Invest to Grow Draft Final Evaluation Report

Through the Looking Glass – A Community Partnership in Parenting

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We would also like to acknowledge the contribution of the Commonwealth Department of Family and Community Services and Indigenous Affairs for funding this Project.

Acronyms used in this Report

CYH	Child and Youth Health
CYWHS	Child, Youth and Women's Health Service
COS	Circle of Security
COR	Circle of Repair
EA	Emotional Availability
HADS	Hospital Anxiety Depression Scale
PCG	Primary Caregiver
PSI	Parenting Stress Index
TtLG	Through the Looking Glass

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1 SUMMARY

Background:

The Through the Looking Glass (TtLG) Project is a health, education and welfare collaborative early intervention strategy that utilizes the existing infrastructure and universality of five child care settings across Australia to intervene with families where there is an identified compromised attachment relationship between the parent and child/children.

The Project is designed to achieve specific outcomes for parents, children and child care staff. The Lady Gowrie management team worked collaboratively with the local evaluator to specify project objectives/outcomes. These were ordered hierarchically and an evaluation plan designed.

The TtLG Project provides intensive psychosocial support, therapeutic intervention and childcare as a package for high risk families in order to develop and support secure attachment relationships between mother and child. The primary target group is mothers of children aged 0-5 years. The participating families come from diverse backgrounds but all exhibit multiple risk factors including anxiety, depression and social isolation and many of the parents have reported early trauma in their own lives. There are up to seven families recruited for each of the five Centres per Wave. There were six Waves planned for the project each lasting around five months.

The TtLG project is based on Attachment Theory. The intervention draws from the 'Circle of Security' (COS) project model (Marvin et al., 2002) which assists parents and child care staff to understand and integrate attachment theory into practice.

This report presents evaluation findings from the first five waves of the TtLG project.

Evaluation Methodology and Procedures:

This evaluation draws on Patton's (1997) Utilization-focused Evaluation using participatory action research procedures (Wadsworth, 1998: Sankaran et al 2001). The evaluation also adheres to the tenets of 'Realistic evaluation' (Pawson and Tilley 1998). The evaluation, designed and managed by the external local evaluator has utilized an Evaluation Assistant position based at Lady Gowrie Adelaide to enhance the integration of evaluation procedures and on-going feedback into project practice. Capacity training in evaluation for all project staff has been on-going, and formal evaluation feedback has been facilitated through the Reference Group.

Evaluation data is obtained through applying a multi-facetted and methodologically triangulated approach. The approach has been flexible in order to adapt to the evolving Project and to minimize disruption to the busy workloads of those professionals approached to participate.

In consultation with Lady Gowrie Management, the evaluators established ethically appropriate systems to collect, compile and transfer confidential data from each site to a central point for analysis. This included allocating unique case identifiers to each family, child, site and Wave in order to link the various pre and post data sets. Clinicians were

engaged to help collect client data and were provided with client consent forms, evaluation information and summary evaluation sheets for each to complete.

The evaluation uses a series pre and post Project measurement tools, surveys interviews and observations to collect quantitative and qualitative data from mothers, children and TtLG staff. The evaluation toolset is attached as Appendix D. The Reference Group was requested to identify appropriated standardized instruments to measure a range of psychological and behavioural dimensions related to the project aim. No one instrument operationalised the multifaceted issues addressed and a suite of tests was subsequently adopted. This necessitated the use of video recording, external assessment (by professional assessors based in Sydney) and additional staff training.

Sustained impact for targeted families over the medium term were addressed through follow-up surveys of all mothers from the first three waves three months after completing the program. Sustained outcomes over a longer time period were addressed through a follow-up survey of Wave 2 and Wave 3 families sixteen to eighteen months after completing the project.

The experiences of project managers, site managers, project clinicians and project co-facilitators have been addressed throughout the project through representations on the Reference Group. However, as part of refining the service model the local evaluator conducted a series of semi-structured (external) interviews with these professional staff across all five project sites. To supplement these two focus groups of site staff who were not directly involved with the project were also conducted to explore the extent to which working practices across the child care centers had been influenced by the project.

Findings:

The Reference Group, Project management, childcare centre directors and TtLG staff are working in partnership to develop and support the TtLG model. A range of suitable partnering agencies have engaged with the Project and are committed to it. A number of logistical issues have arisen in the implementation of the Project. The mechanisms for identifying and addressing these issues have been established through the Reference Group, on-going evaluation feedback, liaison between the sites and the Project manager and through formal training and information exchange sessions which have been well received.

The TtLG project has been very active in providing a range of capacity building activities to staff across the five project sites. This has built capacity to adopt and deliver a integrated primary care giving system, which in turn supports the TtLG families and improves attachment outcomes. This has allowed the organisation to deliver better services for targeted families and their children, (a national 'Invest to Grow' priority).

The project has an excellent client retention rate; 90% of the families recruited completed the five month project (n=106). Formative evaluation has revealed that mothers and fathers have been very positive about their experiences with the project and these feelings continued after completion. Mothers enjoyed the sessions provided and felt comfortable, relaxed and safe in the settings where they could freely explore their parenting and attachment issues.

Given the multifaceted and holistic approach adopted in the project model, it is difficult to identify the most important factors which facilitated improved impacts. More than eight in ten mothers indicated that 80% of the strategies employed had helped them (with six in ten indicating that 70% of strategies had helped them 'a lot') with regard to understanding their child's attachment needs. The combinations of group and individual work with clinicians and reflections on the child/parent video films guided by insights from attachment theory and the 'circle of security' have clearly contributed to greater understanding of attachment. The childcare and primary care giving ethos of the centers were also highly valued.

86% of the 106 mothers who completed the project indicated that it had helped them to feel closer to their child, with nearly eight in ten indicating the project had helped them to feel good about themselves as parents. 70% were more confident to look for other services and supports for their family. Around nine in ten mothers indicated that they had learnt more about parenting and attachment, were more confident to respond to their child's needs, were better able to cope as a parent, felt closer to their child and acquired understanding of their child's attachment and exploration needs. 88% of mothers noted lasting positive changes in themselves since completing the project. All of the mothers surveyed continued to apply learning and skills acquired through the project 16-18 months after completing it; mothers reported sustained benefits for their parenting practice, well-being and family functioning. Around eight in ten mothers formed supportive friendships during the project with over half of the mothers engaged maintaining friendships three months after project completion. Whilst this reduced over time, 28% of mothers indicated they had retained friendships 16-18 months after completing the project.

The above findings have been supported through accounts of professional stakeholders, and are further supported by the applied pre and post standardized tools. Psychological and behavioural improvements were found to be statistically significant in nine of the eleven dimensions measured, with large effect sizes found for reductions in depression, anxiety and stress, and improvements in the child's wellbeing and involvement observation ratings. Over the duration of the project, the number of mothers experiencing 'moderate' to 'severe' anxiety and depression (scoring between 11-21 on the HADS), more than halved; from 52 to 25 (anxiety) and from 37 to 13 (depression). Conversely the numbers acquiring a 'normal' score more than doubled for anxiety (from 21 in the pre measure to 44 in the post) and was 60% higher for depression (from 42 to 67 respectively).

The project has improved parent competence and style and improved family functioning. Parents have increased their knowledge competence and awareness to overcome barriers to attachment, are less stressed, depressed and anxious and better able to cope as parents. Many report better parenting practices, better engagement with their children and improved child behaviours which they attribute to the project. For many parents these impacts have been sustained since leaving the project. These findings provide clear evidence that the project is addressing the national 'Invest to Grow' priority areas of: 'Improved family functioning', 'Improved parent competence and style' and 'Improved child social and emotional development'.

A range of issues have been identified with regard to optimising the implementation of the model. Establishing a 'primary care giving culture' and broader understanding of attachment theory require on-going training in a field known to have substantial staff

turnover. In several sites this task has been embraced as part of the role of the clinician. Moreover, all the centres and staff engaged with the project are committed to the on-going implementation of primary care giving practice; this is ingrained in policy developments at each centre.

Whilst fathers as a group have been engaged in several sites this has tended to be more focussed on information giving activities. This has been more advanced in the longer established Thebarton site where group sessions have included video activities. The logistics of assembling fathers at convenient times have been prohibitive, and many of the mothers do not have a male partner. However, staff have engaged with fathers through their families as part of the PCG approach and this has become standard practice for those involved with the project. Fathers engaged in formal group sessions have benefited in terms of raised understanding of attachment and subsequent parental improvements.

Few C&LD clients were engaged and this has been largely attributed to the demographics of the site constituencies. Lady Gowrie Adelaide is currently conducting a separate study investigating the applicability of the model with Indigenous communities. This study has utilised funds from the project with the agreement of the funding body and is not part of this evaluation.

Difficulties identified in the Interim Report concerning the adoption of multi-disciplinary team working have been addressed and appear to have largely been resolved within each site. This has occurred as project staff have gained mutual appreciation of the expertise each discipline has brought to the project. However, a number of areas of potential refinement relating to this have been identified and are currently being reviewed; these are detailed in Section 7.4 of this report[1]. These should be generally be viewed as considerations for those seeking to implement the model rather than stipulations as there will inevitably be contextual and staff differences in different site locations.

Establishing a coherent set of working, reporting and accountability procedures across the five engaged sites has proven to be highly problematic particularly as each is a sovereign body. This has also been exacerbated by staff turnover and geographical distance, notably with the Perth site which ended its involvement with the project after the fifth wave. However, all sites (including Perth) have expressed strong wishes to continue with the project in some form.

In the light of the evidence presented through this evaluation, there is an overwhelming case to perpetuate the project in order to build on the investment and continue to provide an intervention which has clear multiple positive impacts and sustainable benefits for Australian families. Whilst there are areas of the service model which may be subject to on-going context specific revision, the project demonstrates its flexibility to adapt to and be adopted by different child center practices and contexts and generate a range of successful and profound outcomes for service providers and their clients. However, the need to secure funding for the Clinician and co-facilitator roles and to support the provision of child care for project clients is crucially important to the functioning of the project.

[1] Final recommendations in this area will be included in the Final Evaluation Report.

2 PROJECT DESCRIPTION[2]

The Through the Looking Glass (TtLG) Project is an attachment focused parenting Project based at Lady Gowrie Child Centre Adelaide. TtLG began as a pilot Project in 2002 as a partnership project between Child and Youth Health (CYH) and Lady Gowrie Child Centre with Commonwealth funding. In 2003 the original pilot was extended to 2004 with funding from the South Australian Department for Education and Children's Services (DECS).

A successful grant application in 2005 secured further funding from the Commonwealth Government's Stronger Families and Communities, Invest to Grow Strategy to expand the Project across centres within Adelaide and interstate over a 3 year period. The current TtLG Project involves 5 centres, 3 sites in metropolitan Adelaide and 2 interstate sites, Brisbane and Perth:

1. Lady Gowrie Child Centre, Thebarton, Adelaide;
2. il nido Child Care Centre, Salisbury, Adelaide;
3. Salisbury Highway Child Care Centre, Salisbury Downs, Adelaide;
4. Lady Gowrie Child Centre, Brisbane;
5. Lady Gowrie Child Centre, Perth.

The TtLG Project is a 6 month intervention being implemented in 6 waves across all 5 childcare sites. Each site was limited to a maximum of seven TtLG families per Wave. The Project commenced in July 2005 and is due for completion in June 2008. The first five waves have been completed and Wave 6 is currently underway.

2.1 Project Focus:

The project differs from many more traditionally skill based parenting Projects by focusing on the development of the attachment relationship between parent and child.

The project is a health, education and welfare collaborative early intervention strategy that utilizes the existing infrastructure and universality of child care settings to intervene with families where there is an identified compromised attachment relationship between the parent and child/children. An innovative aspect of the project is the provision of up to two days child care per week to participating families. This acknowledges the importance of providing support to families to enable the development of quality parenting. It also recognizes that secure attachment relationships between children and their parents can be supported by child care staff.

