1. Additional description

South Australia covers the southern central part of Australia and has nearly four times the total land mass of New Zealand. With a population of 1.7 million and over 75 percent of people living in the metropolitan capital of Adelaide, it is a highly centralised state.

The Child and Adolescent Mental Health Services (CAMHS) in South Australia are part of the Women's and Children's Health Network (WCHN) which provides inpatient services and overseescommunity and outpatient services across the state.

Families SA is the child protection service for South Australia and is a part of the larger Department for Education and Child Development. Families SA's primary area of concern is the protection of children. Within this context they are charged with the statutory obligation of protecting children from abuse and harm, supporting families to reduce risk to children and providing alternative care for children and young people when home is no longer an option.

As at 30 June 2015 in South Australia there were 2,690 children and young people under the Guardianship of the Minister (GOM) through care and protection court orders. Of these, 20% or 537 are aged 0-4 with 6% under 12 months of age. Aboriginal or Torres Strait Islander represent 29% of the total GOM children and are seven times more likely to be involved in the child protection system. Of children in out of home care, 42% are in foster care, 44% are in kinship or relative care and 13% are in residential care including emergency care. Seven in every thousand South Australian children now require 'state' parenting and this,represents a growth of 4.4 per cent in the year 2014-15 and more than 70 per cent increase over ten years[1].

This had been recognised in 2009 as a major mental health problem and international responses that provided evidence-based early intervention were researched. The Tulane Infant Team model was chosen and two workers travelled to New Orleans in 2010 to understand more of their model and requirements for local implementation. On return, consultation with child protection services began and a collaborative service response was developed. The ITRS was funded as a discrete program from September 2011.

The Service assesses suitability for reunification based on parenting capacity, and where appropriate, provides a therapeutic reunification program for parents and disturbed infants. This involves intensive weekly dyadic therapy with parent and infant. Where reunification is inappropriate, the service will facilitate therapeutic intervention with relative and foster carers to provide best outcomes for our primary client, the infant/s. The Service works intensively also at a systems level to support child protection workers in the difficult task of understanding and supporting the mental health and developmental needs of their clients.

ITRS is a lean service with a total of 2.7 FTEs. This is allocated between six part-time clinicians: two Child and Adolescent Psychiatrists (0.5 FTE), one Child Psychotherapist (0.6 FTE) , three infant mental health specialists (1.2 FTE) and one administrative assistant (0.4 FTE).

[1] Annual Report 2015, Office of the Guardian for Children and Young People, Government of South Australia

2. Criteria

2.1 Evidence of a significant contribution to the field of mental health on a local, state or national level.

Our clients are those infants who have been harmed or are at risk of being harmed due to maltreatment and/or neglect. There is a growing recognition of the role such early trauma plays in the development of mental health and physical disorders from infancy, through childhood and adolescence to adulthood. The long term sequelae of such experiences are increasingly being reported[2].

There is a well-established link between parenting and healthy development. Care-giving sensitivity and responsiveness predicts healthy development and buffers the effects of other stressors in the family and environment. Early identification of infants requiring support is critical and once identified, targeted early intervention is essential to ameliorate damage already caused and to seek to prevent further trauma.

A series of reports[3] published in 2015 by the American National Office of Planning, Research and Evaluation (OPRE), look at the effects of stress on self-control and executive functioning, taking a wide research-based view of the long term effects of such stress. They conclude that in situations that are prolonged, frequent and severe, stress creates chronic, toxic effects on the developing brain and behaviour. This changes brain anatomy, physiology and biochemistry relevant to self-regulation and to cognitive, affective and behavioural domains of self-regulation. These changes are particularly damaging for infants under three as it impacts on the structural formation of their developing brain.

It is crucial therefore for the ongoing management of mental health and wellbeing in our community that we begin to attend to chronic stressors in infancy, like harsh parenting, maltreatment and environment adversity such as food insecurity and multiple changes of caregiver. We need to address the toxic effects of such adverse experiences. These experiences interact in complex ways to influence how trauma impacts development, with the most severe effects occurring when these stressors occur in infancy[4]. Moreover this developmental and attachment trauma is transmitted inter-generationally[5].

