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Best interests case practice model
Specialist practice resource

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This document is also available on the Internet at: www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/child-protection/specialistpractice-resources-for-child-protection-workers

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About specialist practice resources

The Best interests case practice model provides you with a foundation for working with infants and their families. *Specialist practice resources* provide additional guidance on: information gathering; analysis and planning; action; and reviewing outcomes in cases where specific problems exist or with particular developmental stages.

This resource consists of two parts: an overview of key issues and a practice tool to guide you. *Infants at risk of abuse and neglect: A review of the literature* is available online to provide you with further research in this area at: www.cyf.vic.gov.au/every-child-every-chance/home

Overview

What is infancy?

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

Brain development begins in utero and the brain is about 25 per cent of adult size at birth. In the three years that follow, the brain grows to 90 per cent of adult size and develops the connections between nerve cells (Royal Australian College of Physicians 2006).

Inherited genetic potential predisposes an individual to develop certain abilities, skills and characteristics. However, environmental influences, experiences and relationships in the early years determine the ultimate expression of these potentials in all the domains of development – physical, cognitive, language, social and emotional (Siegel 2001; Stevenson 2007; Melmed 2004).

Infants are extremely vulnerable to the effects of abuse and neglect or deprivation (Melmed 2004). These early experiences affect physical health (Royal Australian College of Physicians 2006), emotional regulation and mental health across the life course, and the capacity for full engagement and participation in relationships, education and employment.

For child protection practitioners, there are specific practice standards for 0–2 year olds.

Infants and the Children, Youth and Families Act

Under the *Children, Youth and Families Act 2005* the grounds for intervention are the same for infants and children of other age groups.

However, attention must be given to the greater physical and developmental vulnerability of infants when assessing whether a child has suffered or is likely to suffer significant harm. Decision making in cases involving infancy may also need to occur at an accelerated pace to take into account the rapid developmental changes occurring in this period.

Unborn children and the Children, Youth and Families Act

Babies in utero experience the adverse effects of poor diet, substance misuse and violence perpetrated on their mother (Klein, Gilkerson & Davis 2008). Under the Children, Youth and Families Act, a person may make a report to Child Protection (s. 29) or a referral to a community-based child and family service (Child FIRST) (s. 32) before the birth of a child, if the person has a significant concern for the future wellbeing of the child after birth. Child protection may provide advice and assistance to the mother of the unborn child or refer the mother to community-based services (s. 30).

It is always important to be culturally sensitive when making a report. Consider the recent history of Aboriginal people, which may manifest itself in fear of removal, fear of judgement or service avoidance. Engagement in a transparent and supportive way that gives respectful choices is of critical importance.

The vulnerability of infants

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

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

Attachment relationships and infant development

The primary attachment figure (usually the mother) is the person who: provides the majority of care to the infant; spends the most time with the infant; has an ongoing relationship with the infant; and is the person to whom the infant turns as a source of safety, comfort and care. This person is, in turn, most emotionally attuned to the infant.

> In this guide, the term infant–caregiver relationship refers to the relationship between an infant and their primary caregiver (for example, the mother, father, grandmother or foster carer).

Sensitive and responsive care-giving builds a secure infant–caregiver attachment relationship and promotes optimal physical, behavioural, social and emotional development, including a greater capacity for emotional regulation, positive social interactions and better coping skills. Interactions within the relationship need to be nurturing, protective, secure and consistent in order for infants to feel confident to explore their environment and to have the psychological resources available for learning. Infants are frequently vulnerable when parents, partners and carers face issues that impact on their own safety and wellbeing, and their ability to parent in attuned and nurturing ways.

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

Attachment relationships can be characterised as secure, insecure (either avoidant or ambivalent), or disorganised (see Table 1).

Table 1: Attachment relationship styles

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

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

Aboriginal families, caregiving and attachment

The *Aboriginal cultural competence framework* (Department of Human Services 2008) states that culture and the maintenance of culture is central to healthy infant development and identity formation in Aboriginal communities. An Aboriginal child knows who they are according to how they relate to their family, community and land. The Aboriginal perspective is holistic and community-based and sees the:

- whole child, not just the child's educational, physical or spiritual needs in isolation
- child's relationship to the whole family, and not just to their mother or father
- child's relationship to the whole community, not just to the nuclear family
- child's relationship to the land and the spirit beings, which determine law, politics and meaning (Department of Human Services 2008).

There are several issues that must be considered in assessing attachment and caregiving relationships within Aboriginal communities:

- It is important to acknowledge the recent history of Aboriginal families, which may have caused unresolved grief and trauma to impact on parenting. Depression in Aboriginal families and communities as a result of the social and historical context of colonisation, racism, poverty and the stolen generation continues today (Atkinson 2002). For many, a lack of parenting skills has occurred as a direct result of their shared history of not receiving adequate parenting and nurturing (Department of Human Services 2008; Westerman & Wettinger 1997).
- '…the understanding and interpretation of the sensitivity and responsiveness of the caregivers are dependent on the values of the community in which the child resides' (Yeo 2003, pp. 295). In communal and collectivist cultures, where several people may share in the care-giving of an infant, it is important to assess these relationships from the infant's point of view. It is important to avoid a narrow Western nuclear family lens that only looks at the mother–infant relationship. For example, assessments of parenting in Aboriginal communities must explore the role of extended family, clans and kinship networks in parenting (Neckowaya et al. n.d.; Yeo 2003). Infants usually have a hierarchy of relationships. Where there are multiple caregivers, it is important to assess whether the infant seems confident of who to turn to when in need, and whether there is a central person who holds the infant and has their needs in mind.

Further considerations with regard to Aboriginal families in Victoria

'Although there is considerable diversity among Aboriginal families, on average they are much more likely to be under considerable stress than non-Aboriginal families with children.

For example, 50 per cent of Victorian Aboriginal families are sole parent families - compared to 21 per cent of all Victorian families with children. This is an increase from 43 per cent in 1996 (ABS Census of Population and Housing 1986, 1996, 2006).

In Victoria, Aboriginal women under the age of 20 are nearly five times more likely than other women of the same age to become pregnant; overall these mothers face risks of poorer birth outcomes, cessation of education and subsequent unemployment and poor housing conditions compared to older mothers.

