

Micah Projects

Child Aware Approaches Project Literature Review

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Clare Tilbury, Peter Walsh & Jennifer Osmond

GRIFFITH UNIVERSITY

SCHOOL OF HUMAN SERVICES AND SOCIAL WORK
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Developed by Clare Tilbury, Peter Walsh & Jennifer Osmond

Griffith University

School of Human Services and Social Work

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SECTION ONE INTRODUCTION

Children's health and wellbeing are important objectives for policy and service provision within Australian society. Positive developmental outcomes for children heighten the likelihood of a happy and productive adult life which is important for the individual and the wider community. As Strazdins, Lucas, Shipley, Mathews, Berry, Rodgers and Davies (2011, p. 6) explain "the future of Australian society and economy depends on the extent Australian children are resilient, educated and mentally and physically healthy, enabling them to participate and innovate once they grow up". Child wellbeing can be conceptualised according to indicators such as: material wellbeing, health and safety, education, family and peer relationships, behaviours and risks and subjective wellbeing (UNICEF, 2007, p.2). Wellbeing may also be viewed via dimensions as: child *needs* - for example, assessed delays in physical and other domains; their *rights* - child has experienced a violation in his/her rights in a particular area (for example, protection); *poverty* - a child's situation is so poor that basic items are not provided; poor *quality of life* – a range of aspects of a child's life are significantly insufficient and the child is unhappy; and a child is *socially excluded* (for example, weakened links and participation to school, social activities) (Axford, 2009).

Irrespective of which conceptualisation of wellbeing is used, many Australian children are doing well, though there are children who are at risk of less than ideal outcomes. The reasons for this are varied and may include structural, environmental, familial and individual factors. One area that has received considerable empirical support is the critical role parents play in their child's wellbeing. Parents who provide consistent, positive, nurturing and responsive care to their children are more likely to facilitate a child who becomes socially competent and experiences positive outcomes in all psychosocial domains (Wade, Llewellyn & Matthews, 2011). The capacity to parent effectively can however be compromised from particular adversities and there are many difficulties that adults may experience in their lives that can impact on their parental capacity and subsequently their child's wellbeing.

Given that children often have significant needs due to their family situation, some services are broadening their service delivery to embrace a child focus. The importance of universal services having a child and family focus has been recognised (Scott, 2009). Non-statutory services come in contact with many vulnerable children and families and are well placed to offer assistance in a non-stigmatising manner. However, the interface between the child protection system and adult service system is a complex matrix of differing eligibility thresholds, knowledge bases, service types, funding contract requirements, and multiple ethical and legal considerations. As a result, adult services may fail to incorporate clients' families into their assessments, and even where workers in adult teams are aware of the existence of children, they may not have the professional expertise to meet child-specific needs.

These barriers highlight the problems of the bifurcated service delivery system. There are services for children and families that are focused on improving the care of children and family functioning (secondary and tertiary child protection and family support services). In this sector there is increasing knowledge about the risks to children who are exposed to domestic and family violence, parental mental illness and problematic alcohol and substance abuse, but workers are not necessarily skilled in these fields of practice and the interprofessional and interagency links are often limited. On the other hand, there are services for adults that are focused on responding to and reducing domestic and family violence, mental illness and problematic alcohol and substance abuse but workers are not necessarily aware of, or skilled in, responding to children in the families of those adults – and they may have limited interprofessional or interagency links into the child and family sector. Problems such as these need to be overcome in order to ensure appropriate consideration of children's needs and effective protection of their rights. Initiatives to develop 'child aware' practices in adult services are aimed at addressing such issues.

This literature review considers five factors that may affect parenting: mental health, substance abuse, homelessness, intellectual disability and domestic violence. The aim of the review was to map existing research pertaining to the impact of these factors on parenting and experiences for children. Recognising the potential impacts on children is imperative for assessment, recognition of their needs, and tailored interventions. The search strategy was comprised of three processes. (1) To search for English language articles from national and international peer-reviewed journals dedicated to social care research, the following databases were accessed - Scopus, ProQuest, Current Contents, Social Services Abstracts and PsycINFO. Multiple words and phrases were used in the search process: child, child focus, child aware, assessment, needs, domestic violence, homelessness, intellectual disability, substance abuse, mental health, engagement, hard to reach, interagency collaboration, multiple problems, families. (2) Google and Google Scholar were used to search the internet for any relevant grey literature. (3) Reference lists and bibliographies of relevant papers were scanned for other articles of interest. Consistent with the methodology for scoping reviews of the literature, all relevant studies were included. The majority of the literature and reports located were dated between 2000 and 2012.

SECTION TWO POLICY DEVELOPMENTS

Developing a more child aware practice approach is consistent with priorities and strategies identified in the *National Framework for Protecting Australia's Children 2009-2020*, specifically to 'Increase capacity and capability of ... adult focused services to identify and respond to the needs of children at risk' (Commonwealth of Australia, 2009: 23). A strategy in the second action plan 2012-2015 of the Framework is to: 'Identify and share best practice in Child Aware Approaches to promote a better understanding of the relationship between the risk factors for child abuse and neglect' (p 20).

Recent Australian initiatives that encompass child aware practices in adult services include:

Child inclusive practice in the Family Court: Over the last decade, the Family Court has developed mechanisms to ensure children's rights to have their views given appropriate consideration in the process of attempting to resolve post-separation disputes in which they are involved. There are two main forms of child responsive practice operating in Australian courts: child-focused practice, in which the focus is on the child's needs, but without their active participation; and child-inclusive practice, which encompasses directly consulting with children (McIntosh, 2007).

Common Approach to Assessment, Referral and Support project (CAARS): CAARS is a way for universal service providers to identify children who may need help and to help connect them to the support they need. The Common Approach resource kit includes a range of tools:

- A desk pad for service providers which includes conversation prompts to assess strengths and needs in conversations with families.
- A self-administered questionnaire for parents and one for older children.
- Professional judgement reference points for preparation for a conversation with families.
- A guidance manual for practitioners.

A trial and evaluation in four locations are underway¹.

Families where a Parent has a Mental Illness (FaPMI): The Victorian Child Protection Inquiry (Cummins Inquiry) recommended that the following Acts should be amended to ensure that service providers assisting adults also have a clear responsibility to the children of their clients: Disability Act 2006; Education and Training Reform Act 2006; Health Services Act 1988; Housing Act 1983; Mental Health Act 1986; and Severe Substance Dependence Treatment Act 2010. Following on from this, the Victorian Health Department introduced the 'Families where a Parent has a Mental Illness' strategy. The FaPMI strategy encourages family focused practice through workforce training and networking to ensure timely identification and appropriate referrals to supportive services and so reduce the possible impact of parental mental illness on the family.

¹ Further information at <http://www.aracy.org.au/projects/caars-common-approach-to-assessment-referral-and-support>

'Let's talk': The organisation 'Children of Parents with a Mental Illness' (copmi.net.au) has been funded to develop an online training resource for health professionals titled 'Let's talk about the children', when the parent has mental health problems. 'Let's talk' is a two-session intervention which consists of collaborative discussions between parents and a worker regarding parenting and children. The aim is to make talking about children and parenting issues a natural part of the mental health treatment process. The intervention assists parents to identify and develop strategies to promote child and family strengths and to assist families to access additional services for children. The program is being piloted in Victoria and Queensland.