2.2 Project Outcomes:

The Project is designed to achieve specific outcomes for parents, children and child care staff. The Lady Gowrie management team worked collaboratively with the local evaluator to specify project objectives/outcomes. These were ordered hierarchically and an evaluation plan designed (see: Appendix A and Section 5 of this report).

[2] This project description is based on information provided by the Lady Gowrie management team.

2.3 The TtLG Project model

The TtLG Project provides intensive psychosocial support, therapeutic intervention and childcare as a package for high risk families in order to develop and support secure attachment relationships between mother and child. The primary target group is mothers of children aged 0-5 years. The participating families come from diverse backgrounds but all exhibit multiple risk factors including anxiety, depression and social isolation and many of the parents have reported early trauma in their own lives.

2.4 Client Recruitment Procedures

Families were recruited to the Project through a variety of channels including from within the service childcare centre and 'self referral'. The majority of referrals were obtained utilizing local linkages to a range of agencies including:

- Child Health Services;
- General Practice;
- Infant Mental Health Services;
- Early Childhood Education / Care;
- Child Protection Agencies;
- Local Church Agencies;
- Out Reach Projects by Non Government Organizations at the local level;
- Allied Health / Social Work / Psychology Departments of Major Children's Hospitals;
- Children's Mental Health Services;
- Community / Neighborhood Houses;
- Community Health Services;
- Women's Health Services;
- Family Support Agencies;
- Children s Centres.

Agencies were provided with information materials and referral forms and the potential recruits identified were subsequently offered an initial assessment at the nearest TtLG childcare centre. Full details of these procedures are provided in the Project Manual (see: Appendix C for the Manual contents).

2.5 The TtLG Intervention

Each participating childcare centre employs a clinician to work with families in partnership with the childcare staff. The clinicians come from social work or psychology backgrounds.

The TtLG intervention is multi faceted and incorporates:

- *Provision of up to 2 days child care per week*. The child care gap is paid for by the project making the child care free to those families on maximum Child Care Benefit and at a reduced cost for others.

- *Primary care giving*. The primary care giving (PCG) model of childcare provides a secure base for each child by ensuring each child has a 'special person' and each parent has a primary contact.

- *Intensive 1:1 individual work with the clinician*. To address individual challenges and unresolved issues all families in the Project work with the clinician for individual family work/counseling and support which is delivered at the child care centre or through home visiting.

- *An 18 session weekly group Project*. A group Project is conducted for 2 hours each week for the mothers whilst the child/children are in care. The small group size supports the establishment of a safe secure environment to share and explore parenting experiences.

  The weekly group component of the Project is facilitated by both the clinician and a childcare co-facilitator. In the Project both the clinician and child care workers work in partnership with each other and the family. The primary caregiver (child care) has a vital role in supporting the parent to achieve their set goals. They develop a significant relationship with the child and the parent and work closely with the clinician to develop and enhance the attachment relationship.

  The sessions are a mix of educative and therapeutic activities offering information and resources which assist mothers to reflect on their relationships, to understand the nature of healthy attachment and examine issues that may be inhibiting their capacity to respond to the child's needs.

- *Video taping of parent child interactions for parent reflection*. Video taping is a key intervention tool in the Project. Parents can explore attachment relationship needs by observation and reflection with the clinician both during individual family work and also within the group setting.

- *Partnerships between parents, workers and agencies*. The clinician, parent and primary caregiver (child care) meet on a regular basis to work together to meet the parents goals. Referrals to other service providers and joint case conferencing are regular practices.

- *Learning stories*. Child care primary caregivers develop with the child, stories about their daily activities which communicate from the child to their parent their relationships, learning and development within the child care setting. Families are provided with stories which specifically report on their child in relationships that nurture and support exploration.

- *Staff Training and Professional Development*. Building staff capacity to work with vulnerable families and to apply attachment theory to their work.

- *Specific father's sessions*. When appropriate, short group sessions are provided for fathers which enable them to be involved in some of the activities which are delivered to their partners as part of the 18 week Project.

The Project works directly with up to 7 families in each group and focuses on their particular defenses that are directly impacting on their attachment relationship with their child/children. The childcare provided and group processes facilitated play an

important role in providing a secure base for the parent enabling them to maximize their exploration, reflections and considerations of their relationships with their children.

2.6 Integration of 'Attachment Theory'

The TtLG project is based on Attachment Theory. The intervention draws from the 'Circle of Security' (COS) project model (Marvin et al., 2002) which assists parents and child care staff to understand and integrate attachment theory into practice. The project specifically utilizes the 'COS' graphic. This model provides an understanding of children's behaviour from an emotional needs perspective and has made attachment concepts more accessible to parents and professionals working with them.

3 PROGRAM LOGIC

The program logic is demonstrated in the evaluation plan by clearly linking the project components (overall goal and listed objectives, the strategies to achieve these, the process indicators to address the strategies, the impact indicators to address the objectives and the methods to collect data for these indicators). The components of the evaluation are clearly and logically related. The objectives have been hierarchically ordered (sometimes referred to as an 'outcomes hierarchy') in logical fashion. Moreover the strategies for each objective have also been logically sequenced.

There are a number of ways of explicating program logic. The one chosen here has been popularized through the 'Planning and Evaluation Wizard' (PEW) co-authored by the local evaluator and adopted for teaching evaluation in Public Health Honors and post-graduate courses in at least five Australian Universities. The model used here is most appropriate for participatory approaches as it is intuitively easy to understand and has been applied through Primary Health Care Research and Evaluation Development (PHCRED) in myriad community health and General Practice contexts. This approach was also used by the local evaluator when awarded a 'National Commendation for Excellence in Evaluation' by the Australasian Evaluation Society. The approach has been used in the capacity building activities conducted with TtLG staff as part of this evaluation and has been well received.

The Evaluation Plan Matrix is attached as Appendix A

4 LITERATURE REVIEW

The evaluation draws on Patton's (1997) Utilization-focused Evaluation approach and uses participatory action research procedures (Wadsworth, 1998: Sankaran et al 2001). The evaluation also adheres to the tenets of 'Realistic evaluation' (Pawson and Tilley 1998). The design of the evaluation plan has been based on the PEW model[3] and this with the evaluation procedures adopted has been published elsewhere[4].

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5 EVALUATION

5.1 Evaluation Methodology

The local evaluator liaised with The Lady Gowrie Child Centre Inc South Australia to clarify the goal and objectives of the Project, identify a range of indicators for each stated objective and compile an Evaluation Plan.

The evaluation goal and objectives are:

Goal:
To develop and pilot a model of collaborative early intervention and prevention for targeted parents to improve secure attachment outcomes for young children in five selected child centre sites across Australia.

Objectives:
1. To forge working and sustainable inter-sectoral partnerships across Australia (childcare, health, education and consumer) overseeing and informing the development and management of the Project.

2. Build capacity of participating Childcare Centers to develop and adopt a sustainable integrated primary care-giver system

3a. To equip and empower a range of parents of young children with the knowledge, awareness, confidence and skills to successfully overcome the barriers to attachment
3b. To foster and nurture positive parent well-being outcomes
3c. To foster and nurture positive child well-being outcomes

4. Develop and enhance social support /friendship networks for the target group

5. To develop and promote the uptake of a 'best practice' model for services working with mothers and fathers and children around issues of attachment

This evaluation adheres to the tenets of 'Realistic evaluation' (Pawson and Tilley 1998), which highlights the importance of investigating the reasons why those individuals targeted made or did not make the desired choices or engage in the desired behaviours encouraged by the Project. This approach focuses on what worked, for whom, in what context, and the mechanisms that made the Project work.

The evaluation has been collecting a broad range of triangulated data from identified stakeholders engaged with the project including all clients (mothers) from each Wave. This includes a range of qualitative approaches (in-depth interviews, focus groups, semi-structured telephone interviews and 'rapid reconnaissance'), and quantitative approaches (systematically collected demographic data, self-completion surveys, and the application of pre and post standardized psychometric tools addressing a range of psychosocial and behavioural dimensions). A follow-up telephone survey of all mothers three months after completing the project has been included for the first three waves in order to provide insights into their reflections on the project, further developments and sustained medium term impacts. Longer term outcomes for clients were addressed through a 16-18 month follow-up survey of Wave 2 and wave 3 mothers[5].

This evaluation acknowledges the importance of both the well being of the project clients, and the established (though potentially fragile) inter-relationships between them and the services providers at participating sites. Given the potentially vulnerable client base targeted by the Project, the need for an appropriate, respectful and sensitive approach to the evaluation has been identified. However, the need to further explore the contextual issues and personal experiences raised by participants is also important in order to yield fuller understanding of the project, its operation and significance for those connected with it. The local evaluation therefore purposely engaged with the project team in partnership to facilitate data collection from clients recruited at each TtLG site. An evaluation assistant was located at the Lady Gowrie Adelaide site to further engage with staff, promote the integration and blending of evaluation procedures with those of the TtLG project and to help coordinate the range of data collection procedures across the five sites. Given the need to engage with the women who had completed the project, the evaluation assistant selected was a mature female evaluator who was experienced in conducting qualitative evaluation work with women in the health arena. The evaluation assistant was overseen by the local evaluator who designed and managed the evaluation.

[5] The findings from the three-month follow-up were highly positive and demonstrated sustained benefits over this period for parents and their children. These findings are included in this report. Following a formal presentation of these findings to the Reference Group (as part of the action research process), and given that the model of delivery had reached maturity by this stage, the evaluator advocated redirecting evaluation resources to investigating longer term outcomes for the targeted families. This was supported by the Reference Group. Wave 2 and Wave 3 families were selected to enable the long term outcomes to be addressed within a 'reportable' time-frame.

The local evaluator also conducted much of the primary data collection from professional stakeholders (focus groups of PCGs and interviews with key staff in all project sites).

Given these factors, a 'participatory' approach to the evaluation research was been adopted. This purposely enlists the collaboration of the Project team to help enact suitable and sensitive data collection strategies in order to facilitate the gathering of richer more authentic data from clients, whilst building capacity across the organisation.

The evaluation approach to clients has been guided by the 'inside' knowledge and experiences of these stakeholders in a collaborative sense. Much of the data collection has been integrated into clinical practice. In this sense, the methods applied whilst being rigorous, were also flexible and sensitive to context.

Drawing on Michael Quinn Patton's Utilization-focused Evaluation approach (1997), the ethos of the evaluation harmonizes with that of the Project; The Lady Gowrie Child Centre Inc are effectively engaged as evaluation partners in order to collect evaluation data in contextually appropriate ways.

Additionally, the need to build capacity and sustainability not only of the Project but also with regard to strengthening the evaluation component of future projects conducted by the Lady Gowrie Child Centre Inc was well recognized by the Project staff and the local evaluator. Formal and informal training in planning and conducting evaluation has been provided to TtLG staff drawing on the expertise and experience of the local evaluator who has developed and taught a range of research methods and evaluation graduate and post-graduate courses over 18 years in the UK and Australia. The training process began with the Evaluator liaising with the Lady Gowrie Child Centre Inc in the production of the Evaluation Plan. The local evaluator has also delivered a series of formal task orientated training sessions involving staff from the five project sites, with mentoring being provided throughout the Project.

The evaluation embraces participatory action research procedures (see Wadsworth, 1998; Sankaran et al 2001), whereby findings are relayed back to the Project to facilitate developmental improvement. This is accommodated through both informal partnership channels and liaison with the Project team, and formally through reporting back to the Reference Group throughout the Project. The local evaluator and evaluation assistant were full partners in the Reference Group with 'Project Evaluation' was a standing item on the agenda to facilitate feedback, reflection and action.

This evaluation fully conformed to NHMRC Guidelines, and the ICC/ESOMAR International Code of Marketing and Social Research Practice (2001). Ethics approval for the Evaluation of the TtLG Project was granted by the 'Children Youth and Women's Health Service Human Research Ethics Committee'.

