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Legislative Select Committee submission: Tasmanian Child and Family Centres.

Dear Clerk of the Select Committee, please accept the following response to your call for submissions.

In the submission that follows, we respond sequentially to the issues that the submission needs to address. We are presenting our opinions based firstly on our long experience as Senior Clinical Psychologists working with children and families. Secondly we have both been involved with one of the Child and Family Centres, Ptunarra, on a weekly basis for the last year running a group for parents and children at the centre that we have called "Feed and Read", featuring a story to enhance literacy and a meal to support nutritional health values. One of us has also functioned as a consultant on a monthly basis to four of the Centres in the Southern Area, almost since the inception of the projects.

In that sense we bring to our submission a unique perspective, drawn both from our observations through direct weekly contact with the Centre, but also informed by our professional experience.

Names and sometimes circumstances have been altered to provide confidentiality.

WHO WE ARE:

Brad Freeman is a Senior Clinical Psychologist with over thirty years experience working in Infant, Child and Adolescent Mental Health. He has worked extensively in Child and Adolescent Mental Health Teams (CAMHS) in Sydney and here in Tasmania. While working in Tasmania, he has provided consultation and supervision to a wide variety of services, in the field of infant, child and adolescent mental health including to child protection services,, Early Childhood Nurses, and staff of the five child and family Centres in the Southern Tasmania region. Brad has implemented and provided training to staff of the Tasmanian Child and Family Centres in attachment theory, infant development and group processes. He has also conducted a private practice specialising in early childhood mental health and attachment disorders for the last 20 years. Brad has been a University of Tasmania staff member teaching the course "Perinatal and Infant Mental Health".

Dr Penny Jools is a Senior Clinical Psychologist working with children and families with over forty years of clinical experience. She has published in relevant journals, presented at International conferences and is currently the Senior editor and a major contributor to the publication pending book, "The Family Within: Object Relations Psychotherapy with Children and Families" (Routledge and Kegan Paul). She has worked in both the public Mental Health Sector with inpatient and community clients. She has also set up and conducted a well regarded private practice in the centre of Sydney NSW. As a Senior Psychologist she has extensive experience both as a psychotherapist and clinical supervisor, working with children and families.

OVERVIEW OF OUR OPINION OF THE ROLE AND FUNCTIONING OF THE CENTRES:

1. CHALLENGES AND BENEFITS OF THE PROVISION OF AN INTEGRATED COLLABORATIVE HEALTH AND WELLBEING AND EARLY EDUCATION AND CARE SERVICE DELIVERY MODEL.

WE STRONGLY SUPPORT THE INTEGRATED MODEL FOR THESE CENTRES FOR THE FOLLOWING REASONS:

IN GENERAL:

Staff have become highly skilled in managing an inclusive, welcoming and highly supportive milieu environment, which despite its informality, provides very specific mental health and attachment enhancing interventions. Visitors do not experience the centres as "institutions" conducted in a state of bureaucratic removal from everyday concerns. Rather, Visitors feel welcomed, personally related to and supported. Because many of the families attending the centres have experienced generations of disrupted attachment, the centres come to function like benign and supportive grandparents or extended family, This "good enough" experience of meeting with staff, coming to participate in groups or informal events, such as lunches and incidental play enables families to have more confidence in educators and the transition into school based learning.

The benefits the centres provide include the following;

a. **Access to resources and assessment:**

They provide accessible, local and informed brokerage to the most vulnerable, deprived and least trusting members of the community, enabling families and children to receive services they would not otherwise be able to access. They do this fundamentally by careful and timely relationship building with attendees, in a context of a supportive and safe, child and family friendly environment. The centres have acquired over the five years of their functioning, considerable trust and respect within their sometimes embattled communities.

Attending children and infants receive supportive assessment which identifies difficulties early in the child's life and allows appropriate and supported referral to further asses and remediate difficulties.