In NSW, as a result of the Special Commission of Inquiry into Child Protection Services 2008, Child Wellbeing Units (CWUs) have been established in the four government agencies responsible for the largest number of child protection reports: Department of Human Services NSW, Department of Education and Training, NSW Health and the NSW Police Force. Trained staff in CWUs assist mandatory reporters in their agency to use a Mandatory Reporter Guide and ensure that all concerns that reach the threshold of risk of significant harm are reported to the Child Protection Helpline. Where a concern does not meet the statutory threshold, the primary role of the CWUs is to support concerned professionals to better respond to concerns relating to the safety, welfare and wellbeing of children and young people. This can be done by identifying potential agency responses or by providing advice on referrals to appropriate services.

State and Territory governments have introduced requirements for agencies working with children to ensure they have adequate child protection policies and systems in place. For example, the *Commission for Children and Young People and Child Guardian Act 2000*, provides that organisations working with children (which fall within the scope of the 'blue card' regime) must develop and implement policies and procedures against eight prescribed areas:

- a statement of commitment about maintaining children's safety and wellbeing
- a code of conduct outlining the organisations' values and expectations
- recruiting, selecting, training and managing employees and volunteers
- handling disclosures, allegations and suspicions of harm to children
- managing breaches of the risk management strategy
- complying with the 'blue card' regime by conducting criminal history checks for persons who work or volunteer with children
- risk management planning for high risk activities and special events
- communicating the risk management strategy to stakeholders (i.e. staff and service users).

These Australian developments are reflected internationally. Two policy developments in the UK are relevant: Safeguarding Children and Every Child Matters.² Every Child Matters was developed in response to death of a child and the subsequent public inquiry that found there was a failure of services to work

² See <https://www.education.gov.uk/publications/standard/publicationDetail/Page1/DfES/1081/2004>).

together. It involved integration of services and information sharing obligations for children's social care, education, and youth offending for the 0-19 years span. It was built on five outcomes: being healthy, staying safe, enjoying and achieving, economic wellbeing, and making a positive contribution. There was a reframing of responsibilities around the child and family, not the professional grouping such as drug and alcohol workers or children's social workers. It also involved requirements for local authority departments to work together to achieve outcomes (making it not just responsibility of child protection authorities).

Safeguarding Children is similar to policies in Australia that require agencies to conduct criminal history checks for persons who work or volunteer with children, and to have policies and procedures regarding work with children. UK agencies must have a child protection policy that demonstrates a commitment to safeguard children involved with agencies from harm, including procedures and systems providing step-by-step guidance on what to do in different circumstances.

SECTION THREE CHILDREN LIVING WITH A PARENT WITH A MENTAL ILLNESS

Context

Although definitive statistics are not available, it has been suggested that the number of children living with a parent with a mental illness could be between “21-23% of all Australian children” (Maybery, Reupert, Goodyear, Patrick, & Chase, 2009 cited in Steer et al, 2011, p. 502). Mental illness denotes a variety of issues and diagnoses such as: personality, mood, anxiety, cognitive, psychotic and can be of varying degrees of severity (Foster, O'Brien, & McAllister, 2004/2005, p. 68). A parent having a mental illness *does not necessarily lead to compromised* parenting. A diagnosis is not a good predictor of parenting ability (Mowbray et al, 2002, cited in Westad & McConnell, 2012). A range of other factors and their interaction impact on capacity, such as: severity and phase of the condition; the parent's level of awareness of their mental health condition; access and compliance to treatment; extent of social support network and others (Westad & McConnell, 2012; Huntsman, 2008). Other co-morbidities (for example, domestic violence, substance abuse) may also exist which may lead to additional difficulties (unemployment, financial difficulties and social isolation) which can impact on stress levels and parenting capacity (Reupert & Maybery, 2007; Westad & McConnell, 2012). Parents with a mental illness are more likely to come to the attention of child protection authorities, with some children being removed from their parents care (Westad & McConnell, 2012).

Impact and effects

Reupert and Maybery's (2007) review of the literature highlighted that some children may be living a lifestyle that is substantially different to their peers. They may be witnessing the presentation and behaviours of their parents' mental illness, be drawn into delusions, have a parent who is not available and consistent with them, and their lifestyle may be disorganised and unpredictable. For some children having a parent with a mental illness can mean having to cope with the hospitalisation of their parent and the stressors associated with this (for example, additional responsibilities in the home for the parent and siblings). Some children may be actively aiming to prevent harm to their parent during periods of relapse (for example, keeping them out of dangerous situations) (Aldridge, 2006).

Given this family situation, *some* children are at risk of adverse outcomes in all domains: emotional and behavioural, the development of mental illness, peer and interpersonal relationship problems, maladaptive coping, attachment issues, academic difficulties, cognitive and language problems, attention span issues, and higher rates of suicide (Foster et al, 2004; Reupert & Maybery, 2007; Steer et al, 2011; Westad & McConnell, 2012; UK Department of Health cited in Cooklin, 2008). Huntsman's (2008, p. 14) review of research found that children who are considered to be a higher risk for adverse effects are: younger children; those with inadequate coping skills; children with temperament issues; “low birth weight”; and lack of positive, supportive relationships. Huntsman also identified psychosocial variables that can either heighten risk or conversely mitigate it if absent, these

include: the family having inadequate social support; family conflict; domestic violence, instability; both parents/guardians having mental health issues; single parent status; being a young parent; and substance abuse.

Having a parent with a mental illness can lead to a child feeling personally responsible, feeling a sense of loss about his/her relationship with his/her parent and being fearful about his/her parent's safety. A child may experience considerable confusion and rejection from others due to his/her parent's behaviour (Cooklin, 2008). Children can be acutely aware of the stigma of their parents' condition and use a range of methods to try and avoid or manage the stigma (Fjone, Ytterhus & Almuik, 2009). Children may employ strategies to monitor and adjust to their parents' behaviour and at times maintain their safety via distancing themselves (Mordoch & Hall, 2008).

Children may have fears: fear about being removed from their parents care, worry that they will develop a mental illness (Falkov, 2004), fear that their parent may harm themselves, concern about the health of their parent, and concerns about school and relationships (Stallard, Norman, Huline-Dickens, Salter & Cribb, 2004). Differences in concerns/issues for children according to their developmental level may also be evident. For example, Trondsen's (2012) research with adolescents highlighted that they may lack information about their parents' mental illness, have an unpredictable existence, have a range of fears, feel a sense of aloneness and experience loss and grief about not having a 'normal' life. Many children may not fully understand their parents' mental illness and from this develop incorrect assumptions (Devlin & O'Brien, 1999 cited in Reupert & Maybery, 2007).

Importantly, not all children will experience adverse implications. Some children's resilience and the presence of protective factors can offset less than ideal family circumstances (Foster et. al., 2004). Foster et. al. (2004) summarise a number of protective factors which are broadly either internal to the child (a quality or skill within them) or externally available. Internal factors are the child's intelligence (higher), self-belief in one's own capacity, easy-going personality, having a sense of humour, good problem solving and communication skills, independence, having a keen interest in something, good emotional self-management, loyalty to particular relationships and others. External factors which may mitigate difficulties and boost resilience include: quality relationships (for example, friends), opportunity to establish a good relationship with a reliable, consistent adult and be in receipt of positive messages about themselves (Foster et. al., 2004).