5.2 Evaluation Methods

Evaluation data is obtained through applying a multi-facetted and methodologically triangulated approach. The approach has been flexible in order to adapt to the evolving Project and to minimize disruption to the busy workloads of those professionals approached to participate.

The evaluation uses a series pre and post Project measurement tools and surveys to collect data from mothers, children and TtLG staff. The evaluation toolset is attached as Appendix D.

In consultation with Lady Gowrie Management, the local evaluators established ethically appropriate systems to collect, compile and transfer confidential data from each site to a central point for analysis. This included allocating unique case identifiers to each family, child, site and Wave in order to link the various pre and post data sets. Clinicians were engaged to help collect client data and were provided with client consent forms, evaluation information and summary evaluation sheets for each to complete (see: Appendix D, 1-2).

The Reference Group was requested to identify appropriated standardized instruments to measure a range of psychological and behavioural dimensions related to the project aim. No one instrument operationalised the multifaceted issues addressed and a suite of tests was subsequently adopted (see: Appendix D). This necessitated the use of video recording, external assessment (by professional assessors based in Sydney) and additional staff training. The tools selected for mothers and children where:

Mothers:

- The Hospital Anxiety and Depression Scale (HADS) measures change in a client's emotional state using anxiety and depression subscales (Zigmond & Snaith, 1983);

- Parenting Stress Index Short Form (PSI/SF) questionnaire measures stress in the parent-child system (Abidin RR, 1995);

- Emotional Availability (EA) framework allows for measuring changes in the parent-child relationship based on parent dimensions: sensitivity, structuring, non-intrusiveness and non-hostility and child dimensions: child responsiveness to parent and child involvement with parent (Biringen, Z., et al., 1998; Biringen, Z., et al., 2000). Videotapes of mother and child interactions are assessed by qualified professional EA scorers.

Children

- Children's Wellbeing and Involvement Observations measure a child's levels of wellbeing and involvement while attending childcare, (Laevers, F., et al., 2005) (Winter, P. 2003). Observations are systematically recorded by childcare staff.

The local evaluation has also developed the following evaluation tools: (see: Appendix D):

- Client demographic form based on National Evaluation Service Users Questionnaire;
- Post Project questionnaires to measure mothers and fathers satisfaction and experiences of the TtLG Project;
- Follow-up qualitative telephone interviews with mothers three months after completion of the project to further explore reflections about the project and identify sustained impacts;
- Email surveys for Reference Group members and TtLG co-facilitators

- Interview Schedules for Clinicians and Directors;
- Topic Guide: Qualitative Interview. TtLG Lady Gowrie Management;
- Longitudinal Follow-Up qualitative telephone interviews with mothers 15 months after completion of project to explore sustained outcomes;
- Topic Guide: Focus Groups of Primary Care Givers;
- Semi Structured Interview schedule with Managers, Clinicians, Co-Facilitators.

At the Process Evaluation level the indicators and data collection methods (as specified in the Evaluation Plan Matrix) assessed the implementation and activities of the TtLG Project in relation to the Invest to Grow Project principles. Primary data is being collected from all engaged parents, and professional stakeholders. This has been complemented by observational data collected through 'rapid reconnaissance[6]' conducted at three 'satellite' childcare centre sites.

A range of impact and outcome indicators have been identified and included in the Evaluation Plan Matrix. Whilst these specifically address the defined objectives for the TtLG Project, they also address several of the national priority areas of the 'Early Childhood Invest to Grow Established and Developing Projects 2004-2008 Project Guidelines', namely:

- Supporting Families and Parents to develop strong parent/child relationships, improve parenting competence and style, family capacity and resources, and family functioning.
- Early Learning and Care to improve child social and emotional development.
- Child Friendly Communities that are inclusive of all families and cultures.

The outcomes specified for these priority areas are therefore highlighted by asterisks (*) in the Evaluation Plan Matrix in order to make explicit the linkages to the national Invest to Grow Project.

5.3 Evaluation Challenges and Changes

The TtLG Project was not implemented in synchronization across all 5 participating childcare sites. Given the variety of evaluation data collected during each wave of the TtLG Project (including pre and post Project measures for families), the coordination, collection and compilation of evaluation data was a substantial challenge.

Much of the data collection was reliant on the cooperation and diligence of the clinicians at each of the five sites. The need to plan and clarify data collection procedures was crucial to ensuring this occurred efficiently particularly as the clinicians were all employed on a part-time basis. Whilst these processes were addressed through training and the provision of instructions and forms, the challenges of establishing the new project in Wave 1, (and a degree of staff turnover later) inevitably led to some delays in the collection and return of data to the evaluation assistant.

There were delays with the Reference Group decision making regarding an appropriate attachment measure to be used in the evaluation. Having identified the Emotional Availability tool, it became necessary to provide TtLG staff with training in videotaping

[6] See Beebe, J. (2001) and Handwerker, W.P. (2001)

and editing skills to produce videotapes of mother-child interactions for EA assessments. Logistical difficulties were engendered by the need to identify and engage professional EA assessors to receive and rate videos of child parent interactions from all sites; the only assessors qualified for this task were located in Sydney, NSW and the mechanisms for channeling information from the five sites to the assessors and subsequently transferring assessment scores back to the evaluator in Adelaide needed careful planning and monitoring.

There were also some difficulties collecting the Children's Wellbeing and Involvement Observations scores. TtLG staff representatives received training in making the observations at the July 2005 workshop and returned to their childcare centres where they subsequently trained other staff members. However few observations were made in Wave 1 and staff reported feeling a lack of confidence and skill in applying the scores. Project management subsequently organised additional training and distributed a training video to all sites. This led to an improvement in the number of observations made. Observations subsequently improved. However other factors also impacted on data collection including staff turnover of trained observers and the need to up skill newly recruited staff members.

As a result of this, observation measurements have not been made of all children in the TtLG Project. However as staff become more confident and skilled increasing numbers of observations were made as outlined in Table 1.

Table 1: Application of the Wellbeing and Involvement Observation Tool by Wave

Wave	Number of TtLG Children		Wellbeing Observations		Involvement Observations	
	Start	Finish	Pre	Post	Pre	Post
1	31	28	7	10	10	10
2	28	25	17	15	19	15
3	29	24	24	19	24	19
4	32	31	28	28	27	28
5	31	28	26	27	26	27
Total	151	136	102	99	106	99

Given the complexities of data gathering and staff turnover, the local evaluator has delivered more training workshops than was originally envisaged in the evaluation design. Moreover, the need for the evaluation to acquire a broader conceptual understanding of how the project operates 'in situ' was identified; the local evaluation therefore embraced an additional 'quasi ethnographic' method 'rapid reconnaissance' for this purpose. Through observations and informal interviews with project staff at a 'satellite' site, further insights were gained regarding the practical application of the project which complemented the 'inside' experiences of the evaluation assistant based at the Gowrie Adelaide Thebarton Centre.

The introduction of staff representatives to the reference group mid-way through the project provided the opportunity to acquire on-going information from their perspectives more efficiently. This has been utilised by the evaluation using these representatives as 'key informants'.

The Evaluation Assistant needed to reduce her working hours mid-way through Wave 4 which precipitated the need for greater 'hands on' involvement form the Evaluation Manager / 'Local Evaluator'. This was facilitated through negotiation with the University of Adelaide.

6 EVALUATION FINDINGS AND DISCUSSION

6.1 Objective 1: *To forge working and sustainable inter-sectoral partnerships across Australia (childcare, health, education and consumer) overseeing and informing the development and management of the Project.*

6.1.1 The Reference Group

The Through the Looking Glass (TtLG) Project is a community partnership between:

- Lady Gowrie Child Centre, Adelaide;
- Child, Youth & Women's Health Service (CYWHS);
    - Helen Mayo House, (an acute psychiatric unit for women with children 0-5 years).
    - Child Youth Health

These Project partners established the TtLG Reference Group to provide high level expert advice to guide and inform the overall TtLG Project. Membership is comprised of representatives from the childcare, health, education and welfare sectors:

- Lady Gowrie Child Centre
- Child, Youth & Women's Health Service (CYWHS)
    - Helen Mayo House (HMH)
    - Child Youth Health
- Adelaide University
- University of South Australia
- SA Department of Family and Communities
- SA Department of Education and Children's Services (DECS)
- Consumer Representative
- Local evaluation team (an external evaluator and internal evaluation assistant)

The Reference Group actively contributed to the development of the TtLG Project, its activities and resources. The group has been responsible for the

- Recruitment of an experienced Project Manager
- Engagement of 5 suitable childcare sites in which to pilot the TtLG Project
- Ratification of the evaluation strategy and recommendation of standardized assessment tools.

The Reference Group has met six-weekly for the first twelve months and quarterly thereafter to consider evaluation feedback and review TtLG activities and resources. A consumer attended three of the earlier meetings and provided insights regarding the perspective of clients to proposed project and evaluation procedures.

In response to TtLG staff feedback the membership of the Reference Group expanded to include representatives of the Childcare centre directors, Project clinicians and co-facilitators. Representatives were able to raise issues or concerns regarding Project implementation and relay information back to their respective centers.

An email survey of Reference Group members during the first wave of the TtLG (October-November 2005) found a high level of satisfaction with their involvement in the TtLG Project (see: Appendix E7). Key findings were:

- 100% of respondents reported their partnership with the TtLG Project was valuable for their professional roles and work responsibilities;
- 100% were fully satisfied with their recruitment to the Project;
- 86% were highly satisfied with the progress of the TtLG Project. Additional comments noted concern that the Project implementation was not synchronized across all sites;
- 71% were fully satisfied with Reference Group meeting processes. One person commented on the difficulty of decision making in meetings due to not all members being able to attend meetings;
- 71% agreed that the wellbeing of clients and Project staff were adequately considered during meetings. However 3 additional comments highlighted concerns regarding the number of assessment tools that clients are asked to complete and the workload for clinicians and other staff[7].

Subsequently, on-going engagement with the Reference group was conducted through regular meetings; the local evaluator and the evaluation assistant (the latter being based at the Thebarton site) were members of the Reference Group with 'evaluation' being a prioritized standing agenda item to enable regular feedback, discussion of findings and project actions to be planned.

The Reference Group expertise and advice has informed a range of TtLG strategies including:

- The recommendation of specific standardized tools utilized in the evaluation;

- Development of OHS strategy regarding home visits to TtLG families by Project clinicians. In response to concerns raised about clinicians safety communication strategies between clinicians and childcare centers during home visits were formalized. Prospective families are now asked to visit the childcare centre to assess eligibility for the TtLG Project. This is a more efficient use of clinicians' time and has helped familiarize families with the operations of the Centre;

- Implementation of the modified 'Strange Situation' technique in which one separation and reunion episode between mothers and their children is videotaped and analysed to address 'attachment' – this has been utilized in two project sites.

[7] The evaluation subsequently addressed this issue with clients. Over the five Waves, twelve mothers expressed difficulties with answering the evaluation questionnaires. However, these tended to focus on concerns with the extent to which the standardized instruments reflected the gravity of their situation and feelings, rather than the demands of completing several instruments. The need to talk about these issues was highlighted thus reinforcing the decision to triangulate the evaluation approach with qualitative interviews.

6.1.2 Childcare sites

Five childcare sites were selected to implement the TtLG Project.

- Lady Gowrie Child Centre, Thebarton, Adelaide
- il nido Child Care Centre, Paradise, Adelaide
- Salisbury Highway Child Care Centre, Salisbury Downs, Adelaide[8]
- Lady Gowrie Child Centre, Brisbane
- Lady Gowrie Child Centre, Perth

The TtLG Project based at Lady Gowrie Adelaide has been operating since 2002 and is relatively well know in childcare, health and education sectors in Adelaide. There are regular referrals to the Project and the enrollment in each wave is now at full capacity.