Some of the key individual, family and community problems associated with unresolved trauma that have been associated with heightened rates of child abuse and neglect in Aboriginal and Torres Strait Islander communities include: alcohol and drug abuse; family violence; social isolation; and overcrowded and inadequate housing (Berlyn & Bromfield 2010). For example, the vast majority (79 per cent) of adults in Victorian Aboriginal families reported having themselves (or family or friends) experienced one or more major life stresses (e.g. death of a family member or close friend, serious illness). This is almost double the rate for non-Aboriginal Victorians (Department of Education and Early Childhood Development 2010). In this context, Aboriginal and Torres Strait Islander children living in such circumstances are particularly vulnerable.

'Development of supports will need to take account of the reality that:

- many new parents are still very young themselves
- significant numbers of Aboriginal children are growing up in sole parent households
- fathers can easily be isolated from their children

The need to better recognise the important role of fathers and to support them to play a greater role in bringing up children was stressed throughout the consultations. Identity, culture, family and community are seen as central to the tailoring of parenting supports, and to the development and learning of young children.' (Department of Education and Early Childhood Development, 2010 pp. 24).

Culturally and linguistically diverse families and attachment

When working with culturally and linguistically diverse groups you must consider:

- the impact of past grief and trauma on the parents' emotional availability and parenting; for example, refugee and migrant communities may have fled from war or oppression and still be struggling with unresolved trauma, grief and loss
- the role of extended family in parenting – where there are multiple caregivers living in the same household, parents may be less vigilant in their responsiveness to infant cues as they can reasonably expect that another carer will be available to attend to the infant's needs.

Issues of safety and cumulative harm for infants, children and young people should not be minimised. However western cultural expectations can impact unfairly upon parenting assessments when working with Aboriginal families and families from other cultures. Consultation with cultural experts helps us to balance the needs of children and complex family issues. Seek advice and supervision.

Impact of trauma, violence and neglect on infant development

A large and growing body of research in neuroscience, developmental psychology and the social sciences has demonstrated the impact of traumatic events on an infant's development. Exposure to trauma (such as abuse, neglect or exposure to violence) affects every dimension of an infant's psychological functioning (emotional regulation, behaviour, response to stress and interaction with others) (Perry 2002). Experiences of neglect and abuse can undermine the infant's basic sense of trust in the world. Infants are especially vulnerable and powerless

because they cannot request help when they feel threatened or unsafe (Hill & Solchany 2005). Infants are also vulnerable to physical injury during an assault (for example, if they are being held by their parent).

Infants can suffer distress, emotional and physical pain and overwhelming fear or terror in response to sudden separations, neglect, being assaulted or witnessing violence. Family violence is most often perpetrated by men against women and children. It is defined as ongoing physical, social, emotional, psychological, financial or sexual abuse used to gain power and control. It is important to note that some women who experience family violence report that the effects of emotional and psychological abuse has as great or greater impact on a woman's mental health than physical or sexual abuse (MacKinnon 2008).

Family violence is both an assault against the mother and an assault on the infant–caregiver attachment relationship because the mother's distress can impact on her parenting (Humphreys 2007).

For infants who have experienced abuse or neglect, people, sensations, images, situations and places may all act as traumatic reminders or triggers. In intimate partner violence, the infant witnesses the parents as victim and aggressor and is unable to rely on either parent for their own protection and comfort. Given this scenario, it is likely that specific aspects of the parents' behaviour, tone of voice and body movement and facial expressions may become traumatic reminders for the infant (Lieberman 2004).

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

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

Refer to the *Child development and trauma specialist practice resource* for further guidance on the impact of trauma on infant development.

Practice tool
Infants and their families

The aim of this tool is to provide some additional guidance about specific things you might consider when working with infants and their families.

Information gathering

Be clear about the presenting concerns before planning your visit so your information gathering is purposeful and mindful of the infant's needs and safety. Your approach needs to be strength based and forensically astute, carefully observing the infant and the family dynamics. Building rapport with the family will enable more comprehensive information to be gathered and sensitivity is required as you calmly explain your role and purpose.

Information gathering is ongoing throughout the life of a case, and includes gathering information from existing case files, professionals involved with the family and, most importantly, from infants and families themselves. Information also needs to be gathered about previous attempts to resolve the problems within the family – by the family themselves, and by professionals and agencies involved with the child and family. Refer to the Best interests case practice model for general tips and guidance on gathering information.

Think broadly about family and the significant people for the infant

If the parents are separated, it is vital to involve both parents, both sides of the extended family, formal and informal childcare providers and other people who may be significant for the infant or their parents. Inclusive practice enables stronger engagement and exploration of concerns and supports.

- Who are the people who care for this infant, or could potentially care for this infant if this is needed? What is the nature and quality of their relationship?

- A family meeting should be held as soon as possible and include extended family if appropriate.

Genograms and Eco maps are very useful to develop early in the response process. They are visual reminders to think and act systemically.

Infants and cumulative harm

Harm caused by multiple adverse circumstances and events accumulates and can damage the developing brain (Bromfield, Gillingham & Higgins 2007), the effects of which are more pronounced in infancy and early childhood (Shonkoff & Phillips 2001). The Children, Youth and Families Act, s. 10(3)(e) requires practitioners to consider the effects of cumulative patterns of harm on a child's health, safety and development.

- What has been the previous involvement of your service with the infant, their siblings and their parents?

- Incorporate the history you are able to collect from other services and professionals who have been involved with the family.

- Summarise the file according to type, frequency, severity, source of harm and duration.

For guidance on recognising, assessing and responding to cumulative harm refer to the *Cumulative harm* specialist practice resource.

Observing and engaging the infant

In the presence of their caregiver, it is important to engage the infant in order to get to know them and gain a better understanding of how the family situation impacts upon them. When gathering information, you need to be attuned to both risks and protective factors, and to the indicators of trauma or abuse in the infant's behaviour or presentation.

