PASDS.

Some of the hurdles with family support agencies have been around confidentiality, as they are expected to report on everything; this can often feel incongruent with their role as 'support' workers.

The review and feedback process seems adequate within the PASDS, with the production of an assessment report and feedback at the end of the skills development process.

The development of the program will depend on building trust between PASDS providers and the Child Protection Service HRI team. The informal contact

between workers is just as important as the formal reporting requirements. Issues are followed up regularly and there is a lot of case discussion. The formal aspect of report writing has developed enormously, the Department has provided training around this and PASDS providers have been very responsive and proactive in improving their reporting practices.

The in-home PASDS design was built on the idea that often you can't separate the support and parenting skill needs of a family. The agreement with agencies in the consortium is that, if needed, PASDS clients can gain priority access to generalist family support services once they had completed a skills development program. Only about half the families who receive a residential PASDS go on to receive in-home skills development, but most of these families go on to receive family support.

There are no general patterns emerging and these would be hard to identify as the program is very case specific. From our experience it appears that the more the family can get out of the service the more likely they are to do well and succeed. It is a relief that QEC is not afraid to say the situation isn't working and then back this up in court.

Barwon South Western Region

The program was designed and developed, in close consultation, by both the PASDS provider in Geelong and the Barwon Region HRI manager. The CPS has had input into the development of the service at a range of levels. The PASDS has been built on a maternal and child health model of evidenced-based assessment. The South Western PASDS was started later and has built on the Barwon model. There has been problems finding appropriately qualified staff in the South Western PASDS.

The program has a basic framework but how things happen is very much organised around the particular needs presented in a case. The service works best if clients like or trust the person they are working with. PASDS are seen as the 'good guys' and exit surveys undertaken by PASDS worker highlight that most families like PASDS.

The PASDS assessment is integrated into the overall Department risk assessment for a family. The flexibility of the PASDS is important as it means there can be a

range of places across the life of a protective case when it can be used and because they have their own brokerage funds. PASDS can get any additional testing done.

The Barwon PASDS is well regarded at court and with local paediatricians. South West is still in development phase so they are yet to forge a strong presence in their area.

Grampians Region

The flexible funding system is essential. We need to be sure it remains available for high risk infants and not used for other purposes within the Department. Also, the flexible way that PASDS can be used is good—they can be immediate and provided either in-home or centre-based.

Every family who comes into the HRI program needs an assessment. Sometimes there is a need for cognitive assessments of the mother, particularly with low functioning or intellectual disability clients.

The need for longer term interventions is becoming clearer. The ten-day residential provides a strong basis from which to plan. Some of the best results have been with clients who have received the ten-day residential assessment and then the in-home skills development program.

The day program is excellent in providing high quality assessments.

Everything seems to work the best when the knowledge and skills of the PASDS staff complement that of the CPS staff. The link with maternal and child health assessments with risk assessment frameworks makes the assessment stronger.

The assessments produced by PASDS are valued and listened to by the courts and protective staff. The reports have helped CPS in their planning. There has been some joint PASDS/CPS work done around assessment formats.

Sometimes the relationship between Foster Care and PASDS, in terms of consistent advice giving, becomes problematic. Foster Care workers need to be providing the same advice as PASDS workers, particularly in cases of reunification.

The PASDS works well because of the knowledge, skills and expertise of the workers who provide it.

To make a difference, it is essential that the parenting style of couples is impacted as soon as possible in the life of the child. If it is a case of reunification, six weeks does not seem long enough for a proper transfer of knowledge and skills.

The fact that the PASDS are not strongly identified with the CPS means parents are more willing to be involved and more likely to be realistic about their own limits.

There are some difficulties in reaching clients in the remote western part of the region.

There are no particular patterns of intervention/outcome emerging.

Gippsland Region

The direction and staffing of PASDS is appropriate. There was a need for QEC to acknowledge some of the differences with the PASDS client group, families with issues present such as drugs and alcohol and domestic violence. But this has been tackled by the agency and workers are becoming more skilled in working with these particular families.

The initial aim of linking families into local services has not happened to the extent expected for a variety of reasons.

The PASDS reports are incorporated into the overall risk assessment as well as the recommendations as to whether the parents can adequately care for the child and the additional supports needed for adequate care to be provided.

The reception of the court to PASDS assessments has been good. Usually PASDS reports are accepted without cross-examination.

No particular pattern of interventions is emerging. No evaluation of maintenance of gains has been undertaken.

Hume Region

The Hume Region has two PASDS, one provided by QEC and the other by Goulburn Valley Family Care. The QEC model is based on developmental assessment and education and is not tied to other services in its

funding structure. Due to the service structure in the eastern side of the Hume Region, some gaps in service are present and collaborative seamless case practice can be difficult to obtain.

The GVFC program uses a compilation of developmental and systemic assessment models and is able to pass the case from service to service within its own agency structure.