Needs and assessment

Children living with a parent with a mental illness may have a variety of needs, which must be individually determined as they are not a homogenous group (Steer et. al., 2011). Needs could include: age-appropriate information; opportunity to express feelings and concerns; timely and constructive assistance during high stress periods (for example, acute period of the illness when parent is receiving inpatient care); assistance to facilitate positive relationships and connections with others; opportunity to learn appropriate coping strategies; increased social support; the

boosting or establishment of protective factors; and assistance for their parents (Reupert & Maybery, 2007; Foster et. al., 2004). Particular wishes children may have are: to have an honest conversation about his/her parent's mental illness; have another adult who is aware of their needs and is an advocate; to understand that they are not alone and that mental illness is common; to have the opportunity to be with other young people who are experiencing this; to gain sufficient knowledge about their parents' mental illness that they can recognise the signs and know how to get help; and recognition of the valuable role and assistance they have provided to their parent (Cooklin, 2008; Cowling & Garrett, 2009).

It is vital that assessment clearly explore children's circumstances and needs. If needs are not clearly recognised, interventions offered may not necessarily match or be appropriate (Steer et al, 2011). Talking with children about their experience is imperative. "Talking is... a way of ascertaining whether a child is confused, fearful, having problems, or ill and requiring treatment in his/her own right" (Falkov, 2004, p. 41). With the right timing, explanations and assistance to children can aid in reducing their anxiety/confusion and help them adapt. Conversations with children about their circumstances can have multiple purposes such as acknowledging their experience and feelings, information provision, facilitating communication between others and assessment (Falkov, 2004).

Reupert and Maybery (2010) indicate that typical professional responses to children involve opportunities to mix with peers, assistance to strengthen a child's capacity to positively cope, respite and education about mental illness. They offer a number of insights on the potential value of education for young people (for example, empowerment, relief, can aid with communication) based on their research with facilitators of education initiatives.

Maybery and Reupert (2009) undertook a research review with the aim of identifying the barriers for psychiatric workers that impact on their ability to respond to children and families when a parent has a mental illness. A number of barriers were identified:

- Inadequate policy and guidelines within a service that identify the parenting status and family situation of service users; insufficient resources and time for staff to adequately undertake this additional focus; insufficient support and supervision of workers' capacity and practice; articulation and conceptualisation of worker's position descriptions; the culture of the workplace and attitude of upper management;
- Inadequate or ineffective interagency collaboration and communication;
- Level of skill, capacity and knowledge of staff. Some staff may feel that they lack sufficient knowledge of how to work with children, parenting and assessment, child development and family work. Workers may be resistant to changing their focus from a particular service user. Workers professional qualifications and perceptions about their professional focus can influence their willingness. Concerns about confidentiality may also inhibit some staff; and

- The service user themselves may not wish to have their family or children involved or be a focus.

Stallard, Norman, Huline-Dickens, Salter and Cribb (2004) identified three categories of potential barriers, as follows: (1) *team barriers*: workers having insufficient time due to current workload demands, children's needs not recognised due to being more client focused than child focused, staff feeling inadequate in their capacity to effectively assess and respond, workers feeling concerned about the impact on the adult client; (2) *parent barriers*: parents needs so substantial that the parent cannot see beyond their own issues, parent not willing to recognise child related issues, fear from parents about being critiqued, not wanting any adverse impact on child; and (3) *child barriers*: child does not want to be involved, and is fearful or ambivalent. They recommend a shift from client-centred to family-centred approach. Because some children of parents with mental illness are at higher risk of childhood psychiatric disorders, Cowling et. al. (2004) proposed that assessment of the child at the time of referral of the parent is an opportunity for problem identification, parental education, and early intervention.

Besides identifying barriers, Maybery and Reupert (2009) offer a number of strategies and processes that may assist to overcome difficulties. Examples include: clear policies and practices within the organisation about family and child screening, clear assessment processes, service statements, and protocols for inter-agency practice. Quality support, training and development of staff are vital. Ensuring that staff have appropriate knowledge and skill in relation to assessing, working with and understanding children's needs and development may be required. Specialised training on particular issues may be necessary for some workers.

SECTION FOUR SUBSTANCE ABUSE

Context

Many individuals in Australia misuse licit and illicit substances (Burke & Taplin, 2009). However, there appears to be minimal data which clarifies the extent of drug use by parents. An Australian survey (Dawes et al. 2007, cited in Burke & Taplin, 2009, p. 16) reported:

- ... 2.47% of adults living with a child under 12 years reported daily cannabis use...
- ... relatively little reported heroin use among respondents with dependent children...
- approximately 8.4 children per 1,000... in households with an adult who uses methamphetamines at least monthly and has done so at home in the last year.

There are a myriad of reasons why parents may misuse drugs and alcohol, which can impact on their capacity to responsibly care for their children. A 'collision of circumstances' and difficulties may be present (Kroll & Taylor, 2000, p. 93). Importantly, other problems may co-exist such as parental mental health problems, domestic violence, and child maltreatment (Centre for Parenting and Research, 2006). Research suggests that children whose parents misuse illicit and legal substances and alcohol are at risk of child abuse and neglect (Scannapieco & Connell-Carrick, 2007).

Impacts and effects

Children can experience a number of unfavourable effects as a result of having a parent with a significant substance misuse problem. However, impacts on children can be variable as substance misuse by a parent does not automatically equate to harm to a child. The riskiness of substance misusing behaviour is critical (Burke & Taplin, 2009). The main impacts reported in the literature are that children may be in receipt of poorer quality care and parenting. Parents' substance misuse habits may mean that they are less involved with their children; home life may be less stable and predictable; the environment may not be safe due to the substance-misuse culture and equipment; and less supervision (Kroll & Taylor, 2000). Some parents may also be involved in illegal activity to support their habit (Taylor, 2011).

A parent who misuses substances may not discern when a child does require care. Their capacity to manage their own emotions in relation to their children may be compromised (Ammerman, Kolko, Kirisci, Blackson & Dawes, 1999 cited in Donohue, Romero, Herdzyk, Lapota, Al, Allen, Azrin & Hassett, 2010). Kroll and Taylor (2000) identify that a child's sense of safety and security (emotional and physical) may be at risk. A substance-misuse lifestyle can impact on a parent's capacity to attach and build a relationship with a child (Kroll & Taylor, 2000). For some children, their opportunity to have a 'normal' childhood may be affected. Children have higher rates of psychiatric disorders when their parents have substance-misuse disorders (Contractor, Celedonia, Cruz, Donaihy, Kogan, Marin & Stein, 2012).

Although some children may enjoy some benefits related to their parents substance-misuse (more freedom, less supervision), it can also equate to a loss of carefreeness and the necessity to take on additional responsibilities (Kroll & Taylor, 2000). It may be difficult for some children to enjoy usual social activities such as having friends over. Kroll (2004) reviewed seven studies which examined children's perceptions and experience of living with a parent with a substance or alcohol problem. These studies involved either an adult recalling the experience or insights from children who were currently or had recently been in this situation. Key themes reported were: children feeling a need to maintain secrecy of the issue in their family; not feeling of high importance in their parents' lives (attachment issues); multiple potential losses (for example, normal life, having friends over, feeling loved, stability and consistent parent, childhood, opportunities for fun and enjoyment); children's needs not being prioritised – parents needs being at the forefront; living with fear and violence; and undertaking additional roles and responsibilities within the family.