> Carl is 2.5 years old. His mother is on a supporting parent pension. Staff identified that Carl's language development was delayed and he was still unable to form sentences and make himself understood. He was referred to a speech pathologist, with staff assisting his mother in having the confidence to make and keep her appointments.

b. **Enhancing and promoting attachment:**

One of the issues we noticed when we first went to Ptunarra and identified at other centres, was that parents tended to cluster in the kitchen while the children ran around outside or were managed by staff. Over time, centres have observed a change with parents showing more interest and involvement with their children. Feed and Read at Ptunarra has been part of this. The centres effectively demonstrate values of child care, safety and responsiveness, which generalise into the

child's home, enabling significant behavioural change for many children and parents towards the kind of enhanced attachment security likely to bring about lifelong improvements in mental health and wellbeing.

Matty is 2.5 and witnessed his sister dying in a motor vehicle accident which took place while his mother was driving under the influence. She herself was significantly injured. Over the course of several weeks of clingy, anxious and demanding behaviour in which he is seen to reject his mother's offers to help, slapping her hands away, leading mother to scowl at Matty and accidentally press on his injured arm, in order to stop him falling over. Witnessing this cycle, staff support Matty and mother to begin to play together in the sand pit. Mother is gradually able to tell her story to staff and feel that attending the centre is safe and not judging her for the tragic circumstances, gradually enabling her to interact with Matty in a less controlling and rejecting fashion. This enables Matty to feel safer with his mother and take more pleasure in their interactions. He stops whining and demanding his mothers presence adjacent to him, and begins to smile and take pleasure when his mother attend. Together they explore the toy vehicles.

In addition, parents have access to quality parenting programs and child enrichment/stimulation early in the child's life which contributes to school readiness.

- Josie was initially gruff and tough in her presence around the centre. She would give her 3 kids under five, a wallop on the backside, if she thought her kids were making too much noise. But over time the staff, brought to her attention the manner in which the children tended to avoid her, made little use of her when they were anxious, and headed off, to play independently when possible. Josie enrolled in a "tuning into kids" group, and is now observably more involved and supportive of the children if they are anxious or frustrated. The children now readily make use of her and prefer to be with, rather than away from their mother.

c. Reducing parental isolation

Parental isolation is significantly reduced, for parents/carers, who often attend weekly or more on a voluntary basis, leading to reduced likelihood of child abuse and neglect.

- Yvonne was a very socially isolated woman who brought her 3 year old child to the centre on a regular basis. She did not socialise with the other parents or staff. After a year of attendance she disclosed to one of the staff that she was a victim of domestic violence and was living quietly to avoid discovery by the perpetrator and to protect her daughter. After the disclosure she started to socialise more with other parents. Her daughter has made a successful transition to school because of the socialisation she received at the centre, that she would not have experienced at home.

d. involving fathers:

We became aware at the end of 2016 that there had been 4 suicides of men in the Derwent Valley community. This had a major impact on the parents and children attending the Centre and on the staff, who knew some of the men. In 2017 the staff have started a Mens Group on Thursday morning where men come with the children. The men in the group are starting to open up about their own backgrounds and difficulties, not least of which is the isolation they feel in the community when they are caring for children.

e. children at risk

The staff are especially available to intervene early where children are identified as at risk. They can offer support and referral to achieve better child protection outcomes. This is made possible in a way achieved by few other services, because trust and good will has been established. Additionally, the centres regularly assist with family crisis mediation and enable estranged or marginalised fathers to be acknowledged and supported.

- Vince is a single father with an autistic 5 year old and a somewhat developmentally delayed two year old. He is on a supporting parents pension and has suffered from severe depression since the children's mother left abruptly, with a local drug dealer. Vince often talks with staff about his struggles to manage the children without hurting them. His depression has been reduced and confidence improved by being able to participate as a volunteer, helping to buy and organise for a food co op.
- Hillary, lost her temper with her two year old in a context of drinking heavily while home alone. Staff noticed bruising and avoidant behaviour in Delaware, and made a notification to **child protection** services. Although initially enraged by the notification, staff worked through the necessity of supporting mother and child firmly and compassionately, enabling Hillary to be referred for her undiagnosed mental health problems stemming from a history of her own child abuse which only became known to staff when they inquired about the stresses that had led Hillary to hit Delaware.
- Greg is good with his kids, but cannot restrain himself from verbally abusing their mother, who split up with him 2/12 ago. The centre provides a safe place for him to have weekly access with his three children under five, without her having to be exposed to him. Staff are working towards mediating their relationship so that he can appreciate how important parental cooperation is to the children.

