Outcome Study on the Use of Children's Services as a Strategy in Child Protection

FINAL REPORT

Chief Investigators
Peter Saunders and Judy Cashmore

For the NSW Department of Community Services

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Publications, SPRC, University of New South Wales, Sydney, NSW, 2052, Australia.
Telephone: +61 (2) 9385 7800 Fax: +61 (2) 9385 7838 Email: sprc@unsw.edu.au

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Project Team

Chief Investigators

Peter Saunders and Judy Cashmore (Social Policy Research Centre, UNSW)

Associate Investigators

Karen Fisher (Social Policy Research Centre UNSW), Elizabeth Fernandez (School of Social Work, UNSW), Kathy Gray (NSW Department of Community Services

Research Team

Robyn Dolby, Judith Brown, Cathy Thomson, Marilyn McHugh and Megan Griffiths (Social Policy Research Centre, UNSW), Amanda Coulston (NSW Department of Community Services)

Authors

Robyn Dolby, Judy Cashmore, Judith Brown, Karen Fisher, Elizabeth Fernandez and Cathy Thomson

Contacts for Follow up to this Report

Karen Fisher ph 02 9385 7800, fax 02 9385 7838, email karen.fisher@unsw.edu.au

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Abbreviations

ATSI	Aboriginal and Torres Strait Islander
CALD	Culturally and linguistically diverse
CBCL	Child Behaviour Checklist
DoCS	Department of Community Services
NGO	Non-government organisation
PSI	Parenting Stress Index
SPRC	Social Policy Research Centre
STRS	Student-Teacher Relationship Scale
UNSW	University of New South Wales

Executive Summary

Introduction

Research suggests that attending child care or pre-school, referred to here as a children's service, may be an important factor in preventing young children at risk of harm (abuse and neglect) from moving further into the child protection system. However, there is little empirical evidence available to indicate whether the use of mainstream care improves outcomes for these children. This study, developed collaboratively by the New South Wales Department of Community Services (DoCS), Office of Childcare and the Social Policy Research Centre (SPRC) was designed to investigate this issue. The Australian Research Council under the Strategic Partnerships with Industry - Research and Training Scheme and DoCS funded the research.

Aims of the Research

The aims of the project were:

- to assess whether the continuing use of child care or pre-school (children's services) protects children at risk from further incidents of harm, assists in maintaining the child within their family and prevents the child being placed in out-of-home care;
- to investigate the perceptions of families who use children's services following referral for the child being at risk of harm;
- to examine the developmental needs of children at risk when they attend a children's service, including their need for relationship support; and
- to make recommendations for a model of best practice within children's services for children at risk.

Study Design

The project consisted of two components:

- a longitudinal analysis of DoCS administrative data over a period of three years; and
- a cohort study following 20 children with a risk of harm report who had used a children's service. The children were followed for twelve months, monitoring their progress at child care or preschool.

Research Findings

Overall the findings from both components of the study show that offering a place in a children's service prevents children from moving further into the child protection system.

Findings from the analysis of the longitudinal DoCS administrative data

The analysis of the longitudinal DoCS administrative data revealed that using children's services significantly reduced the chance of a further child protection report. Children with more prior reports in the preceding year were significantly more likely to be placed into a long-term out-of-home care placement. If long-term out-of-home placements are to be avoided, with the consequent trauma and disruption to the child and family it is important to change the conditions to minimise further reports, particularly in those households where the frequency of abuse appears to be highest.

The analysis also showed that families that received financial assistance were associated with an increased chance of report. This may indicate that those who are financially disadvantaged have the poorest outcomes overall, assuming that families most in need are the ones who receive financial assistance. This finding is important as it highlights the potential importance of financial resources in determining child protection outcomes.

Findings from the cohort study

The cohort study found that the offer of a place in a children's service was an effective child protection strategy for 19 of the 20 children remaining within their families over the 12-month period, after they had enrolled in the children's service. In addition the number of re-notifications of the children significantly reduced once the children were attending a children's service. Over fifty per cent of the sample had no further reports.

Once parents enrolled their child into the children's service, the service became a very stable support for the family. It gave them an anchor point when much else was stressful and chaotic in their family lives (eg some families struggled to find permanent accommodation with up to four moves in 12 months; a commonly reported stress was conflict and argument within the family that upset the children).

What was missing, however, was support to enrol in the children's centre. Failed referrals were high, where parents did not follow through with the enrolment and DoCS did not check to see if the referral went ahead.

Parents and grandparents found the children's service arrangement affordable. The usual arrangement was for DoCS to fund the placement for thirteen weeks after which the families' paid. In this arrangement the substantial part of the fee was covered by the Child Care Benefit allowance. Three families could not afford the fees; in each case the Director of the Children's service kept the children enrolled and carried the costs incurred until the problem could be sorted out with DoCS. Resolution of these problems was often a slow and frustrating process.

Parents and grandparents evaluated the place in a children's service for their child positively. They regarded using the children's service as beneficial to both themselves and their child. It gave them respite and they felt that the placement helped their child learn to play with other children and to develop school readiness skills. This positive regard for the beneficial impact of the children's service on their children must be tempered by the other findings that showed that the children were a high risk group for developmental problems, in particular behavioural and emotional difficulties and speech delay. It appeared that the foundation that the children needed in order to develop school readiness skills was high relationship support to facilitate emotional regulation function.

Emotional regulation is learnt within close relationships. Many of the cohort study children were at risk of experiencing distressed relationships at home as indicated by parent and grandparent responses to the Parenting Stress Index. At every time period that the PSI was administered (at the beginning of follow-up, 6 months and 12 month later) almost 40 per cent of parents reported high distress that met the criteria for clinical intervention on at least one of the three PSI subscales. These scales were: Parent Distress or high distress due to feelings of low self esteem as a parent; Parent-

Child Dysfunctional Interactions with high distress reported due to parent-child interactions not being rewarding; and Difficult Child subscale, with high distress reported due to managing their child's behaviour. At each time period, high distress on the Difficult Child subscale meant that parents were significantly more likely to score highly on the other two subscales.

Parents and children's services practitioners completed the Child Behaviour Checklist at the 12 month follow-up and the results indicated that at least a quarter of the children had difficulties in emotional regulation that met the clinical criteria for support (where the severity of the children's difficulties is within the top 2-7 per cent for severity compared to same-aged peers). Parents and teachers did not always pick up the same children as having difficulties. When either parent or staff report was used to identify children at risk for emotional regulation difficulties, the percentage of children that met clinical criteria for support rose to above fifty percent for externalising problems like aggression; and 29 per cent for internalising problems like emotional reactivity and anxiety,

Children's services staff reported on the quality of their relationship with the children. Nearly half (45 per cent) indicated that they were concerned because the relationships felt distant (less affectionate and less open communication). Twenty five percent reported relationships with the children that felt either highly conflictual or highly dependent. These relationship difficulties were consistent with reports by both staff and parents of a similar proportion of the children showing severe difficulty in managing their feelings.

Given that children learn emotional regulation within the context of close relationships, the other finding that at least 27 per cent of the staff reported very positive relationships with the children was important to follow-up to elucidate how some staff could form supportive relationships. The case examples used illustrated that when the children experienced a secure relationship connection, this gave them the confidence to communicate more clearly, and they were more likely to use the adult as a secure base to explore from (ie the relationship opened up learning opportunities). Three themes stood out in the case example used to illustrate staff's rating of a high positive relationship: the staff were able to read 'under' the child's behaviour to respond to his genuine needs; they consistently ended each interaction with relationship repair so that the child was helped by them to move out of chaotic or distressed behaviour back into a calm settled state; and they showed teamwork in their care of the child.

The children's services staff were effective in accessing support for the children, which was important because only two children (10 per cent) were described by staff as not having any developmental problems and twelve of the twenty children (60 per cent) were described as having speech problems. The children's services were active in referring these children for assessment and treatment. Nine of the children (45 per cent) were assessed and all but one of these children received therapy. This remaining child was placed on a waiting list for therapy. Half of the children received therapy at the children's service. In these cases, the therapist was able to give the staff guidelines to support the children's speech and organised homework sheets for the families. Nine of the twenty children (45 per cent) were described as having behavioural problems, usually conduct problems with aggressive behaviour. The children's services staff accessed behavioural management support (Triple P or Pals programme) in three instances; and they or the children's parents' organised paediatric assessment for four

of the nine children. All four children were diagnosed with ADD or ADHD and received medication.

The project discussed key features for a model of best practice within children's services for children at risk. These features included entry support from DoCS (follow-up of the referral to ensure that the enrolment went ahead); prioritising relationship support for the children; and access to back-up for children's services staff to gain additional support for children where this is needed. The components in a model of intervention developed by Dozier and Seulveda (2004) for foster carers is recommended as salient and equally appropriate for children's services staff.

The findings highlight the need to promote the child protection role that children's services can play in the wider community and the consequent better utilisation of their services. They draw attention to the emotional support that is offered to families (not just a safe physical environment for the child) and show how such support helps parents access other services earlier and more effectively both for themselves and their children. It further highlights the importance of high quality children's services in enhancing the development of children, particularly those from disadvantaged families. The project highlights the need to address the training and resource needs for children's service staff when working with families at risk, particularly resources that facilitate relationship capacity.

1 Introduction

1.1 Overview of the Project

Research suggests that access to child care or pre-school, referred to here as children's services, may be an important factor in preventing young children at risk of harm (abuse and neglect) from moving further into the child protection system. However, there is little empirical evidence available to indicate whether the use of mainstream children's services, as opposed to specialist care, improves outcomes for these children. The project set out to measure the effectiveness of using children's services (including local council, community and private long day care centres and preschools) as a preventive child protection strategy. The study, developed collaboratively by the Department of Community Services (DoCS), Office of Childcare and the Social Policy Research Centre (SPRC) was funded by the Australian Research Council under the Strategic Partnerships with Industry - Research and Training Scheme and DoCS.

The aims of the project were:

- to assess whether the continuing use of child care or pre-school (children's services) protects children at risk from further incidents of harm, assists in maintaining the child within their family and prevents the child being placed in out-of-home care;
- to investigate the perceptions of families who use children's services following referral for the child being at risk of harm;
- to examine the developmental needs of children at risk when they attend a children's service, including their need for relationship support and;
- to make recommendations for a model of best practice within children's services for children at risk .

The project consisted of two components:

- a longitudinal analysis of DoCS administrative data over a period of three years; and
- a cohort study followed 20 children with a risk of harm report who had used a children's service. The children were followed up for twelve months, monitoring their progress at child care or preschool.

1.2 Background

Child abuse and neglect is a significant and ongoing social problem in Australia with substantial long-term economic and social costs. Table 1.1 shows that there has been a steady increase in the rate of children and young people who were the subject of a report and those who were the subject of a report requiring further assistance over the period 2000/01 to 2007/08. It should be noted, however, that increases in the number of reports over this period are due in part to changes in the Department's client information service reflecting amendments in legislation and associated practice change (DoCS, 2004/05).

Table 1.1: Children and Young People Subject of a Child Protection Report

	2000 /01	2001 /02	2002 /03	2003 /04	2004 /05	2005 /06	2006 /07	2007 /08
Rate per 1,000 of children and young people who were subject of a report	41.0	52.8	56.6	59.2	64.1	68.8	78.8	81.0
Rate per 1,000 of children and young people who were subject of a report requiring further assessment	29.7	39.5	42.7	46.2	50.1	54.8	65.1	65.7

Source: 2000/01-2002/03 CIS and KIDS Annual Statistical Extract, DoCS Information Service: Bureau of Statistics (ABS) Population by Age and Sex, Australian States and Territories Cat. No. 3201.0 June 2004. in *NSW Department of Community Services Annual Report 2004/05*. 2003/04-2007/08 DoCS Information and Reporting, ABS ERP NSW, ABS Census in *NSW Department of Community Services Annual Report 2007/08*, Stronger Families, Stronger Communities.

Research on the impact of access to children's services

The early years of a child's life, particularly the first three years, set the base for competence and coping skills that affect later learning, behaviour and health. Child abuse and neglect at this critical stage can have a long term impact on children's social and emotional development. Research shows the sequential manner in which the brain matures and the damage to neurodevelopment that occurs if there are disruptions to the normal developmental experiences in children who are abused or neglected (Glaser, 2000; McCain and Mustard, 1999; Shonkoff and Phillips, 2000). For example, children who do not develop appropriate skills in conflict resolution may show aggressive behaviour as a way of dealing with conflict and stress. Once established, these patterns are very resistant to change (Lyons-Ruth and Jacobvitz, 1999).

Some families are more 'at risk' of moving into the child protection system than others. Research indicates that there is a strong relationship between poverty and the maltreatment of children from high-risk groups, including children under five years of age, children with a disability, children from single parent families, or from an Aboriginal or Torres Strait Islander background (Parton, 1995; Hood, 1998). In the case of sexual abuse of children, power relationships rather than poverty alone appear to be a significant factor (Calvert, 1991). Often when families enter the child protection system there is a stigma associated with referrals targeted services. In contrast, referral to universal services such as mainstream children's services does not carry such stigma. These services have the potential to reduce the need for more extreme intervention, by providing support for parents and developmental opportunities for children (Hayden, 1993). Access to quality children's services which include early intervention programs, may also be protective for 'at risk' children from disadvantaged backgrounds and aid cognitive and social development, particularly if followed up in the early school years (Ochiltree, 1994). However, children from low-income and disadvantaged families are less likely to access children's services than children from middle- and upper-income families (Stipek and Ogawa, 2000; Vinson, 2006).

Research shows that high quality children's services provides a beneficial environment, particularly for children from disadvantaged backgrounds and fosters children's cognitive and social development and can relieve families under stress, thereby minimising the risk of harm to children (Miller and Whittaker, 1988; Weikart and Schweinhart, 1992; Tregeagle and Voigt, 1993; Cooper and Sutton, 1999; Roditti, 1995; Melhuish, 2003; Cauldera and Hart, 2004; McAuley, Pecora and Rose, 2004, Vinson, 2006). High quality centre-based care is associated with better outcomes for children than other types of care, although one

study found that children cared for exclusively by their mothers did not differ from children who used children's services (NIDHD, 2000).

Access to good quality children's services also provides children with the opportunity to develop secure attachments with significant adults outside the home and provides children with safe and stimulating environments (Weikart and Schweinhart, 1992; Peisner-Feinberg and Burchinal, 1997; Cowen, 1998; Vinson, 2006).[1] This is particularly important for children with difficult life circumstances. For example, early children's services relationships have been found to influence later teacher-child relationships when children are in primary school. In children's services children can learn constructive patterns of relating to peers and can develop social competence, which they carry forward to school (Peisner-Feinberg and Burchinal, 1997; Howes, 1999).

Research shows that workers in children's services not only monitor children's welfare, but also play an important role in detecting early signs of abuse and neglect, and reporting concerns to the relevant statutory authority (eg, DoCS) (Fisher et al, 2000). However, the quality of centre-based care can vary substantially and this in turn influences outcomes (Bowman, Donovan and Burns, 2001; Fuller et al, 2004). The research findings also suggest that as a protective strategy, children's services alone does not provide the solution to the problems associated with abuse and neglect. An integrated approach whereby children's services are part of a range of support offered to families and their children seems more likely to be effective (McAuley, Pecora and Rose, 2004).

The importance of early intervention, prevention and risk reduction are embedded in the *Children and Young Persons (Care and Protection) Act 1998 (NSW)*. The objects and principles of this Act focus on the participation of children and their families in decision making and on early intervention to enable children to remain with their families through the provision of support services. Children's services are one type of support service which have been shown to play both a preventative and protective role for children who are 'at risk' (Fisher et al, 2000).

It has been estimated that the social and financial benefits in later life of providing early intervention programs for families with young children at risk far outweigh the costs (Barnett, 1993; National Crime Authority, 1998). This study investigated whether access to children's services is a significant factor in preventing young children at risk of harm from moving further into the child welfare system.

