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A culturally safe referral service for at-risk mothers and infants in marginalised, Aboriginal, and Culturally and Linguistically Diverse families

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ABSTRACT

This case study describes the development and implementation of a replicable early assessment and referral service for mothers experiencing minority group disadvantage and family violence in the perinatal period. The service aims to mitigate harms for at-risk mother-infant dyads that can lead to involvement in statutory child protection systems. In doing this, the service follows a culturally safe, restorative practice approach to supporting vulnerable families, which emphasises the relationship between worker and client to create a nurturing environment for change. The service model has been developed and refined since 2018 to now, involving stakeholders from the service team, the not-for-profit community organisation, and a university partner organisation, who provided evidence enrichment and support for clinical skill development. To date: the model has provided practitioners with structured and evidence-based ways of creating shared understandings with clients to prioritise cultural and relational needs; achieved culturally safe ways of engaging with Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse families; improved practitioners' confidence in detecting risk in parent-infant relationships; promoted effective communications with external providers; and enhanced therapeutic outcomes for vulnerable families at risk of entry into statutory child protection systems. The model may be suitable for uptake by practitioners and services seeking to improve cultural safety and therapeutic outcomes for diverse and vulnerable families. We share reflections on the scope and function of the model of care with reference to potential for broader application.

Keywords: Aboriginal and Torres Strait Islander, child protection, cultural governance, Culturally and Linguistically Diverse, early intervention, family violence, First Nations peoples and communities, model of care, perinatal support, restorative practice.

Introduction

Aboriginal and Torres Strait Islander children in Australia are 9.7 times more likely to be removed from their families by child protection services than non-Indigenous children.[1] There remains much work to be done in promoting the needs of both Indigenous and Culturally and Linguistically Diverse (CALD) families within and surrounding statutory systems involvement.[2] When families require support to mitigate safety risks to children, services are increasingly adopting restorative practice frameworks.[3] 'Restorative practice' aligns reparation of harm with building relationships,[4] wherein health and safety become qualities of relationships and communities.[5] This fosters health equity among diverse cultural groups, through response to families' self-identified priorities.[6]

This article presents a case study of a model of care that prioritises culturally appropriate, restorative practice approaches in supporting the needs of Aboriginal and Torres Strait Islander, CALD, and disadvantaged families in which children are at risk of

entry into child protection systems. The objective of the case study is to describe the development, implementation, and theoretical and pragmatic elements of the model so as to promote learning and potential for broader application and evaluation.[7,8]

Service setting

Child and Family Assessment and Referral Networks (CFARNs) are part of the South Australian government's aim to prevent the need for children to enter the statutory child protection system by providing a protective, pro-active, integrated referral service to formulate support pathways for parent-infant dyads during the first 1000 days of life.[9]

The CFARN model was supported by legislative recommendations made by the South Australian Child Protection Systems Royal Commission.[10] Prior to this, by toddlerhood, many children were entering statutory systems without substantial coordinated support having first occurred. CFARNs now offer early response to pregnant women and families with children under the age of two, through meaningful engagement and referrals including psychology, case management, developmental education, counselling and youth work services.

One regional and three metropolitan CFARNs were established across 2017–18. The Northern, Southern and Regional CFARNs are government-led, whereas Western CFARN (WCFARN), the focus of this case study, is led by a community organisation, Relationships Australia South Australia (RASA).

Service reach and remit

WCFARN involvement with a family spans 6 months on average but is tailored depending on presenting issues and the mother's due date, if antenatal. On average, the service has at least weekly contact with a family for the first 6–8 weeks. WCFARN uses a step-down case management model such that input is intensive at first, followed by establishment of a broader care team for longer-term care. Input typically involves a minimum 4 h of session time per week. This includes liaison with other services. Practitioner caseloads comprise between 10 and 20 families.

The service prioritises Aboriginal and Torres Strait Islander and CALD families. In 2020, 31% of referred mothers were Aboriginal and/or Torres Strait Islander and 13% of mothers were CALD.