The direction of PASDS seems well accepted by both clients and staff alike and it has good credibility in the court system as well. Given the current referral numbers, staffing levels would seem right. It is the ancillary programs, such as the mother baby programs and support services that seem to need enhancement.

In Hume Region, the PASDS are certainly being used the way they were intended. Goals are decided with the family and Department following initial assessment, this sometimes also involves discussion with other service agencies, doctors and maternal and child health nurses.

Reports are provided to the family and other professionals and are presented at case planning meetings for discussion. On the whole, the recommended actions from the PASDS report are included in case plans. Reports are also utilised in court reports.

Each family has had different interventions structured to their needs and success depends upon the case direction. In some situations, PASDS have been utilised to implement successful re-unification of children, in others it has quickly shown that the parent–child relationship is not viable, allowing cases to proceed to long term care in a timely fashion based on the child’s needs. Again, in others it has enabled parents to maintain care of the child in the home while developing parenting skills not previously held.

Impact of PASDS: High Risk Infant Team—Child Protection Service

Eastern Metropolitan Region

PASDS are seen as an integral part of the CPS service delivery process. However, expectations of PASDS can be unrealistic within the Department, which is why the central gate keeping process is so important. There has been a change in thinking about cautious practice and the complexity of risks and parenting practices with young children.

It is difficult for some protective staff to distinguish between PASDS and Families First, so it is often hard for the HRI manager to keep track of how the resources are being used and distributed.

Northern Metropolitan Region

Overall, the QEC model provides a ready check on what is happening in the parenting of some families. It helps shape the referrals and focuses attention on the infant. The PASDS provide the time, ability and competency that can’t be provided by protective workers who for the most part are very busy.

Western Metropolitan Region

Tweddle has taken on a greater commitment to protective clients as a result of delivering a PASDS.

Southern Metropolitan Region

Family support agencies are having more contact with the Department as a result of PASDS and the relationship between the agencies and the Department is improving slowly as a result of this.

Another impact has been to produce good outcomes, this is reflected by feeling confident the family won’t come back into the system, at closure. The program has helped the Department get families into the program in a timely way and to avoid drift. With the clearer assessments, faster decisions can be made. There is no other service that provides what PASDS do, the infant-specific nature of the focus has increased knowledge around working with infants and their needs.

The process with infants has shifted from being court driven to the court following the recommendations provided by QEC. The courts privilege QEC reports in their consideration and their contents are rarely contested.

Links with maternal and child health workers have been strengthened.

Barwon South Western Region

The PASDS has heightened the quality of HRI practice, by providing good specialist information on the parent/infant relationship.

Grampians Region

The establishment of PASDS has had a good impact on CPS by strengthening the assessment process used. Courts and other services are positive about the assessments and there seems to be less contested court decisions as a result.

Gippsland Region

There was initial concern that the service was to be provided by a Melbourne-based organisation, this seems to have dissipated as the workers are local, well established and working from local sites.

Hume Region

Provision of the PASDS have, to my knowledge, allowed the mother baby programs that were present in the Region to continue to operate day-stay and home visit programs that would have been lost due to cut back in funding two years ago.

These programs form an integral part of the post-referral and preventative structures.

PASDS Provider Comments

Uniting Care Connections—Eastern Metropolitan Region

The PASDS program within the Family Focus program is considered expert by the CPS. The referrals have strengthened the work undertaken by UCC with this high risk infant population. The PASDS has required the Family Focus program to attend to the assessment process more and has strengthened their ability to undertake evidence-based assessment.

O’Connell Family Centre—Eastern Metropolitan Region

The knowledge of the general staff has been broadened by having PASDS referrals. Staff development has been focussed on working with some of the issues that are present with this client group, such as anger

management. The way the program is staffed changes—there is a higher ratio worker to service user with PASDS referrals. Workers in the centre have become more sensitised to and more aware of some of the issues facing this client group, such as drug and alcohol issues, anger management, and intellectual disability issues. The program has not seemed to enhance the relationship with UCC but it has with the CPS. Taking PASDS clients impact on the waiting list for other families. The short notice of referrals and cancellations impact on staffing the centre, this creates administrative difficulties that need to be addressed.

QEC Residential—Southern, Northern, Hume, Gippsland

There is an administrative cost to providing PASDS that has not been adequately included in the funding formula.

Staff skills have been sharpened; they are more objective and respectful of PASDS clients. Staff at the centre now hold a more realistic view of what is involved in work with families involved with the Child Protection Service. Because funding hasn't been secured in some regions, QEC has had to take risks and provide permanent employment for workers in these 'interim' services.

The staff to client ratio has had to be modified. For PASDS clients there is more 1:1 work undertaken.

Tweddle Child and Family Health Service—Western

Tweddle has overcome some resistance from within the organisation to working with these clients because their behaviour can be so confronting and also the program requires a lot of additional report writing and paperwork. Workers have been challenged as the result of having PASDS clients and their observation and analysis skills developed.