1.3 Outline of the Report

This report presents the main findings from the study. The first section of the report describes the background to project. Section 2 outlines the methodology and the main findings from the first component of the study - the analysis of the DoCS administrative data. Section 3 describes the methodology and sample of the second component of project– the cohort study. Section 4 presents the key findings from the cohort study. The final section of the report summarises the key findings from the study and identifies the features of a model of best practice within children's services for children at risk.

[1] It does not avoid the lesser risk of child abuse and neglect *within* child care centres and family day care.

2 Longitudinal Analysis of DoCS Child Protection Administrative Data

The first component of the study used DoCS administrative data to investigate the extent to which children at risk of abuse and neglect are referred to children's services for children and the outcomes of such referrals. This section outlines the findings of the analysis of the administrative data.

Analysis of the characteristics of 404 children referred to children's services, over a period of three years (1997-99 to 2000-02), was conducted to investigate whether providing children's for children at risk can prevent them from moving further into the child protection system. It also examined changes over time in the patterns of service utilisation. The measures to assess the impact of children's services on the outcomes for children at risk attending these services included the number of children remaining with their immediate families, changes in the case plan, the number of further reports, the number of agencies the family has been referred to and have received services from, and changes in the types of court orders. Comparable information was analysed for children of a similar age who were referred to, but did not access, such support in order to determine if there were significant differences in outcomes between the two groups. This group of children constituted a quasi-control group.

2.1 Sample of Child Protection Cases with Children's Services Referral

The Department of Community Services (DoCS, Parenting Centre) retrieved case plan narratives from the administrative data for all young children who had a case plan created by DoCS between 1 March 1997 and 28 February 1999, where the case plan contained key words associated with children's services such as 'child care', 'day care' or 'preschool'. Just over a thousand (1009) valid cases were obtained from 1556 records.[2]

The Department collected supplementary information on 425 of these children from paper files.[3] This information was about the role of the Department in referring children to children's services, the financial contributions to the cost of children's services made by either the Department or another government agency; the use of children's services, both before and after the principal case plan, and whether the children were siblings. If the reference to children's services in the case plan referred to a sibling rather than the 'target' child, that case was not included. The final sample for analysis consisted of 404 children.

2.2 Description of the Variables and Analysis

Outcome Variables

The data included a three-year follow-up information on subsequent reports, case plans and placements. Two outcome variables were included in this preliminary analysis:

- the probability of another report; and
- the probability of the first long-term out-of-home placement.

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[2] Records were deleted if the child was not under the age of five or if the abuse was committed by the service provider. Where multiple records for one child were found, the record for the earliest case plan was retained.

[3] Sample size was determined by availability of a paper file in the Sydney region that could be located and examined by a DoCS officer within a one month period.

Determinants

A number of characteristics were considered in this study including: details about the referral to a children's service, payment for and use of children's services and other potentially important factors. The amount of missing data was often sufficient to warrant separate categories within variables, rather than excluding records from the analyses. Where missing data was found to be similar to another category, with respect to the outcome of interest, similar categories were collapsed.

Demographic variables

Demographic variables measured at the time of the case plan of interest were age, gender, location, disability status, indigenous status, country of birth, language spoken at home and the child's legal status.

Children's services use variables

Several important service use variables were included in the analyses. Of prime importance was whether the children used children's services. Other important variables were prior use of children's services, whether a referral to a children's service was included in DoCS case plan and whether DoCS or another government agency contributed to the cost of the children's service.

Reporting and case plan details

Details of the child's history with DoCS included the date of the report and case plan, the assessment issue(s) and court decision. Preliminary exploration of the data suggested that there was little difference in outcome for children who had either experienced a temporary change (eg temporary application by the parent) or had no change in legal status. Thus these categories were therefore collapsed.

Statistical Method

Logistic regression was used to model the probability of another report and the probability of a long-term out-of-home placement within the three-year follow-up period. Given the clustered nature of the data, with children often belonging to the same family, data were modelled using random intercept models. Variables were tested for potential confounding variables. Variables with a univariate p-value of less than 0.1 were included in the full model, along with any potential confounders. The reduced model included variables with a *p*-value of less than 0.05. Analyses were conducted using SAS.

2.3 Description of the Children

The sample of 404 children from 300 families were referred to or used children's services. A description of the children included in the sample by variables of interest is shown in Table 2.1. The average age of the children was two and a half years. Approximately half of the children were boys and half came from Sydney. Most of the children were in the care of their family, did not have a disability, spoke English at home and were not from an Aboriginal or Torres Strait Islander background.

Table 2.1: Descriptive Statistics

		Children	Per cent
Demographic			
Gender	Boy	213	52.7
	Girl	191	47.3
Location	Sydney	186	46.0
	Other metropolitan	218	54.0
Language at home	English-speaking background	377	93.3
	Non-English speaking background	27	6.7
Disability	No disability	336	83.2
	Disability	28	6.9
	Missing	40	9.9
Indigenous	Non Indigenous	333	82.4
	Indigenous	36	8.9
	Unknown	35	8.7
Legal status	None and temporary care order	287	71.0
	Other care order	39	9.7
	Previous care order history	78	19.3
Case plan variables			
Carer	Has a carer	229	56.7
	No carer	167	41.3
	Missing	8	2.0
Family	Cared by family	111	27.5
	No family carer	285	70.5
	Missing	8	2.0
Harm	Yes	121	30.0
	No	275	68.1
	Missing	8	2.0
Risk	Yes	110	27.2
	No	286	70.8
	Missing	8	2.0
Other	Yes	33	8.2
	No	363	89.9
	Missing	8	2.0
Number of prior reports in previous year	None	315	53.2
	One	107	26.5
	Two or more	82	20.3
Decision	No decision	21	5.2
	Closed	241	59.3
	Registered	132	32.7
	Unknown	10	2.5
Payments made by DoCS or other government agencies	Yes	118	29.2
	No	208	51.5
	Unknown	77	19.1
Involvement of case worker in referral	Yes	262	64.9
	No	66	16.3
	Unknown	76	18.8
Children's service use			
Prior service use	Yes	147	36.4
	No	152	37.6
	Unknown	105	26.0
Service use after report	Yes	253	62.6
	No and unknown	151	37.4

Source: DoCS administrative data files n=404

Fifty per cent of the children had no prior child protection history, while 20 per cent had two or more previous reports. Either DoCS or another government agency made financial contributions to the children's services for payment of the fees for one third of the children. Table 2.1 shows that for at least 65 per cent of children a caseworker had some involvement in referring the child to the children's service. However, details for approximately a fifth of the sample were not known. At least 63 per cent of the children had used a children's service after the report.

2.4 Three Year Child Protection Outcomes of Children Referred to Children's Services

Table 2.2 shows that within the three-year follow-up period, a large proportion of the children (over 70%) had a re-notification or further report, while only 12% went into an out-of-home care placement.

Table 2.2: Child Protection Outcomes at Three Year Follow-up

		Children	Per cent
Subsequent report	No	111	27.5
	Yes	293	72.5
Subsequent long term placement	No	354	87.6
	Yes	50	12.4

Source: DoCS administrative data files n=404

Subsequent child protection report

The results of the logistic model for the probability of a subsequent report in the three-year follow-up period are presented in Table 2.3. Children who had not attended a children's service were more than twice as likely as those who were referred to and in a children's service (odds ratio = 2.51) to have another report within a three-year follow-up period. Families that received financial assistance to pay for their children's services were also more likely to experience a subsequent report.

Children who had Aboriginal or Torres Strait Islander backgrounds, who had previous child protection history or who had two or more DoCS reports were also two to three times more likely to experience a subsequent report.

Table 2.3: Probability of a Subsequent Child Protection Report within Three Years

		OR	95% CI		Wald	P-value
	Intercept	3.95	2.23	7.02	4.70	0.999
Indigenous Status	Non-ATSI					
	ATSI	**3.67**	1.40	9.66	2.64	**0.008**
	Unknown	0.24	0.12	0.50	-3.88	0.000
Legal Status	No					
	Other	0.12	0.04	0.32	-4.21	<0.001
	Previous care	2.22	0.97	5.08	1.89	0.059
Reports in previous year	0 or 1					
	2 or more	**3.00**	1.55	5.81	3.26	**0.001**
Payment	No					
	Yes	**2.11**	1.12	3.95	2.33	**0.020**
	Unknown	1.05	0.54	2.06	0.14	0.885
Service use	Yes					
	No and unknown	**2.51**	1.33	4.74	2.83	**0.005**

Note: n=404. The p-value for the variable 'payment' was 0.059. If the significance level was kept at 5% it would not be significant. It has been retained it because it is a key variable of interest. The unknown category does not differ from either yes or no.

Subsequent placement

The results of the logistic model for the probability of a placement in the three-year follow-up period are presented in Table 2.4. Neither the use of children's service nor any of the demographic variables was associated with a long-term out-of-home care placement. Only the number of reports made in the previous year predicted out-of-home care placement. Children who had had two or more reports during the last year were most at risk of entering long-term out-of-home care.

Table 2.4: Probability of Subsequent Out–of–home Placement within Three Years

		OR	95% CI		Wald	p-value
Reports in previous year	0					
	1	0.52	0.17	1.60	1.15	0.25
	2 or more	**3.27**	1.56	6.82	3.15	**0.00**

2.5 Limitations of the Analysis

The results should be treated with caution because of several limitations associated with the sampling and data quality of some important variables. This analysis was not undertaken using a randomised experimental design and the comparison group could not be matched on all variables. The analysis also did not examine quality, frequency or duration of use of children's services, since these data were unreliable.

2.6 Summary of Association between Child Protection Outcomes and Children's Services Referral

The analyses of the administrative data over three years examined the association between the use of children's services and other potentially important factors and child protection outcomes in young children. These analyses showed that using children's services significantly reduced the chance of a further report within a three-year period, and thereby the likelihood of the child entering care.

The finding that financial assistance was associated with an increased likelihood of children being reported may indicate that those who are financially disadvantaged have the poorest outcomes overall. Thus there may be other factors such as financial resources, which may be confounded with the use of children's services. Nevertheless, if this is the case, the finding that children's services use predicts child protection outcomes is strengthened as the model controls for those who are financially disadvantaged.

The next section of the report provides an overview of the methodology and the measures used in the qualitative component of the study.

3 Cohort Study

The second component of the project, the cohort study, involved an intensive study of 20 children with a risk of harm report, who had been referred to and taken up a place in a children's service. The children were followed for 12 months over the period from January 2002 to June 2004. Interviews at six-month intervals were conducted with the primary carers (parents or grandparents) of the children and with staff in the children's services. The types of children's services included in the follow-up were long day care, child care centres and pre-schools, both community and private. Children's services observations were conducted twice, 12 months apart. The methodology and the characteristics of the study sample are outlined in the next section, followed by the results of this study.

3.1 Cohort Study Sample

In total, 20 children referred to children's services by the Department of Community Services participated in the cohort study. These children comprised a small proportion of the children who were actually referred to children's services during this period. For example, in the Wyong area in the period September 2002–March 2003, 43 children were referred to a children's service following a risk of harm report. Eighteen (42%) of these referrals failed either because the families enrolled in the service but did not turn up or their child started in a children's service but left soon after (within one or two weeks). There was no follow-up of these failed referrals. The original sample included two additional children who dropped out of the study within 12 months (one moved interstate and the other's whereabouts is unknown). These children were not included in the analysis. Of the 20 children who did attend a children's service and who participated in the study, 15 children were followed from the beginning of their enrolment in a children's service; seven children had already been attending the service for up to six months.[4] Sixteen (16) of the 20 children were boys and four were girls. All except one child was over two (in the 2-5 year age range). Four

[4] Because of recruitment difficulties, the study expanded the criteria to include children who were already enrolled in the children's service, having been offered this place as a result of a risk of harm report. The initial intention had been to recruit the study sample via DoCS caseworkers. Case workers were to provide the research team with information on all referred children whose parents agreed to participate in the study in each of the selected areas (one metropolitan and one regional area). However, there were significant difficulties with this approach because of changes in the intake of cases and casework practice within the NSW Department of Community Services (DoCS). Although there was a marked increase in the number of matters reported to DoCS following the establishment of the Department of Community Services' centralised Helpline and the proclamation of the *Children and Young People (Care and Protection) Act 1998* in December 2000, very few of these cases were referred to children's services. The cases from which our sample was drawn were the less serious child protection cases in which early intervention is deemed realistic. These children were not allocated to a caseworker and not formally referred to a children's service and therefore not available for recruitment.

Several other approaches were devised, in consultation with DoCS, to supplement the recruitment. DoCS involved other sections of the Department in a largely unsuccessful attempt to overcome the recruitment problem. Sydney Day Nursery, KU Children's Services and the Infants Home at Ashfield were approached to assist in recruiting participants.

Consequently, the second component of the project was amended. This involved reducing the sample size (from 50 to 20) and increasing the intensity of follow-up. The greater depth of information gained from the intensive follow-up was designed to off-set the smaller sample size.

children lived with their grandmothers prior to starting in a children's service (T1). Eight children lived with their mother only, two children lived with their father only and six lived with both parents at T1.

The primary reasons for the children being referred to DoCS included domestic violence (12), neglect (9), physical harm (6), psychiatric problems and the emotional state of the carer (6) other drugs and/or alcohol (3) and sexual abuse (2). There were multiple reasons for the reports for 12 of the children and in four cases, the information was either unreliable or not available).

Just over half of the children (12/20) were identified as having language delays by child care or preschool staff. It is unclear whether the speech difficulties were secondary to relationship difficulties, as in disorganised attachment. The attachments of the children were not assessed. Half of the boys (8/16) were identified as having behavioural/emotional problems, usually conduct problems with aggressive behaviour. Two boys were described as socially withdrawn.

Parents and caregivers

Most of the 16 primary carers (the sample consisted of four sets of two siblings) most were mothers: six were single mothers and 5 were living with a partner initially, but in one family the parents separated over the study period. Two primary caregivers were single fathers and three were grandmothers. Three mothers and one grandmother were caring for more than one child included in the study, and in these cases they completed interviews and standardised scales for each of these children.

Mental illness, domestic violence or alcohol and other drug issues were common elements in many of these families. The primary source of income for most carers was government benefits and allowances. Almost half of the families had moved more twice in the three years prior to the study.

Children's services providers

Twenty-two children's services staff completed the Student-Teacher Relationship Scale for seventeen children at 12 month follow-up. The extra number of staff reports to children was because three of the children attended two children's services and staff from each service completed the questionnaires.

3.2 Data Sources

The cohort study draws on three sources of data:

(1) interviews with the parent or primary caregiver at three time periods

(2) interviews with children's services practitioners, including child care and pre-school directors of the services;

(3) observations of the children at the children's service on two occasions. Each is discussed below.

Parent interviews

The first semi-structured, face-to-face interview was conducted with the parent or caregiver when the family agreed to participate in the study. The original intention was to arrange the

initial interview soon after their child started attending the children's service. However, because of recruitment difficulties, the study expanded the criteria to include children who were already enrolled in the children's service, having been offered this place as a result of a risk of harm report. The initial interview collected information on the parent's views about:

- the circumstances leading to the child protection intervention; and
- their need for the children's service.

On-going contact was maintained with families and follow-up interviews were conducted at 6 months and 12 months after the families were recruited to the study. These interviews covered a range of topics and included several standardised measures. The main areas included:

- the parent's or caregiver's experience of, and satisfaction with, the service including the number of days and hours offered;
- the affordability of the service and the adequacy of the financial arrangements to meet the costs of fees;
- their perception of the value of the children's service, including their assessment of its value in alleviating parental stress, and parent-child relationship difficulties and the effect on their child's development.

At the end of the interviews, parents were asked to complete the short form of the Parenting Stress Index (PSI) (Abidin, 1995) at all three time periods: when they enrolled in the study, and 6 months and 12 months later. A parent's total stress score 'reflects the stresses reported in the areas of personal parental distress, stresses derived from the parent's interaction with the child, and stresses that result from the child's behavioural characteristics (Abidin, 1995, p.55). It measures the stress related to being a parent as distinct from external stress like financial and housing problems, and domestic violence.[5] The latter was assessed using the Life Events Inventory (Sandler and Block, 1979).