Development of the service model

The organisational context of WCFARN was relevant to the shape of the resulting service model. RASA, the host organisation, provides specialist services supporting families in complex circumstances, including when children border on statutory involvement. RASA has partnered with a university team for over 10 years (authors J. M. and A. B.) in a wider study of its vulnerable families and approaches to intervention. This partnership became the vehicle for developing the WCFARN model. Specifically, the university partner provided the WCFARN team with: (i) consultancy in development and implementation stages of the service; (ii) training in infant mental health and attachment-caregiving frameworks; and (iii) support for embedding clinical-research tools into practice to aid common standards for communication across services.

Over a 6-month consultancy period involving RASA, WCFARN and the university team (2017), several unified service aims evolved. The service aimed to build a case management approach that: (i) ensured safe engagement for women from all cultural backgrounds; (ii) held a connection with women until services became available; (iii) represented families' needs accurately to the referral network, to (iv) maximise the chance of women engaging with referrals.

Implementation and continuous improvement of the service model

Service implementation occurred across 2017–18. Ongoing consultancy was offered by the university partner during this phase, and training and clinical supervision needs were co-determined by WCFARN practitioners, RASA, and the university partner in a process of continuous improvement.

Early in service implementation, WCFARN practitioners identified challenges in discerning levels of psychological risk in presenting families, amid the complex background of recent violence and multiple pressing needs including safe housing. Practitioners identified difficulty with appraising women's capacity for reflection on their infants' needs, and a tendency for workers to react to the most pressing needs, sometimes missing more appropriate referral pathways. The key service development goal therefore became one of clinical enrichment of assessment processes. This followed a threefold rationale:

1. The need for a comprehensive assessment that could be conducted *collaboratively* with clients, that might help mothers and workers to focus together on the child's needs and the mother's hopes for support.
2. In the context of recent trauma, the need for a framework including clear, supportive, standardised questions that could give therapeutic structure to otherwise overwhelming content.
3. The need for standardised assessment results that could be discussed with women and assist them to decide with workers on relevant referrals, and the need for these results to advocate for the family as needed in child protection matters.

To address these needs, key stakeholders (WCFARN, RASA and the university team) consulted on how mother-infant assessment in the midst of crisis could be undertaken safely. A suite of engaging assessment tools (Table 1) were then trialled. Gold-standard perinatal risk and mental health assessment tools were selected for this purpose, and the university team provided specialist training in the use of these tools. Instruments were selected for their suitability for describing the parent-infant relationship at the centre of the risk picture, and for their ability to support therapeutic engagement with clients. In particular, the Perinatal Emotional Growth Index,[11] Maternal Postnatal Attachment Scale,[12] Maternal Antenatal Attachment Scale[13] and the Maternal Behaviour Q-Sort[14] have seen excellent uptake in the WCFARN service. Practitioners also routinely use the Detection of Overall Risk Screen,[15] a standardised risk screening framework used service-wide by RASA to screen for family safety.

In addition, various training and supervision inputs (Table 2) were offered to WCFARN practitioners to support the goals of the overall practice approach. These training programs were selected based on their suitability for equipping practitioners with skill and knowledge in attachment and caregiving frameworks, infant mental health, family group conferencing, and relational and developmental trauma frameworks. The list of training providers can be found in Table 2.

Table 1. Instruments and structured approaches embedded into routine WCFARN practice.

Instrument	Reference
Detection of Overall Risk Screen[15]	McIntosh and Ralfs (2012)
Reflective function clinical interviewing questions: 5-item tool[27]	George and Solomon (2011)
Perinatal Emotional Growth Index[11]	McIntosh and Olsson (2017)
Maternal Antenatal Attachment Scale[13]	Condon (1993)
Maternal Postnatal Attachment Scale[12]	Condon and Corkindale (1998)
Maternal Behaviour Q-Sort[14]	Moran *et al.* (2009)

Guiding service principles

Two overarching and interrelated principles guide the WCFARN service ethos and approach: relational safety and cultural safety. Brief descriptions of each are provided below.