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

- Is the infant's play or communication developmentally appropriate?
- Is the infant's emotional regulation age appropriate and congruent with the situation?
- Does the infant seek comfort when they are distressed and from whom do they seek comfort?
- How does the infant respond to strangers (for example, friendly and interested, hyper-vigilant, uninterested or unresponsive)?
- How does the older infant make use of toys? Do they create themes through their play that may represent a possible re-enactment of trauma, aggression or fear?
- Think about what it is like to be this infant in this relationship, in these circumstances, at this time (Zeanah, Boris, Heller, Hinshaw-Fuselier, Larrieu, Lewis, et al. 1997).

If you are unsure about what your observations mean, seek advice.

Use the *Child development and trauma specialist practice resource* to aid your observations and assessment. Check your observations with a maternal and child health nurse, and discuss with your supervisor and the Aboriginal child specialist and support service.

Tips for engaging infants

Infants communicate through play, so take the opportunity to be playful and interact age-appropriately with them. You do not need to set up a contrived 'play' situation to assess the infant's capacity to play. It can be as simple as sitting on the floor playing blocks with a one-year-old while you talk to their parents.

- Be warm, open and responsive to the infant's communication – babies are interested in social interaction and curious about people from birth.
- Acknowledge the infant by speaking to them in age-appropriate language and engaging in eye contact.
- Be playful and interested in the infant's point of view; enjoy getting to know them.
- For babies, speak softly and repeat back cooing and babbling sounds.
- Use the opportunities of everyday care (such as feeding and bathing times) to observe the infant's emotional regulation and interaction with their caregiver.
- Sit on the floor with their primary caregiver and toddler (if appropriate) and respond in a calm and warm manner.
- Play alongside a toddler without expecting cooperative play to engage the older infant/ younger toddler – think of play as a window into the infant's point of view and observe sequences and repetitions.
- Talk with the toddler, perhaps gently asking about the play you observe, for example, 'You are playing with your playdough', 'Can you tell me what's in your drawing?' Remember that an infant can understand more than they can express.

Assessing physical abuse and shaken baby syndrome

Due to their physical fragility, infants are the group at highest risk of fatal abuse (Victorian Child Death Review Committee 2009). Physical injury in infants must be responded to as serious.

Be alert to the possibility of shaken baby syndrome. Babies are not able to fully support their heavy heads and violent and forceful shaking causes brain injury (see <www.aap.org/publiced/ BR_ShakenBaby.htm>). Non-specific signs and symptoms of shaken baby syndrome include: irritability; tiredness; loss of appetite; poor feeding; vomiting; poor sucking or swallowing; lack of smiling or vocalising; poor muscle tone; and pinpointed, dilated or unequal pupil size. Severe symptoms of shaken baby syndrome include: a bulging and/or spongy forehead, rigidity, seizures, loss of consciousness and difficulty breathing (see <www.dontshake.ca/ information/information.php?type=4>). Shaken baby syndrome can be fatal. Urgent medical attention must be sought.

Where there are allegations or you have suspicions of physical abuse (such as signs of bruising) you must (with the parents' consent) conduct a visual check for injuries or bruising. In order to do this check, it is more engaging and respectful to invite the parents to undress their infant for you. If any injuries or symptoms are present a forensic medical examination will be required. If there are disclosures or allegations of sexual abuse, a forensic medical examination is required and this needs to be carefully planned in partnership with the police.

If the parent refuses a request by a child protection practitioner to examine the infant, you need to explain the rationale behind your request and explain the potential consequences of refusing the request. If the parent still refuses, your supervisor *must* be consulted and a court order may be sought.

For child protection practitioners, there is practice guidance available on conducting medical and forensic examinations in the child protection practice manual.

Infant–caregiver relationship

In assessing the infant–caregiver attachment relationship it is crucial to assess how social and historical factors may be impacting on parents' capacity to provide responsive care, and for practitioners to provide assistance practically and emotionally wherever possible without compromising the rights of the child.

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

In practice consider:

- How the caregiver and infant interact. Are they comfortable with each other, make eye contact, smiling, giggling, talking and play? Note the description of this by significant others.
- Does the caregiver notice and respond to infant cues (for example, if the infant seems distressed or overwhelmed, does the caregiver provide comfort)?
- Observe how the caregiver responds to the infant's emotional and safety needs. Are medical problems/illnesses responded to appropriately? Is the infant left crying, with a bottle/dummy, or in a pram or cot for extended periods?
- How does the caregiver describe the infant and interpret their communication and behaviour (for example, five words to describe the infant)? Is this interpretation age-appropriate and empathic? Do the parents' descriptions match your observations?
- What were the parents' experiences of pregnancy and childbirth? (Was the pregnancy planned? Were their traumatic circumstances or events that would impact on the infant–caregiver attachment relationship?)
- What was the postnatal period like for the mother and infant (for example, illness, depression, relationship difficulties, supportive family and friends)?

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

Daily routine

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

In practice consider:

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

Physical environment

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

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

Creating safe sleeping environments

Safe sleeping environments are vital for infants. Describe the sleeping environment for the infant. Are there any risks for sudden infant death syndrome (SIDS)? Where the parent is transient, or the infant is staying with different family members, it is particularly important to help caregivers plan safe sleeping arrangements. For example, you might assist them to purchase a portable cot that meets current Australian safety standards.

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

• Position the baby to sleep on their back from birth – never on their tummy or side.

• Sleep the baby with their face uncovered.

• Keep the baby's environment smoke-free – before and after birth.

• Provide a safe cot, mattress and bedding (not cluttered with soft objects/bedding/ bumpers that can cover the infant's head, not damaged or broken and meets current Australian safety standards).

• Do not sleep the baby in a pusher without appropriate restraints.

• Do not place the cot or pusher near sources of danger, such as a heater.

If an infant sleeps in a portable cot:

• Only the mattress supplied with the portable cot should be used.

• Extra padding should not be added under the mattress because the baby could get trapped face down in the gap between the mattress and padding.

• The portable cot must meet current Australian safety standards (this might be particularly important if an infant is removed and placed with a family member or temporary carer who has an older portable cot).

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

• sleeps with someone who is hard to rouse due to drugs or alcohol, depression, smoking, an induced sleep disorder, prescribed medication, or who sleeps very deeply

• is at risk of getting caught under adult bedding, loose-fitting nightclothes or pillows

• is at risk of falling out of bed or becoming trapped between the wall and the bed.

Refer to current practice instructions to ensure that the most up-to-date advice is given to parents or carers on creating a safe sleeping environment.