At the 12-month follow-up, parents also completed the Child Behaviour Checklist for children aged 1.5 - 5 years (Achenbach and Rescorla, 2000) to gain additional information about any difficulties that the parents were experiencing with their child and to provide a comparison point for parents and children's service providers who also completed the checklist.[6] The scales provide a profile of the child's style of emotional regulation.

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[5] The Parenting Stress Index (PSI) consists of five scales: Total Stress, Parental Distress, Parent-Child Dysfunctional Interaction, Difficult Child and Defensive Responding. The three scales of *Parental Distress, Parent-Child Dysfunctional Interaction* and *Difficult Child* make up the Total Stress Score. Items in Parental Distress assess a parent's sense of self-esteem and feelings of competency as a parent. Items in the Parent-Child Dysfunctional Interaction scale assess to what extent the parents feel that their child is not meeting their expectations and that parent-child interactions are not rewarding. Items in the Difficult Child scale assess the extent to which parents find it difficult to set limits and gain their child's cooperation. The *Defensive Responding* scale supplies a check on the validity of the parents' responses. A score of 10 or below on the scale may indicate that the parent is giving a positive impression to the interviewer and is unable to acknowledge the frustrations, annoyances and pressures of parenting. Raw scores on each scale can be converted to percentiles. The normal range for scores is within the 15^{th} to 80^{th} percentiles. High scores, as a marker for clinical intervention, are considered to be scores at or above the 85^{th} percentile.

[6] The Checklist presents a comprehensive list of behavioural and emotional difficulties in children and parents were asked whether each item on the list was somewhat true of their child, very true or did not apply at all. The Child Behavior Checklist that parents completed is scored on two cross-informant scales:

Difficulties are identified in the form of internalising problems (emotionally reactive, anxious/depressed, somatic complaints, withdrawn) and externalising problems (attention difficulties and aggressive behaviour). Both sets of problems can be compared with standardised norms to gauge the extremity of the emotional or behavioural difficulty in the children.

Children's services practitioner interviews

Once families had agreed to participate in the study, children's services practitioners were interviewed. Again, follow-up interview were conducted at 6 months and 12 months with the children's service worker who knew the child the best. The interviews included the following areas:

- the child's behaviour and emotional development
- the quality of their own relationship with the children
- and any support services they arranged for the children.

Copies of the questionnaires are included in Appendix A. A number of measures were used in conjunction with the interview schedule. Table 3.1 outlines the standardised measures that were used to assess children's emotional and developmental difficulties as perceived by both the parents and caregivers and the children's service staff, the parents' or caregivers ratings of parental stress. More detailed information on the measures is available in Appendix A.

Observation study of the children at children's services

The intensive follow-up of the children also involved systematic observations of the children's interactions with staff in the child care centre or pre-school they attended. The children were observed on two occasions, 12 months apart. This involved a morning in the children's service, including their arrival. The purpose of the observations was to complement and enrich the information provided by children's services workers on the quality of the relationships that they develop with the children. One of the rationales for offering children at risk a place in a children's service is for them to be able to learn constructive patterns of relating to adults and peers and so develop social competence. Children from distressed family relationships come into a children's service not necessarily trusting adults and expecting negative reactions from others. They are therefore likely to have high needs for relationship support. The aim of the children's services observations was to give a picture of the children's relationship needs and the support that they and the children's services staff need for the children to experience and learn constructive patterns of relating that are the foundations for school readiness.

the DSM-Oriented Scales and the Empirically-Based Scales. The DSM-Oriented Scales comprise problems judged consistent with diagnostic categories of the 4th Edition of the American Psychiatric Association's (1994) Diagnostic and Statistical Manual (DSM-IV). The scales correspond to the following diagnoses: Affective Problems; Anxiety Problems; Pervasive Developmental Problems; Attention Deficit/Hyperactivity Problems and Oppositional Defiant Problems.

Table 3.1: Summary of Standardised Measures

Completed by	Instrument	measures	T1	T2	T3
Parent	Parenting Stress Index (Abidin, 1995)	Stress related to being a parent	√	√	√
	Life Events Inventory (Sandler and Block, 1979)	Exposure of parent to external stress	√	√	√
	Child Behaviour Checklist (Achenach and Rescorla, 2000)	Child's behavioural and emotional difficulties			√
	Value of childcare Affordability Satisfaction with childcare		√ √	√ √ √	√ √ √
Children's services staff	Child Behaviour Checklist (Achenach and Rescorla, 2000)	Child's behavioural and emotional development			√
	The Student-Teacher Relationship Scale (STRS)	Quality of the relationship between teacher and child			√
	Attachment Q sort (Waters 195) Emotional Availability Scales (Biringen, 1990)	Child development observations	√		√
	Time-sampling schedule	Tracks the frequency and quality of the bids children to peers and staff	√		√
	Record of support services				√
DoCS staff	DoCS administrative data on number of reports		√		√

3.3 Findings of the Cohort Study

The findings from the follow-up study are organised around the following research questions:

1. How do families find a children's service? What are the perceptions of the families who use children's services following referral for the child being at risk of harm?

2. What supports do children and their families receive on entry to and after children are enrolled in the service?

3. Does the use of children's services protect children at risk from further incidents of harm. Does it assist in maintaining the child within their family and prevent children from being placed in out-of-home care?

4. What is required for children's services to care for children at risk and their families? For example, what are the children's developmental needs when they attend a children's service, including their need for relationship support?

5. What recommendations can be made for a model of best practice within children's services for children at risk?

3.4 Pathways into Children's Services

There were multiple reasons for most of the children being referred to a children's service, but in all these cases, an alternative or additional form of care was a means of protecting the child and monitoring their well-being. Four of the families had contacted DoCS because they needed a break or were experiencing difficulties in caring for their child. DoCS recommended children's services as a form of respite and in a few cases assisted the family to enrol the child in the service.

After the decision to attend a children's service was made, the decision of which child care or preschool their child would attend for most parents was based on the centre's proximity to their home or workplace. The involvement of the Department of Community Services (DoCS) was mainly limited to facilitating an over-numbers placement in a centre. Two parents of children with special needs received a referral to a specific centre. Only two parents indicated that a DoCS worker accompanied them on their first visit to the children's service. All these parents were satisfied with the support that they received from DoCs.

Continuing enrolment in the children's service

While only a relatively small proportion of families successfully navigated the referral process, once children were enrolled in a children's service, they tended to stay there. Children's service placements broke down in only one case when the child care centre closed and the child moved to a new centre. The family did not build up a good relationship with staff in the new centre and discontinued attending the children's service altogether. The remaining 19 children continued to attend a children's service over the 12-month period, and all stayed at the centre they first enrolled in. This stability is remarkable given the mobility of the majority of the families, moving house between one and four times over the 12-month period.

Hours of attendance

The hours of attendance at child care centres or preschools were fairly similar for all of the children. Most involved drop off between 8.30am and 9.30am and pickup between 3.30pm and 4pm. Only one child was picked up close to 6pm. The days of attendance varied between 2 and 5 days per week and in most cases were not consecutive. Seven out of eight parents (eight responded to this question) were satisfied with the number of hours that their child/children spent in a children's service. Only one parent was not satisfied with the number of days their child attended because they wanted to increase the number days and would have preferred consecutive days. Children's services were the primary child care arrangement for most parents, although other relatives looked after the children on an occasional basis for two of the parents.

Affordability

Parents/grandparents found the children's service arrangement affordable. The usual arrangement was for DoCS to fund the placement for the first 13 weeks and then the parent paid the fees. In this arrangement the substantial part of the fee was covered by the Child Care Benefit allowance. Three families indicated that they could not afford the fees; in each case the director of the children's service kept the children enrolled and carried the costs incurred until the problem could be resolved with DoCS. Resolution of these matters was often a slow and frustrating process.

Summary

DoCS became involved with many of the families due to concerns about domestic violence or the ability of parents to cope with the demands of parenting. Attending a children's service was seen as a way to support these families and their children. In most cases DoCS was not involved in selecting the child care centre or preschool but assisted families to gain access to a service if it was full. Most parents were satisfied with the number of hours of child care and the support they received from DoCS. Childcare services were paid by either by DoCs, Centrelink or the parents with the aid of CCA.

3.5 Parents' Perceptions of the Benefit of the Children's Service Placement

Benefits for parents

In the initial interview, eight parents and carers said they expected that the offer of a place in a children's service would benefit both them and their children. They said that access to child care or preschool would give them some respite and time to complete other tasks such as household shopping or chores, confident that their children were happy and well cared for. Three parents indicated that the offer of a place in a children's service would either allow them to remain in or return to paid work.

Over the 12 month period (across the three interviews) parents and carers indicated that one of the main benefits of their children attending child care or preschool was, as they expected, respite. In addition, parents and carers commented that their children were well looked after and stimulated through the various activities at the centre. For two of the grandparents caring for children in the study, access to a children's service enabled them to remain in full-time work. Another parent had returned to paid employment after her child was offered a place. One parent commented that she could now spend more time with her other child. Another grandparent organised the children's service days so she could continue to play a team sport.

Parents and carers also commented that another benefit of children's services was their interactions with staff. Staff provided parents and carers with an outlet to talk about their children and seek advice. Many parents felt quite close or very close to the staff and spoke to them regularly about their child's behaviour, problems at home, eating habits, toilet training and sleeping problems. Over the 12 month period most parents or carers (13/20) had assistance from the childcare staff to access other services such as speech therapy or paediatric assessments.

Benefits for children

At the initial interview, parents and carers indicted that one of the main expected benefits of attending a children's service for their children was that they would learn to interact and play with other children and that it would assist them in the transition to school.

Over the 12 month period parents indicated that socialising with other children was one of the most enjoyable aspects and benefits of attending a children's service for the children. The parents talked about how their children had developed friendships and the importance of this, particularly for children starting primary school. Parents commented that their children had learnt to interact with adults and share and play with other children enabling them to become more independent. Parents also noted that their children enjoyed and learnt from a range of activities that they may not have access to at home. Two parents felt that their children's speech had improved as a result of interacting with other children and adults at the centres.

Summary

Parents' and carers' views at about the time of the referral to the children's service indicated that they regarded the children's service placement as affordable and beneficial both for themselves and for the children. While only about half the referrals resulted in a continuing enrolment, once children started using it, the children's service became a very stable part of the families' lives.

3.6 Parents' Perceptions of Parental Stress and Parent-Child Relationship Difficulty

As noted earlier, many of the children exhibited aggressive behaviours and were difficult to manage. Dealing effectively with this type of behaviour is stressful and challenging for parents under the best of circumstances. Many of the parents and grandparents in the cohort study at the time of the initial interview were also dealing with complex family issues and stressful life events, which in turn are likely to have increased stress levels within the household.

Soon after the referral to the children's service, the levels of stress reported by parents on the Parent Stress Index (PSI) were high, and for a third of the group, at levels that were sufficiently severe to warrant clinical support and intervention (using standardised (US based) norms at the 85th percentile) (Table 3.2). On the three sub-scales, a substantial number of carers reported high stress or distress due to parent-child interactions not being rewarding (Parent-Child Dysfunctional Interaction); due to feelings of low self-esteem as a parent (Parental Distress subscale); or because they were having difficulty managing their child's behaviour, either in setting limits or gaining their child's co-operation (Difficult Child subscale). The more difficult parents perceived their child to be, the more distressed they were ($r = 0.56$, $n = 20$, $p = 0.01$) and the less rewarding they found their interactions with the child ($r = 0.73$, $n = 21$, $p < 0.001$).

Table 3.2: Initial Measure of Parents Reporting Clinically Significant Levels of Parenting Stress (PSI Scores)

	Total parents	Parents with significant stress
Parental distress	20	8
Parent-child dysfunctional interaction*	21	7
Difficult child*	20	8
Total stress	20	7

Notes: Parenting Stress Index (PSI) initial results for scores at or above 85th percentile
When parents have not completed two or more questions in any one sub-scale, their data is not entered for that subscale or for the Total Stress score.

Although the sample is very small so the results are indicative only, one characteristic of the child or the caregiver – whether or not the child had ever lived away from the parent for a significant period of time[7] – might have been significantly associated with the level of perceived parental stress.[8] Families who had a break or separation away from their children, where their child was away from them for at least a fortnight, also reported that their children were easier to manage and were more rewarding in their interactions compared with parents who reported no significant separations.[9] Other characteristics of the child and the caregiver (child's age, belonging to neighbourhood, caregiver's health, whether or not the partner was living in the household, regular family contact) were not significantly associated with perceived parental distress or stress.

Changes across time in parenting stress

Given the very small sample size, the statistical test results of change over time are not reliable. The measures of parenting stress indicate that for some families parenting stress went down over time, for others it stayed the same and for one it increased at the same time as life stress events. However two differences in the pattern of results over time are noteworthy. The parents are a high risk group, with twice as many parents (30-40 per cent; 7-8/20) reporting that they experienced high distress in their parenting role (Table 3.3) compared with standardised norms (where the clinical cut-off used for high distress is the top 15 per cent of the population). There was some indication, however, that the proportion of caregivers who met the criterion for clinically significant levels of stress showed some decrease over the 12 months period (Table 3.3). For example, three of the four parents who indicate significantly less parental distress at the 6-month interview maintained this improvement at 12 months. The fourth parent reported experiencing more distress and moved back into the clinical range. Two other parents reported high distress: one had reported high distress on the initial evaluation and the other had been in the normal range previously (when initially assessed and at 6-month follow-up).

[7] Caregivers were asked 'Has your child ever lived away from you or been out of your care for a significant period of time, say more than 2 weeks total?'

[8] Each PSI scale and sub-scale was converted to a dichotomy by splitting scores at the sample mean (Table 3.3). For example, the mean total stress score across time for the present sample rounded to a value of 80. Those respondents who scored 80 or less were assigned to the 'below average stress' category (with report of less distress in the parenting role) and those who scored above 80 were assigned to the above average stress category (where parents reported more distress in the parenting role).

[9] The association was significant for both the Difficult Child ($\chi^2(1) = 4.96$, $p = 0.026$) and the Parent-Child Dysfunction Interaction ($\chi^2(1) = 6.2$, $p = 0.013$) subscales.

Table 3.3: Longitudinal Measure of Parents Reporting Clinically Significant Levels of Parenting Stress (PSI Scores)

	Time 1		Time 2		Time 3	
	Total parents	Significant stress	Total parents	Significant stress	Total parents	Significant stress
Parental distress	20	8	17	3	18	5
Parent-child dysfunctional interaction*	21	7	18	4	17	6
Difficult child*	20	8	21	8	16	4
Total stress	20	7	15	4	15	6

Notes: Parenting Stress Index (PSI) Time 1, Time 2 (+6 Months) and Time 3 (+12 Months) results for scores at or above 85th percentile
When parents have not completed two or more questions in any one sub-scale, their data are not entered for that subscale or for the Total Stress score.

Second, the pattern of relationships between parental distress and how difficult or demanding the parents reported their child to be changed from the first to the later interviews. At Time 1, the more difficult and demanding parents reported their child to be, the greater their parental distress. No such relationships were observed at Times 2 or 3, however.

There were also some significant associations with other aspects of parents' and children's relationships and level of support including whether children had lived away from the parent, whether the parent had a live-in partner, and the extent to which the parent felt they belonged to the neighbourhood. Where children had lived away from their parent at some stage, parents reported more positive interactions with their child at all three interviews. This may reflect a lack of support for caregivers and the child in which a pattern of being together without respite might exacerbate difficult interactions. Similarly, there was also a trend for caregivers who had a partner living in the household to be less likely to see their child as difficult and demanding and to have lower than average overall parenting stress scores. A further indication of the likely importance of positive support for the parent was the association between parents' and caregivers' feeling that they felt that they belonged to their neighbourhood and the decreased likelihood that they perceived their child to be difficult or demanding[10]; those who felt they belonged were also less likely to have experienced parental distress[11] and overall stress[12], although the sample and cell sizes are so small that these results should be treated extremely cautiously.