The TtLG Project has been implemented relatively smoothly in the other two Adelaide sites, assisted by the strong inter-sectoral relationships between Gowrie childcare and health and education sectors, ease of communication and convenient locations. The childcare staff and management at all three Adelaide centers are supportive of the principles of the TtLG Project and work in partnership to support families.

Project implementation in the Perth and Brisbane sites has been more problematic. The Gowrie childcare partnerships with health and education sectors are not as strong here and this has impacted on Project implementation outside of South Australia.

Acquiring referrals has been the major challenge experienced for the TtLG project in Queensland. The Queensland government offers a range of well known and popular parenting Projects such as the 'Triple P' and 'Future Families'. Health and education agencies support these well established Projects and have been slow to refer clients to the recently established TtLG Project. However, promotional activity by the Brisbane based clinician has resulted in increased recruitment as the project has developed.

The Perth TtLG Project is overseen by the Community Services section of the Gowrie organisation. Due to administration and planning decisions the TtLG Project has been relocated to a different childcare site during each of the first 3 waves. This has been an acute challenge for Project staff in particular the clinician who has to build relationships with different childcare staff and local referral agencies and communities. These challenges have impacted on the starting times of the different waves.

Whilst Lady Gowrie Child Adelaide has a long established tradition of primary care giving, across the other 4 sites there is broad variation in staff knowledge and understanding of the Primary Care giving and Attachment principles which underpin the TtLG Project. Project management has had to provide additional support and training to other TtLG centers as they implement primary care giving.

6.1.3 Project Management

A Project manager was recruited June 1st 2005. The manager is a senior staff member of the project partner CYWHS and has been seconded from her substantive position in the agency to take on the role.

[8] This is a privately run Child Care Centre

There has been a major public health reform within South Australia with consequent amalgamation of government health departments and restructuring. These reforms have impacted directly on TtLG partner agencies:

- The Project Manager has needed to renegotiate time release to the TtLG Project from her substantive role in the agency. Her time commitment to the Project has reduced from 1.0 (full-time) in Waves 1 and 2, to 0.6 in Waves 3 and 4 and has further reduced to 0.5 for Waves 5 and 6, the remainder of the Project. This has resulted in a substantial impact on the manager's workload;
- The CYWHS Chief Executive Officer who was a co-developer of the initial Project submission has left the organisation.

Each child center agency across the three States operated autonomously and had their own policy statements and managerial structure. This generated some difficulties with regard to accountability and responsibility.

Whilst the project was managed and funded through Gowrie Adelaide at Thebarton, the clinicians, being located at specific sites were also subject to managerial requests and structures germane to those sites[9]. This caused some difficulties which may not have occurred had the project been run across sites which were accountable to a single organizational management structure. Establishing MOUs for all participating sites, stipulating the reporting and implementation requirements of the project and the roles of participants and supervisors may have helped to alleviate these problems.

These difficulties were circumvented where there was a keen commitment to the TtLG project at the managerial level and good communications and on-going relations with Gowrie Adelaide (e.g. with the Brisbane site). This was less evident in the Perth site, and disagreements arose regarding the implementation of the project, reporting requirements and adaptations to the model. Staff turnover amongst key players and management exacerbated this and Perth prematurely left the project on completion of Wave 5. It is notable that all the key players interviewed from the Perth site were very positive about the project and regretted its ending. Certainly, the Perth sites are currently formalizing PCG and seeking to retain other elements of the project in their practice.

6.1.4 Project Staff

i. Recruitment, Retention and Communication:

For each site, the TtLG team includes the Directors of the Childcare Centers and the TtLG staff team working directly with families comprising:

- A clinician from a health profession (i.e. social work or psychology),
- A co-facilitator, a qualified childcare worker who assists the clinician in the weekly group session and also liaises with the primary caregivers.
- Primary caregivers, the childcare workers who are the 'prime' carers of the TtLG children.

There has been a turnover of primary caregivers across all sites. This reflects the workforce issues in the children's service sector across Australia[10]; nationally there is a

[9] Clinicians also reported to their clinical supervisors.
[10] See: 'Reflections': Issue 27, Winter, 2007. Gowrie Australia

high staff turnover and shortage of trained childcare staff. This has implications for the TtLG Project as new childcare staff require training in primary care giving and attachment theory.

Whilst staffing at the clinician and co-facilitator levels has been relatively constant in two of the South Australian centres, there has been some staff turnover experienced at other sites:

- The Lady Gowrie Child Centre Adelaide at Thebarton, site of the original pilot TtLG Project, has a stable TtLG team with the original Project staff clinician and co-facilitator remaining in their roles.

- The il nido, Adelaide site also retained a stable TtLG staff team of clinician and co-facilitator across Waves 1, 2 and 3.

- Salisbury Centre experienced a turnover of clinician after Wave 2. The new Clinician started prior to the commencement of Wave 3. The first three Waves have each had a different Co-Facilitator in place, although the person employed for Wave 3 is currently engaged with Wave 4 and should complete Waves 5 and 6.

- Brisbane site experienced difficulties recruiting a clinician, with the two initial appointees resigning before the Project commenced. However the current clinician has successfully implemented the TtLG Project for 3 waves. The original co-facilitator has worked on all 3 waves.

- Perth TtLG Project staffing issues have been exacerbated by the relocation of the TtLG Project across 3 different sites in each wave. There has been a different co-facilitator and centre director for Waves 1, 2 and 3. The clinician has recently left the center following Perth's withdrawal from the Project after Wave 5.

The geographical dispersion of sites has limited the number of collective staff meetings across the Project. However, this has occurred on a number of occasions presenting opportunities to provide capacity building training, exchange experiences and provide evaluation feedback to stakeholders (see: Section 6). Regular teleconferencing and group e mail discussions have occurred for the Clinicians, Managers and Centre Directors.

The implementation of the first waves of the TtLG project required an intensive training program, which whilst being well received and beneficial, nonetheless generated additional workloads for staff engaged with the project. In the early stages the staff were grappling with the project whilst awaiting training in specific areas. There was some anecdotal evidence that initial increased workload may have contributed to staff turnover early in the project. A longer period of induction prior to taking on TtLG clients would have helped to address this.

The evolution of a PCG culture in the workplace has alleviated staff workload as the project progressed; the practice is no longer seen as 'additional' to existing work, but has become "*the way things are done here*". However some staff whilst highlighting the rewarding professional and personal benefits have also pointed out the additional emotional demands the PCG approach generates, the "*Ying and Yang of the circle of Security*".

The amount of training required by the project was comprehensive and intensive and has developed a more capable, skilled workforce (See: Section 6.2.1). These factors have raised questions concerning staff remuneration:

> *'We're better trained and provide a better more intensive service than anywhere else in the sector, so I think we should be rewarded for that in some way'.*

Whilst sites could accommodate individual staff changes, where several staff need to be replaced, a lull in project activity is inevitable whilst new staff are inducted. The preferred option raised by stakeholders is to take measures to retain project staff.

A potential suggested solution to optimizing staff retention and recruitment is to establish a form of accreditation for those who have undergone training. A potential paradox here is that gaining qualifications/credentials from involvement with the project may broaden employment options elsewhere and hinder staff retention. Linking accreditation with a specified period of practice experience might alleviate this. Improving financial remuneration would also help to retain staff. Given the considerable investment in training, and the additional expense of training new staff, this option should be given serious consideration should the model be extended or adopted.

ii. The Role of the Clinician

Feedback obtained through a telephone survey, from interviewing the clinician's Reference group representative and from the Professional Stakeholder Survey conducted after the completion of Wave 4, has revealed strong support for the content and strategies of the TtLG Project and satisfaction with the positive outcomes that are achieved with the participating families. Clinicians are also very satisfied with the individual clinical supervision with experts in attachment and early childhood which has been organized through the TtLG project manager.

The clinicians' role was central to the delivery and running of the project at each site. In practice, this extended beyond direct responsibilities relating to the participating mothers and children. Additional roles identified in this evaluation have included:

i. training and induction of staff in the primary care giving approach and project processes;
ii. promoting the project and approach ("marketing the project") in the community;
iii. Supporting the emotional needs (through debriefing sessions) of PCG staff that have engaged and formed close relationships with project families[11].

Whilst clinicians were expected to network with peers and other agencies in helping to identify potential coordinated options for clients in need (including recruitment and potential follow-up after the project), broader promotion rested with each participating Director.

PCG promoted the development of close relationships with mothers, children and families who were experiencing (sometimes profound and on-going) personal problems;

[11] It is noteworthy that the additional roles ii and iii identified above were not envisioned as clinician responsibilities in the project model and essentially these responsibilities resided with the centers CEOs.

subsequently there was a potential to cause a degree of empathetically nourished emotional distress in PGCs. Whilst the well-being of staff resides with the site manager, the expertise of the clinicians and their centrality to the project precipitated their allocation to or adoption of the staff support role. Clarification of this role and the procedures for its enactment varied across sites and has not been stipulated in the model.

Taking on these roles required the development of new skills in addition to re-orientating to the PCG philosophy and becoming familiar with the TtLG procedures[12]. Moreover, the need to engage with the range of data collection activities for the evaluation added to workload. This was particularly demanding for clinicians in the early stages of the project which would have benefited from more preparation time. Subsequently, the implementation of the project was viewed as being too hasty; staff were broadly of the view that the first Wave of clients were recruited too early and that they were not fully equipped to handle the tasks required early on.

The need for more time to embed clinicians in their respective child care sites was also evident. Many of the clinicians were from welfare backgrounds and did not have prior experience working collegially with child care workers. Certainly the extent to which PCG was operationalised was unfamiliar territory for staff operating at some sites. For other sites PCG had already been established. However, for all sites, more preparation time prior to the first Wave of clients would have helped to establish the PCG practices and collegial working environment encouraged by the project.

iii. The role of the Co-facilitator

Evaluation feedback was collected from the TtLG co-facilitators through email survey, a follow-up interview with the co-facilitators' Reference Group representative and through the professional stakeholder survey. Overall the co-facilitators are very satisfied with the content and strategies of the TtLG Project and their involvement with the families.

In particular co-facilitators valued the training that they had received in Primary Care giving, Attachment Theory and group facilitation.

Co-facilitators acted as two-way conduits between the clinician and PCGs. Good relations between clinicians, co-facilitators and primary care givers were viewed as crucial to the project working at an optimal level. Contextual differences were evident across the sites. In Queensland, the 'grass roots' experience of the clinician was viewed as providing the advantage of greater understanding of the complexities and pressures experienced by PCGs. Here, the co-facilitator was also a director at one of the Brisbane sites which was viewed as having an 'equalizing' status effect with the clinician, but also provided more impetus to disseminating information about the project and encouraging the uptake of staff training.

The need to clarify roles and responsibilities of co-facilitators and clinicians was evident early in the project; disagreements here were deleterious to the efficient functioning of the multi-disciplinary team approach. However, these issues were resolved over time (and in some cases after staff changes had occurred).

[12] The need for clinicians to develop their pedagogical skills for training is discussed in Section 6.2.5.

6.2 Objective 2: *To build capacity of participating Childcare Centres to develop and adopt a sustainable integrated primary care-giver system*

6.2.1 TtLG Training and Staff Development

Project management has developed an inclusive program of training for all TtLG Project staff including primary care givers of TtLG children, co-facilitators, clinicians and childcare centre directors and managers. Staffs at the 5 participating childcare sites receive ongoing attachment theory and primary care giving training. Clinicians also have access to regular professional clinical supervision. Training in evaluation and conducting focus groups was also provided by the local evaluator.

An Action Learning approach has been adopted in order to deliver, evaluate and refine training program. Reflective action learning activities implemented within each site following the initial first round of 'site based' training assisted with the identification of specific needs and gaps in knowledge, skill and confidence which informed the content of subsequent sessions as well the development of additional training modules.