Medically fragile infants

Premature or medically fragile infants can suffer from: low birthweight; feeding, settling and sleeping difficulties; prolonged and frequent crying; and developmental delay, and they may have complex medical needs. These factors, in addition to long hospital stays, confinement in an incubator and loss or separation experienced by parents have an impact on the relationship between the infant and their parents (Brisch 2004; Fegran, Helseth & Fagermoen 2008). Seek advice to fully understand the current and long-term implications of the medical condition.

In practice consider:

- What, if any, characteristics of the infant may place additional stress on the caregiver (for example, if the baby is fussy, is difficult to feed or settle, has a physical or intellectual disability or delay, is medically fragile, or has foetal alcohol syndrome)?
- Have you consulted with all hospital and community medical and other health professionals involved in the care of the infant? Have you accessed assistance from the medical team to develop an accurate working knowledge of the infant's condition, treatment and the burden that the medical condition and treatments might place on the caregivers?
- Proactive and collaborative planning must occur where the baby is due to be discharged from hospital or from a placement. Be practical and attend to the details of the infant's needs and the family context.

Analysis and planning
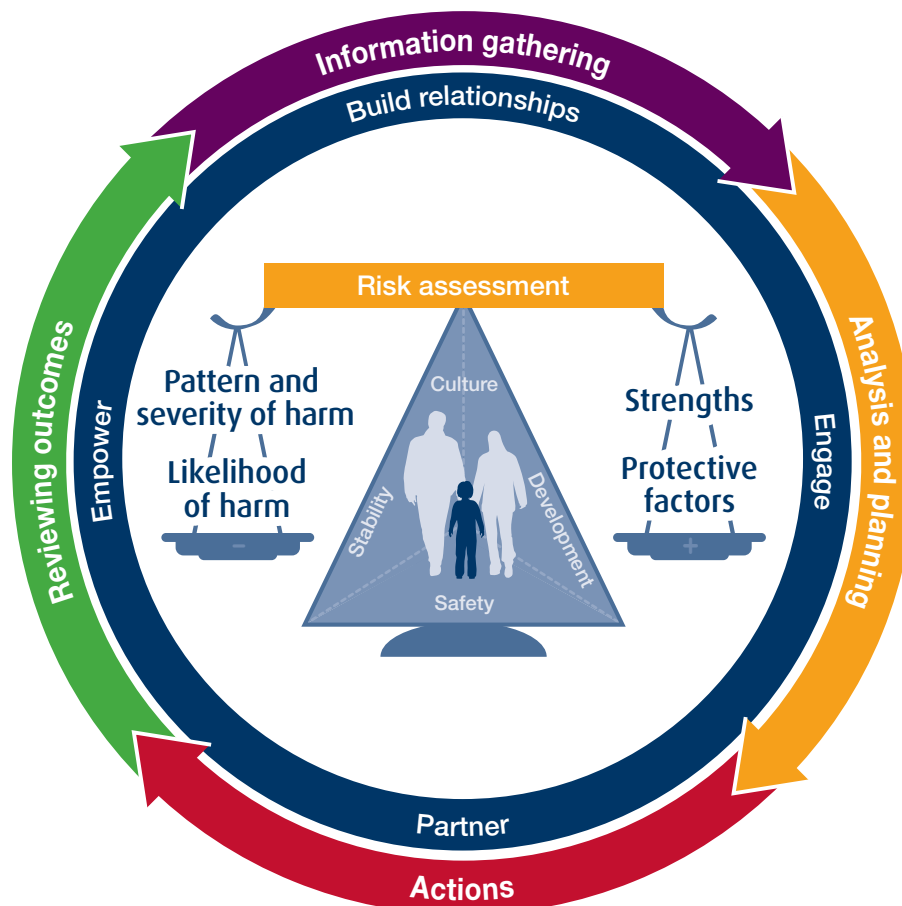
Risk assessment

To formulate a risk assessment, you need to be a critical thinker and to consider multiple competing needs, prioritising the infant's safety and development. Careful attention needs to be given to the balance of risk and protective factors, strengths and difficulties in the family. Your assessment needs to be forensically astute; and you should consider all sources of information such as observation, previous assessments, advice from all significant people and professionals. Do not rely on phone assessments or parental self report where there are suspicions of non-accidental injury, or where there have been previous concerns or offending behaviour.

Synthesise the information you have gathered about the current context and the pattern and history; and weigh the risk of harm, against the protective factors. Keep in mind that the parents' desire to change dangerous or neglectful behaviours does not equal the capacity to change; and that strengths and protective factors need to be sustained over time. The best predictor of future behaviour is past behaviour. Hold in mind the urgency of the infant's timeframes for safety and secure attachment relationships. Imagine the child's experience of cumulative harm. Remember, other than the family's characteristics, the quality of the relationship you form with the family is the single most important factor contributing to successful outcomes for the infant.

Characteristics to consider when assessing risk

Based on examination of file records and other data relating to over 1500 children, Reid at al (1995) identified three important organising principles consistently associated with occurrences or recurrences of child abuse or neglect for children:

1. The first and most important dimension of caregivers' characteristics that should be considered, is their prior pattern with respect to the treatment of children. The number of maltreatment events they have initiated, their severity and recency are the most basic of guides to future behaviour. In the absence of effective intervention these behaviour patterns would be expected to continue into the future.

2. If an individual believes that they are correct in their opinions about children, they will attempt to continue their behaviour so long as they are not prevented from doing so.

3. The third dimension concerns the presence of 'complicating factors', most significantly, substance abuse, mental illness, violent behaviour, and social isolation. The relevance of complicating factors is the extent to which they, singularly or in combination, diminish the capacity to provide sufficient care and protection to the child or young person.

The Best interests case practice model is underpinned by a strengths based approach that assesses the risks, whilst building on the protective factors to increase the child's safety.

Attention to safety factors within the risk analysis recognises that:

1. Both the potential for harm and for safety must be considered to achieve balanced risk assessment and risk management

2. Strengths which increase the potential for safety are evident in even the worst case scenarios and these are fundamental building blocks for change

3. A constructive approach to building safety can be taken which may be different to efforts to minimise harm

4. A strengths perspective can be actively (and safely) incorporated into what may otherwise become a 'problem saturated' approach to risk assessment and risk management

(cf. Turnell and Edwards, 1999)

Current risk assessment

Current risk assessment highlights the fact that it is made at a *point in time* and it is therefore limited and will require modification as further information comes to light. Your risk assessment should address the following key questions: Is this child/young person safe? How is this child/young person developing?