This lifestyle can subsequently result in children displaying behavioural problems, becoming isolated and disconnected from their community, physical and emotional difficulties, school and academic problems, increased risk of substance abuse themselves, and children taking on greater responsibility than is reasonable (see Burke & Taplin, 2009). Children whose parent misuses alcohol during pregnancy can develop a foetal spectrum disorder, which can lead to delays and difficulties for the child (Taylor, 2011).

The risk of adverse consequences is heightened by the level of severity of alcohol misuse, how long parent/s had been misusing (longer time frame more likely adverse impact), the nature of the drinking activity (for example, binge or constant drinking) and how many members of the child's family used alcohol inappropriately (larger number possible greater effect). It is the amassing of risk factors (a cumulative effect) that raises the likelihood of negative outcomes for children (Centre for Parenting and Research, 2006).

Needs and assessment

Given that research suggests that children whose parent/s misuse substances *may* be at risk of child maltreatment, this issue requires assessment. "Assessment must focus not only on the substance use of the parent, but also characteristics of the child, parental capacity, home environment, social environment, and the maltreatment pattern of the family. Substance use in and of itself does not predict child maltreatment, and an ecologically focused and comprehensive assessment is necessary to determine the danger or potential danger in which a child may live" (Scannapieco & Connell-Carrick, 2007, p. 1551).

In relation to assessing alcohol misuse, three main issues require examination: (1) exploring the role, nature and extent of a parent's use of alcohol in everyday life, (2) the impact of their alcohol use on their capacity to care for their child, (3) other sources of support and assistance for the child's needs being met (see Centre for

Parenting and Research, 2006 for detailed discussion). A useful screening tool for use with parents with possible substance misuse issues is the World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) (WHO ASSIST Working Group, 2002). Although the ASSIST was developed principally for use in primary health care, it can be used in other settings, including social welfare agencies. The revised version of the ASSIST (V3.0) consists of eight questions or items, covering tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants (including ecstasy), inhalants, sedatives, hallucinogens, opioids and other drugs, that can be answered by most people in around 10 minutes. The ASSIST is an interviewer-administered pencil and paper questionnaire and screens for all levels of problem or risky substance use. A risk score is provided for each substance, and scores are grouped into low, moderate or high risk. The ASSIST has undergone significant testing to ensure that it is feasible, reliable, valid, flexible, comprehensive and cross-culturally relevant (Humeniuk, et al., 2008).

Children living in homes where substance misuse is a major issue may then have multiple needs that require assessment and intervention. These needs may include: opportunity to have a relationship with a caring, consistent and reliable adult; stability; to enjoy a lifestyle that is as normal as possible; counselling and/or play therapy to help address issues; opportunity to develop prosocial behaviour; reconnection and involvement with the community; and if young, attendance at high quality childcare (Burke & Taplin, 2006). Children may benefit from being involved in more community activities so they can receive additional sources of support (Contractor et al, 2012). Children may need assistance with their feelings: to feel valued and safe; to have professionals be patient and understand the difficulties they may have in talking about home life; have someone they can trust and openly talk with; the opportunity to interact with other children who had encountered similar problems, and continued support (Kroll, 2004).

There are a range of interventions that may be beneficial for substance-misusing parents (see Burke & Taplin, 2006; Taylor, 2011; Donohue et al, 2010). Given that many difficulties may be experienced or co-exist, comprehensive interventions are often required. For instance, Burke and Taplin (2006) highlight that dependency issues usually require long-term intervention.

For children, early identification is important, so as to strengthen their resilience (Wolin & Wolin, 1995 cited in Bonder, Hulisz, Marsh & Bonaguro, 2006). Importantly, barriers for addressing the emotional issues that children could have may require effort. Barriers to discussing issues may include stigma; little confidence in the helpfulness of interventions; and children's willingness to attend and be involved in assistance (Contractor et al, 2012).

SECTION FIVE HOMELESSNESS

Context

In Australia, a considerable number of people are homeless, of which some are homeless families with children. Moore, McArthur and Noble-Carr (2011, p. 115) report that “children who accompany their parents or guardians during a period of homelessness make up 37%...of all people accessing Supported Accommodation Assistance Program (SAAP) services (Australian Institute of Health and Welfare, 2008a,b)”. Homelessness statistics are likely to be higher than reported because of the number of people who may not access services and reside in other forms of temporary accommodation. Indigenous families are over-represented in those seeking assistance (Mission Australia, 2011).

There are a range of factors that can lead to family homelessness: parental mental illness; poverty and financial difficulties; unemployment; inadequate social support; domestic violence; substance abuse; eviction; relationship breakdown; a significant major personal event; and previous experience of child abuse and neglect (Dotson, 2011; David, Gelberg & Suchman, 2012; Gibson & Johnstone, 2010; Kirkman, Keys, Turner & Bodzak, 2009; Noble-Carr, 2006). Given this, families experiencing homelessness may have a matrix of issues, structural and individual contributing to their present circumstances (Noble-Carr, 2006). For many people, a combination of difficulties has led them to homelessness (Crane, Warnes & Fu, 2006). Notably, these potential difficulties may not necessarily be all caused from homelessness with other factors contributing (Kirkman et al, 2009).

Impact and effects

The impacts of homelessness on parents and children can be substantial in both the short and long-term (Noble-Carr, 2006). They can have increased risk of health problems; family relationships difficulties; their participation in a range of activities can be reduced; children may experience periods of instability; educational impacts due to frequent moves and lack of regular attendance; developmental delays; behaviour difficulties; social exclusion, internalising disorders; intergenerational homelessness; mental health issues; and the capacity of parents to parent effectively (Moore et al, 2011; David et al, 2012; Moore, McArthur & Noble-Carr, 2011; Kirkman et al, 2009; Noble-Carr, 2006; Nabors, Weist, Shugarman, Woeste, Mullet and Rosner, 2004; Mission Australia, 2011). In relation to parenting capacity, the stress of homelessness can “challenge family dynamics and the qualities of parenting associated with child well-being (i.e. nurturance, discipline, monitoring, management, and developmentally appropriate stimulation” (Howard, Cartwright and Barajas, 2009, p. 326). Moore et al (2011) explain that additional difficulties or vulnerabilities such as domestic violence can further compound the family situation and the capacity of the parent.

Moore et al (2011) explored young people's perspectives (n=25) on homelessness, and found:

- young people may be aware of the impact homelessness is having on them and their family and may need assistance to discuss, including discuss with their parents;
- some may desire additional age-appropriate information about the situation, but others do not want to hear such distressing information;
- young people want to be heard, listened to and assisted, so providing time and relationship building with the child is vital;
- the priority is to feel safe;
- continuity of relationships is important, this includes workers;
- some young people may need assistance to reconnect and rebuild their relationship with their parents; and
- recognition of the strengths of their family.

Kirkman, Keys, Turner and Bodzak (2009) outline that not all children will perceive or experience homelessness the same way. Some children are aware and mindful of the stigma associated with homelessness; feel insecure and unsafe; and may experience anxiety or sadness associated with the instability of homelessness. Children may feel considerable uncertainty about their future (Strategic Partners, 1997 cited in Noble-Carr, 2006). Grief and loss can also be an issue (for example, for family, friends, pets, normal life) (Strategic Partners, 1997; cited in Noble-Carr, 2006; Bryant, 2003 cited in Kirkman et al, 2009).