Formal Evaluation data has been collected from each of the main internal training activities conducted for staff across all five sites; this is presented in Table 2. All workshops below were conducted at Adelaide with the exception of the two waves of short training sessions which were delivered 'in situ' across all five sites. The Project has been particularly active in delivering formal training to Project Staff from all participating centres; the amount of formal training activity has exceeded that originally detailed in the Evaluation Plan.

The training plan for 2007 – 08 financial years was reviewed in consultation with all site teams and the project manager to ensure that staff development requirements relating to the project were identified and accommodated into the final year. Each participating site continued to focus on consolidating and building on the previous years learning.

Each site continued to utilize the skills and expertise of staff (usually the clinician) within the individual site at the local level. The clinician session outlines for in-service training were shared via email with follow up communications regarding the information to be delivered. Sessions focused on Attachment and PCG and were integrated into the monthly staff team meetings.

Mentoring was providing through staff exchanges between sites and this occurred between Adelaide and Perth and Il Nido and Salisbury (August-September 2007).

Articles of interest were circulated and several attachment focused reference books were purchased for staff access. Examples of articles circulated were:

- AFRC Briefing Paper on Building relationships between parents and carers in early childhood
- The Circle of Security: roadmap to building supportive relationships, Robyn Dolby

- Pam Cahir, What matters in Early Childhood? A conversation with leading national and international experts.[13]

[13] References supplied by the Project manager TtLG

Table 2: TtLG Formal Internal Training Activities Across Sites.

Training	Date	Attendees	Training Project Content
1. A series of short training sessions (Two sessions at each site delivered by two Adelaide Gowrie Staff)	July 2005 to November 2005	All Childcare staff from participating TtLG centers (n=105)	Primary care giving Attachment theory Circle of Security and Repair TtLG Project information
2. Two-day TtLG introductory workshop	July 2005	TtLG team representatives: clinicians, co-facilitators, primary caregivers and centre directors (n=26)	Attachment theory and Circle of Security Children's Wellbeing and Involvement Observation Scales TtLG Project processes (referrals, assessments etc) TtLG Evaluation
3. Three-day workshop at the end of Wave 2	August 2006	TtLG team representatives: clinicians, co-facilitators, primary caregivers and centre directors (n=15)	The TtLG documentation (manual, forms, session activities) TtLG Evaluation Group facilitation Video work with parent Reflective practice for childcare staff TtLG training plan for childcare sites
4. Two-day workshop end of Wave 3	February 2007	TtLG team representatives: clinicians, co-facilitators, primary caregivers and centre directors (n=17)	Team building – family case study sculpturing exercise Reflective practice Emotional Availability Assessment Interpreting Parent Child Dyads
5. Project Day	April 2007	TtLG team representatives: clinicians, co-facilitators, primary caregivers and centre directors (n=20)	Project review focusing on the TtLG principles of partnership, collaboration and integration.
6. Kent Hoffman Two-day Circle of Security Training	August 2007	TtLG Representatives from all five sites	Introduction to Core Sensitivities
7. Kent Hoffman – Two-day Advanced Training	August 2007	TtLG Representatives from all five sites	Advanced Core Sensitivities
8. Marte Meo – Five –Day Training program	Feb 2008	TtLG Representatives from four sites	Developmental Support Program

The formal Evaluations of training sessions appear in Appendix E.

The action learning approach has embraced the identification of and response to staff concerns which required further development and support. For example, whilst sessions

1 and 2 were planned as part of the Project model, subsequent sessions 3 and 4 arose from communication between management and the Project team which identified issues requiring further staff development.

6.2.2 Summary of Evaluation Findings from each capacity building activity conducted across sites.

1. ***Childcare Staff Training***

A series of Primary Care giving and Attachment Theory training sessions were offered to childcare staff at each of the 5 TtLG sites during Wave 1 of the Project. Attendees reported high levels of satisfaction with their training and perceived the training as useful and appropriate for their work practices.

93% (n=98) of respondents identified helpful aspects of the training. The Circle of Security and Circle of Repair concepts were identified as the most helpful aspects of the training. Printed materials, group discussions and role playing with other childcare workers clarified and reinforced these concepts. Other helpful aspects of training included information on professional boundaries 'looking after ourselves'; reflection and review of primary care giving information.

88% (n=92) respondents rated the overall training as very good to extremely good.
80% (n=84) respondents found the training content very useful to extremely useful.

90% (n=94) reported they would implement the training into their work practices. The most frequently described implementation strategies focused on the childcare worker becoming the secure base in the Circle of Security, using reflective practices and team work.

> *'I will be more understanding, listening to children, 100% available ...not just being there';*
>
> *'Thinking about the child first and focus on feelings not behaviours';*
>
> *'I will be more understanding, more realising the child's reaction is from their unexplained feelings and emotions not just their attitude;'*
>
> *'I will reflect more on my own feelings and thoughts, will be bigger, wiser and kinder'*
> *"I will continue to work as a team, communicate, support and reflect on primary care'.*

88% (n=92) perceived the training as beneficial for families at their centers

> *'Children will feel safe that you're there for their needs. Parents will feel secure leaving their children with people that understand them';*
>
> *'Better attachments, better understanding of what parents feel as they drop off their child';*
>
> *'Building trusting relationships, using knowledge and applying it to parents with secure base wording about attachment theory';*

'Forming relationships to give a sense of security and comfort…families will have an understanding of our involvement with their child and I will have a better understanding of their child';

'Improved transitions in and out of our room…assisting parents understanding of enrollment';

'Increased understanding of children's behaviours has made me reflect back on some children in my care and understand their behaviours'.

2. July 2005 TtLG Project Team Training Workshops, Adelaide[14]

Workshop training items:

- Attachment theory and Circle of Security
- Children's Wellbeing and Involvement Observation Scales
- TtLG Project processes (referrals, assessments etc)
- TtLG evaluation plan

Attendees reported high levels of satisfaction with the workshop format, Project and organization:

- 90% agreed to strongly agreed that the training materials were clear and easy to understand;

- 95% agreed to strongly agreed that they felt equipped with skills to use the attachment model in their work;

- 75% of attendees reported multiple benefits from attending the workshop including increased understanding of TtLG Project strategies, networking, learning about other workers roles and experiences.

3. August 2006 Workshop, Adelaide

Workshop training items

- The TtLG documentation (manual, forms, session activities)
- Introduction to Evaluation and the TtLG Evaluation plan
- Group facilitation
- Video work with parent
- Reflective practice for childcare staff
- TtLG training plan for childcare sites

Attendees reported high levels of satisfaction with the workshop activities, training materials. In particularly all co-facilitators (n=5) reported an excellent overall rating for their specific group facilitation training including relevance of the course content, quality of training handouts and the trainers' facilitation of the workshop.

Workshop attendees participated in group evaluation activity brainstorming responses to evaluation questions outlined on a whiteboard. Responses highlighted the Project success factors and impacts, and areas of concern.

[14] Summary Evaluation Reports from each workshop appear in Appendix E

4. February 2007 Workshop, Adelaide

Workshop training items:

- Team building – family case study sculpturing exercise
- Reflective practice
- Emotional Availability Assessment
- Interpreting Parent Child Dyads

This workshop Project was informed by an action learning approach based on feedback that there was a need for role clarification and a clearer understanding of the ways in which the different workers engage with a TtLG family.

Participants were asked if there were changes in their understanding of the various roles in the TtLG Project:

- 77% reported some increase to quite an increase in their understanding of other staff roles;
- 59% reported some increase to quite an increase in understanding their own role;
- 35% indicated they already had a clear understanding of their role and hence there was no change.

In the overall rating of the training:

- 71% agreed the team building exercise was useful;
- 83% agreed to strongly agreed the Project 'sculpturing' exercise was relevant to their work;
- 83% agreed to strongly agreed that the style of presenting was good;
- 77% agreed to strongly agreed that the training materials were clear and easy to understand.

Additional comments indicated that clinicians would prefer to explore and discuss Project components which relate more specifically to their role.

> *Should be additional training for clinicians as a separate group to explore at a deeper level in order to support the work we do in the group'.*

5. TtLG Project Day 30th April 2007, Adelaide

This Project Day reviewed the TtLG principles of partnership, collaboration and integration.

Feedback from the February 2007 workshop informed the planning of this Project day. Representatives of key players within the TtLG Project (centre directors/managers, clinicians, co-facilitators and primary caregivers (n=20) reviewed the TtLG Project 'through the lens of the underpinning principles of partnership, collaboration and integration'.

Group discussions identified a range of factors that require further action by Project management.

1. Investigate communication options and guidelines regarding working with families taking into account professional boundaries and confidentiality.

2. The roles of each Project team member to be reviewed and documented to reflect more accurately the specific roles and associated responsibilities.
3. An induction package to be developed for new staff joining the Project, in particular new childcare staff.

Project management is currently working on addressing these factors.

Evaluation data from childcare centre directors indicates that childcare staff are supporting primary care giving practices. Directors reported that childcare staff now:

- place more importance in relationship based care as their knowledge about attachment theory and in particular the Circle of Security has grown;
- disseminate parenting information more confidently to the wider parent body (e.g. sleeping information);
- use attachment theory in their Learning Stories to inform parents of the importance of providing a secure base for children to return to;
- The co-facilitator from one site has commenced a post-graduate Degree in Infant Mental Health, which is developing her capacity to better support the TtLG families.

6.2.3 Internal Training Sessions conducted within sites.

There has also been regular 'site specific' training delivered on a monthly basis within each Centre. These have allowed contextual issues for each Centre to be explored with regard to applying the TtLG Project. The areas addressed in this 'internal' training have included:

- Revisiting attachment concepts and primary care giving as the approach to child care in the centers;
- Mandatory Reporting;
- Professional Boundaries;
- Reflective Practice;
- Video taping, worker child dyad;
- Ferre Laevers Children's Wellbeing and Involvement Scales Implementation[15];
- Review of TtLG evaluation activities to ensure that staff are confident in their application;
- A child care worker was supported to visit WA Perth and Brisbane sites from Adelaide to deliver an update on primary care giving and to provide follow up support in the rooms;
- Revision and update Attachment and Primary Care giving;
- The COS review and introduction to State of Mind Concept;
- Being Emotionally Available;
- A single induction session was held to support new staff and other staff as an update. These staff were not familiar with the underpinning theories of the Project, the Project itself its components and associated activities;
- Training in 'Learning Stories'. Staff with the relevant expertise visited sites and presented the information.

[15] This was implemented following identification of difficulties encountered by some staff in Wave 1 (see: Section 5.2). This training was complemented by the distribution of a training video (see: Section 6.2.4).

6.2.4 Externally Provided Training / Conferences and Workshop

The project has actively engaged external expertise to provide additional specialized training directly relating to aspects of the TtLG project (see: Tables 3 and 4).

The training received by staff through the project has been extensive. Staff across the board expressed profound impacts in the ways they interpret and respond to child behaviour, the adoption of PCG in professional practice, the utilization of new skills in early childhood education. Several staff indicated that the training had been a revelatory insight to the human condition, and had informed relations between staff, staff and clients, staff and management and social and personal relationships outside the workplace. Managerial practices had also been influenced.

The Kent Hoffman training was specifically highlighted as the most substantial impact for clinicians and co-facilitators[16]. The 'Marte Meo' training (again utilizing video methods) was also cited as particularly beneficial. Training of less use was the 'sculpturing' exercise and team gatherings which had been, according to some stakeholders, mislabeled as 'training'.