The ratio of staff to client is higher for PASDS clients.

QEC In-Home—Northern

One of the impacts experienced by workers was to adjust their sense of 'adequacy' and risk with these clients. Child protection workers seem to be increasing

their knowledge of the need to include developmental information in their assessments and PASDS workers are often sought out for their opinion.

QEC In-Home—Southern

Has strengthened the relationship between QEC and the local family support agencies. Having the PASDS within family support services has strengthened their understanding of infant developmental needs. Services find that the prioritising of PASDS clients into generic family support programs has increased the waiting list times for other clients.

Abercare—Western

It is difficult to only be working on specific goals without having any involvement in the assessment process. Once the funding became interim, development of service linkages and other ways of strengthening the PASDS have been put on hold because of the uncertainty. The CPS seems unclear about exactly what they want. The lack of secure funding has impacted the agency's commitment to the PASDS and limited the amount of contact between CPS and Abercare. There are no longer any formal meeting points for the agencies involved in delivering PASDS.

By placing services at Abercare, the CPS was able to gain benefits from the multi-program agency.

Anglicare—Western

Providing the PASDS has increased the skills of the workers in the family support program particularly in the area of infant development, report writing and working with clients with complex problems, who are often volatile. Because the service is funded on an interim basis there has been a lack of adequate resources. The program is resource intensive and the need for fairly constant use of cars means they are unavailable for other program staff. Most PASDS clients are not in the Werribee catchment area. Workers have increased their knowledge of services available outside the Werribee area.

QEC In-Home—Gippsland

Maternal and Child Health Nurses have wanted to refer directly into the program. The establishment of PASDS has strengthened the relationship between the child protection service and maternal and child health services. It has also increased the awareness of infant needs within the CPS. The PASDS fills a gap as a

specialist service for 0–3 year-olds. Sometimes CPS workers see PASDS involvement as an excuse to do less with families and this compromises the quality of the work with the family as the PASDS is supposedly separate.

The Koori community has been positive in its reception of the program. It has provided a much needed set of concrete indicators around caring for children.

QEC In-Home—Hume

PASDS clearly complement existing services. They have helped child protection workers become more aware of children's needs and parenting competence. PASDS workers are more sensitive to the pressures workers within the CPS are under.

Goulburn Valley Family Care—Hume

Establishing the PASDS within the existing programs has increased the expertise of the service and helped build linkages with other service systems such as disability.

Ballarat Child and Family Services—Grampians

Having a PASDS has helped BC&FS see another side of these parents and what they need. The PASDS have also helped protective services see these families can learn to parent and has increased the Department's understanding of impacts on parents. The links with CPS workers have been strengthened with the establishment of PASDS.

City of Greater Geelong—Barwon/South West Warrnambool City Council—Barwon/South West

Establishing the PASDS has helped clarify roles between agencies and programs. Now the PASDS are seen as a complement to existing services. There is a positive exchange between many services that traditionally worked with children such as paediatricians, maternal and child health nurses and Koori liaison workers. The profile of maternal and child health in the provision of family services has been heightened.

High Risk Infant—Child Protection Workers Comments on the Lessons Learnt from the Establishment of PASDS and the Future Development of Services

Eastern Metropolitan Region

The establishment of PASDS has highlighted the need within the Department to integrate and raise the consciousness of CPS workers around the needs of young children. This is a constant process because new workers often have very little knowledge of children.

PASDS have provided the opportunity for families to learn and develop parenting skills. In a number of instances this has meant families have been kept together.

Initially it was assumed there would be a flow from assessment to skills development for all families but this hasn't necessarily been borne out.

In the future, there is a need to do more work on the structure of the final assessment report with services and more work with other assessment providers via brokerage.

The fact that UCC had previous involvement with protective clients was important as the PASDS has quickly become well known within the community.

Northern Metropolitan Region

The program needs to continue, it is helpful to the CPS and families gain a lot from the in-home PASDS. Clients don't particularly like residential services; clients with psychiatric conditions or drug and alcohol issues generally don't stay and complete the residential program.

Ideally, the HRI team would like to access other specialist services via the PASDS and to institute something like the panel idea, with specialists who can assess issues like the impact of violence and research support for case planning.

Western Metropolitan Region

Having a range of services providing PASDS has enhanced access for clients. This in turn helps to identify some of the features of service delivery

necessary for protective clients. The ability to use brokerage funding to purchase additional ‘expert’ assessments has strengthened the total assessment process.

The ability of the program to be flexible and tailored to client needs and circumstances is a great strength of the program. In the future it is important that a range of models exist, particularly in relation to assessment that can be differentially applied depending on the circumstances of the family.

Southern Metropolitan Region

There needs to be some way of dealing with families requiring residential support when there are children over five years old. Currently these families cannot be located at the Queen Elizabeth Centre.

It has often been necessary to organise cognitive assessments for parents prior to PASDS provision.

There is a need to maintain and develop the skills of child protection workers regarding infant development.