We were prompted by the increasing numbers of infants coming in to the care system, as more workers understood these long-standing negative effects of early developmental trauma on all aspects of a child's development. The outcomes for

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[2] Tremblay, R.E. (2010) Prevention of Mental Illness: Why not start at the beginning? Bulletin on Early Childhood development, 9(1) 1-6.
Van Der Kolk, B.A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress,* 18, 389–399.

[3] OPRE Report 2015Office of Planning, Research and Evaluation, Administration for Children and Families, US Dept. of health and Human Services. http://www.acf.hhs.gov/programs/opre

[4] Schore, A.N. (1997). Early organization of the nonlinear right brain and development of a predisposition to psychiatric disorders. *Development and Psychopathology*, 9, 595–631.
Schore, J.R., & Schore, A.N. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. *Clinical Social Work Journal*, 36, 9–20.

[5] Fonagy, P., & Target, M. (2005). Bridging the transmission gap: An end to an important mystery of attachment research? *Attachment & Human Development*, 7(3): 333 – 343.

children-in-care are very poor, as these children tend to bounce in and out of the care-system.

Our service works in a social context of intergenerational trauma due to the effects of poverty, violence, sexual abuse, cumulative loss (trauma), substance abuse as well as the effects of colonisation, including the Stolen Generations. We believe that only by intervening early can we address the long-term effects these stressors are having on infants, their families and our communities.

Our goals are to make timely decisions when infants first enter the care system - decisions that address their long-term needs. We work whenever possible with their biological parents to increase their ability to hold their infant's needs in mind, helping them learn to see things from their infant's perspective. However we only support reunification when it can fit within the developmental timeline of the child. From the outset our aim has also been to increase the capacity in the child protection system to meet the social, emotional and developmental needs of infants.

2.2 Evidence of innovation and/or recognised best practice.

Concerned about intractable problems influencing outcomes for these infants, our approach is based on the Tulane Intervention[6], a systemic model for maltreated infants which addresses the child-parent relationships and the many interacting contexts which bear upon them. Since 2010 we have been collaborating with Zeanah, Larrieu and colleagues at Tulane University in New Orleans, to translate this intervention to Adelaide.

Our intervention is a threetiered model with creating relationship at its core. We have clearly defined roles and responsibilities within the service, delineating assessment and court processes from therapeutic endeavour and addressing the needs of the wider system.

The first level is assessment. We take referrals antenatally, during investigation process, or once a Court Order is in place. We accept referrals from Families SA, the Women's and Children's Hospital and the two health-funded child protection services that primarily provide state-wide forensic services.

Our assessment process has two phases: the first phase assesses the parenting capacity of either or both biological parents. Where there is any capacity for reflective function[7], or more simply, being able to see things from the infant's perspective and demonstrate any ability to accept some responsibility for their child's predicament, we move to the second phase of our assessment.

This is a therapeutic relational assessment with parent and child – sometimes over an extended period. It targets the relationship, identifies the level of infant disturbance and provides a focus for therapy. This second part of our assessment

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[6] Zeanah, C.H., Larrieu, J.A., Heller Scott, S., Valliere, J., Hinshaw-Fuselier, S., Aoki, Y., & Drilling, M. (2001). Evaluation of a preventive intervention for maltreated infants and toddlers in foster care. *Journal of the American Academy of Child & Adolescent Psychiatry*, 40, 214–221.

[7] Allen, J.G. (2013) Mentalizing in the Development and Treatment of Attachment Trauma. London: Karnac Books;

Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment & Human Development,* 7(3): 269 – 281.

uses structured tools: the Working Model of the Child Interview and the Crowell Procedure.The basis of all assessment is assisting with timely decision-making to meet infants' developmental imperatives.

Following our assessment we meet with Families SA workers to discuss our recommendations. At this stage we may recommend that Families SA either return to court to seek long-term orders (GOM 18). In this situation we deem that the problems are too chronic and extensive to be able to be addressed within the developmental timeline imperative of the infant. Therefore in the long-term best interests of the infant, difficult decisions need to be made.