Relational safety

WCFARN makes transparent and collaborative referrals to child protection in cases where a mother's trauma has overwhelmed her ability to keep her infant safe. These referrals are negotiated with the mother whenever possible. This is especially important to counter the possibility of practitioners concealing from mothers their plans to refer to statutory services.[16,17]

The service maintains awareness of the delicate situation of working with clients bordering on statutory involvement and prioritises collaborative contact with other services in a sector that tends toward silo-work. For multi-agency assessments involving high-risk families, referrals are discussed with stakeholders at a local partnership group.

Cultural safety

The model is based on the guiding philosophy of *restorative practice*, which champions a therapeutic balance between challenge and support (where too much 'challenge' is punitive practice and too much 'support' equates to inadequate empowerment or poor recognition of problem magnitude).[18] Restorative practice emphasises the relationship between

Table 2. Specialist training inputs provided to the WCFARN team.

Training program/input	Provider/reference
Family group conferencing	Restorative Practice Leeds
Clinical supervision	Professor Jennifer McIntosh, Deakin University
My Early Relational Trauma Informed Learning (MERTIL) online training	Professors Jennifer McIntosh and Louise Newman, Deakin University and La Trobe University
Maternal Behaviour Q-Sort training	Dr Anna Booth and Professor Jennifer McIntosh, Deakin University
Observing infant attachment	Professor Jennifer McIntosh, Deakin University
Newborn Behavioural Observations (NBO) training	NBO Australia
Infant observation training	Helen Mayo House – Perinatal and Infant Mental Health Services
Developmental trauma training	Australian Childhood Foundation
Circle of security training	Circle of Security International
Bringing up great kids in the first 1000 days	Australian Childhood Foundation
Family partnership model	Centre for Community Child Health

worker and client to create a nurturing environment for change.[19] This fits well when working with Aboriginal and Torres Strait Islander families, where neo-colonial influences on practice remain common.[3] For WCFARN, this approach has enabled therapeutic process where practitioners might previously have worried about dominating the family or rescinding a responsibility of care because of these worries.

WCFARN prioritises dialogues and processes that involve truth telling[20,21] and self-determination.[22,23] Truth-telling provides an opportunity for Aboriginal and Torres Strait Islander peoples to record truths about Australia's colonial history and to share their culture and heritage with broader communities. Truth-telling supports local and national decolonising efforts by way of privileging Indigenous knowledge and acknowledging the cultural strengths of Indigenous individuals and communities.[20,24] The right to self-determination prioritises Aboriginal and Torres Strait Islander values within Western systems and is needed for equitable healthcare.[23,25] In support of self-determination, the WCFARN service appreciates the therapeutic value in encouraging families to lead their own treatment and healing plans. Critically, *families* are seen as a protective resource to be directly involved in therapeutic process. WCFARN views family as 'whoever comes into the room': this has been especially important for therapeutic work with Aboriginal and Torres Strait Islander and CALD families. WCFARN uses family group conferencing[26] to develop tailored action plans with both family and services present together.

Key service approaches and their outcomes

Using standardised instruments in flexible ways

WCFARN is guided by the philosophy that elucidating the *context* of risk is essential for therapeutic outcomes. To this end, standardised instruments (Table 1) were selected for embedding in routine practice to describe the parent-infant relationship at the centre of the risk picture. Practitioners also routinely use five clinical interviewing questions with clients that gauge readiness to change[27] (Table 3). These are designed to elicit an indication of the mother's reflective function: her capacity to reflect on her own parenting behaviour and her child's experiences. Parenting reflective capacity has been found by WCFARN practitioners to be the most meaningful indication of a client's capacity to change.

Practitioners had previously experienced ethical dilemmas about how to make routine service paperwork acceptable to clients, and how to manage client anxieties about the possibility of information being used against them. However, these instruments give structure to early conversations with women about their relationships with their infants, at a time when women's core needs for safety are typically very high. These 'talking tools' are now seen by practitioners as inherently therapeutic, providing a way for clients to organise their thinking. Practitioners are able to use these instruments to identify evidence-based risk factors and prioritise those that require urgent attention.