Future development is needed is to see men become more involved in the program. We would like to see the development of preventative services by using a similar model with young mothers not yet involved legally with child protection.

There seems to be a lack of idea sharing between Regions. Would like to see a standardised parenting assessment tool used throughout the PASDS.

Barwon South Western Region

There is a need for special psychological assessments of parents to assist in case planning; this would strengthen the analysis of cases.

Grampians Region

There is a need to ensure that consistent advice is given to parents across services.

There is a need for more workers to cover the Region. There is a need for a dedicated worker in the western part of the Region, which has a strong Koori population with special needs.

Working closely with the PASDS is essential for strong relationships to be maintained.

The HRI staff want to see the program maintained as it is the only community-based program that is so clearly child-focussed in its approach and adds an important dimension to the work undertaken with families in the Region.

Gippsland Region

PASDS have been well received by CPS staff, especially decision makers, as it provides vital information prior to case planning that wasn’t previously available.

A number of parents have said they have learnt much and realised they are not the only ones who have problems caring for an infant.

Hume Region

A PASDS is only effective if the family is receptive to the intervention.

Contact on a regular basis between the PASDS worker and CPS caseworker is essential.

Flexibility in assessment and service provision is necessary to meet families needs.

Skills that may be assessed as adequate in residential assessment may not be adequate in the client’s home environment, thus the ability to provide the service in both settings is essential.

The generic services provided by day-stay and mother baby home visiting services are an essential adjunct to the PASDS.

PASDS Provider Comments Regarding the Lessons Learnt during the Implementation of PASDS

Uniting Care Connections—Eastern Metropolitan Region

The skills development process occurs less than initially anticipated. This can be difficult for workers if the only work they undertake is assessment without the possibility of working with the family to address the concern highlighted.

Having PASDS workers integrated into the existing service structure has heightened the quality of practice within the Family Focus program.

The importance of building social support networks for families.

Minimising the number of services involved in these families’ lives has a positive impact on the ability of the family to engage in the work.

Some families are very difficult to engage and a great deal of time can be spent getting a family to work with the service making flexibility in service provision key to the service’s success.

O’Connell Family Centre—Eastern Metropolitan Region

Most clients need ten days for an adequate assessment to be undertaken. Unclear about the role they play with UCC. The relationship has not strengthened since PASDS and there are no ongoing formal meetings between the services. Most referrals seem to be coming directly from the HRI team within the Department and not brokered through UCC. CPS workers do not have a strong understanding of infant development needs.

QEC Residential—Southern, Northern, Hume, Gippsland

We vastly underestimated the coordination and clerical time involved in running the program. The report writing contributes to this but if don’t spend time on producing high quality reports then would spend more time in court contesting them.

Tweddle Child and Family Health Service—Western Metropolitan Region

The amount of resources required to get a framework together for the PASDS was greater than anticipated. Training staff well prior to working in the program would have been preferable. That you undertake a certain level of administrative and coordination work with clients who then don’t attend or abscond, this becomes frustrating and wasteful.

QEC In-Home—Northern Metropolitan Region

There isn’t a neat flow between the assessment and skills development components of the service. Work with the families is impossible if there are other distractions in their lives such as court cases pending. If the result is negative the working relationship is affected negatively.

As the development of a trusting relationship is essential to the work progressing well, using the same worker across the life of a PASDS is essential.

Flexibility is a key strength of the program.

The point at which the referral comes into the program has an impact on the outcome achieved. Clients have to be ready and motivated to change for the process to work. The scope for change is better the earlier the referral is made in the infant’s life.

QEC Consortium In-Home—Southern Metropolitan Region

The need to provide family support services concurrent with initial parenting assessment was not anticipated by PASDS.

The difficulty in engaging some of these families was a shock for some services. Some consideration needs to be given to the suitability and timing of referrals into the program. Sometimes more should be worked through with clients before commencing a skills development program. There is a demand for extending the model of the PASDS beyond the HRI initiative. There is also a need to remain engaged with these families beyond the delivery of an in-home PASDS, to ensure maintenance of learning and wellbeing of the child.

Abercare—Western Metropolitan Region

The key lesson has been that for PASDS to be useful, they need to be delivered early in the infant’s life. Assessments provided for clients are often too general to be useful in guiding skills development interventions.

Anglicare—Western Metropolitan Region

The program works well when the assessment process and intervention are well linked. A strengths-based focus is important with this population as they have often never been praised for anything they do.

QEC In-Home—Gippsland Region

There is a difficulty working effectively with long term chronic clients of CPS. They don’t want PASDS set up to prove the failure by being used to provide the evidence the court will accept regarding the inability of a family to provide adequate care for their child. A strengths-based approach works well with the client

group as often they have very low self-esteem. The process of reunification does not sit neatly in the model, the issues of access and assessment prior to provision of PASDS needs consideration. The model doesn't provide for adequate coordination time.