A caveat here was that in promoting the PCG approach, there was a danger of devaluing existing staff skills. However, this pitfall was successfully avoided. The strategy of promoting and explaining the PCG rather than critiquing existing practices was well recognized. Having received training in the approach, seen it in action and practiced it professionally, staff were convinced of its benefits and relished the opportunity to engage with it. The training has also promoted an awareness of the need for and a desire to continue with on-going learning in PCG. The experiences have in this sense set several staff on a new educational pathway:

> *'I've been studying infant mental health and I'm now doing a Masters… this was totally influenced by the project'.*

6.2.5 Professional benefits and Working Practice Improvements

Workers recognised some need for some of their peers to be persuaded initially to consider the PCG approach as changing work practices took time and some motivation, and in some cases they alluded to colleagues who had yet to fully adopt it. However, all were convinced that once established PCG became irreplaceable, and highly valued by its adopters. The need to ensure that 'this is how we do things here' through policy, training and the professional practice of all workers underpinned this. Where this became established, the practice of PCG and working in child care generally was viewed as became easier:

> *'When something new comes along, you always get some people who are reluctant to change at first unless they have to. But there's no doubt in my mind*

[16] It is notable that several key players applauded the training sessions received in evaluation. Whilst this is consistent with the findings from self-completion a survey, given the evaluator was conducting the interviews a degree of 'Hawthorne effect' cannot be excluded. However in two cases stakeholders affirmed that the learning acquired through the evaluation training had been applied in other projects ran from the center.

that once this has happened, and people start to see the benefits it then comes easier';

'Yes, when you start practicing it and seeing how it works, you just want to learn more about it and experience it more. It's changed how I work. You just start thinking differently and reacting differently. Using the circle of Security. Much better';

'I'd say that child care work's been made easier by PCG. Your working more with the family and it makes child care a much more positive and growing experience for everyone';

'When you see how the project effected some of the children and mums, you know its made working life easier because some of these mums we'd be seeing anyway… The bond you make with the children and the family';

'It was a bit daunting at first, and a bit stressful. But no, it's got easier and easier. Once you have it (PCG) and it's established you'd never go back';

'It's made work more pleasant and positive. There's actually less pressure and stress than before the project now'.

The cultural change in ways of working has benefited service provision for other children attending the centers:

'The project has really equipped us to handle all kinds of difficulties. You get past the behaviour and start addressing underlining causes I suppose. It's really helped us in working with all kids at the centre'.

The professional benefits gained and the benefits for child care practice generally has led the primary care givers to champion and advocate for the more whole sale adoption of the PCG approach in the sector:

'We need to promote primary care giving generally and the project in particular. I just couldn't work any other way now. It's just so much better than before and has mad the job so much more enjoyable and rewarding. It's been a pleasure to come into work!'

'We need a broad change so that all child care centers adopt the approach'.

The professional impact of the approach on those engaged with the project has been profound and influenced career paths for PCG staff:

'It's been fantastic for me; it's really changed the work I work and what I want to do in the future work wise. I want to do more of this. It's been an absolute joy to see the real differences you can make in people's lives';

'I've decided to try and take things further and to do some post-grad studies in this area';

'I originally thought of the job as a bit of a stop-gap thing really, although in my case it's lasted longer than I intended. But this project and the primary care giving approach and the training and everything, well it's just blown me away. I can definitely see a future in working in this area now… yes, I shall look to develop my career in this area now'.

6.2.6 The Need for on-Going training

Staff turnover across a number of sites emphasized the need for on-going training in PGC and the procedures of the project (see below). Given the centrality of the clinician and co-facilitator to the project and their intensive engagement with it, they are well placed to play a central role in training staff in these areas. Elements of the project Manual contribute to this. It is also the case that other child-care staff have also become skilled in these areas and could potentially take on training responsibilities. Additional the need for more professional staff appraisal procedures to identify training needs was identified.

Given the profound re-orientation toward PCG needed in some centers, this training activity is crucial. Both clinicians and co-facilitators have been happy to take on this role both through formal training and informal mentoring activities. However, currently neither clinicians nor other staff have received training in practical capacity building skills, the "how to" procedures of running workshops.

The model would benefit from identifying specific staff as PGC/TtLG trainers, and ensure they are equipped with the pedagogical skills to deliver capacity building sessions for other workers as required. These sessions might supplement or replace PCG training delivered as part of staff induction.

6.2.7 Capacity Built Through Multi-Disciplinary Working

The application of a multidisciplinary approach to child care provided new ways of working which benefited staff by enabling access to a range of expertise and through promoting an appreciation and raised awareness of the insights and skills of contributing stakeholders. Stakeholders felt that the project has subsequently helped to raise the profile of child care expertise and the professional recognition of child-care staff.

Several clinician and co-facilitator staff have indicated profound influences on their professional development through engagement with the project. This has been mirrored in reports of changes in career pathways:

'It's put me on a completely different career path';

'For me, I've discovered a whole new pathway in my career… I want to keep working with families and kids, not just as a child care worker'.

At the management level, the learning acquired through establishing and managing a multi-site project involving the complexities of multi-disciplinary team-work was highly valued.

The engagement of the Reference group was also valued. An unexpected outcome from this was the embedding of two research students at Gowrie in South Australia engaging with related projects:

- 'Secure and insecure attachment relationships in a preschool, long day care setting'. Masters thesis, School of Psychology, University of Adelaide, 2006
- 'The attachment relationships between toddlers and their caregivers in child care'. Sophie Mumford , Honours thesis, School of Psychology, University of Adelaide, 2007

The project has also promoted staff collaboration across the Lady Gowrie sites for the first time. Clinicians and managers from outside of South Australia have been keen to point to the support and training supplied by the Gowrie Adelaide Centre. This centre has also acted as an example of a working model for others and staff benefited from visiting the centre and seeing the project operating first hand. However the extent of collaborative relationships varied across sites; Perth questioned the need for inter-site collaboration given its differing mission and community development focus.

6.2.8 Operational Issues

Directors of childcare centers have raised concerns with Project management regarding the practical capacity of sites to embrace the workload generated through the TtLG project:

- The process of keeping childcare places available for TtLG families can sometimes impact financially on the centre's operation, particularly when a family withdraws from the Project at late notice.
- The challenge of finding spaces for the wide age range of children in each TtLG wave. This was particularly difficult when there were numbers of babies in the Project due to tight staffing ratios in the babies' rooms. Directors have identified the need to consult closely with the clinicians in regard to accommodating the children of TtLG families. Clinicians may need to vary the enrollment of families across different waves depending on the age range of children.
- Many families continued with childcare after they complete the group TtLG Project. This can sometimes lead to a 'cumulative' impact on staff workload as these families (some with on-going problems) continue to look to childcare staff for support with their child at the same time as 'new' TtLG families join the centre.
- It is sometimes difficult for directors to release staff for TtLG activities due to the shortage of childcare staff. At times there is no staff member available to backfill a vacancy. An overall industry sector shortage of staff impacts on directors' capacity to release childcare workers from the centre rooms.

Many mothers retained the child care services after leaving the project and were subsequently still in regular contact with their PCG. The project has promoted the development of greater understanding between PCG and client informed by 'inside' knowledge of family circumstances; in some cases personal circumstances have been exchanged in a reciprocal process of trust development and the forging of friendships. Whilst this was viewed as highly positive, the nurturing of close relationships during the project created the potential for further working demands for staff from clients who had completed it. There was evidence of some need for further guidance or an 'exit strategy'

which clarified the professional aspects of the nature of the relationship post project for all agents.

Summary

Clearly the TtLG project has been very active in providing a range of capacity building activities to staff across the five project sites. This has built capacity to adopt and deliver a sustainable integrated primary care giving system, which in turn supports the TtLG families and improves attachment outcomes. This has allowed the organisation to deliver better services for targeted families and their children, (a national 'Invest to Grow' priority).

Table 3: Conferences / Workshops Project Staff Supported To Attend

Date	Event	Details
Aug 2005 /University of South Australia	UNI SA de Lissa Oration for Children's Week 'Giving Children the Emotional Oomph to Learn- Relationships and Their Importance to Learning'	Staff from 3 Project sites in South Australia Attended Sessions
March 06 / Adelaide	ARACY Conference 'Capacity Building'	Project Manager and Evaluation Assistant Attended Session
May 2006 / Adelaide	Parenting Imperatives Conference: "New Perspectives, New Directions, New Connections"	Staff Attended Workshop 'An Introduction To The Incredible Years- Parent, Child and Teacher Projects'
May 2006 / Adelaide	Parenting Imperatives Conference: "New Perspectives, New Directions, New Connections"	Staff Attended Workshop 'The Father Involvement- Building of Children's Character'
July 2006 / Paris	International Attachment Conference	Clinician Attended
Aug 06 / Adelaide	DECS District Early Years Conference : Children's Wellbeing	Staff from 3 Project sites South Australia Attended Sessions
Oct 2006 / University of Adelaide	Healthy Development Adelaide 'Early Childhood Development- The Dawn of a Paradigm Shift'	Staff from 3 Project sites in South Australia Attended Sessions
Oct 06 / Adelaide	Helen Mayo House Perinatal and Infant Mental Health Conference- 'Controversies In Infant Mental Health'	Clinicians from 3 Project sites South Australia Attended Session
Nov 06 / Adelaide	Australian Centre for Child Protection Seminar Series	Staff from 3 Project sites in South Australia Attended Session
Dec06 / Adelaide	Child Abuse Prevention Projects: What Works	Staff from 3 Project sites in South Australia Attended Session
March 07 / Adelaide	Early Childhood Research Seminar Series presented by the Thinker in Residence Dr Frazer Mustard	Staff from three South Australian sites attended
May 07 / Adelaide	Perinatal and Infant Mental Health Services Conference, 'Feeling Attached'	Staff from three South Australian sites attended
May 07 /Sydney	Pickler Approach in early Childhood education and Care 1 day workshop	Staff from all five sites attended

Table 3: continued		
May 07 /Adelaide	Summer Symposium, session provided by Dr Helen Buckley "Developing a framework for assessment of vulnerable children and their families"	Staff from three South Australian sites attended
Sept 07 / Perth	Working With Men Workshop – Relationships Australia	Staff from the Perth site attended
Oct 07 / Perth	The Childhood Trauma Conference (Bruce Perry) Brain Development	Staff from the Perth site attended
Oct 07 / Adelaide	Bower Place Training centre – attachment workshop	Staff from Thebarton attended
Oct 07 / Adelaide	Helen Mayo House Annual Conference, 1 day conference	Staff from three South Australian sites attended
Nov 07 / Adelaide	'Its all about Relationships', training by Patricia O'Rourke and Mandy Seyfang,	Staff from three South Australian sites attended
March 08 / Adelaide	Our Children the Future seminar presented by Margay Whaley and Ron Lally	Staff from three South Australian sites attended
April 08 / Newcastle	National Indigenous Conference	Attended by one staff member
April 08 / Newcastle	'Engaging Fathers' Workshop	Attended by one staff member

6.3 Objective 3:

3.1 To equip and empower a range of parents of young children with the knowledge, awareness, confidence and skills to successfully overcome the barriers to attachment
3.2 To foster and nurture positive parent well-being outcomes
3.3 To foster and nurture positive child well-being outcomes.

The following findings are taken from data amalgamated across all project sites for Waves 1-5 (August 2005 – April 2007).

Primary evaluation data was collected from mothers using a self-completion post-project questionnaire administered universally on completion of the Project. If mums who did not complete the program are excluded, this yielded a response rate of 100% (n=106). This was further triangulated with the application of the pre and post standardized tools to assess project impacts. A further telephone survey of mothers from the Project's first three waves was conducted three months after Project completion yielding a response rate of 82% (n=50)[17]. A further follow-up survey of mothers from Wave 2 and 3 was conducted sixteen-eighteen months after project completion in order to address sustained outcomes for families. This yielded a response rate of 73% (n=29)[18].

As mothers were the primary group targeted and engaged in the intervention, most of the findings presented in this section relate to this group and these are triangulated with findings from other stakeholders where appropriate. Fathers attending formal group sessions organised through the Gowrie Adelaide center (including fathers from the il nido center) where also surveyed, yielding a response rate of 58% (n=14)[19].