Needs and assessment

Children's needs require a focused assessment that includes consideration of their physical, emotional and developmental domains. This requires a holistic and comprehensive approach (Noble-Carr, 2006) and being aware of the potential particular challenges children in a homeless situation face. What can be important to them when attending services is to have a place to play with a range of age-appropriate toys and technology, approachable staff, opportunity to participate in leisure activities and to be assisted to reintegrate or reconnect to school/community (Brown, 2006 cited Gibson and Johnstone, 2010). Recognising the value of and fostering children's hope has also been identified (Herth, 1998; cited in Gibson & Johnstone, 2010). The importance of a child-focused approach is emphasised. Other needs that children experiencing homelessness may have are: health (physical and dental), emotional (for example, counselling), education (capacity to attend school regularly) and material assistance (for example, clothes) (Gibson & Morphet, 2010).

Thomas (2007) (cited in Gibson & Johnstone, 2010) identified six principles for child-centred work in this context, namely:

- offering a child-friendly space where engagement with children can occur through play;
- displaying respect and understanding of the issues that children may be managing;

- offering children support and conveying messages to them that they are not to blame or responsible for the situation;
- keeping in mind a child's best interests;
- using age-appropriate processes; and
- exploring with a child his/her comprehension of the situation.

Gibson and Morphet's (2010) research identified strategies for improving service provision to children experiencing homelessness, such as: increases in staffing with some staff highly skilled in working with children; more housing available to families; to continue to develop and strengthen interagency links/sectors so resources can be shared; for children to have timely access to specialised assistance; and for children to have the chance to participate in recreational and group processes.

SECTION SIX CHILDREN WITH PARENTS WITH AN INTELLECTUAL OR LEARNING DISABILITY

Context

There is an absence of statistics to indicate how many children are living with parents with an intellectual or learning disability. Estimates are between “1 – 2% of families” (NSW Department of Community Services, 2007 cited in Lamont & Blomfield, 2009, p. 3). However, some suggest that numbers are rising due in part to changes in policies and practices over a number of years facilitating individuals with disabilities inclusion and participation in everyday life (Tarleton, Ward & Howarth, 2006; Wade, Llewellyn & Matthews, 2011).

The traditional assumption and stereotype that parents with an intellectual disability are unable to provide adequate care for their children is not convincingly supported by evidence. As Wade et al (2011) explain these parents are a diverse group with diverse circumstances and needs. This means that some parents with an intellectual disability will provide sound care for their children and some will experience considerable difficulties (see Wade et al 2011). However, Wade et al (2011) cite research which highlights that many child risk factors may be evident in these family’s circumstances. These include issues such as lack of support, health and mental health problems, and financial difficulties. In addition, some parents with an intellectual disability may be experiencing high stress from multiple issues (for example, unemployment, previous maltreatment, insufficient social support). These issues can adversely impact directly and indirectly on parenting (Wade et al, 2011). However, in the main, conclusions about the impact for children from being parented by an adult with an intellectual disability are conflicting (McGraw, Scully & Pritchard, 2010). Intellectual disability in itself is not a good predictor of parental capacity (Mildon et al, 2003; NSW Department of Community Services, 2007 cited in Lamont & Blomfield, 2009). However, as Collings and Llewellyn (2012) highlight if these families become involved with the child protection system these children are more likely to be removed from their parents care. Tarleton and Porter (2012) suggest that some parents with learning disabilities may be reluctant to seek assistance for parenting difficulties because they worry that their children will be taken from them.

McGraw, Scully and Pritchard (2010) explored in a preliminary manner what might distinguish high-risk parents with intellectual disabilities to low-risk parents with disabilities in terms of the potential for child harm. A number of factors were associated with higher risk: (1) the parent had a history of child abuse and neglect; (2) the parent had additional issues other than just their intellectual disability (for example, physical disability, mental health); (3) the child also had “special needs” (p. 706); and (4) the male partner of the parent with an intellectual disability did not have an intellectual disability or had a history of being involved in anti-social and criminal behaviour.

Impact and effects

Collings and Llewellyn (2012) recently undertook a research review to ascertain children's outcomes and experiences of being parented by a parent with an intellectual disability. In terms of the impacts on children there was little agreement, with some research reporting that children may have additional responsibilities, feel lonely and socially isolated, have feelings of ambivalence towards their parents yet others experience positive feelings and normal experiences of love and connection. "Some studies suggest these children will be disadvantaged by their parents' low intellectual capacity, others suggest that once other factors are taken into account, such as heightened risk of pregnancy, and poor birth outcomes, poverty and troubled parental childhoods, and social isolation and stigma, child development approaches population norms"(p. 80).

Some children with a parent with an intellectual disability may experience stigma, bullying and rejection which can impact on their self-esteem, behaviour and psychological wellbeing which can influence a range of areas (for example, education) (Collings & Llewellyn, 2010; IASSID Special Interest Group on Parents and Parenting with Intellectual Disabilities, 2008). Some children may feel quite stressed by the ostracising they may receive due to their parents' disability (IASSID Special Interest Group on Parents and Parenting with Intellectual Disabilities, 2008) and be concerned that they too will develop a disability (Perkins, Holburn, Deaux, Flory & Vietze (2002). However, the effects of stigma for some children can be potentially mitigated by a warm, caregiving style (Perkins et al, 2002).

Needs and assessment

It is important to consider the potential challenges for children who have a parent with an intellectual disability, but not assume that there are difficulties. If issues of parental capacity have been identified, assessment of how the intellectual disability is affecting parenting and other adversities in their circumstances that potentially heighten risk of child harm should be explored (Lamont & Blomfield, 2009). Parenting assessment "should incorporate valid methods that directly evaluate parenting knowledge and skills, and consider the role of ecological factors that may impede or support positive outcomes" (IASSID Special Interest Group on Parents and Parenting with Intellectual Disabilities, 2008, p. 303).

Parents with an intellectual disability (and therefore their children) may benefit from: tangible, practical support and skill training that is performance orientated (McGraw & Newman, 2005; Mildon et al, 2003 cited in Lamont & Blomfield, 2009); and a respectful relationship characterised by quality listening; and varied assistance. Tarleton and Porter (2012) state in relation to parental learning disability "that parents' ability to access information, to understand the concerns about their parenting and respond to support is key to their engagement" (p. 241). Support that is likely to result in positive outcomes involves working with parents' strengths, supportive assistance to help them develop skills via a competency approach and positive relationships with those assisting them.

Ward et al (2011) conclude that attention given to strengthening parenting responses to children can positively impact on child wellbeing. They suggest that information needs to be clear and accessible and efficacy building. They highlight that social support can be critical for these families and make a difference to parenting interactions. Parenting limitations can be improved with suitable training and assistance (Feldman et al, 1986; Feldon & Case, 1997, 1999 cited in Aunos, Feldman & Goupil, 2008). Tarleton et al (2006) comprehensively specify what effective support can entail. Examples include: clearly assessing the support needs of parents; providing quality training to enhance skills; emotional support; canvassing assistance from the extended family and others.

As with the other issues for children (i.e. substance abuse, mental illness) children may benefit from the opportunity to discuss any issues or difficulties they may be experiencing and have appropriate forums to do this. Although providing assistance to a child's parent maybe extremely valuable and directly and indirectly assist a child, it would seem imperative to ensure that support is not purely parent focused.