QEC In-Home—Hume Region

The PASDS are seen by clients as advocates for them with the CPS. There has not been the need to maintain the protocol of sending two workers to each home visit. For families doing well within the PASDS there is a ripple effect in terms of building their confidence and breaking a cycle of hopelessness.

Goulburn Valley Family Care—Hume Region

The integrated model works well in the country as families can be linked into a range of services provided by the one agency. Early intervention is essential if PASDS are going to break entrenched negative parenting practices. Early intervention is important as it is the only chance of providing kids with a good start to life.

Ballarat Child and Family Services—Grampians Region

The sustainability and transferability of skills into the home environment is essential for the PASDS to be successful. There is a need to have some follow-up contact or ability to keep in touch with families across time to see how they are going, particularly at times of change and development for the infant.

City of Greater Geelong, Warrnambool City Council—Barwon South Western Region

The ability to respond immediately to these families is essential. This is made possible by the flexible service delivery model.

The SIPW role is essential in reducing the administrative and report writing load of PASDS workers.

It has been difficult to attract appropriately qualified staff at the PASDS in the South West of the Region.

PASDS Provider Comments on the Future Development of PASDS

Uniting Care Connections—Eastern Metropolitan Region

For the PASDS to develop, funding needs to be more secure. It has been difficult to expand the service or commit to building up a 24-hour access facility without funding certainty. It is essential to maintain program flexibility and access to brokerage funding.

O'Connell Family Centre—Eastern Metropolitan Region

O'Connell would like to be involved in providing training for CPS regarding infant development.

To integrate a home visit into the residential program would assist with transition out of the program and the transferability of the skills learnt to a home setting.

QEC Residential—Southern, Northern, Hume, Gippsland

Funding needs to be secure with adequate administration time built into the formula. Provide scope to develop more multidisciplinary teams where QEC Residential can link more with drug and alcohol services or other service systems the clients are involved in.

Tweddle Child and Family Health Service—Western Metropolitan Region

The program needs to be made viable with secure funding at appropriate levels. Resources for training staff to work effectively with this client group need to be included in the funding for the program. To run a 24-hour PASDS requires secure and ongoing funding, at present Tweddle actually underwrites the costs of the program.

QEC In-Home—Northern Metropolitan Region

More flexibility is needed in terms of how the PASDS providers can remain involved with families.

Funding needs to be more secure and clearly structured.

Referrals need to be made to PASDS earlier in the life of a child.

QEC Consortium: In-Home—Southern Metropolitan Region

To keep working and refining the consortium model involves gaining secure funding for the program. Develop a system of training for workers that ensures a high standard of service provision across providers. To have the model funded securely enough to maintain staff. Family support programs need to be funded adequately to absorb the flow on from PASDS.

Abercare—Western Metropolitan Region

Need for funding to be secure to enable proper program development for PASDS clients. Need for stronger communication between all players by sharing information, discussion of cases, development of interventions and assessment frameworks. To build some quality control into the program design.

Anglicare—Western Metropolitan Region

There is little contact with SIPWs, only case managers. The service would like more of an exchange with HRI staff within the Department for training and information sharing. Funding needs to be more secure so longer term program planning and development can occur. More feedback to services from the Department on the outcome of cases they have worked with and feedback regarding the PASDS process.

QEC In-Home—Gippsland Region

Need for more frequent contact with CPS around the progress of families and what's happening, particularly issues arising. CPS staff need to be properly informed of the role and function of PASDS. The funding formula needs to be redeveloped in light of the operational realities of the program. Flexibility of the program needs to continue.

QEC In-Home—Hume Region

There is a need for a proper family support service east of the Hume Highway. The program needs to remain flexible enough to provide support to families beyond the 12-week period, particularly given the lack of medium intensity family support available in the Region.

Goulburn Valley Family Care—Hume Region

There is a need to establish what is best practice in the field and to develop models that integrate this knowledge.

Ballarat Child and Family Services—Grampians Region

The program needs extension to include any infant involved with the Department. All these infants are at high risk. CPS and PASDS need to collaborate closer and look at the impact of the PASDS across time. The program needs to remain flexible enough to be able to respond to the client when they are ready to receive assistance. Families need ongoing support in their role as parents. They need programs for building their self-esteem, how to communicate with their child, playing with children and how to set limits and appropriate discipline.

City of Greater Geelong, Warrnambool City Council—Barwon South Western Region

The program needs to be continued and be funded securely so the work with families can develop and evolve.

Appendix E: PASDS Evaluation PASDS Provider— Interview Schedule

1. Referral into the Program

- What referral process is used and who is eligible for the program?
- Who and how are decisions made regarding what sort of service is suitable for a family?
- How do you manage and allocate staff to these families?
- What do families have to do prior to commencement of PASDS?