6.3.1 Process Evaluation - Mothers

i. Recruitment and Retention of Families to the TtLG Project

A total of 118 families have been recruited to the Through the Looking Glass Project to date. In 2 of these families the grandmothers of the children participated in the Project as they were solely responsible for the children.

Formal TtLG sessions for fathers has occurred at the Gowrie Adelaide centre at Thebarton where 24 fathers (partners of recruited mothers) have attended. A summary evaluation report of these sessions appears in Appendix E2. There is some anecdotal evidence of individual consultations with fathers occurring at other sites and an informal group session at Perth.

[17] See: Summary Report Appendix E1.
[18] See: Summary Report Appendix E14.
[19] See: Summary Report Appendix E2.

Table 4 outlines family enrollment across the 5 sites for each Wave.

Table 4: TtLG Families enrolled in TTLG Waves 1, 2 & 3

Childcare Sites	Wave 1		Wave 2		Wave 3	
	Mothers	Children	Mothers	Children	Mothers	Children
Thebarton	7	8	6	6	7	8
Il nido	6	9	4	6	4	7
Salisbury	4	6	5	6	4	4
Brisbane	2	3	3	3	3	3
Perth	4	5	6	7	5	7
Total	23	31	24	28	23	29

Childcare Sites	Wave 4		Wave 5		Total	
	Mothers	Children	Mothers	Children	Mothers	Children
Thebarton	6	7	5	6	31	35
Il nido	5	6	5	6	24	34
Salisbury	5	10	4	6	22	32
Brisbane	2	2	6	6	16	17
Perth	5	7	5	7	25	33
Total	23	32	25	31	118	151

One hundred and six families (90%) completed the TtLG Project including 136 children (see: Table 5). Four recruited families failed to commence, and eight withdrew participation from the Project prior to completion.

Table 5: Total Enrolment and Completion Rates (Mothers and Children)

WAVE	Enrolled		Completion rates	
	Mothers	Children	Mothers	Children
1	23	31	21 (91%)	28 (90%)
2	24	28	21 (86%)	25 (89%)
3	23	29	19 (83%)	24 (83%)
4	23	32	22 (96%)	31 (97%)
5	25	31	23 (92%)	28 (90%)
Total	118	151	106 (90%)	136 (90%)

For the twelve families who began the project but did not complete, a range of reasons for their departure were given, however none of these were attributed to the project itself. Reasons provided were: Work commitments, Child sickness, Family moved interstate, and child enrolled in another centre.

ii. Demographic Characteristics of Participating Families

Demographic information about mothers and children was collected using items from the National Evaluation Service Users Questionnaires. A spread of ages was engaged by the Project; whilst the majority of mothers were under the age of 35 (56%, n=60), 39% (n=41) were in the 35-44 age bracket, with ten mothers being 18-24 (see: Table 6).

Table 6: Mothers Age range

Age Range(years)	N	%
18 -24	10	9
25 -34	50	47
35 – 44	41	39
45 – 54	4	4
Missing	1	1
Total	106	

The large majority of mothers identified themselves as 'Australian' (84%, n=89) but only one as an 'Aboriginal or Torres Strait Islander'. The remaining respondents who indicated their backgrounds (n=16) were from eleven different mainly European countries. Fourteen respondents indicated speaking a language other than English at home: five indicated 'Greek', and two citing French, Italian and Serbian. Other languages indicated by single respondents in each case were: Italian, Romanian, Serbian. Japanese, Romanian and Spanish were cited by individual mothers.

41% (n=43) of mothers indicated they were married with a further 16% (n=17) being in 'de facto' relationships. 27% (n=29) were single, 9% (n=9) separated and two mothers indicated they were divorced.

Half of the mothers recruited to the Project have educational qualifications beyond Year 12 (n=53), with 22% (n=23) having a University degree and 28% (n=30) a Vocational Certificate or Diploma from a TAFE or college. However one in five indicated they had not reached Year 12 (n=22), and there was a further 15% who indicated some other qualification or did not respond, (see: Table 7).

Table 7: Mothers Education level

	N	%
University degree	23	22
Vocational certificate or diploma from TAFE or college	30	28
Year 12	16	15
Year 11	8	8
Year 10	1	1
Year 9 or lower	13	12
Other	7	7
Missing	8	8
Total	106	

44% of respondents (n=47) were in some kind of paid employment during the time they were engaged with the Project; 56% (n=59) indicated the main source of household income came from wages or salaries, (see: Table 8). However, for one third of families the household's main source of income came from Government Benefit, Pension or allowance (33%, n=35). These tended to be single mothers; 85% (n=22) of single mothers indicated government benefits, pension or allowance as the main source of

household income; single mums made up 67% of those on benefit/allowance/pension. If 'separated' and 'divorced' are included this proportion rises to 82% (n=27).

Table 8: Employment Status and Main Household Income

Current Employment Status	**N**	**%**
Full-time work	21	20
Part-time work	16	15
Casual work	10	9
On leave from paid work	7	7
Unemployed & looking for work	6	6
Not working (but not looking for work)	13	12
Studying	2	2
Full-time parent	18	17
Other	5	5
Missing	8	8

Household's main source of income	N	%
Wages/Salaries	59	56
Govt. benefit, pension or allowance	35	33
Other (self-employed)	3	3
Missing	9	9

One hundred and thirty six children enrolled and completed the TtLG Project (72 female and 64 male). Ages were skewed toward younger children with one quarter being under the age of 1 year (25%, n=34) and more than half being under two years old. Table 9 presents a breakdown of children by age.

Table 9: Age Ranges of Children engaged with the Project

Range (months/yrs)	**N**	**%**
0-11 months	34	25
1 year	36	27
2	22	16
3	26	19
4	18	13
Total	136	

Seventy one percent (n=97) of children continued on in childcare after their mother had completed the Project. Clinicians reported several reasons why some families did not continue with childcare including:

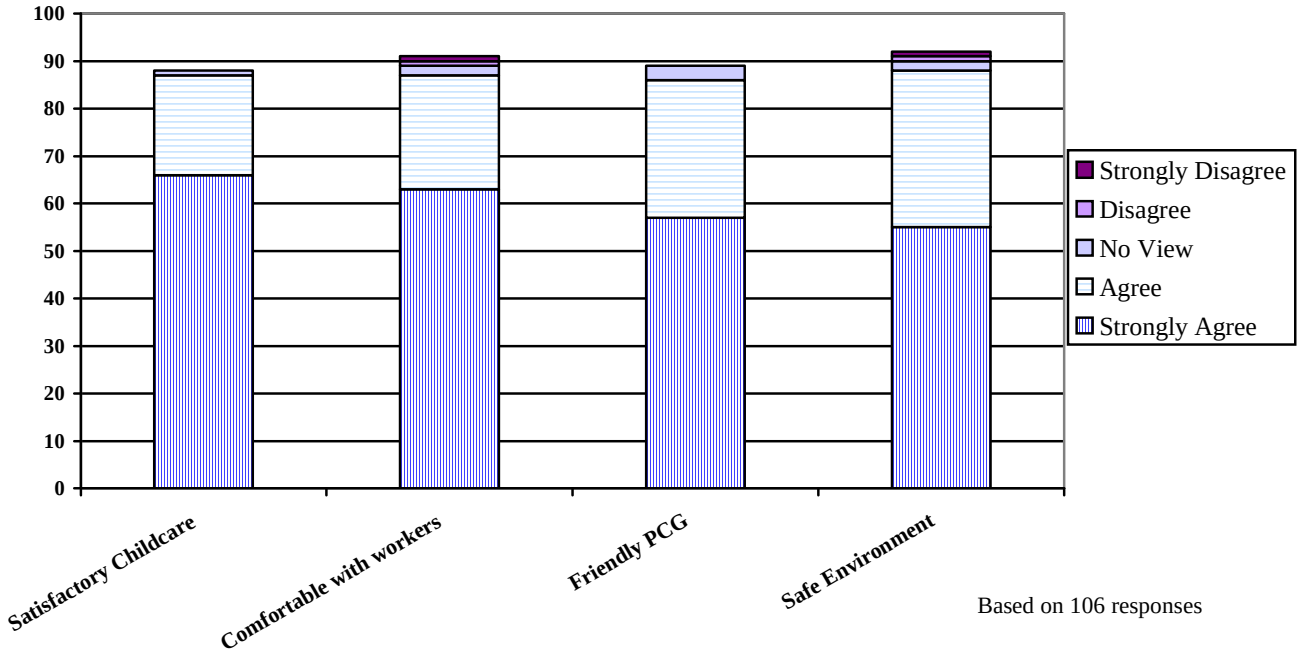
- Location and transport factors, family homes were not convenient to the centre;
- The ending of subsidized child care rendered continuation too expensive;
- Mother was home on maternity leave and wanted child at home;
- Child started kindergarten or school.

Retaining children from the TtLG project in childcare has resource implications and presents challenges to staff at participating sites (See: Section 6.2.7). This issue has been identified by management at each site and has ultimately been governed by established capacity guidelines for each centre.

iii. Mothers experiences with TtLG Project

On completion of the project, respondents indicated that they felt positive, appreciative and safe in the Project setting (see: fig i):

Fig i: Likert Scale findings concerning Centre Staff and Facilities:



Based on 106 responses

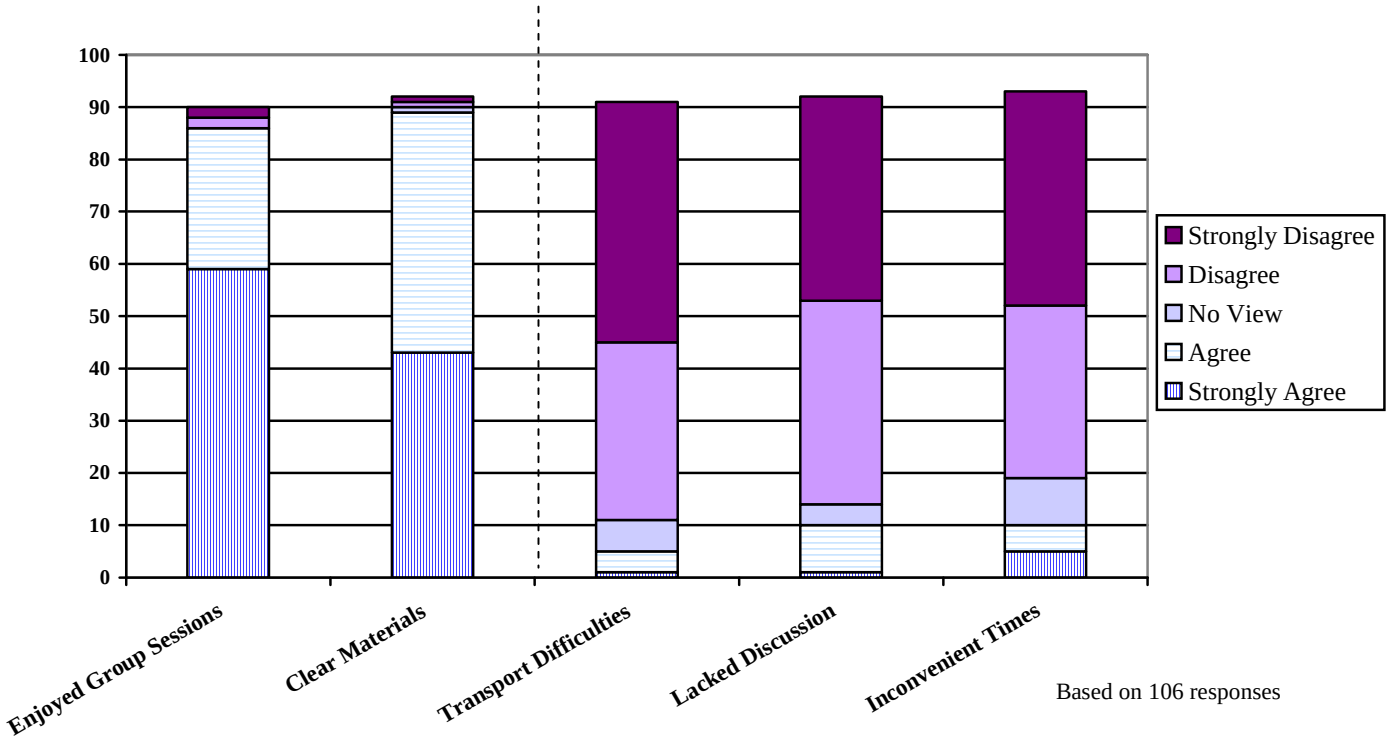
- 87.7% (n=93) agreed that they felt relaxed and safe at the centre (with over half, 54.7% strongly agreeing);
- 86.8% (n=92) agreed that they felt comfortable with the Project workers (with 63.2%, n=67 strongly agreeing);
- 86.8% (n=92) thought that the childcare arrangements were satisfactory (66%, n=70 feeling strongly);
- 85.8% % (n=91) agreed that it was easy to get along with their child's primary caregiver (57%, n=60 indicating 'strongly agree').