Together these results may suggest, at least initially, a behavioural and psychological cycle where poor parent-child interactions, difficult child behaviours, parental distress and life stress affect each other.

[10] Parents and caregivers were asked 'Do you feel like you **belong** to this neighbourhood?' All the parents/caregivers who reported they did not feel like they belonged fell in the above average Difficult Child category whereas most who said they did belong were in the below average Difficult Child split: $\chi^2(1) = 6.87$, $p = 0.009$.

[11] $\chi^2(1) = 5.09$, $p = 0.024$.

[12] $\chi^2(1) = 6.24$, $p = 0.013$.

3.7 Parents' Perception of Children's Behavioural Difficulties and Emotional Regulation

Table 3.4 reports on the children's behavioural difficulties as indexed by the DSM-Oriented scales of the Child Behaviour checklist, completed by parents (and grandparents) at the 12-month follow-up. DSM-oriented scales are comprised of problems consistent with diagnostic categories on DSM-IV: affective problems, anxiety problems, pervasive developmental problems, attention deficit/hyperactivity problems and oppositional/defiant problems. The percentage of children who fell into the borderline or clinical range compared with a normative sample is reported (comparison to US children; Australian comparative data were unavailable). The cut-off for the clinical range is the 98th percentile or severe enough to place the child in the top 2 per cent for severity of problem compared to same-aged peers. The borderline range is between the 93rd and 98th percentiles, so that severity of the child's difficulties is within the top 2-7 per cent for severity compared to same-aged peers.

Table 3.4: Children in Borderline or Clinical Range for Severe Behaviour Problems

	Children	Per cent
Affective problems	4	21.0
Anxiety problems	2	10.5
Pervasive developmental problems	4	21.0
Attention deficit hyperactivity problems	2	10.5
Oppositional defiant problems	3	15.8

Notes: DSM-Oriented Scales of Child Behaviour Checklist
Completed by parents or Grandparents at Time 3 (+12-month)
Results for scores at or above 93th percentile.
n=19

Four of the children (4/19) were rated as having difficulties severe enough to place them in the borderline/clinical range for affective problems and pervasive developmental problems. This rate is three times more than one would expect compared to standardised norms (where 2-7 per cent of children show such extreme behaviour). The items that make up Affective problems include looking sad or unhappy, showing little interest, crying and having trouble eating and sleeping. The items making up pervasive developmental problems include, being disturbed by change, being afraid to try new things, not making eye contact and not answering, not getting along with peers, showing little affection and being unresponsive to affection and having speech problems. Almost sixteen percent (3/19) children were rated as having severe difficulties with oppositional/defiant behaviour. This frequency is twice what could be expected when compared with standardised norms (where 2-7 per cent of children show such extreme behaviour). The items that make up the oppositional/defiant problem area include defiance, disobedience, angry moods and being unco-operative.

Table 3.5 reports on the children's difficulties in emotional regulation as indexed by the Empirical Scales of the Child Behaviour checklist. These scales can be clustered into two poles, Internalising difficulties (withdrawn) and Externalising difficulties (attention and conduct problems). Within the Internalising cluster, five children were rated as having severe difficulties in Emotional Reactivity, a pattern where children become emotional quickly and have trouble returning to a calm emotional base. This rate is almost four times greater than what could be expected when comparing to standardised norms (where 2-7 per

cent of children show such extreme behavioural difficulty in regulating their feelings). The items on the Emotionally Reactive scale include, being panicked, labile or shifting quickly between sadness and excitement, moody, and disturbed by change.

Table 3.5: Children in Borderline or Clinical Range for Severe Emotional Regulation Problems – Parent or Grandparent Perception

	Children	Per cent
Internalising difficulties		
Emotionally reactive	5	26.3
Anxious or depressed	3	15.8
Somatic complaints	3	15.8
Withdrawn	2	10.5
Externalising difficulties		
Attention problems	1	5.3
Aggressive behaviour	3	15.8
Total problems	4	21.0

Notes: Empirical Scales of Child Behaviour Checklist
Completed by parents or grandparents at Time 3 (+12-month)
Results for scores at or above 93th percentile.
n=19

Four children were rated as having severe emotional problems, indicted by their Total or overall score. In three other scales, 15.8 per cent of the children reached the cut-off denoting extreme behavioural difficulty in the borderline/clinical range. The scales were Anxious/Depressed (with items like being clingy, fearful and having feelings easily hurt and fearful); Somatic Complaints (with items such as complaining of aches and pains without medical cause and not being able to stand things out of place); Aggressive behaviour (like being easily frustrated, lacking guilt after doing something wrong; hurting others, uncooperative and being seen as selfish or stubborn. However, again the sample was too small to conduct meaningful multivariate analysis about the interrelationship between children's behaviour, parenting stress and life events stress.

In summary, based on parent/grandparent report the children present as a high needs groups with up to a quarter of the children meeting clinical criteria for very severe difficulty in managing their feelings; and 21 per cent meeting clinical criteria for very severe behavioural difficulties (Affective problems and Pervasive developmental problems) consistent with diagnostic categories on DSM-IV.

3.8 Identified Developmental Concerns and Support Needs

As indicated earlier, the children in all but one family remained in the children's service in which they enrolled. The children's service placement broke down in only one case. The remaining 19 children continued to attend the children's service over the 12-month period. This stability enabled the workers to get to know the children and to understand what services they might require.

Use of other support services

According to the case file data, over half the parents or carers (12/20) participating in the cohort study received a range of support from other services as well as the children's service. For the remaining 8 parents/carers no information on services was listed on the DoCS case files. The support included attending playgroups, family support, and homecare access to allied health and other specialist medical services. In all these cases, families accessed more than one of these services.

Table 3.6 lists the developmental concerns detailed by children's services staff at any of the follow-up interviews and the support that they accessed for the children and their families. Only two children (10 per cent) were described by staff as not having any developmental problems. Twelve of the 20 children (60 per cent) were described as having speech problems. The children's services were active in referring these children for assessment and treatment. Nine of these 12 children were assessed and all but one of these children received therapy. This remaining child was placed on a waiting list for therapy. Half of the children (8) received therapy at the children's service. In these cases, the therapist was able to give the staff guidelines to support the children's speech and organised homework sheets for the families.

Nine of the 20 children were described as having behavioural problems, usually conduct problems with aggressive behaviour, and two other children were described as socially withdrawn. While staff were effective in accessing outside help for children (eg Triple P and Pals program in three instances) and paediatric referral (staff or parents made these referrals in four instances), these services did not feedback information to the children's services or assess the children at the children's service in the context where they were showing difficulties and posing challenges for staff. Thus, feedback on the children did not reach the 'coalface' to give staff direct support. Children's services advisors within DoCs and within childcare/preschool organisations were the primary support for staff in helping them to organise referrals for the children. All four paediatric referrals resulted in the diagnosis of ADD or ADHD, where the children were prescribed medication.

Table 3.6: Developmental Need and Support Organised by Children's Services Staff

ID	Developmental Need	Support organised by Children's Service
1	Speech – expressive (Director said he had a 6 month delay in expressive language)	No support organised - spoke to teacher as part of school transition
2	Speech – extreme expressive and receptive delay	Organised speech assessment; speech therapist given at child care centre
3	Speech – moderate expressive delay Socially withdrawn (very quiet)	No support organised
4	No problems	
5	Attentional/behavioural	Teacher organised for transition support into school (six day orientation); father organised paediatric assessment leading to ADD diagnosis
6	Speech – moderate expressive delay	Organised speech assessment and speech therapy (outside centre)
7	Speech – mild-moderate expressive delay	Organised speech assessment and speech therapy (outside centre)
8	Speech – severe expressive and receptive delays	No support organised – child stopped attending child care.
10	Behavioural (Conduct problem - aggression)	Referred by preschool for paediatric assessment, diagnosed ADD.
11	No problems initially; by end of 12 month follow-up, child care concerned about his behaviour/conduct - defiance	Mother self referred to paediatrician, diagnosed with ADD
12	Speech – receptive language delay (severe); mild expressive delay Behavioural/conduct problem – aggression	Organised speech assessment; grommets and speech therapy (outside centre) Organised behaviour management classes for grandmother (Triple P); Transition into school support organised
13	Over-eating (using food as a comfort)	No support organised
14	Speech – mild expressive and receptive delay	Organised speech assessment and speech therapy at the preschool; transition into school support organised
15	Speech – severe receptive and expressive delays Socially withdrawn	Organised speech assessment and speech therapy at the preschool
16	Severe expressive speech delay; moderate receptive delay and hearing loss Mild intellectual disability	Organised hearing assessment (child given hearing aid) and speech therapy on-site; art therapy on-site; transition into school support organised
17	No particular problems	Attended a high needs child care centre since child was a baby.
18	Behavioural/conduct – defiance	No support organised
19	Behavioural/conduct –aggression	Organised behavioural management classes for grandmother (Triple P). GM did not attend the classes
21	Speech expressive Behavioural/conduct (aggression)	Organised speech assessment and speech therapy (outside centre) Behavioural management for child in centre (Pals program) Paediatric assessment leading to ADHD diagnosis; referred to preschool for children with high needs for behavioural and emotional support.
22	Speech – expressive delay	Organised speech assessment; child on waiting list for therapy

Note: ID 9 (contact lost with child) ID 20 (child moved interstate) not included in the analysis

When children were going to school the following year, the children's services staff organised transition into school support for all these children. Often the transition support had come about through informal but sustained links built up between the children's service and the local primary school.

The following data indicates children's services staffs' perception of the developmental needs of the at-risk children when they attend a children's service, including their need for relationship support.

3.9 Children's Services Practitioners' Perception of Children's Behavioural Difficulties and Emotional Regulation

The perceptions of the children's emotional and behavioural difficulties by child care and pre-school staff were assessed by the Caregiver-Teacher Report Form and are reported in Table 3.7. The Teacher Report form is a teacher version of the Child Behaviour Checklist, yielding scales similar to, but not exactly the same as the Empirical Scales on the Checklist. The Scales can be clustered into Internalising and Externalising poles so that parent and teacher ratings of the children can be compared. Because three of the children each attended two pre-schools (mainstream and services for children with high needs) staff at both services completed questionnaires on the children. The number of children rated by any one staff member as meeting the borderline or clinical cut-off for very severe emotional regulation problems is presented in Table 3.7.

Table 3.7: Children in Borderline or Clinical Range for Severe Emotional Regulation Problems – Children's Services Workers

	Children
Internalising difficulties	
Anxious or obsessive	2
Depresses or withdrawn	0
Immature	3
Externalising difficulties	
Attention problems	2
Aggressive behaviour	4
Total problems	5

Notes: Caregiver-Teacher Report
Completed by children's services workers at Time 3 (+12-month)
Results for scores at or above 93th percentile.
n=17. Missing=5. One child moved interstate; one was lost to follow-up; one child was removed from parental care; one child was not using child care at 12 months; and one teacher reused to complete the questionnaires.

Table 3.7 indicates that 29.4 per cent of children (5/17) were rated by children's services staff as having severe difficulty in regulating their emotions based on their Total or overall scores. This is comparable with the parent ratings of 21 per cent on Total score. As well, 23.5 per cent of the children (4/17) were rated as having severe difficulties with aggression. Items on the aggression scale include being defiant, lacking guilt, having an explosive temper, being selfish, loud, uncooperative, getting into fights and not liked by peers.

The rate of severe problems overall is four times what could be expected compared with standardised norms. Similarly, three times as many children (compared with the established norms), met the cut off for very severe problems with aggression. Staff also rated 17.6 per cent of the children (n = 3) as being immature (ie as falling into the borderline or clinical range on the Immature scale). This rate is twice what would be expected from comparison with peers. Items on the 'immature' scale include being clingy, jealous, wanting attention and having feelings that are easily hurt.

Table 3.8 collapses the separate scales into the Internalising and Externalising clusters so that parents' and grandparents' ratings and children's services workers' ratings can be compared.

Table 3.8: Children in Borderline or Clinical Range for Severe Internalising and Externalising Emotional Regulation Problems – Comparison of Parent and Children's Services Worker Ratings

	Parent rating		Children's services worker rating		Combined rating	
	Children	Per cent	Children	Per cent	Children	Per cent
Internalising difficulties	4	23.5	3	17.6	5	29.4
Externalising difficulties	5	29.4	5	29.4	9	52.9

Notes: * Combined ratings are children who were rated as in the borderline/clinical range by either their parent or the children's service worker.
Results for scores at or above 93th percentile.
n=17. Missing=5. One child moved interstate; one was lost to follow-up; one child was removed from parental care; one child was not using child care at 12 months; and one teacher reused to complete the questionnaires.

The same percent of children (29.4%) are rated by parents and children's services staff as having severe emotional regulation difficulties on the externalising dimension. Parents' ratings placed 23.5 per cent of the children in the borderline/clinical range on the internalising dimension. Staff rated slightly fewer children (17.6 per cent) as having emotional regulation difficulties on the internalising dimension.

While there is some overlap, staff and parents do not always rate the same children as in trouble. The final column in Table 3.8 indicates the percentage of children who fall into the borderline/clinical range, based on either parent or staff report. Using this criterion, difficulties in emotional regulation on the externalising dimension rise to 52.9 per cent. Given that between 2-7 per cent of children are judged to have problems this severe on the standardised norms, the rate of children in trouble based on parent or staff report combined is seven times greater than one would expect to find in the normal population. Table 3.8 further shows that 29.4 per cent (5/17) of children have difficulties in emotional regulation on the internalising dimension when either parent or staff report are considered. These difficulties include emotional reactivity and anxiety. Further analysis would consider subgroups such as children rated by both parents and teachers as difficult; children rated by parents as difficult but not by teachers; and children rated by teachers as difficult and not by parents.

Summary

Overall the perceptions of children's services staff are consistent with parent's perceptions and indicate that almost a quarter of the children have difficulties in emotional regulation that meet clinical criteria requiring support. Parents and teachers do not always pick up the same children as having difficulties. When either parent or staff report is used to identify children at risk for emotional regulation difficulties, the percentage of children that meet clinical criteria for support rises to above fifty percent for externalising problems like aggression and 29.4 per cent for internalising problems like emotional reactivity and anxiety.

3.10 Child Protection Outcomes

Overall the outcomes from the cohort study indicate that children's services for children at risk of harm may protect them from further incidents of harm, assists in maintaining the child within their family and prevents them from being placed in out-of-home care.

Children remaining with their families

Nineteen of 20 children stayed in their families (parent/s or grandparent) over the 12-month period. One child and the siblings were removed from the mother's care and placed in relative (paternal grand-parent) care. This child continued to attend a children's service but was offered a place in another centre that was closer to where the grandparents lived.

Number of further reports (re-notifications)

Information gained through DoCS case files had reliable data only for 16 of the 20 children at T1 and T2. Over time the number of reports decreased once the children attended childcare for three-quarters of the sample (12/16). At T1 the number of reports ranged from 15 to 0 with an average of 4.3 reports per child. At T2 the number of reports ranged from 6 to 0 with an average of 1.3 reports per child. No reports were received for 56.3 per cent of these children (9/16) during the study period. Of the 16 children for whom reliable information was available, 7 children experienced further reports once they attended a children's service. It should be noted that the number of reports for four of these children had decreased since starting children's services. In one case, 15 reports were received prior to attending a children's service, after which there was only one at T2. In two cases the number of reports had increased since the child started at a children's service which may reflect greater 'surveillance'. In the other instance the number of reports (2) remained the same over time.