2. PASDS Service Delivery

- What did you bring to the delivery of PASDS—expertise, knowledge, frameworks, experience etc.?
- Outline the service provided to the client?
- How are goals established for a family? Who is involved in this process?
- What assessment frameworks are used?
- How do families learn? What educational tools are used and what activities are clients involved in?
- To what extent have you had to modify procedures to deal with different families and situations?
- Is there any pattern to what works with whom to produce successful results?
- How is progress reviewed?
- What is the outcome of this work, such as reports to whom?
- What happens once the PASDS is finished? When are cases closed?

3. Impact of PASDS

- What impact has providing a PASDS had on your service?
- How receptive has the court been to PASDS assessments?
- What impacts has PASDS had on the functioning of other services for infants and families?
- What, if any, are the unintended consequences of establishing PASDS?

4. Lessons

- What have been the lessons for your service of working with this client group?
- What do you believe is needed to improve PASDS?

Appendix F: PASDS Evaluation HRI Manager and SIPW—Interview Schedule

1) Referrals into the Program

- Do all high risk infants get referred into PASDS?
- If not, who receives PASDS? Is there a pattern to service use?
- Is there an optimal time to provide a PASDS? (to get better results)
- Have you always been able to access a PASDS place when you have needed to?

2) How Are You Using PASDS

- On what basis is a decision to use a PASDS formed?
- How do you decide what type of PASDS (residential, in home-, assessment, skills development) is appropriate?
- Who decides on the goals for each family?
- Are you using PASDS in the ways that were intended in developing the program?

3) Your Opinion on the Quality of the PASDS Provided

- What do you think of the program’s design?
- Has the development f the program been a joint effort between the Department and service provider?
- Do you think PASDS are appropriately staffed?
- Are some arrangements more workable than others?
- Are any patterns emerging regarding the kinds of interventions that work with different families? Is there any combination that produces particularly successful results?
- How are PASDS integrated into the overall assessment and work undertaken with families by protective services?

4) Impact of PASDS

- What has been the impact of PASDS on existing infant and family service providers in the region?
- What has been the impact of PASDS on work with high risk infants within protective services?

5) Key Lessons

- Regarding the establishment of parenting support programs.
- Regarding the future development of PASDS.

Appendix G: PASDS Evaluation—Staff Profile Questionnaire

1. Formal tertiary qualifications of staff delivering PASDS.

This image shows a full page of primary-ruled paper. It features ten sets of horizontal dashed lines, each set consisting of three parallel lines. These lines are evenly spaced vertically across the entire page, providing a guide for handwriting practice. The background is white, and there are no margins or other markings present.

2. Major areas of previous employment for staff delivering PASDS.

[illegible]

3. Other relevant training undertaken by staff delivering PASDS.

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Appendix H: PASDS Evaluation: Information Gathering

Checklist of Items

This checklist has been developed by the evaluation team to assist in the process of information gathering. The following items will be gathered at the proposed site visits. You can help us in this process by either having the material available for collection at the visit or forwarding the material directly to the team by post. Some services have already sent material and we do not expect these services to duplicate their effort but rather make available items they haven't yet provided.

- Staff profile questionnaire completed.
- All information provided to clients about the service and its use.
- Policy documents that outline service operations.
- Copies of funding agreements with the Department of Human Services.
- Intake forms.
- Interview schedules.
- Assessment formats.
- Intervention formats.
- Case review formats.
- Case note formats.
- Case closure formats.
- Reporting frameworks.
- Evaluation materials used, that is, statistics forms, quality assurance forms, service satisfaction forms.

Appendix I: PASDS Evaluation: Case Sample Data Collection Instrument—HRI Manager (or Delegated SIPW) Questionnaire

This questionnaire is designed to give the evaluation team some basic case and referral information about those families referred to a PASDS who have been selected into the sample (a case series in each region) and, where possible, to obtain the views of the HRI manager or SIPW on the utility of the PASDS for each of these cases. This questionnaire provides the basis for the evaluation team to interview the relevant protective worker and PASDS worker for each case.

Basic Case Descriptors

- 1. Region:
- 2. CASIS Number:
- 3. Date of Birth of High Risk Infant:...../...../.....
- 4. Infant’s first name only (to facilitate interviews with PASDS and protective workers):
.....
- 5. Name of HRI manager/SIPW filling out this questionnaire:
.....
- 6. Current allocated Child Protection Worker (if unallocated or closed, the protective worker or team leader most appropriate to interview about this case):
 - Name:
 - Telephone number:
 - E-mail address:
- 7. Describe the key protective concerns/type of actual or imminent harm to the infant, in this case. (If a particular incident precipitated a report please include.)
.....
.....
.....
- 8. Describe the major infant/parent/family or service system risk factors present. (Please note who the problem was with and if a previous child had been removed from the parent/s or had died in parental care.)
.....
.....
.....

Details of PASDS Referral

- 9. Date of Referral to PASDS:
- 10. Name of PASDS agency:
- 11. During which phase of the protective process was the case referred to PASDS? (tick appropriate box)
 - [] initial investigation
 - [] protective intervention

What Order, if any, was the infant subject to at the time of referral? (please specify)

.....