SECTION SEVEN DOMESTIC VIOLENCE

Context

Many children are exposed to and witness domestic violence. Although the exact numbers of children in Australia witnessing domestic violence are unknown, it has been suggested that it is likely to be over “one million” children (Australian Bureau of Statistics, 2006 cited in the Australian Domestic and Family Violence Clearinghouse, 2011, p.3).

Most children are aware of the domestic violence occurring within their home (Mullender, 2001), although many parents underestimate the impact on children and how aware their children are of the situation. Many children may have difficulty understanding why it is happening and find it very confusing (Gorin, 2004).

Impact and effects

For children, living with domestic violence is a highly stressful experience. As the Australian Domestic and Family Violence Clearinghouse (2011) outline, children’s experience may involve hearing violence happening, being caught in the middle of violence, being physically hurt themselves, trying to stop the violence, being used as a threat to a partner, or personal threats. Children may observe precious objects being broken, rape, actual acts of violence, use of weapons, and verbal aggression (see also DeBoard-Lucas & Grych, 2011). They may experience the escalation to violence, the violence itself and the outcome of the violence (for example, injury, hospital, police, parent behaviour) (Sterne, Poole, Chadwick, Lawler & Dodd, 2010).

Escalation of violence and level of risk can increase when partners separate (see Holt, Buckley & Whelan, 2008). Home life then for children can be highly frightening and unpredictable. Children can be fearful and hypervigilant about when the next incident may occur. It can be highly traumatic because the violence is being committed by someone in a position of trust (Sterne et al, 2010). Exposure to domestic violence has been recognised as a child protection issue (Edleson, 2004 cited in Cross, Mathews, Tonmyr, Scott & Ouimet, 2012). The risk of co-occurrence of physical and sexual abuse of children has been indicated in some research (see Holt, Buckley & Whelan, 2008).

Witnessing domestic violence has been established as being potentially detrimental to children. Kitzmann, Gaylord, Holt and Kenny (2003, p. 347) meta-analytic review which examined 118 studies concluded that “exposure to interparental aggression is associated with significant disruptions in children’s psychosocial functioning, at least in the short term”. Likewise, Wolfe, Crooks, Lee, McIntyre-Smith and Jaffe (2003) meta-analysis of 41 studies highlighted that children’s exposure to domestic violence can lead to compromised emotional and behavioural outcomes. Wood and Sommers (2011) also report that there can be gender differences in how boys and girls react to witnessing domestic violence. Boys are more likely to show externalising behaviour such as aggression (for example, to friends). Girls however are more likely to have internalised reactions (for example, depression and post-traumatic stress disorder), though some may display aggression

in dating relationships. Other social factors that are associated with the impact of witnessing domestic violence include: “lower family income associated with child neglect, alcohol use by parents, and decreased social support is linked to child witnessing of IPV” (Wood & Sommers, 2011, p. 231).

Children who experience more than one type of violence or victimisation (for example, co-occurrence of domestic violence and child abuse) have a greater likelihood of experiencing detrimental effects and perpetrate violence themselves in the future (Wood & Sommers, 2011). Other effects that have been reported for children are: post-traumatic stress disorder, impacts on peer relationships, reduced academic performance, trauma effects on a child’s developing brain and neurophysiology, distress related to memories and images, self-blame, language and learning delays, anxiety, increased responsibility, inability to trust others, attachment problems and tiredness (Sterne et al, 2010; Stanley, Miller & Foster, 2012). Humphreys, Lowe and Williams (2009) point out that sleep disturbance can be an issue for some children witnessing domestic violence. It can be an indicator of trauma and manifest as nightmares, inability to sleep, bed wetting, night screaming, panic and terrors.

The impact of domestic violence on a parent’s capacity to parent has been noted. Usually discussed in relation to mothers, domestic violence can significantly compromise a mothers’ capability to respond to her child’s needs. This can be due to the immediacy of her own safety and trauma, decrease in confidence in her own parenting ability and lifestyle changes to accommodate the perpetrator (Stanley, Cleaver & Hart, 2010). The relationship between the mother and the child may suffer (Humphreys et al, 2006 cited in Stanley, Cleaver & Hart, 2010).

The experience, thoughts and feelings of children living with domestic violence has been explored. For example, DeBoard-Lucus and Grych (2011) highlight from their study with pre-adolescents that young people may have a range of reactions. For instance fear that their parent will be hurt or killed, feeling uncertain about what is going to happen, concern or fear for their own wellbeing, and concerns about the future of their parents’ relationship and their relationship with them. Some young people reported that they felt they should intervene when the violence occurs. They had intense feelings of sadness, anger and fear. Some of these young people when asked offered opinions on who was responsible for the violence (usually seen as perpetrator or both parties) and reasons for why the violence occurred (provoked, perpetrator unable to manage anger, particular traits within perpetrator).

Children’s reactions to domestic violence vary. The age of the child, their personality and frame of reference, protective and resilience factors and personal familial circumstances can create differences (Mullender, 2001; Sterne et al, 2010). Parent factors can impact such as: having a parent who can still parent adequately; a parent who can still be a positive role model; the mother having good mental health; the mother being reliable and responsive to her children; and a good support network (Humphreys 2006 cited in Sterne et al, 2010). Further, it is important to note that although it is highly likely that witnessing domestic violence can be harmful to children’s psycho-social wellbeing, definitive causation cannot

assumed, other difficulties can have an impact (Knutson, Lawrence, Taber, Bank & DeGarmo, 2009).

Needs and assessment

Children who witness domestic violence may have a variety of needs. One need is to have the opportunity to discuss what is happening within their home. For this to occur, the environment needs to be safe, supportive and facilitative (McGee, 2000 cited in DeBoard-Lucus & Grych, 2011). Individual and group processes for children can potentially provide this opportunity. Given that some children may have developed thoughts about the justifiability of violence, exploring this issue may be beneficial so as to reduce the potential for the continuation of violence by the young person in other or future relationships (DeBoard-Lucus & Grych, 2011).

The exploration of the feelings and reactions children may have can assist in the identification of positive coping strategies (DeBoard-Lucus & Grych, 2011). Listening and validating young people's experience and perceptions of the domestic violence occurring within their homes is vital (Stanley et al, 2012). Importantly, some children may be reluctant to talk because of concern about the ramifications for their family (Stanley et al, 2012). Children may also need quality age-appropriate information about domestic violence and the opportunity to experience fun and mix with other children in similar situations (see Gorin, 2004).

Edleson, Ellerton, Seagren, Kirchberg, Schmidt & Ambrose (2007) undertook a research review to examine measures and assessment tools that could assess children's exposure to domestic violence. They suggest that there are minimal options available that clearly assess the complexity of children's exposure to violence. They review a number of tools: the adapted "Conflict Tactics Scales (Straus, 1979; Straus et al., 1996)", "Things I have seen and heard (Richters & Martinez, 1990)"; "Juvenile Victimization Questionnaire (Finklehor et al., 2005)"; "Victimization scale (Nadel et al., 1996)"; and "The Violence Exposure Scale for children (VEX-R; Fox & Leavitt, 1996) (pp. 965-968)". They conclude that these measures are broad "but inadequate in their ability to extensively measure children's exposure to domestic violence" (p. 968). They further explain that more sophisticated assessment tools are required that enquire directly about a child's exposure to domestic violence, captures and details the actions of a child, involves an appraisal of risk and protective factors in the child's system, and uses a self-report process for the child that seeks to gather their perception of the domestic situation. However, there is guidance in the literature on assessment of children living with domestic violence. For example, Rowsell (2003) identifies a number of elements that can be considered (cited in Calder, Harold & Howarth, 2004).