3.11 Findings from the Child Development Observations

Children's service practitioners' rating of the quality of their relationship with the children

Table 3.9 shows the children's services staff's perceptions of the quality of their relationship with the children. Again, because the sample size is small categorical data is used. The percentage of staff that indicate either a high level of concern about their relationship with the children, or alternately describe a very positive relationship is presented. A high level of concern is defined by teacher report of high conflict or high dependency in the relationship (at or above the 75th percentile on the Conflict or Dependency subscales) or low closeness (at or below the 25th percentile on the Closeness subscale or the Total subscale). The author of the Student-Teacher Relationship Scale (Pianta, 2002) uses these percentiles as the cut-off for recommending intervention in which teachers are offered counselling to better meet

the relationship needs of the children. On the other hand, percentiles at or above 75 for the Closeness subscale and the Total scale are considered a marker for a significantly high level of positive qualities in the relationship (Pianta 2001:12).

Table 3.9 shows that almost half of the staff (45%) expressed high concern about their relationship with the children, with their descriptions of the relationship falling into the Low Positive category (at or below the 25th percentile on either the Closeness subscale or the overall Total Scale). Low scores on these Scales indicate a more distant; less affectionate relationship with less open communication. For example items that staff may have answered negatively on the Closeness Scale include 'I share an affectionate, warm relationship with this child; 'If upset this child will seek comfort from me; 'This child openly shares his/her feelings and experiences with me' and 'It is easy to be in tune with what this child is feeling'. The Total scale measures the degree to which overall that staff see their relationship with a child as positive and effective.

Table 3.9: Children's High Concern or High Positive Relationship with Children's Services Workers

		Children	Per cent
High concern relationship report*			
High conflict	At or above 75th percentile	5	
High dependency	At or above 75th percentile	6	
Low positive	At or below 25th percentile on closeness or total scales	10	
High positive relationship report			
High positive	At or above 75th percentile on closeness or total scales	6	

Notes: Reports by children's services workers at Time 3 (+12-month)
n=22
* Some staff reports indicated high concern across categories (eg high conflict and Low positive)

Approximately a quarter of the staff reported highly conflictual relationships (22.7 per cent on the Conflict subscale) and/or highly dependent relationships (22.7 per cent on the Dependency Subscale) with the children. 'A teacher endorsing high Conflict scores tends to struggle with the student, perceives the student as angry or unpredictable, and consequently feels emotionally drained and believes himself or herself to be ineffective with that student (Pianta, 2002,p.11)'. Items include: 'This child and I always seem to be struggling with each other'; 'This child remains angry or is resistant after being disciplined'; and 'When this child is in a bad mood, I know we're in for a long and difficult day'.

When dependency scores are high, staff endorse statements that describe the children as emotionally ambivalent so that the staff are often genuinely uncertain as to how best to help them. Items include: 'This child asks for my help when he/she really doesn't need it' and 'This child appears hurt or embarrassed when I correct him or her'.

In contrast to staff who reported high levels of concern in their relationship with the children, there was a group of 27.3 per cent of staff who reported a highly positive relationship. Higher scores on the Closeness and Total scales reflect a more positive and affectionate relationship, with more open communication and lower levels of conflict and

dependency. Further analysis of the contrasting perceptions between parents and teachers might identify which subgroups of children were more likely to achieve positive change.

Overall the reports by children's services staff on the quality of their relationship with the children showed that staff expressed high concern about up a large number of the children. Forty five percent of the staff checked responses that indicated that they were concerned because the relationships felt distant, (less affectionate and less open communication). Twenty five percent reported relationships with the children that felt either highly conflictual or highly dependent. This picture of relationship difficulty is consistent with reports by both staff and parents of a similar proportion of the children showing severe difficulty in managing their feelings. Given that children learn emotional regulation within the context of close relationships, the other finding that at least 27 per cent of the staff reported very positive relationships with the children is important to follow-up to elucidate how some staff could form supportive relationships. The child development observations that follow go down this path.

Children's Bids to Staff is used to describe the child's immediate experience prior to approaching a staff member, how directly the child makes his or her needs known, what the staff member responds to and what the happens as a consequence (what the child does then) (Table 3.10).

Table 3.10: Children's Bids to Staff

Child's bids to staff				
Bid no.	What comes before? (Child's immediate experience prior to bid)	What does child do? (How directly does the child express his/her needs?)	What does teacher do? (What bids do they respond to?)	What does child do then?

Staff Interventions to Children describes what comes before the intervention, (ie the child's immediate experience prior to the teacher intervening) what the teacher does, how the child responds and what happens in the end (Table 3.11).

Table 3.11: Staff Interventions to Children

Staff intervention to child				
Bid no.	What comes before? (Child's immediate experience prior to teacher intervening)	What does teacher do? (What is the teacher's intervention?)	What does child do? (How does the child respond to the teacher's intervention?)	How does it end?

The clinical 'diary-feel' of the note taking is maintained in the summary table format. Conveying the child's immediate experience before he or she made a bid to staff gives a context for the bid. From this, more is learnt about the nature of the bid and how clear the child is being in expressing himself or herself. For instance, it shows whether the child is able to 'just be himself' in expressing his needs. Such directness would assist the teacher in being emotionally available to him. Alternatively, the context may reveal that a child is being indirect (presumably because she feels uncomfortable about expressing that particular

need). This indirectness from the child would involve the teacher having to read between the lines and work out what the child is really in need of in order to be emotionally available.

The Circle of Security map (Marvin et al 2002; Hoffman et al 2006- see Figure 4.2) was used to give a coherent understanding of the kinds of bids that children might make to staff.). It shows a circle held between two hands: one supports the top half of the circle, representing the secure base that children need for play. 'I need you to watch over me, help me, enjoy with me'. The other supports the bottom half of the circle, depicting the safe haven that children return to after exploring long enough. 'I need you to protect me, comfort me, delight in me or help me to organise my feelings'.

The conceptual framework for the Circle of Security map comes from attachment theory, especially Mary Ainsworth's (1978) concepts of 'secure base' and 'safe haven'. The map is designed to help parents and carers to observe the dynamic equilibrium between children using significant adults as a 'secure base' for exploration and a 'safe haven' for comfort. When children can use the relationship to meet their attachment and exploration needs, this is apparent in 'circle moments', whereby children transition smoothly in to the caregiver for comfort, which, in turn, promotes their return to play.

The Circle of Repair (Marvin et al, 2002 – see Figure 4.2) was used to evaluate how the children's bids or staff interventions ended (the entries written in the last column of both tables). For example, from a behavioural management perspective, when things go wrong or the child does something that you don not want them to do, the natural end-point is to stop the negative behaviour (eg stop the aggression, stop the dispute between the child and his peer, fix up play that is failing). From a relationship support perspective there is an extra step and that is relationship repair. The adult touches base with the child so that the relationship between themselves and the child is re-established. In relationship repair the adult not only 'walks the children through' difficult situations, but assists them back to a calm state when things go wrong.

Figure 3.1 The Circle of Security

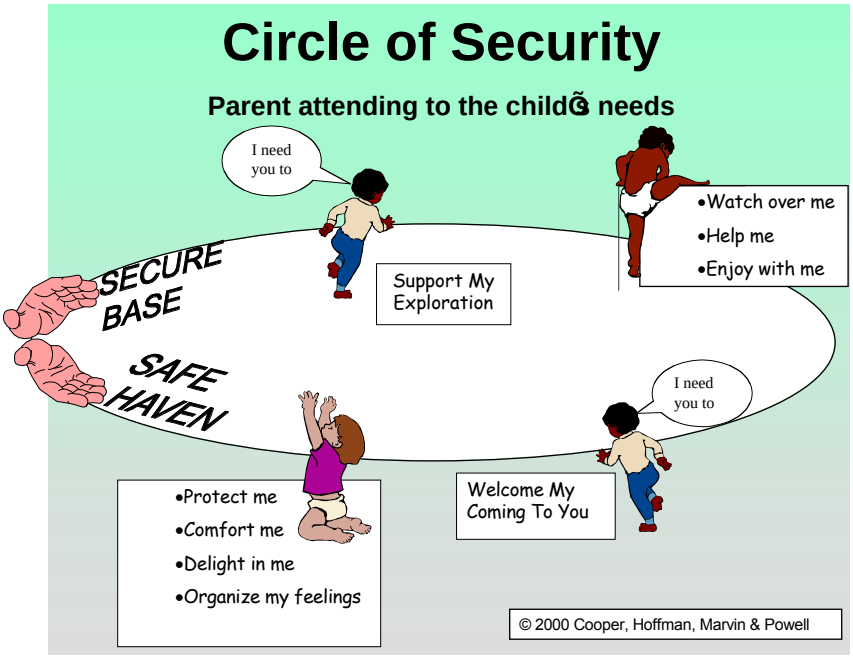
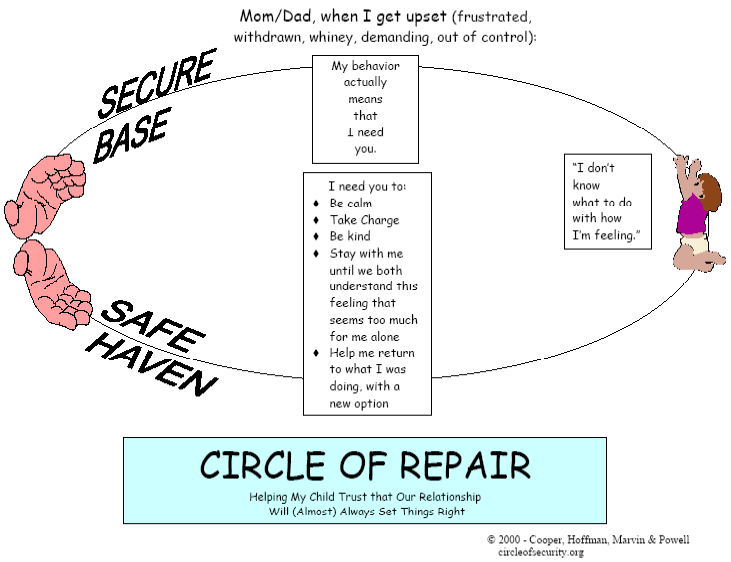


Figure 3.2: The Circle of Repair



The child development observations were designed to observe the interactive process between staff and children. Case examples are presented when staff reported experiencing very positive relationships with the children (above the 75th percentile in Closeness or Total score on STRS scale) and when they experienced high concern about the relationship (Above the 75th percentile for Conflict or Dependency or below the 25th percentile for Closeness).

The observations were made at the same time at the beginning of the children's day. They ran for 1.5 hours and included the child's drop-off at the service by the parent or grandparent.

Two tables are presented for each case example. The first table presents the child's bids or approaches to staff and the second records the staff's interventions or times when they came in to the children.

Case example I illustrates the interactive process when the staff member who completed the STRS reported experiencing a very positive relationship with this child (above the 75th percentile in Closeness or Total score on STRS scale). 'Teacher' is used in the tables to refer to all the early childhood practitioners. It does not refer to a staff member's professional qualification. The 'teacher' may be a tertiary trained member of staff or be unstrained.

Table 3.12 shows that over the period of the observation the child made 9 bids to staff for support. The context for eight of the nine bids (all bids except bid 8) was that he was upset and needed support for emotional regulation as depicted on the bottom side of the Circle of Security (around attachment needs). His distress stemmed from having to deal with separation (from his parent and then Teacher 1) and from having to manage play with other children (which he was not successful at on his own).

The entries in column 3 indicate that the child did not always show his distress and ask for comfort/connection in a straightforward way. For example, in bid 3 the child increased his bids for play (instead of comfort) when his teacher's availability was threatened. At another time (bid 6) his need for support was disguised by his being very bossy and controlling of teacher 2 who had come in to be with him when teacher 1 left. The child stayed with teacher 2 but could not at first use the relationship with her to calm down; once he did he was no longer bossy. Column 4 showed that each of the staff was able to read 'underneath' the child's behaviour and respond to his genuine attachment needs. The support that they gave him helped him to organise his feelings. Column 5 indicated that the natural endpoint of their support was relationship repair. Seven the 9 bids led into 'touching points' where the child was able to use the relationship to calm down and feel the availability of the adult. Each 'touching point' worked in that it gave the child the confidence to move out into exploration. This was apparent in how the child's behaviour improved over time in the observation. He grew steadier, his affect became more positive and he began to use the staff as a secure base to play from. He displayed kindness to another child (being empathic to a girl who was distressed), he experienced competence and shared genuine joy with his teacher as he put a puzzle together and other children noticed and valued his accomplishment.

Table 3.12: Child's Bids to Staff in High Positive Relationship

Bid No.	**What comes before?** (Child's immediate experience prior to bid)	**What does child do?** (How direct is child's attachment or play bid?)	**What does teacher do?** (What bids do they respond to?)	**What does child do then?**
1	When he arrives, child does not go into the playground where the children are. His mother encourages him to go out but child refuses. Teacher 1 sets up a craft table just where inside and outside divides and sits down at it.	Child approaches Teacher 1 at the craft table. He sits opposite. Mother kisses child goodbye. Child starts to mould the clay.	Teacher 1 starts to mould some clay too. He does not ask the child questions. They play in parallel and no pressure is put on the child talk.	Child begins to look at teacher and tell him what he is doing. Teacher expresses interest. Child talks to teacher more, shares smiles.
2	Another child sits down at the craft table.	Child looks at the other child warily and increases his bids to teacher 1, 'watch what I can do'.	Teacher 1 makes room for the second child at the table and continues as before, moulding with the clay and expressing interest in what child is telling him/ showing him.	Child relaxes and he and other child play in parallel.
3	Second child leaves. Teacher 1 also moves away to attend to some other children then comes back.	When teacher sits down, child engages him with some intensity. Child says he will make his work bigger and better than the teacher's. He laughs loudly, gets a bit rough with the clay, and is over-bright.	Teacher responds with interest, but is not overbright back**.**	Child looks at teacher more steadily and overbrightness stops. He becomes genuinely interested in what teacher is making and in sharing what he is doing.
4	Teacher1 leaves child to help some other children who are fighting. Teacher 2 comes over to sit with him instead. Child is clearly disappointed that teacher 1 has left. However, he stays with teacher 2. A new child comes over to the craft table.	Child protests to teacher 2 that this child might break teacher 1's work.	Teacher 2 reassures child that she will put it somewhere safe and asks child to think of a safe place. She places the teacher's clay figure in the safe place that the child suggests.	Child remains anxious that new child will take some of his own clay.
5	A third child comes to the craft table and stands near child. Child tells her to go away and that all the clay is his.	Child's bids to teacher 2 are in the form of orders, 'You make this for me! You make it now!'	Teacher 2 settles in each child so that they work calmly with their own clay with no possibility of intrusion on child. She says 'I can see you are worried but it's OK' and then talks with him about the shapes he has asked her to make.	Child stays with teacher but remains ruffled. While he is anxious he continues to boss both the teacher and the other children.