.....

.....

12. Why was the case referred to PASDS? (tick appropriate box/boxes)

- (a) Protective planning task:
- ☐ reunification

☐ placement prevention
- ☐ permanent care planning

☐ other
- (b) for PASDS to assist through:
- ☐ assessment only
- ☐ assessment and skills development
- ☐ skills development only
- (c) through PASDS arrangement:
- ☐ residential
- ☐ in-home
- ☐ centre-based (eg. day-stay)

13. Was this PASDS referral an extension of a previous unit of PASDS service? (tick appropriate box)

- ☐ No

☐ Yes
- ☐ residential

☐ residential

☐ home-based

☐ home-based

home-based

further residential

residential

further home-based

14. What additional resources from the HRI program were deployed to complement the PASDS service to this family? (e.g brokerage—how much, what for; SIPW input to service planning or court report)

.....

.....

.....

Outcomes of PASDS Episode

15. Was this planned PASDS intervention completed? (tick)

☐ Yes

☐ No (please state why)

16. At the completion of the PASDS intervention what was the outcome for this child?
(please describe...i.e. infant’s safety, status and placement)

.....

.....

.....

17. Did this outcome meet the goals set by the department for this family?

- ☐ Yes
- ☐ No

(Please provide a reason for your answer)

.....

.....

.....

18. To your knowledge, did this PASDS episode result in the use of the PASDS report or testimony at Court?

☐ Yes

☐ No

If yes, your estimate of the effect of this on the court determination:

.....

.....

.....

Other PASDS episodes of service experienced by this family

19. To your knowledge, had this family received a PASDS service prior to the referral on which this survey is based/

☐ Yes

☐ No

If yes, was that prior PASDS service for (please tick if known)

☐ Same child☐ Same problematic parenting issues☐ This region☐ Residential☐ Assessment

☐ different child☐ different problematic parenting issues☐ another region☐ in-home

☐ skill development

☐ both

20. Have additional PASDS resources been accessed by this family since the referral on which this survey is based?
(tick the appropriate box/boxes if known)

☐ None

Same Child	New Child
<div><input type="checkbox"/> assessment<input type="checkbox"/> skills development<input type="checkbox"/> residential<input type="checkbox"/> in-home<input type="checkbox"/> centre-based</div>	<div><input type="checkbox"/> assessment<input type="checkbox"/> skills development<input type="checkbox"/> residential<input type="checkbox"/> in-home<input type="checkbox"/> centre-based</div>

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Parenting Assessment and Skill Development Program: Evaluation 107

Appendix J: PASDS Evaluation—Child Protection Service Case Manager Questionnaire

Program Implications of this PASDS Case

21. To your knowledge, did the PASDS service to this infant and family raise any policy issues, inter-agency matters, resource needs or service gaps relevant for the HRI program development? – if yes, what?

.....

.....

.....

22. To your knowledge, did the PASDS service to this infant and family reveal any training needs (for PASDS or associated services)? – if yes, what?

.....

.....

.....

23. Compared with other service options, did the PASDS, in your opinion, provide good value for money in this case?

Yes / no /don't know

Comment:

.....

.....

.....

.....

24. To your knowledge, did this case yield any particular learning about the strengths and limitations of the PASDS as a way of working with high risk infants and their families?

.....

.....

.....

.....

25. Any other comments:

.....

.....

.....

.....

Signed:

HRI manager/SIPW completing questionnaire

THANKYOU FOR YOUR HELP AND COOPERATION...IT IS CRUCIAL TO THIS PHASE OF THE EVALUATION.

This schedule is designed to elicit the Protective Worker’s perspective on the family’s needs, the effects of the PASDS interventions, and what services families moved on to after the PASDS episode.

Region Sub-Office

CASIS File Number

Infant’s Date of Birth and First Name:...../...../.....

Date of PASDS Referral under Consideration:.....

Name of Protective Worker:

FEEDBACK ON PASDS SERVICE—from your perspective...

1. What did the PASD intervention in this case contribute to your protective decision-making?

.....

.....

.....

2. What, if anything, could the PASDS have done in this case that would have been more helpful to your own work on behalf of this infant?

.....

.....

.....

3. What were the main achievements of the PASDS service for this infant and family?

.....

.....

.....

4. What were the main limitations of the PASDS service for this infant and family?

.....

.....

.....

5. Were you satisfied with the report back to child protection from the PASDS?

.....

.....

.....

.....

Yes / No (Note any particular strengths and limitations)

6. Do you think that working with the PASDS has had an affect on your practice with other infants? (eg....)

.....

.....

FEEDBACK ON PASD SERVICE—from the parents’ perspective.

If the parents discussed the PASDS experience with you and you can recall:

6. What did the parents report as being most helpful about the PASDS intervention?

.....

.....

.....

7. What did the parents report as being least helpful about the PASDS intervention?

.....