We also make recommendations regarding the ongoing care of the infant including their development and therapeutic needs and if necessary, assist with the assessment of the ability of kinship- or foster-carers to meet these needs and support reunification.

Alternatively we may recommend Families SA seek a short-term order (GOM 12) to facilitate and support the possibility of reunification with the parent who demonstrates at least limited responsibility for their infant's situation.

In this instance therapy is usually intensive weekly therapy involving infant and parent. We offer a variety of evidence-based treatment models that we can tailor to the family's individual needs. Therapy includes Parent-infant Psychotherapy, mentalisation-based therapy, Interactive Guidance and video review and Attachment and Biobehavioural Catch-up therapy (ABC) – a therapy for foster-carers and infants. All therapy models aim to increase the capacity for relationship by increasing a parent's capacity to think about their infant and increase their ability to manage their feelings and those of their infant.

Our model is relationship-based. We work to promote and support relationship-building and reflective practice at all levels of the system. Our assessment, therapeutic and consultation endeavours are all relationally focussed.

Our experience is that it is the lack of relationship that is at the heart of the absence of reflective capacity. This absence reflects a deficit in the development of self-regulation and executive functioning in parents, due to their own adverse experiences of childhood neglect or trauma which has impaired their ability to trust being with other people and being in relationship. We can only learn self-regulation in relationship with a sensitive other. Our parents have generally not had this as part of their childhood experience and its provision is a major therapeutic goal.

The ITRS model focuses on managing risk at all levels of intervention. Our primary aim is to reduce the risk of further harm to infants by ensuring a level of care and safety that addresses both their current predicament and promotes their long-term healthy development. Our assessment model ensures timely, decision-making when infants first enter the care system in order to best address their long-term needs. This may involve permanency planning or where ever possible support reunification through intensive therapeutic support.

The broad aim is to interrupt the ongoing harm caused by the intergenerational transmission of trauma by intensively supporting the development of parent's ability to provide a safe and nurturing environment for their children. Where this is not possible, children are protected by timely permanency planning.

Our interdisciplinary team meets weekly to review cases, monitor case direction and ensure ongoing progress towards short-term and long-term goals. Regular reflective clinical supervision assists therapists to maintain their ability to respond reflectively with the infants and parents.

At a systems level our case conferencing model ensures regular case discussion with all services involved with the family. This process builds open communication, reduces fragmentation and minimises duplication of service delivery. Over time it creates trusting working relationships that enable responsive and timely decisions when inevitable crises arise. This system of wrap around care supports the infant, the family and the system.

2.3 Evidence of participation of mental health consumers in the planning, implementation and evaluation. There may be exceptions to the involvement of mental health consumers. If so, please address this when responding to this criterion.

When setting up the ITRS service we were unable to involve any current and prospective clients in our planning and implementation. However, the infant therapeutic reunification service is part of the Child and Adolescent Mental Health Service (CAMHS) in South Australia. This service has broad consumer representation at all levels of operation including at the executive level of governance.

CAMHS, of which we are a part, designed its services for Guardianship of the Minister (GOM) children, with the involvement of, and in consultation with, multiple stakeholders. These included the CREATE foundation which is the national peak consumer body representing the voices of children and young people with an out-of-home care experience (including kinship care, foster care and residential care) and the Office of the Guardian which is charged with the responsibility to advocate for and promote the rights and best interests of the children and young people under the Guardianship.

As part of our original proposal we requested funding for the evaluation of our service but we have been unable to further this as contacting either former clients or Families SA social workers has not received ethical permissions. However, we have collected data which Families SA have then mined, using their own internal systems to assess the service's effectiveness. This information is reported in the final section.

2.4 Evidence of Partnerships and Linkages (collaboration for continuity between organisations).

The ITRS is a collaborative partnership project between Families SA, which is service within the broader Department of Education and Child Development, and CAMHS, a service of SA Health. A collaborative approach is required to address the complexity of need of our target population. The service requires equal involvement of child protection services and health to address health outcomes as well as safety requirements of vulnerable infants and their families. In addition the expertise of a range of agencies is required to provide the necessary wrap around care.