Bid No.	**What comes before?** (Child's immediate experience prior to bid)	**What does child do?** (How direct is child's attachment or play bid?)	**What does teacher do?** (What bids do they respond to?)	**What does child do then?**
6	A fourth child comes over to teacher 2. She is very distressed on separation from her mother. She stands close to child. He offers her one of his clay making tools. She does not take it but stands closer to him. He offers her a different one. She does not take it.	Child looks over to teacher 2 for support.	Teacher tells him that the girl doesn't want to play because she is a bit upset. 'But she will use the tools later. Now she just wants to look'. Teacher asks girl if she would like to sit down and puts her chair beside child.	Child seems pleased that girl sits beside him. He starts to mould the clay again and now politely engages Teacher 2 'excuse me (name), I am making a horse'. Quite soon after, he leaves Teacher 2 and ventures out into the playground. Some of the children are filling watering cans to water the plants. He gets a can and waters the garden like the others.
7	Child finishes watering and looks around the playground a bit lost looking.	He comes back and sits down beside Teacher 2.	She invites him to do some puzzles.	Child accepts her invitation and settles into the first puzzle. He reflects on what he's just been doing with the other children, 'We water the garden so the plants can get a drink and grow'.
8	Teacher 2 goes off for a break and invites Teacher 3 to take her place.	Child asks Teacher 3 to do some puzzles with him. He chooses a very big one.	Teacher and child consult with each other as to where the puzzle pieces go. Teacher 3 lets him take the lead.	Other children come in to watch the puzzle grow. Two boys come in and lean on child's chair. He does not mind. Each time he places a piece correctly he looks at Teacher 3 and smiles. His pleasure is genuine. It comes to the last piece. Child lets out a whoop, 'It goes there'. 'I want to do another one'. He runs inside to choose another puzzle. Meanwhile a girl who has been watching, tips up his completed puzzle and starts to do it herself. He does not mind. He politely comments on how the girl is attempting his old one.
9	Teacher 4 tells child it will soon be group time. She waits while he puts his puzzle away and they walk to group-time together. Teacher 1 sits next to him. Child starts talking to teacher. Teacher I leaves briefly to bring some other children into the group.	Child gets up and approaches Teacher 3 who is reading to the children. He sits beside her, which means he sits facing the children. He points to the pictures and repeats what Teacher 3 says, a bit like a co-teacher.	Teacher 3 allows him to slide in beside her like this. Neither she nor the children draw attention to where he has chosen to sit.	Teacher 1 comes back and sits down with the children in group time. Child gets up and returns to Teacher 1. He sits close to him and attends to the book reading throughout the group.

Table 3.13 recorded the staffs' interventions toward the child. The staff intervened three times compared to the child's nine bids to them. Their interventions occurred around transitions. If one staff left the child another stepped in to support him; or if the children were moving from free play to group time (as in intervention 3) a staff member gave the child support in advance for this transition. The teamwork between the staff was high. They anticipated the support the child needed, rather than reacted to his behaviour.

Table 3.13: Teacher's Interventions to Child in High Positive Relationship

Bid No.	**What comes before?** (Child's immediate experience prior to teacher intervening)	**What does teacher do?** (What is the teacher's intervention?)	**What does child do?** (How does the child respond to the teacher's intervention?)	**How does it end?**
1	Teacher 1 leaves to sort out a dispute between two other children. Child's interest in play falls away. Teacher 2 notices and comes over and sits down with him. Child points to teacher 1. He shows the new teacher what teacher 1 has made with the clay. Teacher 1 is clearly important to him.	Teacher 2 watches child play and asks questions instead of playing in parallel as teacher 1 had done.	Child answers her questions without looking up. He does not spontaneously talk to her.	Child stays with teacher 2. However when other children come over he initially is less able to use teacher 2 as a secure base. He bosses her and the other children and does not wish to share. Over time he settles and his bossiness stops. He then uses the teacher as a secure base to explore from, leaving her to go to water the garden with his peers.
2	Teacher 2 leaves for a break and invites teacher 3 to step into her place and continue to do puzzles with child.	Teacher 3 and child consult with each other as to where the puzzle pieces go. Teacher lets him take the lead.	Child flourishes, completes a very big puzzle and is proud of his achievement. He shares much delight with his teacher.	Other children come to watch and he does not mind**.**
3	It is coming up to a transition.	Teacher 4 comes and squats beside child and tells him that it will soon be group-time.	Child tells teacher 4 his big news, 'I finished it (the big puzzle)'.	He packs away his current puzzle. Teacher waits while he does this, They walk down to group time together.

Case example 2 illustrates the interactive process when the staff member who completed the STRS reported experiencing a low positive relationship with the child (at or below the 25th percentile in Closeness or Total score on STRS scale). Items checked on STRS indicated a pattern where the relationship was experienced as more distant, less affectionate and with less open communication.

Table 3.14 shows that over the period of the observation the child made 13 bids to staff for support. The context for ten of these bids was either that he was not included in play with peers or that this play was failing. The experience of not being included must have felt rejecting, but he did not make his distress obvious to staff. His pattern was the equivalent of going out to play, tripping over (as when the play attempt or play failed) then getting up and running away. He struggled to make a connection with a secure relationship. Instead he asked the staff for functional support (eg a drink of water, bids 1 and 6) or he simply sought proximity to staff (bids 2,11 and 12). The staff responded in kind to his functional requests (eg, got him a drink, found a place for him at the craft table and in the card game). However, they underestimated their own importance to him in providing emotional support. In

the 13 bids that he made there was only one where the natural end-point was relationship repair. In the card game (bid 7) the staff member stayed with the children and the child showed that he could use the relationship with her to calm down and regulate his feelings during the card play. This was the only occasion where he shared positive, if muted affect, with another person.

After the experience of this secure connection his next bid was very direct (bid 8). He approached the same staff member and asked her to join in the card play with he and his peer. Presumably, the secure connection that he had just experienced motivated him to try to re-create it and gave him the confidence to use a clear communication this time. His teacher missed this link and instead responded at the level of 'you know (the rules of) the game so you don't need me'. In bids 9 and 10 he made two more direct attempts to call the teacher back, now when the card game was failing. The last of these (bid 10) drew the teacher to him but did not promote the contact that he wanted. When she left he showed great upset and need for comfort but not in a direct way that was easy for her to respond to. He rushed past her rather than to her and he heightened his affect by throwing himself on the ground. His teacher thought that he was feigning and rebuffed his need for comfort. She was also struggling to make a connection with him and was unable to read 'under' his behaviour and recognise that he genuinely needed comforting but was too fragile to ask directly. After this, he stopped approaching the staff and instead followed peer C in wild, chaotic play.

Table 3.14: Child's Bids to Staff in Low Positive Relationship

Bid No.	**What comes before?** (Child's immediate experience prior to bid)	**What does child do?** (How direct is the child's attachment or play bid?)	**What does teacher do?** (What bids do they respond to?)	**What does child do then?**
1	Parent had left child at the door. Child tries unsuccessfully to join into peer play: either he withdraws when children invite him to play; or others say 'no' when he tries to enter their play.	Asks Teacher1for a drink (teacher is sitting down serving morning tea; child asks by pointing to his cup).	Teacher 1 Gives child a drink (responds to his functional need)	Finishes drink, leaves, wanders
2	He is unsuccessful in joining children's play in the same way as before. He watches others play from the sidelines.	Returns to Teacher 1 who is still sitting down serving morning tea and stands near her.	Teacher does not notice him	Child leaves, wanders.
3	Wandering	Approaches Teacher 2 to join craft activity (painting). Teacher 2 has organised the painting table and stays with the children	Sets child up to paint. Three other children already painting. Teacher 2 stays with them.	Child paints- absorbed in his work.
4	Completes his painting	Stands up to show Teacher 2 his painting.	Two children distract Teacher 2, one of whom puts her painting on top of child's to show teacher first. Child leaves and Teacher 2 tries to call him back by praising his work	Leaves, wanders

Bid No.	**What comes before?** (Child's immediate experience prior to bid)	**What does child do?** (How direct is the child's attachment or play bid?)	**What does teacher do?** (What bids do they respond to?)	**What does child do then?**
			and asking questions about his painting.	
5	Child tries unsuccessfully to join in peer play. He approaches a boy (Peer C) who has just arrived. This boy greets Teacher 2 and doesn't acknowledge child who stands quietly beside him.	Child follows peer C to Teacher 3	Teacher 3 greets both boys, tries to cuddle them	Child runs away from Teacher 3 twice; he follows peer C
6	Follows peer C into peer play with cars. Peer C dobs him in over an accident. He withdraws to the sidelines to watch others play.	Asks Teacher 4 for help to get a drink. Calls 'teacher' from a distance.	Teacher does not hear him). Peers help him instead.	Finishes drink; does not respond to conversation bids from the two helping children.
7	He tries to join-in peer play, a card-game that Peer C is part of. The children do not include him.	Asks Teacher 4 for help to join in the card-game. He stands in front of Teacher 4, calls 'teacher' in an urgent way and points to the card group.	Teacher 4 helps child join card group; she finds a place at the table for child, sits beside him, makes turn-taking safe and predictable; and stays through one complete game.	Child takes his part in the play; uses teacher to manage his feelings (eg, he looks at her in a losing moment and her look back tells him it's OK). He plays on after she leaves.
8	After other children leave, Peer C and child together continue to play the snap card game and they do so successfully	Child invites Teacher 4 back to join in their successful play. He approaches teacher, takes her hand and tries to lead her back	Teacher doesn't take up his invitation, 'I showed you the game'.	Child returns to card play with peer C
9	Peer C wins more of the cards	Child calls to teacher 4 to fix play that is failing (he is finding it hard to manage losing)	Teacher 4 does not hear him	Child keeps playing cards with peer C
10	Peer C wins all cards, declares 'I'm winning'	Child calls out for teacher 4 to fix play that is failing. He calls 'teacher' in an urgent way	Teacher 4 comes over but does not fix play so that the boys stay together. Peer C leaves; Teacher 4 offers child the cards; he chooses some but she does not stay to play with him.	Child gets distressed, rushes past Teacher 4, rather than to her.
11	Child is distressed	It is not clear if he is seeking comfort from Teacher 4 because he has not gone directly to her. He whines and sinks to the	If he is seeking comfort, Teacher 4 rebuffs his bid. She reads his whining and sinking to the floor as	Child wanders, can't settle to any play. He looks at Teacher 4 as he walks past her

Bid No.	**What comes before?** (Child's immediate experience prior to bid)	**What does child do?** (How direct is the child's attachment or play bid?)	**What does teacher do?** (What bids do they respond to?)	**What does child do then?**
		floor in a dramatic way not far from Teacher 4. By keeping proximity to her, it appears that he is showing her his distress.	insincere. 'Don't pretend like that'. She he tells him that she has her own work to do and directs him out to play.	again and then tries to follow peer C.
12	Child tries to join in the same stilt walking activity with buckets as peer C but no-one has buckets to give him.	Child seeks physical proximity from Teacher 4 but does not directly ask for help	Teacher 4 did not see child	Child follows peer C into new peer play with cars; another child asks Teacher 4 to fix play because peer C isn't taking turns. She goes to the boys and stops the conflict but leaves before the three children can play together well.
13	Conflict between peer C and third peer over turn-taking.	Child approaches Teacher 4 to get help for play that is failing; he points to peer C and other child who are not sharing with each other	Teacher 4 directs child back out to play	Child wanders. Bell is rung for outside play. Child follows peer C into peer soccer play. He keeps hold of the ball to support to peer C. Child breaks soccer ball by accident and peer C dobs him in to Teacher 4; child looks distressed but does not go to Teacher 4. Instead, child follows peer C who now swoops on and disrupts other children's play; child copies. Teacher 2 stops this play. Child makes no more bids to staff.

Table 3.15 indicates the staff interventions to the child. In the one and a half hours of the observation, the staff came in once to the child to ask him and a peer to play more gently. Given that they made only one intervention, they may have seen this child as someone who kept to himself and was not a control issue, except when 'mislead' by peer C. His inability to directly seek affectionate contact may have contributed to staff reporting a distant (low positive) relationship with the child.

Table 3.15: Teacher's Interventions to Child in Low Positive Relationship

Bid No.	**What comes before?** (Child's immediate experience prior to teacher intervening)	**What does teacher do?** (What is the teacher's intervention?)	**What does child do?** (How does the child respond to the teacher's intervention?)	**How does it end?**
1	Child follows peer C in the playground and	Teacher 2 called the two boys over to her	Child followed Peer C into another	Peer C still showed chaotic energy by

	copies him as he swoops on and disrupts other children	and asked them to play gently.	part of the playground.	swooping on and disrupting soccer play of other children; child copied the swooping but din not display the intense energy of Peer C.

Case example 3 illustrates the interactive process when the staff member who completed the STRS reported that the relationship was of concern and checked items that fitted an overly dependent pattern (at or above the 70th percentile on the Dependency scale of STRS). When dependency scores are high, teachers check items that give a picture of the child as emotionally ambivalent so that they become uncertain as to how best to help the child. This pattern was evident in the manner that the child in the case example made bids to the staff. It was like he was genuinely unsure about how to ask for help and receive it.

Table 3.16 shows that each of his bids or responses contained something negative that could keep staff off-balance when trying to meet his needs and perhaps reinforce his expectancy that 'big people' were unreliable. His pattern was the mirror opposite to the child in the previous case example in that he heightened rather than hid his attachment needs. For example, when he was corrected for using rude language he fell over 'accidentally on purpose' and asked his teachers for comfort. The first teacher he approached offered the hug that he asked for but he pulled away. He asked help from another staff member when it was clear that she could not be available because she was already comforting a distressed child. The fourth bid that he made for comfort was both intense and dysregulated, taking the teacher by surprise.

Teacher 4 was able to absorb his intensity (the negative bit in his approach) and in doing so, created an opportunity for relationship repair. The child stayed with her rather than moved away too soon. He was able to use the relationship with her to become calm and then he could use her as a secure base to explore from (eg, to attend well in group time).

Table 3.16: Child's Bids to Staff in High Dependent Relationship

Bid No.	**What comes before?** (Child's immediate experience prior to bid)	**What does child do?** (How direct is the child's attachment or play bid?)	**What does teacher do?** (What bids do they respond to?)	**What does child do then?**
1	Mother kisses child goodbye. Teacher asks child to say goodbye to his mother; child calls rudely. Teacher 1 reprimands child.	Child deliberately falls off his chair. He approaches teacher 1 to show her his 'sore' knee and asks her for a hug.	Teacher 1 lifts child to her knee.	Child slides off teacher's knee as soon as he is picked up. He walks away.
2	Child walks from teacher 1 to teacher 2.	Child shows teacher 2 his 'sore' knee.	Teacher 2 asks him what happened.	Child walks away.
3	Child walks from teacher 2 to teacher 3.	Child asks teacher 3 for a bandaid	Teacher 3 is comforting a distressed child. Teacher 1 gets him a bandaid. She and child sit together while she puts it on.	Child walks to the puzzles, where just one child is playing. He plays in parallel for less than one minute then walks to the home corner that is empty of children.
4	Child and Girl 1 have been playing together. This play is disrupted when Girl 1 and another girl get into conversation. Child 'hangs on' in the play by pretending to fall off the slide then come up to them as a puppy for a pat. Teacher 5 arrives at the centre. She gets a delighted greeting from many of the children.	Child walks over to teacher 5 and sits in front of her. Without warning he turns and presses his face into hers. He rubs his face fiercely into hers.	Teacher 5 accepts his unpredictable greeting. She doesn't pull away; instead she seems to absorb his intensity and soften it. He slides onto her lap.	Child stays with teacher 5. When she stands up he holds her hand. Another boy asks her for a cuddle. Child waits and takes her hand again as soon as she is free. Teacher 5 reads the children a story. Child almost sits beside her then appears to reconsider and sits with the children instead. He is attentive through group-time.

Table 3.17 presents the staff's interventions to the child. A different pattern to the two previous examples is immediately apparent in that the staff came into this child frequently (9 interventions from staff compared to three and one respectively in the high positive relationship and low positive examples). The usual reason for the staff to intervene was because the child had got out of his depth and was hitting peers or screaming at them. The child rallied each time staff came in and gave the appearance of being settled and able to return to play. Consequently the staff left, only to be called back again soon, when the child became dysregulated once more. This pattern worked against him experiencing relationship repair, because the staff became caught in a reactive loop instead of staying with the child until he completely calmed.