Strengths-based work with diverse parenting styles

Specialist training inputs about the cross-cultural, behavioural markers of caregiving sensitivity and infant attachment have offered WCFARN practitioners a level of observational clarity where previously assumptions about clients' contexts tended to cloud assessments about the safety of the parent-child relationship. This input has been useful in aligning the universal elements of caregiving sensitivity across culturally diverse parenting practices.[28]

Nevertheless, attachment frameworks can be Western and unidimensional. WCFARN practitioners voiced strong initial reservations about the possibility of families 'failing' when judged against 'white standards' of parenting. Over time practitioners moulded attachment approaches into culturally safe practices by working with the behaviourally specific markers of relational safety that attachment perspectives hold as universally important for development. For example, attachment-based knowledge about the developmental

Table 3. Clinical interviewing questions for supporting parental reflection.

Theme	Question/s
Engagement/motivation	Tell me about some moments of joy you have had with your child? Tell me about moments of joy your child has had with you?
Reflection	Tell me about a time when you felt real frustration about being [child's] mum?
Accountability	No parent is perfect. When you look back, are there times you wish you had done things differently as [child's] mother/mother to be? Looking back, what are some moments you regret now?
Restoration/repair	What do you wish you had done instead?
	What would you want to say to your children about that now?
	If you could apologise and repair that for your baby, what might you say to them?
Change/connection	What do you want your baby to get out of YOU being their mum?
	What would you like to promise your baby about being parented by you?

mechanics of co-regulation aligns with the significant cultural role of grandparents and community members in creating safety for the infant while the mother is focused on re-establishing safety. Examples of culturally safe WCFARN applications of attachment principles have included delivery of pictorial information with the support of translators, and use of therapeutic caregiver formulations that illuminate strengths as well as challenges.

Restorative practice and cultural safety

The WCFARN practice of talking directly with families about child protection concerns sits strongly within the restorative practice framework. Allowing families a right of response achieves a restorative balance by inviting families to deepen practitioners' knowledge and to co-create appropriate referral pathways. Practitioners from different cultural backgrounds too have found the model restorative as it is based on client self-report and direct observation of the infant in interaction with their parent, which circumvents culturally biased views on family functioning.

'Circle work' is a key part of WCFARN's restorative practice framework, in which the client and their family sit in a circle with the practitioner to yarn. This is a culturally safe conversational practice in which stories are shared to promote connection and understanding.[29] The circle is a safe space for families to share their feelings with each other in the practitioner's presence. The practitioner does not make use of any pens or paper, instead offering open body language and 'deep listening.' This has been an important approach for connecting with Aboriginal and Torres Strait Islander families.

Risk management

Working in the subthreshold child protection space involves significant consideration of risk. WCFARN practitioners report that the use of evidence-based frames for detecting risks in the parent-infant relationship instils confidence in carrying this responsibility safely. For example, where family violence remains a current risk, practitioners must ensure timely information sharing while maintaining a family-led response. This is achieved by involving a range of family members as stakeholders and sharing information not just with other services but with family and community.

WCFARN works with clients who might otherwise be deemed above an acceptable risk threshold. The service approach is to distinguish between *risk* and *harm*: while each client presents with a level of risk, it is not always harmful for the baby/unborn child.

Discussion

The scope of this article was to provide a case study overview of the WCFARN service, which embeds culturally and relationally safe engagement approaches with marginalised, Aboriginal and Torres Strait Islander, and CALD families. By way of a case study methodology this article has described the development and implementation phases of the WCFARN model of care with the intention of promoting knowledge across service systems and among practitioners and researchers. Approaches presented here may be suitable for uptake in other services working with families at risk of statutory system involvement and/or by practitioners working with diverse cultural groups. Formal outcomes evaluation will next be required to measure therapeutic progress for clients and impact in the service system.

Collaboration between RASA and the university partner organisation has enabled evidence enrichment in the service development process as well as ongoing specialist training and supervision for WCFARN practitioners. This collaborative approach may lend itself to application in broader communities of practice in the child and family services sector. To date, the WCFARN service has improved practitioner confidence in detecting risk; achieved culturally safe ways of engaging with families; and promoted therapeutic outcomes for families at risk of entry into statutory systems. This model has potential for application in other services seeking to improve cultural safety and therapeutic outcomes for diverse and vulnerable families.

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