SECTION EIGHT COMPLEX AND MULTIPLE NEEDS

Families may be trying to contend with an array of complex, interconnecting issues, spanning personal and socio-environmental dimensions of their life (Bromfield, Sutherland & Parker, 2012). Where this can be potentially harmful for children is when a child's living situation is challenging for a long period of time (cumulative harm and chronic neglect) (Bromfield et al, 2012). Like single adversities, having a combination of difficulties can adversely impact on parents' capacity to parent. As Bromfield et al (2012, p. 9) explain, parents may be attempting to manage such stress and from this their capacity to effectively care and parent their children may be reduced. "Their parenting may include disengaged, unresponsive, inappropriate, harsh, punitive or abusive responses to children". In reference to Quinton (2004), Bromfield et al (2012) highlight that parenting involves attending to a number of tasks, such as: responding to their basic physical needs, demonstrating love, warmth and care, being responsive and aware of their cues, providing security by predictability, providing guidance and setting boundaries, facilitating development via opportunities, teaching and demonstrating prosocial behaviour, providing opportunity to develop their cognitive abilities/skills, and the chance to develop socially and social connections/networks. Parents then who experience a number of complex difficulties may have difficulty providing one or many of these tasks for their children.

When there are complex, interconnecting multiple issues for a family, the approach, methods of gathering information, assessment and coordinated intervention are important. Bromfield et al (2012) propose:

- A whole-of-family approach;
- Combination of risk and a strengths focus;
- The need for integrated, effective multi-service collaboration. Cleek, Wofsy, Boyd-Franklin, Mundy and Howell (2012) explain a lack of coordination can hinder the potential assistance that each service can provide and in addition heighten the likelihood of a fragmented and confusing service to families (Micucci, 1998 cited in Cleek, Wofsy, Boyd-Franklin, Mundy and Howell, 2012). Effective collaboration requires good communication and sharing of relevant information, clear direction and leadership and adequate resourcing (Darlington, Feeney & Rixon, 2004). Well functioning collaborative teams are beneficial (Green, Rockhill & Burrus, 2008), so addressing potential barriers to collaboration may be necessary;
- In order to effectively gather information with families, it is important to positively engage with them via the use of a number of skills and facilitate a relationship with them. The importance of the relational capacities and qualities of the worker has been recognised in family preservation research as an important component of enhancing positive outcomes. For example, Gockel, Russell & Harris (2008) report that clients value a positive relationship with the worker, communication that is respectful, a caring ethos, flexibility in responding to client needs, being honest and reliable, acknowledging

improvements and others. Likewise Mason (2011) suggests that relationship-based practice is critical to success;

- A comprehensive assessment of the family which considers, for example, history, current circumstances, needs, protective factors and strengths, child's experience, and is culturally sensitive;
- Specialist assessment may be required;
- Interventions require prioritisation, match to needs and consideration of where best to resource (both formal and informal, internal and external to the family); and
- Importance of regular reflection, review and monitoring of outcomes.

Aiming to keep families together and facilitate healthy functioning is one of the goals of family preservation work. Family preservation is generally considered an intensive approach that involves time-limited, crisis, often home-based intervention and can include support such as counselling, parenting education, skill teaching and concrete assistance (National Family Preservation Network, 2003 cited in Tully, 2008, O'Reilly et al, 2010). Although there are mixed results on the effectiveness of family preservation, those approaches that are similar to the 'Homebuilders Model' have greater empirical support (Nelson, Walters, Schweitzer, Blythe & Pecora, 2009; Tully, 2008). The Homebuilders model involves service delivery such as "contact with the family within 24 hours of the crisis, small caseload sizes for workers, flexible service delivery; service duration of four to six weeks; and intensive service delivery" (Tully, 2008, p. iii). A range of family situations can benefit from family preservation assistance (Gandarilla, 2009) though there has been mixed findings and limited research on what type of family situations would be most suitable (see Tully, 2008; Bitonti, 2002; Gandarilla, 2009).

For families who are experiencing difficulties, a family preservation approach is one option. Berry (2004) proposed the key elements of best practice in family preservation work were: (1) time – providing intensive one-on-one time with families; allowing sufficient time for families to make progress; (2) increasing a family's motivation by facilitating early progress. This can be achieved by starting with issues that can be easily solved, boosting social support and advocacy; (3) exploring uncommon solutions for difficulties. Sometimes issues are experienced by communities not just by individuals. However, the importance of individualised assessment tailored to needs is noted; (4) *working with* families; and (5) honesty in responses with families and keeping families informed of progress.

SECTION NINE ASSESSMENT OF CHILDREN'S NEEDS

In relation to difficulties that a family may be experiencing, quality information gathering and assessment is integral to the process of identifying child needs and tailoring intervention. Early recognition of a child's difficulties is beneficial, so as to prevent problems from becoming consolidated and harder to treat. As Rose (2010, p. 36) explains, "research on the effectiveness of interventions have continued to emphasise how important it is to identify the onset of difficulties as early as possible in a child's life and to take action quickly, in order to increase the potential for making a difference...".

In considering children's needs, assessment may be required on a number of dimensions (Department of Health, 2000). For example, a focus on their *development* could mean considering the status of their health, education, behaviour, relationships and identity. A focus on the *family and wider system* could draw attention to: how the family operates, housing, employment, financial situation, network and community. Finally, a consideration of how a child's *parents* are parenting him/her could involve examining the relationship, level of warmth, responsiveness and stability, whether they are safe, opportunity for learning and development plus others (Department of Health, 2000; see also Rose, 2010).

Rose (2010) indicates that this assessment framework (as detailed above) as formulated by Department of Health (2000) has spawned a number of tools/instruments which can aid in the systematic consideration of these dimensions (see Rose, 2010 for details). This assessment framework can form the basis for specific consideration of a particular difficulty. For example, Stanley, Cleaver and Hart (2010) refer to Hart and Powell's (2006) '*Adult drug problems, children's needs: Assessing the impact of parental drug use. A toolkit for practitioners*' and illustrate how each dimension of the assessment framework (development, family and environment, parenting) can be specifically analysed in relation to substance misuse. For instance, on the child development dimension some examples are: "access or exposure to drugs/equipment; effect on school attendance and ability to learn; attitudes to drug use and offending behaviour" (p. 339).

Practitioners making assessments require knowledge and skills in: the assessment process, relationship and engagement, communication, analysis of information, planning, identifying desired outcomes, and monitoring and evaluation of practice (see for example, Horwath, 2010a; Horwath 2010b; Holland, 2010; Howes, 2010). Timely and appropriate referral for specialised assistance is required, particularly if children are experiencing significant harm. The decision to make a referral for a child or family should be informed by a clear identification of need and risk. It should not be assumed that children will necessarily require referral to a service based on their parents' circumstances, as identifying someone as potentially at risk can be stigmatising (Steer et. al. 2011). Referral to a service should be based on *clear identification of how this response can address particular needs*.