Table 3.17: Teacher's Interventions to Child in Highly Dependent Relationship

Bid No.	**What comes before?** (Child's immediate experience prior to teacher intervening)	**What does teacher do?** (What is the teacher's intervention?)	**What does child do?** (How does the child respond to the teacher's intervention?)	**How does it end?**
1	Child walks ahead of his mother into childcare. He joins some other children at the play-dough table. His behaviour quickly becomes dysregulated. He grabs all the play dough, squashes it together, puts it around his neck, and greets his friend (Boy 1) with an overbright (anxious) expression.	Teacher 1 comes over to child. She sits down opposite him.	Child steadies once Teacher 1 is there.	Teacher I tries to connect further by asking questions. Child becomes dysregulated again. He throws some of the play dough up in the air. He puts some in his mouth. His mother comes and stands behind him. As soon as she stops talking to another parent, child turns to her, reaches stiffly for her leg and looks at her overbrightly. She kneels beside him. Now he seems sure of her availability because he hugs her with genuine feeling (no overbrightness)
2	Mother kisses child goodbye.	Teacher 1 asks child to say goodbye to his mother.	Child says goodbye rudely 'bye bum,bum,bum'.	Teacher 1 corrects child, 'I don't like that word please'. Child quietly mimics teacher. Then he deliberately falls off his chair and asks his teacher for a hug. Teacher 1 offers him a hug but he pulls away.
3	Child sits in the construction corner. Boy 1 and girl (Girl 1) sit down with him. The girl acknowledges him with a gentle hug.	Teacher 1 sits down with the three children and helps them start their play. They decide what they will do and what materials they need while she is with them. She helps them sort the materials they need then leaves them to play.	Child manages the give and take of play in this group of three.	Child and Boy 1 play together till the next transition (pack-up for morning tea). Boy 1 leads the play and child follows. Child sides with Boy 1 when he refuses to let other children come into their play. He takes toys from other children to bring into his and Boy 1's play.
4	Teacher 3 calls for all the children to pack away. Child unpacks. Boy 2 packs up responsibly. Child teases him by sitting in the basket that Boy 2 is packing into. They get into wild 'silly' play.	Teacher 3 comes over and asks both boys to pack up. She walks off before waiting to see if they comply.	Both children stay in high-energy play (pretending to be bouncing monkeys). They also begin to clear up.	Child teases Boy 2 by saying he has packed away his favourite toy, then he deliberately drops the basket so that all the toys fall out. Boy 2 walks away. Child calls out, 'I'm not going to tidy up'. He leaves as well and other children clear up the toys

Bid No.	**What comes before?** (Child's immediate experience prior to teacher intervening)	**What does teacher do?** (What is the teacher's intervention?)	**What does child do?** (How does the child respond to the teacher's intervention?)	**How does it end?**
5	Child and Girl 1 play in the sand-pit. Boy 2 takes toy from child. Child screams, in the manner of a younger child; he has an emotional 'melt-down'.	Teacher 3 comes over and asks Boy 2 to give the toy back. He refuses. She asks the child to ask him. Boy 2 still refuses.	Although the conflict is not resolved, child appears calm enough to play with Girl 1. Teacher 3 leaves.	When three more children come into the sandpit, child leaves to play on his own.
6	Boy 1 invites child to look at what he can do (jump from a ledge). Child has a play idea that is more risky (he puts a plank over the ledge which up-ends as he 'walks the plank')	Teacher 1 asks child to return the plank to the sand-pit.	Child complies but his behaviour is edgy.	He throws sand on the other children, calls out 'bum- bum' and mock-fights with his friend (Boy 1).
7	Boy 1 invites child to play (dig holes in the sandpit). Child makes better progress than Boy 1 who begins to infill child's hole with sand. Child 'melts down' again and hits Boy 1 repeatedly.	Teacher 2 comes over and stops the hitting. She asks both boys what has happened.	Boys stay together and resume digging. Teacher leaves	Boy 2 trickles sand into child's digging hole. Child teases him back in a good-humoured way. He picks up some fibrous root and says that he has found some of Boy 2's 'hair'.
8	Boy 1 tells child that his own digging hole is bigger than child's. Child gets upset and yells at Boy 2.	Teacher 2 comes over and asks Boy 2 to move away. 'You can have a hole for yourself'	Child steadies and placates Boy 2. 'You can dig a hole deeper than mine'. Teacher 2 leaves.	Boy 2 stays beside child, 'I'm about to fall into your hole, my hair is about to fall into your hole'. He holds up some of the fibrous plant that the child had found earlier. Child laughs at Boy 2's joke. Girl 1 comes and digs beside child. He helps her with her digging. Later on Boy 1 and Boy 2 use graders to push sand into child's digging hole. He gets frustrated but does not scream or hit out. Instead he follows Girl 1. He crawls after her pretending to be a puppy dog.
9	Girl 1 looks after child; she tells him to keep his hat on so he won't have to sit on the veranda; she finds the toy that Boy 2 had taken from him. She gives this to child. Child crawls along beside her, still as a puppy dog. They sit on the far side of the playground where there are no other children.	Teacher 4 comes over and greets the two children but does not stay.	Child stays with Girl 1. She tries to be affectionate or mothering. He pretends to be a bouncy puppy and slides down the slide before she can hug him.	Another girl comes over and she and Girl 1 talk. Child stays with them by pretending to fall off the slide then come up to them as a puppy for a pat.

The three case examples were chosen to illustrate the interactive process between staff and children when staff reported highly positive relationships versus those of high concern (low positive relationship or highly conflictual or dependent). In each of the examples, the children were often indirect in how they expressed their needs. They wanted connection but could not 'just be themselves' to ask for this. The staff had to read between the lines to work out how best to support them. In the case example where the staff member reported a positive relationship, three themes stood out.

Staff were able to read 'under' the child's behaviour to and respond to his genuine attachment needs.

As well a behavioural management that addressed stopping negative behaviour they also followed up with relationship repair. This process of relationship repair was not a feature in the two examples where relationships were described as troubled. In the process of relationship repair the adult not only 'walks the children through' difficult situations, but assists them back to a calm state when things go wrong. With this relationship repair support, the child's behavioural and emotional capabilities improved over the course of the observation. He shared delight with his teachers and was able to use them as a secure base for play and learning.

Teamwork between the staff on behalf of this child was apparent and made for smooth transitions.

4 Conclusion – Factors Leading to Successful Outcomes for Children at Risk in Children's Services

The discussion is framed around the fourth question that the research project asked, namely, 'What recommendations can be made for a model of best practice within children's services for children at risk?'

The findings have three implications.

1. Ensure entry support for the children's services placement (with DoCS follow-up of the referral to check that the enrolment goes ahead);
2. Prioritise relationship support for the children in the children's services; and
3. Provide back-up for children's services practitioners (in the form of a network of services that staff can draw on to help them manage the children). These services need to support staff at the children's services, in the context where the children are experiencing difficulties.

Entry support

The cohort study found that the offer of a place in a children's service was protective with 18 of the 19 children remaining within their families over the 12 month period, after they had enrolled in the children's service. The number of re-notifications significantly reduced once the children attended a children's service. Fifty-six sixty percent of the sample had no further reports and an increase in the number report occurred in only 2 cases. .

Once parents enrolled their child into the children's service, the service became a very stable support for the family. It gave them an anchor point when much else was stressful and chaotic in their family lives eg, some families struggled to find permanent accommodation with up to four moves in 12 months. A commonly reported stress was conflict and arguments within the family that upset the children.

What was missing, however, was support around the enrolment in the children's service. Failed referrals were high, where parents did not follow through with the enrolment and DoCS did not check to see if the referral progressed. The process of recruiting families into the cohort study showed a pattern of failed referrals where there was not consistent follow-up by DoCS. In contrast, the cohort study showed that if families had transition support into the service, then the families' use of children's services remained stable.

Prioritise Relationship support

Findings from the cohort study give three reasons why relationship support should be a priority for the children entering preschool or child care. The first reason is that the PSI data, where parents reported on the stress of parenting, showed that many of the children were at risk of growing up in distressed relationships at home. At each time period in the follow-up (initial, six and twelve months) 40 per cent of parents reported either distressed interactions with their children or distress because they found their children difficult to manage. The level of their distress was at the clinically worrisome level where intervention is recommended. Distress in managing their children's behaviour increased with the age of the child and when parents reported that their

children were difficult they were also more likely to report that their interactions with their children were less rewarding and that their own self –esteem as parents was lower. When parents are distressed like this they are less able to visualise the needs of their children and their parenting may become more punitive and coercive as a result (Kobak and Esposito, 2002). .

The second reason for recommending relationship support for the children at childcare comes from the findings that both parents and children's services practitioners identified the children as having difficulties in emotional regulation. On the basis of their reports on the Child Behaviour Checklist at the 12 month follow-up, a quarter of the children scored in the borderline or clinical range for emotional regulation problems (this is where the severity of the children's difficulties is within the top 2-7 per cent for severity compared to same-aged peers). Parents and teachers did not always pick up the same children as having difficulties. When either parent or staff report was used to identify children at risk for emotional regulation difficulties, the percentage of children that met clinical criteria for support rose to above fifty percent for externalising problems like aggression; and 29 per cent for internalising problems like emotional reactivity and anxiety.

Emotional regulation is learnt within relationships. 'Intense negative *and* positive emotional experiences that are beyond the capacity of the child to self-regulate are managed (coregulated) with the help of the caregiver. Through the process of emotional coregulation, the child's self-regulation ability is enhanced (Cooper et al, 2005, p. 138)'. While most research has focused on how the parent-child relationship facilitates emotional regulation capacity in the child (Schore), teacher-child relationships also support emotional development and emotional regulation in children (Denham and Burton, 1996). These same relationships support the development of peer relationships (Elicker, Egeland and Sroufe, 1992; Howes, Matheson and Hamilton, 1994).

Emotional regulation is one of the foundation capacities that children need in order to be prepared to go to school. Resources to facilitate emotional regulation skills should be placed at least on a par with programs focused on numeracy and literacy and general school readiness. The recent report by Professor Tony Vinsome into 20 preschools attached to public schools in disadvantaged areas of NSW, found a lack of school readiness in the children with many of the children having speech delays. In the cohort study, sixty percent of the children also experienced speech delays; the children's difficulties with emotional regulation is just as concerning.

The third reason for prioritising relationship support for the children was that the children's services staff reported that it was difficult to make secure or positive relationships with many of the children. When children's services staff reported on the quality of their relationship with the children, 45 per cent checked responses that indicated that they were concerned because the relationships felt distant, (less affectionate and less open communication). Twenty five percent reported relationships with the children that felt either highly conflictual or highly dependent.

This is consistent with child protection research with older children, that has shown that while the children report a desire to be close to teachers, at risk or maltreated children tend to behave toward teachers in less positive ways than children not at risk (Lynch and Cicchetti, 1992). When they are distressed these children often cope by being very controlling and cannot rely on or value the judgments of adults at the very time that

they need the support of an 'older and wiser' person (Hughes, 1997). The childcare observation examples that were used to illustrate the process of communication between children and staff indicated that the children were not always direct in signalling what they needed, so that the teachers were faced with second-guessing what help the children required. Sometimes the children behaved in a controlling way, sometimes they were resistive to the help that they sought and sometimes they hid their need for support.

The two case examples that were used to illustrate the interactive process when relationships were reported as of high concern, indicated a pattern of response that would be important to investigate further. Both examples contained very few instances of relationship repair in the staff's interactions with children. This was in contrast to the case example used to illustrate the interactive process when the staff member reported that the relationship was very positive (as measured on STRS). In that example, relationship repair was consistently the natural ending to the child's approach for help.

Relationship repair is the process whereby the adult helps the child with strategies to move from distressed feelings or upset and chaotic behaviour back to a calm state. In the case examples where this did not happen, it appeared that the staff underestimated the great need of the children for this kind of support and the important role that relationship repair plays in helping children to learn emotional regulation.

The NSW Curriculum Framework for Children's Services in NSW, which is called the 'Practice of Relationships', prioritises relationship support for children in childcare and preschool. The childcare observations highlight that one significant component of relationship support is the process through which staff can offer children relationship repair. From a behavioural management perspective, when things go wrong or the child does something that you don't want them to do, the natural end-point is to stop the negative behaviour (eg stop the aggression, stop the dispute between the child and his peer, fix up play that is failing). From a relationship support perspective there is an extra step and that is relationship repair. The adult touches base with the child so that the relationship between themselves and the child is re-established. In relationship repair the adult 'walks the children through' difficult situations and assists them back to a calm state when things go wrong. The emphasis on relationship repair would involve a shift from training in behaviour management techniques to support staff to build relationship capacity.

An intervention model (Dozier and Sepulveda, 2004) has been developed for foster carers to build their relationship capacity as a way to support them to manage children with emotional difficulties. The same program would appear very applicable to support staff in children's services to care for children at risk. The program has three components: (1) learning to interpret the children's cues and signals, especially when these are not direct; (2) providing nurturing care even when it does not come naturally and; (3) providing a responsive interpersonal would so that the children can develop their regulatory capabilities. In children's services the latter could be done at both a classroom and individual level by focusing on ways to heighten the availability and predictability of staff; and to practice relationship repair.

Back-up for children's services practitioners

As reported above, the findings of the cohort study indicated that the children coming into the children's services presented with emotional and behavioural difficulties and also developmental problems like speech delay. The other finding was that staff were highly effective in seeking out help for the children, through organising referrals and services for the children. The CSA's were a firm support for staff in helping them to organise referrals. Unlike, the findings reported in the Vinsom study, children's services staff were successful in accessing speech assessment and therapy for 9 of the 12 children where staff were concerned that the children had a speech delay. Of these children, eight accessed therapy. In 50 per cent of these cases the therapy was offered on site, so that the staff were given feedback on how to support the children. The remaining child was placed on a waiting list for therapy.

It was a different scenario when the staff sought help for the children's emotional and behavioural difficulties. While they were effective in accessing support, the referrals were most likely to be to a tertiary level of care such as paediatric assessment. All four children who were referred for paediatric assessment (either by staff or the children's parents) were diagnosed with ADD or ADHD. When it was a behavioural or emotional concern that they staff had about the children, it was difficult for them to access services that would work in partnership with them and support them on the ground and see the children in the context in which they were having difficulty.

The cohort study, especially the child development observations, has highlighted the emotional work of childcare. Preschool and childcare staff work in a field that involves intense emotional relationships, but often do not benefit from the informed support or 'reflective consultations' that other professionals have access to. In order to offer the children a secure emotional base they need effective back-up themselves. What determines whether a child develops a secure attachment with a particular childcare provider are the caregiver's state of mind in regard to attachment, and the child's expectations about the availability and responsiveness of adults (Ritchie and Howes, 2003). On this basis, effective back-up support should be of a kind that helps staff understand the emotional needs of the children so that they can be more available to them; and that helps the staff become more aware of their own emotional responses in response to the children and to develop comfort in managing negative emotions so that they in turn can help the children.

One project that has taken this approach in Australia is a joint collaboration between the Benevolent society and KU children's services in a preschool where many of the children were like the cohort children. They experienced distressed relationships at home and the children at preschool presented with emotional and behavioural difficulties that were of concern to staff. The preschool was also part of the Learning Togethers program that took referrals from DoCs for children with physical, emotional and developmental disabilities. The program is called 'Attachment Matters - from relationships to learning at preschool' and one of its significant component is layered support for reflective practice for staff. Each person in the preschool community has someone to turn to if they are unsure about what the children need. A psychologist works alongside the staff four mornings a week. She provides a secure base for the staff to help them become more sensitive to the children's feelings and more aware of their own. The staff make video-clips of the children and these are reviewed with the psychologist and the clinical consultant to the project. Together they reflect on the

children's needs, guided by materials from the Circle of Security Project (Marvin et al, 2002). The evaluation of this project after twelve months of intervention indicated that emotional and behavioural difficulties (as measured on the Child Behaviour Checklist) reduced in severity from pre to post test by 62 per cent. Staff changed in how they viewed their relationship with the children, shifting from concerns about control to emphasis on being a reliable source of comfort and emotional support to the children They enjoyed the children more, with more positive memories Staff turnover was reduced (Dolby et al, 2004; 2006). An intervention program based on this model is being delivered to support staff in 15 childcare centres and preschools through the Partnerships in Early Childhood Project (The Benevolent Society).