.....

.....

CASE SITUATION POST-PASDS

8. What services were used for this child and family at the completion of the PASDS? Please specify type of services and duration if known.

.....

.....

.....

9. If the infant remained with or returned to parental care at the end of the PASDS intervention, in your view have any gains in parenting practices made during the PASDS been sustained? Yes / no. Please give examples if possible.

.....

.....

.....

10. Overall, please summarise your view of the influence of the PASDS on the course of the case and the resultant well-being of the infant and capacity of the parents.

.....

.....

.....

THANK YOU FOR YOUR HELP AND COOPERATION.

Please return completed form by e-mail to lyndamc@unimelb.edu.au or mail to Dr. Lynda Campbell, School of Social Work, University of Melbourne, Victoria 3010.

Appendix K: High Risk Infants Evaluation—PASDS Worker Questionnaire

This questionnaire is designed to elicit the PASDS worker’s perspective on the family’s needs, their own service efforts to help the infant and family, the effects of their interventions, and any learning about practice, service delivery and systems that arose in the course of the case.

RegionAgency

CASIS File Number.....

Infant’s D.O.B./...../.....

Name of PASDS Worker/s Completing Questionnaire:

REFERRAL

RESIDENTIAL / CENTRE-BASED/ IN-HOME (circle)

REFERRED FOR	DATE REFERRED	DATE COMMENCED	DATE CLOSED
ASSESSMENT ONLY			
ASSESS. & SKILL DEV.			
SKILL DEVEL. ONLY			

Family members involved in service: (tick)

- ☐ Infant
- ☐ Mother

☐ age: under 20

☐ 20+
- ☐ Father
- ☐ age: under 20
- ☐ 20+
- ☐ Partner of parent
- ☐ age: under 20
- ☐ 20+
- ☐ Other offspring

☐ age: under 2

☐ 2–3

☐ 4+
- ☐ Other

specify.....

CASE SITUATION

PROBLEMS NAMED IN REFERRAL

Baby.....

Mother

Father

Parent’s partner

Other

SPECIAL NEEDS OF INFANT OR FAMILY THAT INFLUENCED YOUR WORK WITH THIS FAMILY:
(e.g. language, culture, disability, violence...)

PARENTING ASSESSMENT OUTCOME

At the conclusion of the PASDS assessment period with this family, what were:

- The key parenting deficits identified?

.....

.....

.....

- The key parenting strengths identified?

.....

.....

.....

- The agency’s conclusions about parenting capacity?

.....

.....

.....

SKILLS DEVELOPMENT

Did the parents receive help with skills development: (tick)

- ☐ No—assessment only
- ☐ As an integral part of the assessment process
- ☐ As a separate PASDS component of service

If the family did not go on to skills development, please explain why.

.....

.....

.....

If there was skills development activity, what areas of parenting performance were targeted for *change*?
(include specific risks to be reduced, new learning needed, existing skills and knowledge to be implemented/
consolidated)

.....

.....

.....

SUMMARY OF PASDS INTERVENTION WITH THIS FAMILY

Please summarise the **major areas** of assessment and skills development activity with this family in the chart below.

Purpose code A= assessment Sd= skill development	Activity (e.g. feeding routine)	Who (e.g. Early childhood worker)	Where (e.g. home)	How often? (e.g. four sessions over first week)	How long? (e.g. one hour each session)

Overall, please estimate the total hours of direct contact with this family and the number of weeks over which this occurred.....hours overweeks.

OUTCOMES

From your perspective as a service provider to the infant and family, on balance was there improvement in the parents’ parenting performance over the course of the PASDS intervention?

- ☐ Yes – improved
- ☐ No – much the same
- ☐ No – deteriorated

How do you explain the outcomes in this case?

	Family attributes/ circumstances	PASDS interventions	Other factors-e.g. other services
Factors leading to parenting improvements			
Factors impeding parenting improvements			

If the family withdrew prematurely or if you terminated service prematurely, please explain why.

.....

.....

.....

.....

.....

CLOSURE—RECOMMENDATIONS

What recommendations (if any) did you make to the child protection service at the end of the intervention?

.....

.....

Referrals made for further service:

.....

.....

Outcome of referrals for further service (if known)

.....

.....

Re-presentation

Has the family had any further contact with your service? (who, what, why?)

.....

.....

.....

If there has been a repeat presentation, has it been for the same risk factors?

.....

.....

.....

SYSTEMIC ISSUES

Was there anything the PASDS needed to make the work with this family more successful? – e.g. components of service, specific training needs

.....

.....

.....

Did this case raise any issues about the Child Protection Service/ PASDS working arrangements? (please specify)

.....

.....

.....

.....

[illegible]

Please return completed form by e-mail to lyndamc@unimelb.edu.au or mail to Dr. Lynda Campbell, School of Social Work, University of Melbourne, Victoria 3010. Telephone for queries (03) 83449418