1. Given all the information you have gathered, how do you make sense of it?

   Consider the **vulnerability** of the child and the **severity** of the harm:
   - What harm has happened to this child in the past?
   - What is happening to this child now?

2. What is the **likelihood** of the child being harmed in the future if nothing changes? Hold in mind the **strengths and protective factors** for the child and family.

3. What is the **impact** on this child's safety and development, of the harm that has occurred, or is likely to occur?

4. Can the parents hold the child in mind and prioritise the child's safety and developmental needs over their own wants and constraints?

5. From the point of view of each child and family member, what needs to change to enable safety, stability and healthy development of the children?

6. If the circumstances were improved within the family, what would you notice was different – what would there be more of? What who there be less of? Who would notice?

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

The postpartum period is demanding and challenging for all parents but particularly for those with a disability and those experiencing postnatal depression or other mental illness, financial stress, substance abuse, homelessness, family violence, isolation or unresolved trauma. However, risk factors become meaningful to an infant through their effects on the parents' behaviour and the impact on their parenting capacity. Mental illness in one woman can have completely different effects on her infant and her parenting capacity than those of another woman with the same mental illness who may have a supportive partner and extended family. It is important to take into account both *risk* and *protective factors* impacting on the infant.

If parental problems are present, the critical questions you must answer in your assessment are:

- How do they impact on parenting, the parent–infant relationship and the infant's experiences and development?
- Is the infant physically and emotionally safe?
- Can the parent provide adequate care?
- Can the parent be supported to provide safe and appropriate care?

Child protection practitioners can refer to the full list of high-risk infant practice guidance and advice in the child protection practice manual to assist with critical decisions about threshold for child protection intervention and decisions to remove children.

Make a holistic assessment

Interdisciplinary assessments of infants will provide information about the infant's current health, development and mental health as well as assist in the planning of interventions for the infant based on their individual needs.

In practice, draw together the observations you and others have made, and the information you have collected about the family, the infant, the infant–caregiver attachment and their environment:

- How are parenting problems impacting on parenting capacity and, in turn, the infant's safety and development? How might you be able to engage the parents in these difficult conversations?
- What needs to change? What could be done differently to protect the safety and healthy development of the infant?
- What does the family see as the problems? What does the family think might lead to solutions?
- You need to be clear about the concerns. Acknowledging the difficulties and the strengths is key, but the needs of the baby must be privileged.
- If there has been abuse or neglect of the infant, are the parents accepting responsibility and engaged in change? Are they willing to try new approaches within a reasonable time frame and work constructively with services?

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

Assessing parenting practices in Aboriginal families

Like most cultures, Aboriginal culture and parenting practices are not homogenous. Aboriginal communities will have characteristics specific to geographic location and social networks with significant variation across urban, rural and remote communities (Neckowaya et al. n.d.).

- Consult with Aboriginal community-controlled organisations (ACCOs) and the local Aboriginal community to gain a better understanding of cultural differences in parenting practices.
- Be cautious about imposing Western parenting norms onto Aboriginal families – your role is to secure the safety and wellbeing of the infant, not to enforce a universal set of parenting practices.

For Aboriginal children child protection practitioners need to involve an Aboriginal Child Specialist Advice and Support Service (ACSASS) practitioner in making the assessment and planning the intervention.

Where problems are more complex, intensive early support must be provided to assist Aboriginal families to address the problems that led to child protection involvement.

In practice consider:

- holistic family healing approaches that plan to provide for the physical, mental, emotional and spiritual wellbeing of the infant and their family
- the healing value of culture, which affirms identity and connection to community as protective factors that encourage resilience.

Assessing parenting practices in CALD families

Consult with culturally specific services and the local community to gain a better understanding of cultural differences in parenting practices. For example, in some cultures the eldest daughter may traditionally have caring responsibilities for younger siblings. If siblings or other family members do have a caring role this caregiver relationship must also be observed as part of your assessment.

- If traditional parenting practices are incongruent with the cultural context in which the family is now located (for example, it will not be safe for families to leave children in a playground or other public place and assume that other adults present will watch them), work with parents to educate them about the cultural differences so they can understand the need for change – avoid being accusatory or blaming.
- Think about what cultural resources support culturally specific parenting practices and whether they need to be put in place. For example, in some cultures mothers are confined to the home for 40 days after giving birth. In these cultures the mothers are supported during this period by female relatives who tend to the mother's domestic work and other caring responsibilities. If a new mother is also a new arrival to Australia without a social network, this cultural practice may increase her risk of depression due to social isolation and lack of nurturing care.

Working in partnership with other services

It is critical that services involved with infants and their families communicate and collaborate with one another, sharing appropriate and relevant information regularly to enable that infants receive the optimal care they require.

These services might include a: paediatrician; GP; maternal and child health nurse; early parenting centre; parenting assessment and skill development services; Aboriginal child specialist and support services; infant mental health worker; speech pathologist; or domestic violence, drug and alcohol, housing and disability service.

> A case conference is essential for professionals connected with the family – and the family – to work together to explore the current concerns, past patterns and practical solutions.

In practice:

- Decide at the case conference who is the 'key practitioner' who will have regular contact with the infant/family. Be clear about other services' roles and expectations about their responsibilities and timelines for review.
- Consult with the hospital where the infant was born regarding their pre- and postnatal care.

- If the infant was born or has resided interstate, consult with child protection services in that jurisdiction.
- Consider the use of multidisciplinary assessments for infants and parents. Be purposeful with regard to how these assessments will add value to your analysis and decision making.
- Child protection practitioners need to consult with ACSASS and their supervisor and in the case of a high risk infant the Practice Leader.

> It is not enough to refer to a service and expect that the family will engage with that program or that the treatment will be suitable for a particular family. Because time is so critical, practitioners may need to keep a case open until the family has engaged with a service, and/or to facilitate priority access to services.