Our collaborative reflective team processes ensure assessment and therapy are both relational experiences that support reparative work with parents and ensure infant needs are in the forefront. This same process works to support workers from other agencies who are involved with the family. The strongly relational principles upon which this model is based can be transferred into many health contexts.

The ITRS model involves all services working with the family by developing a care team through regular case conferencing. Services including Drug and Alcohol Services SA, domestic violence services, financial support, and sheltered accommodation services are often at the table. An in-home reunification service provided by Non Government Organisations (NGOs) like Centacare, Anglicare and Uniting Care Wesley is always involved once reunification becomes a goal.

This process creates a system of care that can hold and contain the often difficult dynamics, that are usually mirrored throughout each level in the system. This case conferencing process also up-skills the workers involved with these families – workers who are often young, frontline and inexperienced. The case conferences provide space to reflect, in what is generally a very tight, constrained context.

The ITRS places a high value on providing reflective space in the child protection and mental health service arena as all services are working with limited resources in a highly conflicted environment. We have hosted two hourly forums each month throughout 2012-15 to help establish common practices among the lead agencies servicing this area. Managers and clinical leads from Families SA, child protection services at the WCH and Flinders Medical Centre have attended regularly. The resultant discussions usually based around actual cases have increased the knowledge base, extended working partnerships and developed much needed relationship. This serves to combat the isolation of services and breakdown the silos of working that have previously existed.

In addition, client care is highly collaborative within the ITRS team. When necessary, we meet regularly to reflect on the complex dynamics involved and support reflective practice in the extended care team. This practice promotes a level of collaboration which can contain the difficult dynamics intrinsic in these families. This in turn up-skills workers both within our own service and those we are working alongside by creating supportive relationships.

In summary, the ITRS model has ‘creating relationship’ at its core. We work to create ‘holding’ across all service provision by working in partnership, collaborating through case conferencing and discussion and most importantly creating the space to reflect on experience.

2.5 Verification and evaluation of the program’s effectiveness e.g. quality improvement activity, data collection and its use including graphs and tables, achievement of performance indicators, e.g. attendance figures, outcome measures, number of document downloads, page views, click through rates.'

Funding for the service began in September 2011. The service is funded for 24 families per year. From September 2011 until March 2016 the service has seen more than 160 families. Currently we have 50 open cases, 31 in the assessment phase or court and 19 in therapy.

The following early outcome data was provided by FSA from statistics we submitted to them. This data covers a period of two years from September 2012 to September 2014 and demonstrates positive outcomes. Of the n=117 children that was provided by the ITRS program, the case status of 114 on C3MS (Families SA's Case Management System) were reviewed to determine the success of reunification through the ITRS program.

Of a total of 114 cases, 45 infants were succesfully reunified and living with biological parents and17 families were working towards reunification. Therefore just over 1 in 3 children were reunified or remained in the care of their biological parents (almost 40%). Around 10% of cases were working towards reunification with the biological parents. These outcomes demonstrate an almost 40% reunification rate which is 10 % higher than the average.

Where reunification was not possible, timely, long-term decisions that met the infants' developmental imperative were made. At that time, 35 infants were under long-term guardianship orders with a further eight pending, four infants were in the care of their biological grandparents and four other infants were in other care arrangements.

Another outcome is an ever-increasing rate of referral from FSA workers as they work with us or hear about the service. We have also been asked to provide training in the child protection space for child protection workers. However current resource constraints mean this is a difficult request to meet for now.

3. Conclusion

The ITRS is an innovative, evidence-based service developed in response to an alarming increase in the number of infants coming into the statuary child protection system in South Australia. With the infant at the centre, the service seeks to ameliorate the devastating long term mental health impacts of early abuse and trauma, and where possible interrupt patterns of intergenerational trauma and abuse. The service seeks to enhance the care-giving environment by building supportive and reflective relationships at every level of service delivery. To date the service has achieved a 40% reunification rate. Our emphasis on reflective practice and the creation of reflective space is an effective way of working across complex systems.