Children's service was affordable for families

Parents/grandparents found the children's services arrangements affordable. The usual arrangement was for DoCS to fund the placement for thirteen weeks then the parent paid the fees. For these families substantial part of the fee was covered by the Child Care Benefit allowance. Three families could not afford the fees; in each case the Director of the Children's service kept the children enrolled and carried the costs incurred until the problem could be sorted out with DoCs (reach proved slow and frustrating to get resolved).

Families who used a children's service were positive

Parents and grandparents evaluated the offer of a place in a children's service for their child positively. They regarded the offer as beneficial to both themselves and their child. It gave them respite and they felt that the placement helped their child learn to play with other children and to develop school readiness skills. This positive regard for the beneficial impact of children's services on their children must be tempered by the other findings, that showed that the children were at risk for severe behavioural and emotional problems. The foundation that the children needed in order to develop school readiness skills was high relationship support to facilitate emotional regulation function.

The project has also highlighted a gap between the socio-emotional skills of the children and what would be required of them at school. A common concern of the children's services staff was that the children were not emotionally ready for the demands of school but that age-wise they were required to go or eligible to start school. Parents sometimes opted to send children to school at a younger age because this was less costly. In view of this concern and the findings regarding the children's speech and socio-emotional needs, the industry partner, the Department of Community Services in NSW made funds available to fund the follow-up of these children into school.

Children entering the children's service had high needs for relationship support

The children had high needs for relationship support (based on both parent and children's services practitioner reports of the children's difficulties in emotional regulation). Emotional regulation is learnt within close relationships. Parents and teachers did not always pick up the same children as having difficulties. When either parent or staff report on CBCL to identify children at risk for emotional regulation difficulties, the percentage of children that met clinical criteria for support rose to above fifty percent for externalising problems like aggression. If one took only parent report or only staff report approximately a quarter of the children met the clinical

criteria for intervention (ie, the Borderline and/or Clinical range for extremity of difficulty).

When children's services staff reported on the quality of their relationship with the children, 45 per cent checked responses that indicated that they were concerned because the relationships felt distant, (less affectionate and less open communication). Twenty five percent reported relationships with the children that felt either highly conflictual or highly dependent. This picture of relationship difficulty was consistent with reports by both staff and parents of a similar proportion of the children showing severe difficulty in managing their feelings. The case examples illustrated that when the children experienced a secure relationship connection, this gave them the confidence to communicate clearly the next time and to use the adult as a secure base to explore from (ie the relationship opened up learning opportunities). Three themes stood out in the case example used to illustrate staff's rating of a high positive relationship: the staff were able to read 'under' the child's behaviour to and respond to his genuine attachment needs; they consistently ended each interaction with relationship repair; and they showed teamwork in their care of the child.

The project was able to identify key features for a model of best practice within children's services for children at risk. These include

Support for parents and follow-up from DOCS to make the transition into childcare successful referrals (without this support and follow-up often failed).

Back-up for children's service staff to help them support the children and remain focused on relationship support for the children.

The case examples indicate features that make for good relationship support. These include:

- a framework that gives staff a coherent understanding of children's needs;
- to use relationship repair as the step after behavioural management; and
- staff teamwork on behalf of the child.

The findings highlight the need to promote the child protection role that children's services can play in the wider community and the consequent better utilisation of their services. They draw attention to the emotional support that is offered to families (not just a safe physical environment for the child) and shows how such support helps parents access other services earlier and more effectively both for themselves and their children. It further highlights the importance of high quality children's services in enhancing the development of children, particularly those from disadvantaged families. The project highlights the need to address the training and resource needs for children's service staff when working with families at risk.

Appendix A Cohort Study Interview Schedules and Standardised Measures

Measures used to assess parenting stress and difficulties in the parent-child relationship

Parents completed the short form of the Parenting Stress Index (PSI) (Abidin, 1995) at the three time periods: when they enrolled in the study, and 6 months and 12 months later. A parent's total stress score 'reflects the stresses reported in the areas of personal parental distress, stresses derived from the parent's interaction with the child, and stresses that result from the child's behavioural characteristics (Abidin, 1995, p.55). It measures the stress related to being a parent as distinct from external stress like financial and housing problems, and domestic violence.[13] The latter was assessed using the Life Events Inventory (Sandler and Block, 1979).

The primary caregivers of the children completed the questionnaire. Eight of the primary caregivers were single mothers; two had two children who were followed in the study and they completed separate questionnaires based on their relationship with each child. Two primary caregivers were single fathers. Three primary caregivers were grandparents, one of whom was caring for two children who were in the follow-up. Again she completed a separate questionnaire based on her relationship with each child. Six of the primary caregivers were in couple relationships.

At the 12-month follow-up, parents also completed the Child Behaviour Checklist for ages 1.5 - 5 years (Achenbach and Rescorla, 2000) to gain additional information about any difficulties that the parents were experiencing with their child and to provide a comparison point for parents and children's service providers who also completed the checklist.[14] The

[13] The Parent Stress Index (PSI) includes 36 items which are negatively worded (e.g. 'my child seems to cry or fuss more often than most children do'). Caregivers respond by rating their strength of agreement or disagreement on a 5-point scale where 'strongly agree' gives a value of 5 and 'strongly disagree' gives a value of 1. Each of the sub-scales allows a minimum score of 12 and a maximum score of 60. The Parenting Stress Index consists of five scales: Total Stress, Parental Distress, Parent-Child Dysfunctional Interaction, Difficult Child and Defensive Responding. The three scales of *Parental Distress*, *Parent-Child Dysfunctional Interaction* and *Difficult Child* make up the Total Stress Score. Items in Parental Distress assess a parent's sense of self-esteem and feelings of competency as a parent. Items in the Parent-Child Dysfunctional Interaction scale assess to what extent the parents feel that their child is not meeting their expectations and that parent-child interactions are not rewarding. Items in the Difficult Child scale assess to what extent parents find it difficult to set limits and gain their child's co-operation. The *Defensive Responding* scale supplies a check on the validity of the parents' responses. The Total Stress score is a simple aggregate of the sub-scales (a minimum of 36 and a maximum score of 180). A score of 10 or below on the scale may indicate that the parent is giving a positive impression to the interviewer and is unable to acknowledge the frustrations, annoyances and pressures of parenting. Raw scores on each scale can be converted to percentiles. The normal range for scores is within the 15th to 80th percentiles. High scores, as a marker for clinical intervention, are considered to be scores at or above the 85th percentile.

[14] The Checklist presents a comprehensive list of behavioural and emotional difficulties in children and parents were asked whether each item on the list was somewhat true of their child, very true or did not apply at all. The Child Behavior Checklist that parents completed is scored on two cross-informant scales: the DSM-Oriented Scales and the Empirically-Based Scales. The DSM-Oriented Scales comprise problems judged consistent with diagnostic categories of the 4th Edition of the American Psychiatric Association's (1994) Diagnostic and Statistical Manual (DSM-IV). The scales correspond to the following diagnoses: Affective Problems; Anxiety Problems; Pervasive Developmental Problems; Attention Deficit/Hyperactivity Problems and Oppositional Defiant Problems.

scales provide a profile of the child's style of emotional regulation. Difficulties are identified in the form of internalising problems (emotionally reactive, anxious/depressed, somatic complaints, withdrawn) and externalising problems (attention difficulties and aggressive behaviour). Both sets of problems can be compared with standardised norms to gauge the extremity of the emotional or behavioural difficulty in the children.

Measures used in interviews with children's services workers

Assessment of Children's Behaviour and Emotional Development: The measure to assess children's behaviour and emotional development was the Caregiver-Teacher Report Form for Ages 2 to 5 years (Achenbach, 1997). The Teacher Report form consists of empirically-based scales that assess the quality of the child's emotional regulation. Difficulties are reported in terms of Internalising Problems (anxious/obsessive; depressed/withdrawn and fears) and Externalising Problems (attention problems and aggressive behaviour). Children's services staff completed the Teacher Report form at the 12-month follow-up and their responses were compared with parents' 12-month report on the Child Behaviour Checklist (CBCL). The two questionnaires can be compared on the dimensions of Internalising and Externalising Problems.

Assessment of Quality of Relationship: The Student-Teacher Relationship Scale (STRS) (Pianta, 2001) was used to assess the children's services practitioners' perceptions of the quality of their relationship with the children. The STRS is appropriate for children of preschool age up to eight years and has been used with children's services staff in the US and Australia (The Australian Longitudinal study). It is a self-report questionnaire that assesses a teacher's or children's services practitioner's perception of his or her relationship with a child, the pattern of the child's relating to the teacher, and the teacher's belief about how close the child feels towards them.

The STRS defines child-teacher relationship patterns in terms of *conflict, closeness* and *dependency*, as well as the overall quality of the relationship. Percentiles at or above 75 for the conflict and dependency subscales indicate high levels of concern about the relationship on the teacher's part and Pianta uses the 75th percentile as a marker to recommend intervention to offer the teachers support. Similarly, *closeness* or total scale percentiles at or below 25 indicate significantly low levels of a positive relationship and in this case the 25th percentile is a marker for supporting the teacher. Percentiles at or above 75 for the *closeness* subscale and the total scale are used as a marker for a significantly high level of positive qualities in the relationship (Pianta 2001. P12).

Record of Support Services Accessed for the Children and Families: The children's services worker and/or director were asked if they had accessed any services on behalf of the children and the families, whether the families attended the service and whether any services were supplied on site.

Child Development Observations

The child development observations were designed to observe the interactive process between staff and children. Each child was observed twice, and the observations were 12 months apart. In this report, selected observations will be used as case examples to

illustrate the interactive process when teacher-child relationships are clearly positive (above the 75th percentile in *closeness* or total score on the STRS scale) or are in trouble (above the 75th percentile for conflict or dependency or below the 25th percentile for closeness).

Measures used in the child development observations

Several measures were trialled to conduct and score the observations, including the Attachment Q sort (Waters 1995), the *Emotional Availability* Scales (Biringen, 1990) and a time-sampling schedule (Watson and Harrison, 2002). The Attachment Q sort and the Emotional Availability scales did not fit the context for the observations as both procedures assess single staff-child relationships. In the child care and preschool contexts being observed it was usual for the children to relate to several staff (up to five) and not to be attached to a single staff member. Watson and Harrison's (2002) time-sampling schedule, which tracks the frequency and quality of the bids children make to peers and all staff and receive from them, better fitted the varied and dis-continuous relationships being observed. Instead of using time–sampling, a running diary was kept of the bids that the children made to staff and other children and received from them. These notes were written out in detail after the observation was completed and then summarised into table format as follows. The table format was developed by Associate Professor Judy Ungerer (Macquarie University) and Dr Robyn Dolby (SPRC) after pilot testing of the observations.

Appendix B Scoring of Parenting Stress Index

Table 1: Scoring of Parenting Stress Index (PSI Short Form) and Life Events Inventory: Initial interview

ID	DefensResponding	Parental Distress (PD)	%ile Range	Parent-child Dysfunctional interaction (P-CDI)	%ile Range	Difficult Child (DC)	%ile Range	Total Stress	%ile Range	Life Events No of Yes's
1	19	31	80	29	95	39	95	99	95	3
2	30			34	99	36	90			15
3	22	35	90	25	80	41	95	101	95	3
4	25	39	95	14	20	18	15	71	55	4
5	20	30	75	25	80	29	70	84	80	9
6	20	31	80	25	80	22	30	78	75	13
7	20	31	80	25	80	22	30	78	75	13
8	18	26	55	28	90	36	90	90	90	10
9	30	45	99	39	99	54	99	138	99	19
10	23	40	95	21	60	46	99	107	99	12
11	23	36	90	16	35	26	55	78	75	12
12	12	21	25	19	50	23	35	63	30	10
13	12	21	25	19	50	23	35	63	30	10
14	20	33	85	22	65	28	65	83	80	17
15	20	33	85	22	65	28	65	83	80	17
16	23	33	85	31	95	33	85	97	95	13
17	-	-	-	-	-	-	-	-	-	-
18	20	31	80	17	40	25	50	73	60	10
19	14	24	40	14	20	24	40	62	25	10
20	21	31	80	26	85	26	55	83	80	9
21	19	28	65	31	95	39	95	98	95	4
22	11	16	10	13	10	18	15	47	5	7

Note 1 ID 17 Parents have intellectual disability preventing them completing the questionnaire

Note 2 When parents have not completed two or more questions in any one sub-scale their data are not entered for that subscale or for the Total Stress score.

Table 2: Scoring of Parenting Stress Index (PSI Short Form) and Life Events Inventory: 6 month follow-up

ID	DefensResponding	Parental Distress (PD)	%ile Range	Parent-child Dysfunctional interaction (P-CDI)	%ile Range	Difficult Child (DC)	%ile Range	Total Stress	%ile Range	Life Events No of Yes's
1	16	28	65	27	90	29	70	84	80	3
2	29			34	99	35	90			12
3	-	-	-	-	-	-	-	-	-	-
4	22	32	80	12	5	17	10	61	25	3
5	20	30	75	25	80	28	65	83	80	7
6	14	22	30	25	80	27	60	74	60	13
7	14	22	30	25	80	27	60	74	60	13
8	22	40	95h	29	95	33	85	102	95	10
9										
10	23	36	90	21	60	41	95	98	95	6
11	23	36	90	17	40	24	40	77	70	6
12	8	16	5	23	70	34	85	73	60	2
13	8	16	5	21	60	26	55	63	30	2
14	12	20	20	-	21	25				12
15	12	20	20	-	21	25				12
16	17	29	70	28	90	34	85	91	90	5
17	-	-	-	-	-	-	-	-	-	-
18	18	30	75	17	40	26	55	73	60	6
19	8	14	5	13	10	23	35	50	10	5
20	-	-	-	-	-	-	-	-		-
21	16	26	55	36	99	41	95	103	99	1
22	18	31	80	16	35	23	35	70	50	4

Note 1 ID3 Data missing
ID 9 was lost to follow-up; mother moved location and child care centre closed down
ID 17 Parents have intellectual disability preventing them completing the questionnaire
ID 20 Parent and child moved interstate.

Note 2 When parents have not completed two or more questions in any one sub-scale their data are not entered for that subscale or for the Total Stress score.

Table 3: Scoring of Parenting Stress Index (PSI Short Form) and Life Events Inventory: 12 month follow-up

ID	DefensResponding	Parental Distress (PD)	%ile Range	Parent-child Dysfunctional interaction (P-CDI)	%ile Range	Difficult Child (DC)	%ile Range	Total Stress	%ile Range	Life Events No of Yes's
1	16	27	60N	26	85	27	60N	80	75N	7
2	Out	Out	Out	Out	Out	Out	Out	Out	Out	Out
3	23	35	90	33	99	43	95	111	99	16
4	21	31	80	12	5	17	10	60	20	2
5	18	27	60	25	80	27	60	79	75	5
6	16	24	40	26	85	27	60	77	70	9
7	16	24	40	26	85	27	60	77	70	13
8	15	27	60	26	85	37	90	90	90	11
9	-	-	-	-	-	-	-	-	-	-
10	23	37	90	22	65	45	99	104	95	14
11	23	37	90	21	60	30	75	88	88	15
12	9	17	10	23	70	-		-	-	2
13	9	17	10	19	50	-	-	-	-	2
14	19	31	80	23	70	32	80	86	85	13
15	19	31	80	20	55	32	80	83	80	13
16	21	33	85	27	90	27	60	87	85	2
17	-	-	-	-	-	-	-	-	-	-
18	21	35	85	17	40	25	50	77	70	8
19	9	14	5	12	5	23	35	49	10	1
20	-	-	-	-	-	-	-	-	-	-
21	16	26	55	-	-	36	90	-		0
22	9	18	15	19	50	27	60	64	35	5

Note: ID2 had been removed from mother's care into relative (grandparent care)
ID 9 was lost to follow-up; mother moved location and child care centre closed down
ID 17 Parents have intellectual disability preventing them completing the questionnaire
ID 20 Parent and child moved interstate.

Note 2 When parents have not completed two or more questions in any one sub-scale their data are not entered for that subscale or for the Total Stress score.

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