Planning mechanisms for child protection practitioners

For child protection practitioners, effectiveness in working in partnership with families, other professionals and services will be aided by formal departmental planning mechanisms. As part of your intervention you will need to undertake one or more of the following:

- a case plan
- a cultural support plan
- a stability plan
- an Aboriginal family decision-making meeting.

Thoughtful consideration of what planning mechanisms are required will enable you to be purposeful in your action in coordinating plans where the goals are clear and the family has been included in the development of them.

Understanding constraints on parenting capacity

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

Parental substance misuse

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

- be responsive and sensitive to their infant's emotional needs
- meet the infant's feeding and sleeping needs
- ensure the infant and their physical environment is clean.

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

Parental mental illness

There are many different types of mental illness (for example, depression including postnatal depression, schizophrenia and bipolar disorder) and mental health problems (borderline personality disorder, postnatal anxiety or adjustment disorders), each of which may affect parenting in a different way. Mental illness can cause the parent to withdraw, lack emotional engagement, be less responsive to the infant or be more negative (Newman & Stevenson 2005; Seifer & Dickstein 1993). Mothers with borderline personality disorder, have a core disturbance in their sense of self, and experience disordered personal relationships, variable changes in mood, disturbed thinking patterns and often engage in significant self-harm (Sved Williams 2004). They may be fearful of abusing their infants and so become withdrawn, or alternatively they may feel an intense need to protect and so appear intrusive and anxious (Newman & Stevenson 2005). Severe mental illness involving hallucinations and delusions or fixed beliefs about the infant may put the infant at risk of serious harm including violence or abuse and, sometimes, death (Sved Williams 2004). Parents may be unable to care for their infant if they lack insight into their illness, have trouble coping with the side effects of medication, or their symptoms remain untreated or are poorly controlled.

Postnatal distress may range from 'baby blues' in the first few days following the birth of the baby that spontaneously resolves, to sadness and weepiness including maternal fatigue and sleep deprivation, to sustained lowered mood and impaired functioning that merits the clinical diagnosis of postnatal depression. A mother who presents with symptoms of postnatal depression should be referred to a sympathetic GP for an assessment to exclude physical illness that can emerge after the birth (such as thyroid problems or anaemia) and to assess her mental state. There are a range of treatments and interventions that are effective for postnatal depression, including medication (for some women), counselling, group work, infant–parent psychotherapy, and peer support from an organisation such as PANDA. If depression has impacted on the mother–infant relationship this relationship may need treatment in addition to the interventions targeting the mother's mental state.

If the parent has not accessed mental health services consider appropriate referrals. If the parent has accessed mental health services, practitioners should clarify the following issues with the treating mental health professional.

- Does the parent have a diagnosed mental illness?
- Is the illness being treated? Has the illness been stabilised? How does any medication use impact on their parenting of the infant?
- If mental health services are involved, what is their understanding of the risk to the infant?
- What are the manifestations of the parent's mental illness and/or the side effects of treatment? Does this impact on their capacity to care for their infant?
- Are there other care providers (for example, the father or a grandparent) who are able to assist the parent and have an effect on the infant's developmental outcomes?

Family violence

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

The physical and psychological impacts of violence on mothers may affect their parenting, particularly their emotional availability and attunement to the infant's needs. Infants and their mothers are likely to benefit from specialist family violence services and programs that seek to enhance the attachment relationship between infants and mothers (Bunston 2008) and support the mother in her parenting.

> Refer to the Family violence risk assessment and risk management framework (Department of Human Services 2007) to aid your planning and assessment.

- The first priority is to assess that the infant and their caregiver are physically safe from further violence. If safety cannot be supported in the home, detailed comprehensive planning needs to occur to help the caregiver exit from the crisis or from the relationship. Women are most vulnerable and unsafe when fleeing family violence situations and the decision to leave can push them into poverty and homelessness.

- Violence frequently escalates post-separation (Holt, Buckley & Whelan 2008) and women are most vulnerable to family violence homicides post-separation. Liaison with police and specialist family violence services is critical. Pre-exit planning and post-separation support needs to be proportionate to the level of risk and the family's needs.

- Mothers who have experienced domestic violence are frequently held responsible for 'failing to protect' their children (Holt et al. 2008). However, research shows that mothers can make considerable efforts to protect their children (Mullender et al. 2002) and may choose to remain with violent partners as they consider it too dangerous to leave. These findings suggest it is important to carefully assess and sensitively explore the constraints on the mother's capacity to act proactively to protect the infant. Identify the context in which the violence occurs and the repeating patterns of each partner.

- After the violent episode, the partner may express remorse and the woman may be drawn back into the relationship by her genuine belief that 'he can change, he is sorry'. At this point the mother experiences intimacy and her desire for normality can lead her back into the dangerous relationship so that 'the baby can have a father'. It is important to enquire about the positive and negative feelings she may still have towards the violent partner. The history of the positive connections and hopes for the relationship now and in the past need to be explored, so that the cycle of violence and repeating patterns can be better understood, and planning and current actions can be more effective.

- Issues of safety should not be minimised, and consultation with other experts is essential when making critical decisions that require you to balance the needs of infants and complex family issues. Injury and physical abuse of infants is more common in families where there is family violence (Fish, McKenzie & MacDonald 2009).
- Think about how you might also engage men who have been violent towards their partners to take responsibility for their actions and recognise the impact on their partner and infant. Make every effort to link them with appropriate services. Liaise with local men's behaviour change services and be proactive in ensuring other adult-focused services are aware of the children's issues and the parenting role of their client.

Parents with intellectual disabilities

There are great variations in severity of intellectual disabilities and in parenting skill levels and family circumstances. Parents with an intellectual disability may struggle to understand and flexibly respond to their infant's changing needs, putting the infant at risk of neglect. Studies do not agree as to whether it is the intellectual disability that causes child abuse and neglect, the accompanying socioeconomic difficulties, or discrimination and prejudice faced by many of these families. Parental competence must be assessed on a case-by-case basis (Mildon et al. 2003). It is generally agreed that greater support is required for parents with an intellectual disability and their infants (Booth & Booth 1993; Dowdney & Skuse 1993; Feldman 2004; Feldman & Léger 1997; Llewellyn & McConnell 1998; 2003).