4. Referees

Removed for privacy

5. Appendix of Support Material e.g. back up material such as research abstracts, publications, data charts, news clippings, feedback and photographs. CV of the person required for Exceptional Contribution

Publications

- O'Rourke, P. & Warne, H. (2016) Psychodrama and Infant Mental Health. *Journal of Australia and Aotearoa New Zealand Psychodrama Association Inc.*
- Warne, H. (2015) *Moments from inside an Infant Therapeutic Reunification Service* AAIMHI Newsletter Vol 28 No.3 October 2015
- O'Rourke, P. & McEvoy, P. (2012). Infants in alternative care. In Newman L. & Mares S. (Eds.) Contemporary approaches to infant and child mental health. Melbourne: IP Communications
- O'Rourke, P. (2011). The Significance of Reflective Supervision for Infant Mental Health Work. *Infant Mental Health Journal*, 32(2), 165-173

Winner: Ann Morgan Prize, AAIMHi – Victoria, 2015

Moments from inside an Infant Therapeutic Reunification Service…

He turns up, regularly, weekly, though sometimes late. Today he's on time, and sits awkwardly in the waiting room. He's thick set, 24 years old, pumps weights and drinks Red Bull. He never wears a jumper. His baby, a girl, soon to be a toddler, sits in her pusher, face slightly dirty, big blue eyes alert, wispy hair awry and poking out from under a red and white knitted hat with red pom poms dangling from the ear flaps. Her feet are bare. Today she grins at me, a wide toothy smile – she has a big gap between those two front teeth, and she looks just like her dad. Although her paternity is obvious, in the beginning it was contentious and required scientific verification.

He is less effusive in his greeting, doesn't directly say hello. He's a bit shy, socially awkward. The greeting is important. Sometimes our parents can't share, not even with their infant, and it can be a mistake to greet the infant first; if the parent flickers, and turns away just slightly with dry displeasure, we're off to a bad start. This dad is not like that, but he is on the edge of his comfort zone, here under duress. Mostly he warms up as we trundle down the corridor, through the grey security door then right, left, left and into the playroom. He reminds me of a friendly but slightly inept bear with a dolly in a flimsy toy pusher.

Usually he connects with me, on his own terms, by way of cars. He relates his latest mechanical exploits – the new shockers he's just installed on the V6, the deal he's wrangled for good second-hand tyres, and after this (meaning the session), he's off to the wreckers with his dad because the timing belt is on its way out. I will ask him again, a little later, about where the baby will be and I'll say something like, 'Wow that's a long time for her to sit in the car …' And he will say, 'Oh she's used to it,' and I will grapple with how much of a problem it is in the general scheme of things.

But today it's a bit different – he sucks on his can of Red Bull and fiddles with his phone as he pushes her along. He's not looking at me. Just as we get to the room his phone rings, and he says can he answer it? Perhaps he's remembering last

time, when, sitting on the floor with the baby, I relayed what I felt, what the baby might feel, as he texted back and forth, one of the candidates he's vetting for a relationship. Perhaps he's remembering something of that conversation, carefully delivered with humour and empathy, so as not to shame him. I said how I felt alone and forgotten right then and there, while he held his phone, in his hands and his mind, and it was probably like that for his baby too. He scrabbled about, keen to tell me that the 'chick' on the receiving end of his attentions was only free now, since it was lunchtime … How would he manage, I wondered out loud, the romance and compulsion of a new relationship, while caring for a baby? Easy he said, we'd only do stuff where she could come too. He has criteria, has learned from his mistakes, he says. Good with kids is on top of his list, and he can provide details.

But maybe he did feel criticised, or there's something else on his mind. Whatever it is, the baby is here, however he feels, and how does he manage that? She's off by herself, busy with the toys, but she looks at him more than when they first came; she was eight months old. Now she's almost walking and he's keen for her to be properly mobile. Small babies are not really his thing.