2.THE ROLE OF CHILD AND FAMILY CENTRES IN PROVIDING EARLY LEARNING TO CHILDREN:

We have observed that about a third of families attending centres commence to have contact in the first year of children's life. The earlier that support and stimulation is provided the more effective it will be.

Younger children thrive in family sized groups, not classrooms. The centres provide this opportunity while allowing important child to child social opportunities.

Most importantly, the centres offer safe, supportive encouragement for children to learn and explore. Crucially the centres **bridge the gap** between home and school by enabling children to socialise, meet trustworthy and supportive adults, in the company of their parents/carers. This enables transition to Kindergarten and school much less frightening for children who may have already experienced significant disruption and loss of security. It enables the children to use what is offered educationally, without feeling disabled by anxiety. **The younger the child, the more reliant the child is on the success of their primary attachment relationship, to provide stimulation and cognitive, emotional and physical achievement.** This is especially so, in households which are economically and socially disadvantaged.

- Clara 18, comes with her nine month old baby. She tells staff that it is the only place she can visit outside her mum's house where she feels she is not judged. She puts

baby Celeste down and after a bit another 13 month old, Katya toddles over and lays down beside her. The two babes are smiling at each other and Katya passes to Celeste the toy she is holding. Clara comments "I am amazed how friendly she can be. I never knew a baby could do that".

- Shara is 3 and seems perpetually scowling. Her mother, Keela says to staff she wakes all through the night. She doesn't eat well. Her GP has told Keela that she will grow out of it. Seeing how often Shara is unhappy and how dismissive of Keela offering her food or a lap to sit on, staff ask more and discover that Keela had several febrile fits, at 11/12. They encourage Keela to get some more expert medical opinion which result in some brain scans and placing Shara on low dose epilepsy medication. Shara becomes a dramatically different child, who announces on entering the centre with a big smile "I am here".

- Carla and baby Emma sit and listen to a story being read to the group of parents and children attending our feed and read event. In conversation after the story, we comment on how interested one year old, Emma wwasin watching the other children, and following the tone if not the content of the story. Carla comments, "No one ever read to me, when I was a kid. My mum and Dad worked and my sisters, looked after us. We don't even have any books at home".

- Chris is struggling with Cameron (2 years old) in listening to the story being read to the group. He wants to run off and play with trucks. He cries at being restrained. Penny takes him on her lap and uses his name in the story. He becomes interested and settles. In conversation afterwards, Chris readily takes up the idea that he could read to Cameron each night as a bed time routine, as Cameron hates going to sleep and has huge tantrums each evening about sleep time.

3. THE ROLE OF CHILD AND FAMILY CENTRES IN PROVIDING EDUCATION AND SUPPORT TO FAMILIES AND CARERS IN THEIR PARENTING ROLE AND PARTICIPATION IN EARLY LEARNING PROGRAMMES.

The most vital role the centres play is to highlight the importance of relationships and active relating to the children. All learning occurs in the context of relationships and without appropriate and positive relating, learning is impaired for both adults and children. It is because of the milieu nature of the centres, in which relationships can be built up over a period of time, on a voluntary basis so that the centres' parent groups or educational events come to have greater traction and effectiveness.

As psychologists we know that family life is profoundly disrupted by trauma, poverty and mental illness including secondary self medication by illicit and licit substances. These disruptions in turn prevent children from forming healthy and secure attachment to their carers, in turn leading to a transgenerational cycle of disadvantage, neglect and abuse. These experiences lead families to function in a chaotic, distrustful and disrupted fashion in relation to service providers as well.