If a parent with an intellectual disability is referred to child protection or other family services:

- Do not automatically assume a lack of competency in parents with an intellectual disability.
- Be conscious of the way in which you communicate (verbally and in writing). Is it sensitive and appropriate to the individual's ability to communicate?
- In what way, if any, is their disability impacting on their ability to provide adequate care? Do different developmental stages require different resources for the infant and parent/s?
- Are they vulnerable to predatory offenders?
- Consider a referral to parenting assessment and skill development services.
- Are there other issues associated with the intellectual disability that are putting additional stress on the individual's parenting (for example, housing, isolation or lack of support)?
- Who are the supportive extended family members who can strengthen the protective networks around the infant and offer practical help to the parents?
- What services or supports might be of assistance?

Adolescent mothers

Most adolescent mothers do not abuse their children, but the infants of adolescent mothers are at a higher risk of parent–child relationship problems and neglect (Carter, Osofsky & Hann 1991). An Australian study found that 60 per cent of pregnant adolescents had a major social or psychological problem adversely affecting their ability to carry out daily living activities (including parenting activities), and the consumption of drugs and alcohol was higher than that reported for the general adolescent population (Quinlivan, Peterson & Gurrin 1999). Studies have found that adolescent mothers talk less to their infants and frequently have difficulty interpreting infant cues or identifying the feelings of their babies (Carter et al. 1991; Osofsky, Hann & Peebles 1993), all of which affect infant development and the infant–caregiver attachment relationship. However, it is worth noting that home-visiting programs have been

found to be effective for young parents, particularly in assisting young mothers to re-engage with education (Sweet & Appelbaum 2004). It is preferable to engage with adolescent mothers during their pregnancy to assess and make every effort that they have the supports they need.

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

See *Infants at risk of abuse and neglect: A review of literature* (Sketchley & Jordan 2010) for a more comprehensive discussion on the ways in which different risk factors impact on parenting.

Action

Timely interventions are important for all children, but time is especially critical for infants. Use your analysis and planning to inform your intervention. What extended family and community supports can be engaged to assist? What services, supports or interventions do the infant and their parents need? What services are available to assist with the infant–caregiver attachment relationship?

Cases involving infants are complex and time is critical. You need to access appropriate supervision and in the case of a high risk infant consult with the Practice Leader.

Professional involvement needs to be manageable, supportive and change oriented rather than overwhelming for the family. Take care not to 'over refer' parents to services. A key practitioner needs to take responsibility to make every effort to engage the family in a staged and coordinated process; however, all practitioners need to respond urgently and decisively to basic issues of safety for the infant.

Build on non-professional supports and also consider the following referral points:

- There are professionals and services to assist with parent problems, such as housing assistance, home visiting, family support, drug and alcohol, mental health, family violence, men's behaviour change, victims of crime, sexual assault, family counselling, refugee and culturally specific services.

- If the infant is of Aboriginal or Torres Strait Islander descent, child protection practitioners must remember to consult with the ACSASS/Lakidjeka practitioner.

- Consider referral to an Aboriginal child and family service, Aboriginal maternal and child health, Aboriginal in-home support services, Aboriginal family preservation and Aboriginal family restoration services, and any other appropriate Aboriginal services/programs in the area.

- Infant-specific services include maternal and child health nurses, paediatricians, Child Adolescent Mental Health Service (CAMHS) (specialist infant mental health), early parenting centres and specific therapeutic groups (for mothers and infants who have experienced family violence or mothers with postnatal depression).

- In-home, day-stay or residential parenting assessment and skill development services (PASDS) assist parents to develop the skills they need to meet the needs of infants.

- Connections to universal services or community programs or clubs (for example, housing services, health services, childcare, mentoring programs, community centres, neighbourhood houses, first mothers' groups, playgroups, parenting groups and toy libraries).

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

Working with infants and families

The best interests principles of the Act clearly state that we must give the widest possible protection and assistance to the family. The goals of the intervention need to be developed with the family and be purposeful.

> The reason for child protection or family services involvement must be clearly understood by the family. Where parent problems are the reason for intervention, the impact of these problems on parenting behaviour and capacity, and on the infant, must be clearly articulated without jargon. Clear goals and outcomes need to be established in relation to what needs to change for the infant.

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

It is critical that the intervention is purposeful and clearly linked to the needs of the infant. Make your interventions 'SMART' – specific, measurable, achievable, related (to the concerns) and timely, and make a point of letting the parents know when they have been successful.

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

Working with Aboriginal children and their families

'The Aboriginal person's sense of security is ultimately derived from having a positive Aboriginal identity' (Yeo 2003, p. 299). Cultural support plans are a tool to assist child protection practitioners in their capacity to safeguard the culture of Aboriginal children in out-of-home care. If the infant is Aboriginal, child protection practitioners need to make a referral to the Aboriginal family decision-making facilitator and the convenor to assist in the development of a cultural support plan. The infant's family, extended family, community, child protection, ACSASS and other relevant professionals will be involved in the development of the cultural support plan.

> For further information and guidance child protection practitioners should refer to the following sections of the child protection manual: Responding to Aboriginal families, Aboriginal child and family service system, Planning in best interest case practice and Cultural support plan.

Holding the family through transitions

'Holding the family whilst assisting them to make transitions to, and become engaged with, appropriate services, is fundamental to good practice and positive early engagement' (Miller 2010, pp. 13). Delays or failure to hold families and manage risk during transitions can be detrimental for infants.

- Prioritise case allocation for infants.
- Closure should be considered only after the family has engaged with services to which they were referred. Keep cases allocated until after the family's engagement with support services and carefully plan the closure process, paying attention to contingency/safety plans.

For child protection practitioners, a case planning meeting must be held prior to case closure to confirm arrangements for ongoing supports. The case closure decision must be endorsed by a Team Manager and where the infant is a high risk infant, the Practice Leader.

Contact arrangements for infants in care

Arrangements for infants to visit their parents must factor in the importance that the infant should be feeling as secure and alert as possible in order for them to have the curiosity and emotional energy to invest in getting to know and interact with their parents. This is especially true if the parents have never been the primary caregivers for the infant. As the paramount consideration, visiting arrangements must prioritise safeguarding the infant from further harm. Parents often need coaching to read the cues of the infant. Use contact time to support the parent in a therapeutic and educational way to heal and develop their relationship with their infant.