There's no doubt she's in his heart, I can feel it in the room. He no longer goes out drinking, he doesn't tangle with the law. He's solid and reliable and committed. He's recently been shopping for her, for new clothes, and, apart from the hat, she's decked out in pink. Sometimes she arrives buttoned at the front when I'm pretty sure the buttons belong at the back. Her bottles are clean, and he tells me she gobbles up the vegies he cooks for her. She's healthy, growing well, and meeting her developmental milestones – a far cry from the emaciated, silent, dull-eyed infant who arrived, aged four months, precipitously into his care.

Our service, small, committed, and meagrely resourced, works with infants and parents at risk. All of our clients are involved with the child protection system. Our job is to put the infant first; we grapple with the complexities of parenting capacity assessment, out-of-home care, early decision-making in the best interests of the infant and within their developmental timeframe, and where possible, intensive therapeutic support with the infant and their parent/s or carer/s. Most of our therapeutic work is with mothers and their infants, most of the fathers are violent and don't have what it takes.

This father, however, is not violent, and took on his daughter's care when the mother couldn't do it. Within the hour he'd said yes, and had rallied his network and the basic necessities – cot, nappies, bottles and formula, singlets and grow suits and blankets. Fatherhood was huge for him, and he took it on. She arrived from her mother via a child protection worker, a haunted shell. Her mother was homeless and mostly drugged. This infant, like many we see, had witnessed violence, ugly and terrifying. She was left alone, to scream and despair, her bottles filthy and unfilled. She spent days at a time with mere acquaintances when her mother failed to return. She'd been seriously ill and was way too thin, admitted to hospital for 'failure to thrive'. Her body told the story. Her mother, repeating her own history, did not know how to do it differently.

He had fallen into a relationship of sorts when the mother was 'up'. They met through a friend, and for a few good weeks, she was fun loving and affectionate; then she moved in. She needed somewhere to stay. They talked about children, but she didn't stay faithful. He found the evidence on her phone. By then she was pregnant, and stealing his money, and leaving her other child in his care. He left, or threw her out, it's not clear which. He never went back. She alleged that he

threatened their unborn child and took up again with a man who beat her. The father, our client, wasn't at the birth, and she disputed paternity. Hence the test.

He's not good at relationships, he says. As a boy he was angry, difficult to manage, and struggled at school. He received a dual diagnosis that has stuck. Asperger's Syndrome and ADHD. Heavily medicated to keep him compliant, he gained huge amounts of weight, and thus dulled and conspicuous, struggled more at school. He started drinking and thieving, and 'got in with the wrong crowd'. It seems no one heeded that he lived in fear, his father drank and abused his mother. When his parents separated, home was a toxic soup of blame and acrimony. When we talk about it now, he glides over the pain, says his father has given up the drink, goes fishing instead, and that he, the grandfather, has Asperger's as well. The idea that something else was going on is very difficult to face and he doesn't appear to have taken in the recent psychiatric opinion that he was labelled wrongly…

He says he doesn't think his baby has Asperger's, and I agree. We edge about it some more. Trauma can look like Asperger's, I say, and again we talk about her brain, what all those stress hormones do to a small baby, how she learned not to rely on anyone and what she needs now. He says he's getting better at that, and I agree. At some point, he gathers her in, a bit rough, but he holds her close and for a moment she snuggles in. She goes to him more. There's an authentic quality in what he says, and I trust it. He says he's not good at the feeling stuff, and finding a way to say things.

And so it goes. We talk about the past, and what happens in the moment. I try to give to him what I want him to give to her. I wonder what he's thinking and feeling, what does he imagine she's thinking and feeling, tell him what I see him doing, let him know that I like him and know him to be a good person, understand that parenting is hard. Especially when you weren't expecting it and are going it alone when you really want a family, different from when you were little. Back and forth we go, between the baby and him, including both. What do you think that's like for her? Did you see what she did when you sat on the floor? What do you think it's like for her to see her mother? Is she any different when she gets home? This sounds like an interrogation, but I hope it's not. It's to and fro, joining them up, making links that weren't obvious before.