The relating provided by staff, enables families to identify difficulties experienced by their children and be brokered into helpful interaction with services in a supportive context. We doubt that many of the families attending the centres, would be able to keep appointments or make use of sessional

services offered by doctors and mental health or educational staff, without the support, structuring and encouragement offered by the centre staff.

Some of the examples above illustrate this. We would make the point, however, that access to these programmes only occurs because of the relationship building done by the staff. This building of relatedness and trust is not easily quantifiable and is demanding and time consuming. Staff frequently have interactions with 30-100 individuals in the course of the day. This involves welcoming them to the centre, having some meaningful exchange, attempting to touch on core difficulties and respond to emerging crises for some visitors.

Because relationships are the conduit that enables early detection and response to difficulties, the workers at the centres are at the front line of intervention, with all the stresses, tensions and challenges of such work. Unfortunately, as their role is primarily identified as educational, this relationship functioning of the centres is not adequately supported.

a) Current training programs attended by staff are often of an educational nature and provided in an ad hoc fashion, largely focussed on running parenting style education for parents. While there are undoubtedly useful in supporting staff and educating them in a wide range of issues they face, programs such as Tuning into Kids, Circle of Security training and Newborn behavioural observation (to name 3 trainings centre staff have participated in recently) are not sufficiently attuned to the nature of the centres and the work they do. We would recommend a tailored package be created, to specifically address the actual work conducted at the centres and its unique demands.

Such a package might include

- Conduct of a milieu environment, large group processes and group dynamics.
- Using play to enhance parent child relationships. (Theraplay and play therapy training)
- Common mental health presentation and responses in adults, children and families).
- Child protection issues and strategies
- Strategies for supporting parents with mental illness
- Emotional development in babies and children
- Family development and couple functioning.
- Legal and social issues facing the contemporary family.
- Self care of staff and understanding burnout.

As you will see, this package is not primarily structured around child education.

b) One of the most crucial functions of the centres is intervening in the actual interaction of parents/carers with their children.
    - Over a period of six months:
        - Kylie is initially continually reproving and censuring of her child along the lines "Stop picking your nose, Cassie." Cassie slaps her mothers hand away. Kylie smacks it and says to the worker "She can be such a little shit". But after some challenging by staff and supporting Kylie in moving out of an abusive relationship, Kylie is supported in being able to play with Cassie at an age appropriate level. Cassie becomes less challenging with her mother and her language skills improve dramatically.

In our experience the majority of families attending the centres live in households with few or no books, and in which children are unlikely to be read to. Exposing children to literacy programing needs to be done in the context of parent care and lifestyle.

Tasmania has literacy levels similar to the Northern Territory. **The proposal to reduce the age of children entering school to 3.5 would be a profound mistake in our opinion. It would reduce the social capacity of children and level of secure attachment even further.** It would also reduce the effectiveness of kindergarten teachers in schools by burdening them with a the level of care 3.5 year old children require, and restrict their capacity to respond to 4 year olds.

Funds for this initiative would be better diverted into Child and Family Centres. This would allow support for families to occur from birth and even prenatally.

4. THE OUTCOMES AND BROADER IMPACTS OF CHILD AND FAMILY CENTRES TO THE COMMUNITIES WHICH THEY ARE LOCATED IN.

We believe that the examples given above illustrate the enormous importance of these centres to their local communities. The success of these centres at the community level is demonstrated by the increased attendance at the centres over a four year period. Attendance at the centres occurs through word of mouth, which in turn is only established because of the trusting relationship the workers have established with the parents who already attend the centres.

5. THE LEVEL OF GOVERNMENT FUNDING PROVIDED TO CHILD AND FAMILY CENTRES AND WHETHER THERE IS A NEED FOR MORE CHILD AND FAMILY CENTRES IN PARTICULAR COMMUNITIES OR LOCATIONS.