For a discussion of infant contact with parents while in out-of-home care see *A stitch in time saves nine: Preventing and responding to the abuse and neglect of infants* National Child Protection Clearinghouse Issues paper no. 30 <www.aifs.gov.au/nch>

Frequency of contact

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

If an Aboriginal child is placed in care the Aboriginal child placement principles should be adhered to as a legislative requirement. Contact arrangements and cultural support plans must be implemented promptly for Aboriginal infants. Support and guidance should be sought from ACCOs, ACSASS and Aboriginal family preservation and Aboriginal family restoration programs.

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

Disruption to the infant's daily routine

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

Breaks in continuity of experience with foster or kinship carers

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

Transport

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

Infants' experience of contact

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

Planning towards reunification

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

Preparing matters for court

Child protection needs to be able, when required, to present evidence to the court that shows the effects of abuse and neglect on infants.

The court will need to know who the infant's attachment figures are, the quality of these attachment relationships and the possible impact of attachment disruptions.

The court will also want to know what assistance has been provided to the family and the outcomes of previous interventions.

When preparing matters for court, it is important to advocate for the infant regarding any contact arrangements while respecting the infant–parent relationship.

- As much as possible, minimise conditions that may place undue stress on infants (disruptions in routine, breaks in continuity of care, transport).
- What is the optimal frequency to secure high-quality, safe contact that does not unduly stress the infant?
- Does the parents' behaviour during contact cause the infant distress? Be mindful of aggression and substance-affected parents, and carefully note the impact on the baby, ceasing contact if warranted.
- Have parents been coached and supported to respond to infant cues and to change behaviours that cause the infant distress? Carefully record the infant's behaviour before, during and after access and the parents' responses to the practitioner's parenting guidance and prompts.
- Monitor the way in which infants respond to their parents during contact. The court will need to know if contact with one or both parents consistently distresses the infant and an assessment may need to be made to make certain that contact is not causing further harm.

For guidance in preparing matters for court, refer to the Court guide and consult with a supervisor.

The baby needs sensitive, caring and stable relationships

The need for sensitive caring and stable relationships is especially crucial for infants who have been neglected or abused (Melmed 2004). Infants may not be able to afford the time to wait for their parents to recover from risk factors such as mental illness or drug addiction when these seriously impair parenting capacity. It is still a common misconception that (especially younger) infants are 'resilient' and can manage moves from one foster carer to another.

However, the disruption of attachment ties with foster parents is likely to constitute a severe trauma that reinforces feelings of abandonment (Gauthier et al. 2004; Goldsmith et al. 2004; Melmed 2004). With each disruption comes progressively more difficulties in managing the stress of transition, and with each loss, the capacity to adapt and adjust to new challenges is compromised, as is the capacity to develop trusting relationships.

• Minimise the number of placements wherever possible.

• Think about the impact on the attachment relationships of the infant of other children coming in and out of the carer's household.

Reviewing outcomes

We need to remain curious about our effectiveness, and constantly review our assessments and planning in light of emerging information and the outcomes of our actions. Practitioners are reminded that a referral to another service will not guarantee that the family will engage with that service, that change will occur *in time* for infants or that it will be sustained over time.

A primary focus when reviewing outcomes is the safety and developmental progress of the infant. Are they meeting milestones? Have they gained weight? Are they relating well in their family and external relationships? Are there behavioural indicators of trauma? Are the parents able to hold the infant in mind and privilege the infant's needs before their own? Is there greater stability in the family and in the infant's life? Is there 'good enough' parenting?

Good practice may involve trying several strategies or interventions before coming up with an approach that works. However, infants may not be able to afford the time to wait for their parents to recover. The infant's immediate safety (physical and emotional) is paramount and ill-considered and overly optimistic attempts at reunification exacerbate the long-term negative effects of multiple disrupted attachments in infancy.

Previous service system responses and outcomes of interventions need to be assessed more frequently for infants. Child protection practitioners should consider:

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

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

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

- Have parents been provided 'the widest possible assistance'?
- Has the intervention been culturally competent? Has ACSASS been consulted?
- What is the parents' capacity for change? Has change been demonstrated and sustained over time?
- Will it be fast enough given the infant's needs for safety and secure attachment relationships with biological parents or other carers?
- Practitioners also need to give themselves permission to say 'enough is enough' (Cousins 2005, p. 6).
- Keep in mind the need to assess the effectiveness of responses and outcomes for infants.
- What's changed for the infant? How do we know?
- Is the infant more able to play, self-regulate, communicate and learn?

Other relevant resources

For a comprehensive discussion of the literature on infants and their families that underpins this specialist practice resource refer to:

- Department of Human Services 2009, *Protecting Victoria's children: Child Protection practice manual*, State Government of Victoria, Melbourne. Online: <www.dhs.vic.gov.au>

- Department of Human Services 2007, *Strategic framework for family services*, State Government of Victoria, Melbourne. Online: <www.cyf.vic.gov.au/family-services/library/publications/strategic_framework>

- Department of Human Services 2007, *Guide to Court Practice for Child Protection practitioners 2007*, State Government of Victoria, Melbourne. Online:<www.dhs.vic.gov.au>

- Jordan, B & Sketchley, R 2009, 'A stitch in time saves nine: Preventing and responding to the abuse and neglect of infants' *NCPC Issues*, 30, Australian Institute of Family Studies, Melbourne, viewed <www.aifs.gov.au/nch/pubs/issues/issues30/issues30.html>

- Miller, R 2010, *Best interests case practice model: summary guide*, State Government of Victoria, Melbourne. Online: <www.dhs.vic.gov.au>

- Miller, R 2007, *The Best Interests principles: a conceptual overview,* State Government of Victoria, Melbourne. Online <www.dhs.vic.gov.au>

- Miller, R & Bromfield, L 2010, *Cumulative harm specialist practice resource*, State Government of Victoria, Melbourne. Online: <www.dhs.vic.gov.au>

- Miller, R & Noakes, R 2010, *Child development and trauma specialist practice resource*, State Government of Victoria, Melbourne. Online: <www.dhs.vic.gov.au>

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