And I talk about how weird it is to come in here and talk to someone as old as me in ways that he's not used to and not comfortable with and is anything we're doing here helpful because sometimes it's hard to tell … and at regular intervals he talks about cars. He's not deterred by my ignorance.

Although awkward and at times repetitive, these sessions are not that difficult. Despite some worries about the time this baby spends in the car and wrecking yards, and sitting in her playpen next to the latest being worked on vehicle, this dad is good enough. He knows his baby, thinks about her, plans for her. He accepts help. And she relies on him. She makes a beeline for him when she's hurt or frightened, looks for him and cries when he's not there. Though she's too self-sufficient, and cruises the furniture on tiptoes, and parts of her are hidden, she is safe, and held in his arms and mind.

Not so, for others that we see. Young infants, for example, with unexplained bruising or broken bones, the ones who hold themselves rigid and stare with hopeless eyes into the distance, the ones who look down, with flat lifeless faces and their hair worn away in telling patches from too much lying down or rocking back and forth. The ones who spit up their milk and scream without warning, or the ones who are eager

and overbright and latch on to strangers with desperate eyes. These are the ones who are not safe and not seen, and exist in helpless desperation.

As I recall the many such infants who come in through that grey security door, part of my brain disengages, and something else, akin to instinct, takes over, as it does in the room. The language of young infants is powerful and primitive. It is as if they speak through the feeling states that they evoke, how they hold themselves, and where they look. Infants cannot lie. They cannot help but tell the truth of their experience, the truth of their connection with the adult who holds them. Feeling states that are difficult to bear invade the room. Helpful theories and models simply evaporate, and, just as the infant cannot escape, I feel as if I am living on wits alone, with nowhere to hide. Trapped in their bodies, exquisitely sensitive, and helplessly vulnerable, the infant has no choice in the matter … the best they can do is to not look, hold themselves rigid, go still and silent and sometimes floppy, or overly bright and wide eyed, whichever serves them best. There's such rawness in the room, so much excruciating need. And there is always more than one baby, though only one is visible. The mother's infant self, as well as mine, are also present.

The mothers we work with are always wounded, horribly wounded, and champions of survival. They say the things that, logically, we would want to hear, and they trust no one.

'Good mother, no drugs, no violence, reformed, unfairly treated, love my baby, baby perfect, a few past hiccups but all good now. No one will listen, it's so unfair, I've done nothing wrong, I really am a good mother, had a few issues keeping things tidy, I'm not seeing the father, the baby is perfect, my world, my life, I'll do anything for him. I will get him back, I know it. It's just a matter of time and showing up here. I've done everything they've asked of me.'

How can she believe, though we've made it clear, that her best chance is to tell the truth? In her mind the truth, some version of this, would surely seal her fate: her childhood, or what little she remembers of it, was awful. She didn't feel safe, wasn't safe. From early on, she knew violence, abuse, neglect, terror, abandonment, and utter aloneness. She learned to numb herself. At some point, often very young, she fell pregnant. The promise of a baby, as if by magic, would fill the void. Here at last was someone who would love her, and not leave her.

It was not as she'd hoped. The infant screamed, was helpless, needed her. There was no one to help, she trusted no one to help. The partner, jealous, became more violent. She did her best, but sooner or later, she spiralled down, and reports were made. Or even worse, she'd been through it all before, once, twice, three times or more, and they took the baby early, straight from hospital …

We search for the signs that show she recognises her part. She has, though she did not mean to, hurt her baby. Either directly, or indirectly, either way the baby was not safe, as she was not safe. She has to see that she has done to her baby what was done to her, and to face the shame of that. She needs to face and to feel what that was like for her baby. Then we can work with her, that little chink in her armour.

The process will be long, imperfect and blundering, with moments of triumph and no guarantee of success. We will sit through session after session of rage and blame, anguish and grief. It will be the infant who leads the way; he will turn in circles, or back away, he will spill his jumbled world onto the floor. We will sit with chaos, sit in chaos, amongst a sea of plastic coins, pots and pans and teacups, dinosaurs and crocodiles, wild animals and items from a doctor's set. It will be a long time before the train tracks join up and the train doesn't crash. We will wait for the crocodiles to

move out of the doll's house. We will try to make sense of it all, and see through the infant's eyes.