SECTION TEN HARD TO REACH SERVICE USERS

Families who require the most assistance do not always access services or do not always effectively engage with service providers (Boag-Munroe & Evangelou, 2012). These families have been described as 'hard to reach' or 'hard to engage'. Hard to reach generally denotes "... those people who are eligible for assistance but who, for a range of reasons, do not usually take up the help available or are difficult for service providers to identify and engage (Barrett, 2005; Doherty et al, 2003)" (Cortis, 2012, p. 352). Community and voluntary services have been recognised as pivotal in their potential to reach these groups (Flanagan & Hancock, 2010).

Boag-Munroe and Evangelou (2012) undertook a review of the literature in the fields of education, health, crime and social services to gain greater understanding of issues pertaining to hard to reach families and barriers and strategies for engagement. Some of the key points reported in their review were:

- There is variation in how hard to reach is understood and defined;
- Non-engagement may be an issue related to the family or service. "Wherever the 'problem' lies, Landy and Menna (2006, 180) believe that 'working effectively with families, who might be labeled "hard to reach" involves a shift from perceiving the family as being 'hard to reach' to thinking about what makes the service that is being offered hard to accept for a particular family" (Boag-Munroe & Evangelou, 2012, p. 213);
- Organisational barriers identified:
 - Communication barriers within the service: for example, insufficient information about what the service provides, culturally and linguistically unfriendly or inadequate recognition of cultural needs, service not appearing responsive or interested in service users, lack of opportunity for hearing impaired or individuals with literacy difficulties, and putting service users off by using professional jargon (Boag-Munroe & Evangelou, 2012);
 - A number of organisational setting barriers were identified, including: service not visible to client and not welcoming; the appearance of the service; only catering to specialised clients; not meeting the needs of clients; service not providing opportunity for parents to participate with their children; hours of service not compatible for all potential service users; and accessing the service is stigmatised (Boag-Munroe & Evangelou, 2012). McMahon (2009) suggests that some clients can be intimidated by highly formalised processes and tools which staff use;
- Service quality barriers included: service being perceived as under resourced, unpredictable, not offering a quality service experience, regular staff changes and turnover, and the actual location and site of the service (Boag-Munroe & Evangelou, 2012);
- A range of factors can contribute to individuals and families being hard to reach, such as: poverty, inability to access transport, illness, crisis in home life,

isolation, lacking in skills and personal resources, lack of English language skills, and a range of life difficulties such as domestic violence, mental health, and single parent status (Boag-Munroe & Evangelou, 2012); and

- Families may be hard to reach due to isolation related to their particular vulnerabilities for example, refugees, sex workers, substance abusers. They may be hard to reach due to factors that can make them wary or disengage from the service (for example, uncomfortable about requesting assistance, concern that staff will interfere in their lives, distrust, previous negative service experiences, uncomfortable with authority plus many others) (Boag-Munroe & Evangelou, 2012).

A number of suggestions are offered on how services can more effectively engage with hard to reach families. These include: recognition that families may not engage with a service for a myriad of complex reasons; services need to utilise innovative and creative ways of aiming to draw in hard to reach families (e.g. technology, text message, and internet); and that relationship development is critical in engaging these families (Boag-Munroe & Evangelic, 2012; see also McMahon, 2009). Other possibilities for drawing in hard to reach families are: a holistic approach to the family; “shared scripts” between service providers (p.235); and supportive and empathic approaches without judgment. Given the importance of the relationship between staff and families, services should have a mixture of staff in terms of gender, style and cultural background. Other strategies for increasing engagement include: home-based support; parent ambassadors; appropriate infrastructure and welcoming facilities; providing a reliable and trustworthy service; aiming to understand the needs of hard to reach families; use of outreach work (Rots-de Varies, de Goo, Strokes & Garret sew, 2011) and the use of snow-balling techniques and chain-referral processes (Boag-Munroe & Evangelic, 2012).

Winkworth, McArthur, Layton, Thomson and Wilson (2010) highlight from a small scale study of 20 sole parents from Canberra, Australia who had financial issues and considered themselves lacking in social connections, that hard to engage groups may have a range of interconnected factors at individual, service provider and community levels that can stifle their engagement. It was identified that not having a network, contacts or mechanism that could facilitate their knowledge of and introduction to particular services impacted on engagement. Other barriers identified were: individuals feeling reluctant to access services due to fears of surveillance or judgment about their parenting; and that opportunity for information provision and possible connection to services were missed by some universal providers (for example, Centrelink and general practitioners). One recommendation was to continue to support non-stigmatising ways of assisting families through universal services and networks (for example, playgroups, schools) (Winkworth et al, 2010).

Curtis (2012) highlighted from research with case managers and coordinators, four main strategies to capture hard to reach clients: addressing access barriers (for example, service non-stigmatising, service within other universal services);

investment in the development of effective relationships between staff and service users; developing effective collaborations and networks with other service providers; and staff capacity (for example, employment of diverse practitioners, training, outreach capacity, sensible caseloads). It is important to offer a flexible service and facilitate partnerships and participation with service users (for example, volunteers) (Flanagan and Hancock, 2010). McDonald (2010) adds that single strategies are not likely to be effective, multiple strategies should be employed. Other suggestions are seeking contact where families are likely to be (for example, shopping centres), using empowering approaches with families, and developing relationships with families, the community and other service providers.

SECTION ELEVEN KEY MESSAGES

- Parents' capacity to parent effectively can be compromised from a range of adversities.
- Five adversities were considered: mental illness, substance misuse, homelessness, intellectual disability and domestic violence. Although there were some specific issues for children living in these situations which are vital for consideration, there was substantial commonality of potential effects. Impacts included: emotional and psychological difficulties, physical and mental health problems, academic difficulties, language delays, peer difficulties, attachment problems, stigma related issues, trauma reactions, fears and concerns, loss and grief, instability, social exclusion and others.
- How children react to particular difficulties within their family situation is variable. Resilience, protective and mitigating factors, a child's frame of reference, and other factors within the family can create differences and offset risks.
- Some of the common needs of children identified in research were: opportunity to talk in a safe and facilitative environment; recognition of the particular challenges children may be experiencing; quality age-appropriate information provision; assistance with feelings, reactions and grief; recognising the strengths within a child's family, safety, stability, regular support; positive and consistent relationships; assistance for parents; opportunity for normality and fun; connection with school and community; child-friendly environments and the opportunity to mix with children who are experiencing similar difficulties.
- Some families may be experiencing multiple, complex problems which can heighten difficulties for parents, and risks to children.
- Assisting families with multiple problems requires attention to: a whole of family approach; strengths and risks within the family; integrated and effective multi-service collaboration; quality assessment, planning, and evaluation; and highly skilled practitioners who can engage well with families.
- Quality assessment involves multiple dimensions, including child development, family and wider system, and parents' capacity. Tailoring the assessment to particular problems (for example, parent with substance misuse) will be required.
- Some families and groups will be hard to reach. Services will need to consider barriers and use a variety of methods to engage with these families.
- Services aiming to be more child focused should have clear policies, well-articulated and clear staff roles, provide adequate practice support via training, supervision and workload management, child-friendly environments and resources, effective collaboration with other service providers and innovative strategies for overcoming the personal barriers that parents and children may have.

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Phone (07) 3029 7000 | Fax (07) 3029 7029

Ground Floor, 162 Boundary St, West End Q 4101

PO Box 3449 South Brisbane Q 4101

www.micahprojects.org.au | info@micahprojects.org.au

Twitter: [@micahprojects](https://twitter.com/micahprojects) | Facebook: Micah Projects