The role of the centres in providing social support to both families and community is invaluable. It offers a unique opportunity to break cycles of deprivation, neglect and abuse which impede the development of Tasmania. More centres in disadvantaged areas would be of enormous benefit for those identified disadvantaged areas. From our perspective, however, we would like to focus on what additional funding could be provided to existing centres:

1. The centres do not receive sufficient integrated support from workers with with mental health experience, such as psychologists and social workers. There is inadequate consultation and thinking time provided for staff to reflect on their daily experience, with the level of expert support needed to respond to the high level of psychological distress experienced by visitors to the centres.
2. The current staff do not get adequate provision for stress leave, time out from face to face demands, and school holiday reprieve from the daily face to face work.
3. Sick leave provisions and centre opening hours, are inadequate to provide safety and protect staff from "burn out" and compassion fatigue" effects. Appropriately trained back up staff are not available to step in when necessary. The burden of responsibility experienced by staff for the welfare of children and adults is very high. We have frequently heard from staff at the centres of their difficulty in "clocking off" at the end of the day, disturbed sleep, nightmares and a sense of acute stress.
4. Provision of speech therapy, paediatric and dental services from the centres should be funded and rolled out consistently across centres.

The Child and Adolescent Teams are not able to provide more than monthly contact with Child and Family Centres. Specialist Mental Health outreach is not provided as a matter of course, as CAMHS teams are themselves very stretched.

We would think group consultation with all staff, should be available to such centres at least for 1.5 hours weekly from an external mental health expert, to review and support responding to the intense level of risk and attachment disruption experienced by families using the centres.

Conclusion

In conclusion, we would make the following summary points

- The existing centres make an invaluable contribution to the immediate, medium and long term wellbeing, development and secure attachment needs of children and families in the State.
- The existing infrastructure offers opportunity to build further community support, outreach and educational resource at the earliest possible point of intervention, potentiating its effects. We would recommend increases in staffing and greater access to social work and mental health professionals, speech therapy and Occupational therapy, integrated into the staffing of the centres.
- We would urge consideration of the Child and Family Centres being recognised as a new kind of facility which is neither a medical style practice functioning by specialist appointment, nor a school for parents that excludes children, or a school for children that tends to exclude parents. The centres primary work is with relatedness of children and adults. They operate as milieu environments with their own unique dynamics, requiring specialist governance, management and staffing which may not be best understood within the framework of the Department of Education. Consideration might be given to whether the centres should be more effectively linked to health, or child protection or the Attorney Generals Dept, or held in some unique matrix relationship with all relevant agencies.
- The demands of this kind of work on staff are very great, and the sustainability of the Centres is reliant on adequate non face to face, processing time and staff development programs to prevent serious injury and burn out. Centres may need to reduce opening hours, have access to back up staff in the event of illness or staffing by trained and supervised volunteers.
- The greatest resource of the centres is the commitment and professionalism of the staff. The greatest vulnerability of the centres is the loss of staff, through burnout, secondary trauma arising out of the intensity of the clinical mental health and social deprivation load they carry, or serious injury. Consideration should be given to how best to support and maintain existing staff, including a career path within the centres, opportunities for further specialist training and professional recognition and relief from face to face demands at the centres.
- Funds should be made available for further research on the work and clinical demographics of the centres based on an "action research" model, which would allow maximum flexibility and responsiveness, rather than a more statistical proof of effectiveness of the model.
- Discretionary funds should be available to promote further community development initiatives emanating from and coordinated with the centres, such as food co-ops, volunteering programs, and home visiting outreach initiatives.
- Further consideration should be given to increasing the accessibility to centres by
    - increasing their number
    - increasing staffing

    - operating similar programs from within schools as a better solution than lowering the school entry age to 3.5.
- We would argue that the centres offer the most cost effective model for achieving the earliest possible intervention in the most efficient manner to vulnerable and disadvantaged populations in Tasmania. They are the real game changers for culture shift in parenting capacity, secure attachment, literacy and sound nutrition in this State.

Thank you for your consideration.

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