My part will be to show up regularly and willingly. The process will challenge me to the core, to sit with what is not contained, to hold a boundary, to stay thinking and connected, with myself and them. At best we will build enough safety for a real relationship to emerge, one in which vulnerability can be shown, pain can be held, and soothing experienced. It will be difficult to get there. The work requires a team, regular supervision, and a shared belief that change is possible; intergenerational trauma does not have to go on and on.

They're back, the dad and his baby. They're fifty minutes late. I go to the waiting room, pleased to see them; I thought they weren't coming. She's straining to get out of her pusher, and missing a sock. He's dishevelled but upbeat. They have been on holiday to see his mum and celebrate the baby's first birthday. They've been on the road since early morning, have just arrived in town. I take a breath and imagine them, flying down the highway in the V6 with the spoiler on the boot and her strapped into the baby seat, staring out the window with eyes glazing over, or asleep. I'm glad they're safe. It's not that he's keen to see me; he's in trouble with his social worker for missing access, and he didn't dare not show up. Nevertheless, he bubbles with news. His mum is proud of him, she even said so, and they went camping, all together, and cooked lamb on a spit. The baby had a great time too, he said, and his best mate has just become a father. He wants to move back to the town he grew up in. It's as if in claiming his baby he has also been claimed, back into his family.

A while ago I asked if I could write about them, and told him why. He laughed, a bit bemused and said 'yeah, sure', as long as he didn't have to write anything.

The next thing, he says, will be to take her fishing, out in the boat. I feel instantly queasy, and I say so. He's been thinking about that, the way he got his sea legs was to get started early, when he was five. She's only one, I say. We'll just do little trips, he says, and if she's not okay, we'll turn around and go back in. He's saving up for a very small life jacket.

Outcome Data for ITRS September 2012 – 2014

Reproduced below is an email received from Families SA in early 2015. It provides a summary of our achievements over the first two years of ITRS funding.

The information below was taken from the data review of the ITRS program that was undertaken in February 2015.

The data used in the review was provided to Families SA in November 2014 - the timeframe of the data provided was from September 2012 to September 2014.

Of the 117 children that was provided by the ITRS program, 114 case status's on C3MS (Families SA's Case Management System) were reviewed to determine the success of reunification through the ITRS program.

Case Status	
Successfully reunified / Living with biological parents	***45***
Working towards reunification	***17***
Children on GOM 18 orders - *1 GOM 18 order but lives with biological mum* - *1 x living with grandparents but biological father also resides in the home*	***35***
Seeking GOM 18 Orders	***9***
Living with paternal / maternal grandparents	***4***
Other - *1 x FSA assisting mum with personal issues* - *1 x child in care as mum is on GOM 18 order* - *1 x child is under care of half siblings father (closed)* - *1 x case in investigation & Assessment phase*	***4***
TOTAL	***114***

- *Just over 1 in 3 children were reunified or remained in the care of their biological parents (almost 40%)*
- *Around 10% of cases are working towards reunification with the biological parents*

Of the 114 cases the following notifications were received:

Notifications	
Unborn Child Concerns	*64*
Notifier Only Concerns	*144*
No Grounds for Intervention	*34*
Tier 1	*93*
Tier 2	*306*
Tier 3	*11*
Other	*8*
TOTAL	***660***

Tier 2 categories:

- *1 x Tier 2 (1 day)*
- *181 x Tier 2 (3 days)*
- *67 x Tier 2 (5 days)*
- *57 x Tier 2 (10 days)*

Other

- *5 x General Practitioner concerns*
- *1 x Interstate Request*
- *2 x Extra Familial Allegation*

Number of notification pre and post-ITRS referral	
Number of notification pre-ITRS referral	*469*
Number of notification post-ITRS referral	*177*
*Unknown**	*14*
TOTAL	*660*

**unable to locate referral dates for 3 out of the 114 children (14 notifications between the 3children)'*

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