The three month follow-up survey confirmed that most mothers (88%, n=44) continued to view the childcare centre as providing a 'safe space' for their families. They recalled feeling relaxed and being able to freely talk about their issues.

> *'(Children) were clingy and I was anxious about them, but I could watch them play through a window and this made me feel better';*
>
> *'Everybody was welcoming not like other places I've had to go to with our issues'; 'Good place... childcare workers are friendly I could ask his carer any questions';*
>
> *'Meeting in the childcare centre was relaxing for me I looked forward to Tuesdays was a great experience'.*

The Post Project questionnaire for clients included a balance of positive and negative Likert items concerning Project delivery. The large majority of views were very favorable about the Project: (see: fig ii):

Fig ii: Likert Scale findings concerning Client Assessment of Project Processes



- 86.8% (n=92) respondents agreed that the weekly group sessions were enjoyable (59.4%, n=63 strongly agreed);
- 88.7% (n=94) agreed that the 'information materials were clear and easy to understand' (42.5%, n=45 strongly agreed);
- 80.2 (n=85) disagreed that it was 'difficult to find transport to and from the childcare centre' (46.2%, n=49 strongly disagreed);
- 77.4% (n=82) disagreed that 'there were not enough opportunities to discuss my experiences of being a parent' (38.7%, n=41 strongly disagreed).
- 73.6% (n=78) disagreed that 'the timing of the sessions was not convenient for me' (40.6%, n=43 strongly disagreed);

These favorable views were sustained over time[20]. The follow-up survey revealed that 98% (n=49) of mothers were clearly satisfied with their experiences of the TtLG Project three months after completing it, with 72% (n=36) indicating they were highly satisfied with the way in which the Project helped them feel closer to their child. Project staff and the opportunity to meet other mothers were highlighted:

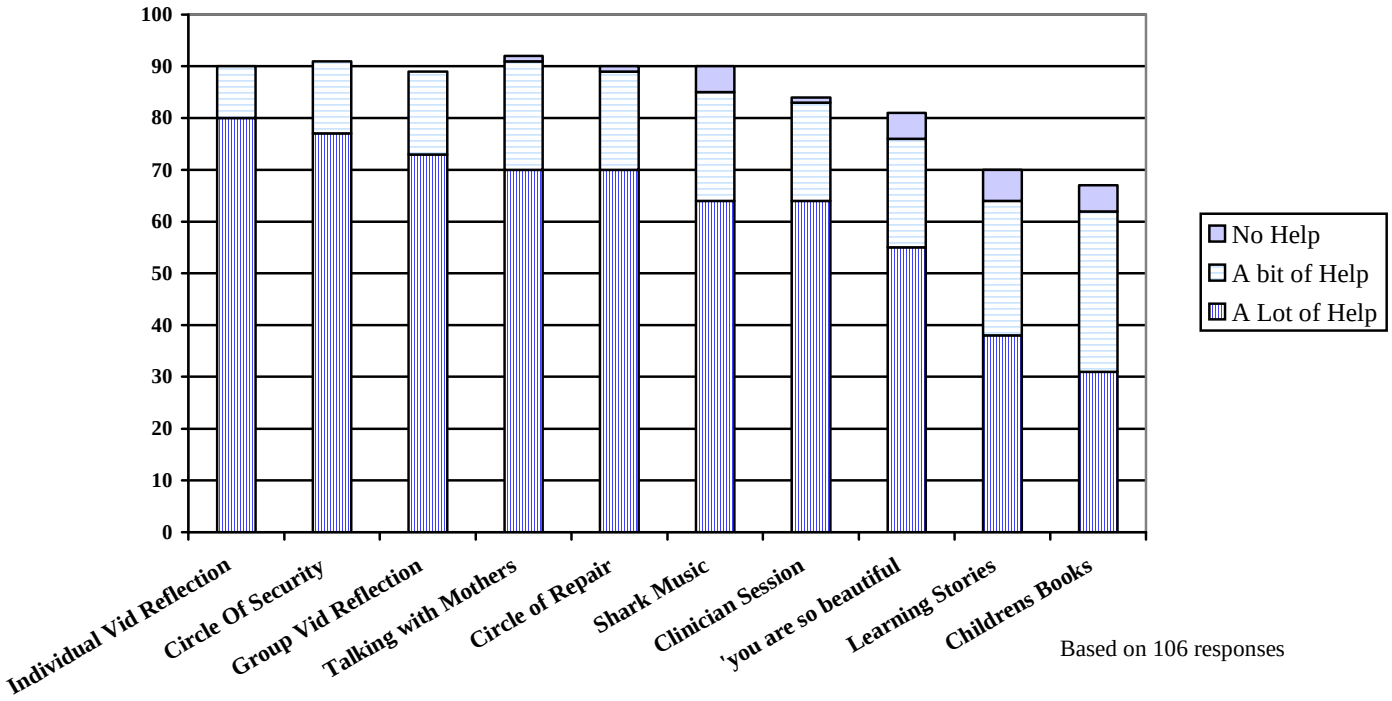
> *'All the people were wonderful there; the whole thing was about getting in touch with little brains';*
>
> *'Very satisfied…it made me look at childrearing in a different light';*
>
> *'Satisfied …it made me feel happier meeting other people like me";*
>
> *'Really satisfied with it, all activities worked, (clinician) made you feel comfortable';*
>
> *'Wonderful …it should be compulsory for all mothers leaving hospital; they shouldn't be without this information'.*

[20] See: Appendix E1 for a summary report of the findings from the 3 month follow-up survey and Appendix E12 for a summary report of the fifteen month follow-up survey.

iv Mothers assessment of Project Activities

In order to address the issue of what works best and for whom, mothers were asked how helpful each aspects of the TtLG Project had been to helping them to understand their child's attachment needs. The findings are summarized in Fig iii.

Fig iii: Mothers' assessment of helpfulness of Project elements to understanding their child's attachment needs.



The following figures refer to the percentage of mothers indicating the strategies helped them to understand their child's attachment needs a lot:

- 80.2% (n=85) indicated 'Reflecting on the videotape of your interaction with your child';
- 77.4% (n=82) indicted the 'Explanation about the Circle of Security model';
- 72.6% (n=77) indicated 'Group reflection on individual family videos';
- 69.8% (n=74) indicated 'Talking with other mothers in the group about parenting';
- 69.8% (n=74) indicated 'Explanation about the Circle of Repair model';
- 64.2% (n=68) indicated 'Discussion about the Shark Music video';

- 64.2% (n=68) indicated 'Individual sessions with the clinician';
- 54.7% (n=58) indicated 'Talking about the video 'You are so Beautiful' (with 20.8% indicating helped 'a bit');
- 37.7% (n=40) indicated 'Your child's Learning Stories' (with 25.5% indicating helped 'a bit');
- 31.1% (n=33) indicated 'Talking about the book 'I Love my Mummy' (with 31.1% indicating helped 'a bit').

More than eight in ten mothers indicated that 80% of the strategies employed had helped them (with six in ten indicating that 70% of strategies had helped them 'a lot') with regard to understanding their child's attachment needs. Over half of the mothers on the project found 80% of the strategies had helped them 'a lot'. Even the two least successful strategies from the mothers' perspective helped mothers to some degree in over six out of ten cases. There was no relationship between the likelihood of finding a strategy very useful and demographic variables (age, educational level or ethnic background).

Mothers' additional comments highlight the ways in which these Project strategies tended to be viewed holistically and taken together increased parents' understanding of their children's attachment needs.

> *'The whole concept. I have changed my views on child needs and parenting';*
>
> *'Although there will always be situations and issues with my child which will challenge me, I feel the information discussed has provided me with a working model with which I can face these, now and in the future. It is one which I am comfortable with and which solves much confusion';*
>
> *'The circle of security makes sense and it's good to watch the video of me and my kids and see the circles actually happening in action. Develops understanding';*
>
> *'Reinforcement of attachment model through many different examples, situations etc, especially video of each attendee was good as it helps me with thinking of how to respond to different situations at home. Opportunity to really discuss parenting issues with other mums away from children in a non-judgmental group helped';*
>
> *'Learning about Circle of Security and Repair. Looking at my child's feelings – what's going on behind the behaviour and helping him to work through his feelings';*
>
> *'The personal videotaping was very helpful; it helped be to gain insight about my behaviour and my children's responses and vice versa';*
>
> *'The Shark Music clarified my worries. I am more aware of my fears and my child's needs and emotional transference';*
>
> *'Shark music before and during the group I had a lot of shark music and I was able to understand why and what it just meant. Now I feel I am able to prevent that shark music by being a lot more aware of it';*
>
> *'Personally for me the most beneficial aspect of the Project was the shark music. Recognising my own irregulation of emotion (or shark music) and staying with that during times of high emotional support for my child has made those difficult situations somewhat more bearable with a clearer understanding of my shark music';*

'Learning Stories – don't think they have helped me understand the attachment needs but I think that this and the family photos are very valuable in building attachment & relating to my child about the day at childcare. Also for the primary care giver to learn about home life and my child's interests etc'.

The three month follow-up survey revealed that mothers spontaneously asserted that they continued to value both the childcare and primary care giver components of the TtLG Project:

'Childcare – the best thing for me has been taking the opportunity to have 'time out' without the children. Breathing space – time to find who I am again – I am actually a human being!';

'The childcare has been amazing giving me the opportunity to have some time out. I never realised how important that is. It has allowed me to get a job and find myself again';

'The Primary Care Giver system should be compulsory as it is better for the security of the child. Wow. Works well'.

The 16-18 month follow-up of mothers found they reaffirmed the usefulness of the broad range of project elements; over half of the sample spontaneously indicated several or all aspects of the project were the 'most helpful'. The role of the clinician, use of video in group and individual sessions, the circle of security, and meeting and talking to other mums were all individually cited:

'(Clinician's) advice and looking at the video of all the other families. That made it easier to understand how children move around the circle';

'It was all helpful. The circle information helped understand that children need to explore you don't have to control everything for them... Watching the videos helped me understand the different ways that children ask for help';

'The circle, showing how children move around and need to explore and how you have to be there for them. Watching the videos really helped understand plus it gave you some ideas about what the other mothers were doing with their child';

'The other mothers talking about how they did things. Their ideas really helped, gave you some tips to remember';

'It was all a lot of help, (clinician) really helped with the video showing me how (child1) was behaving and doing things with (child 2). Now I can better anticipate what they will be doing'.

Given the multifaceted and holistic approach adopted in the project model, it is difficult to identify the most important factors which facilitated improved outcomes. However, the combinations of group and individual work with clinicians and reflections on the child/parent video films guided by insights from the 'circle of security' have clearly contributed to greater understanding of attachment.

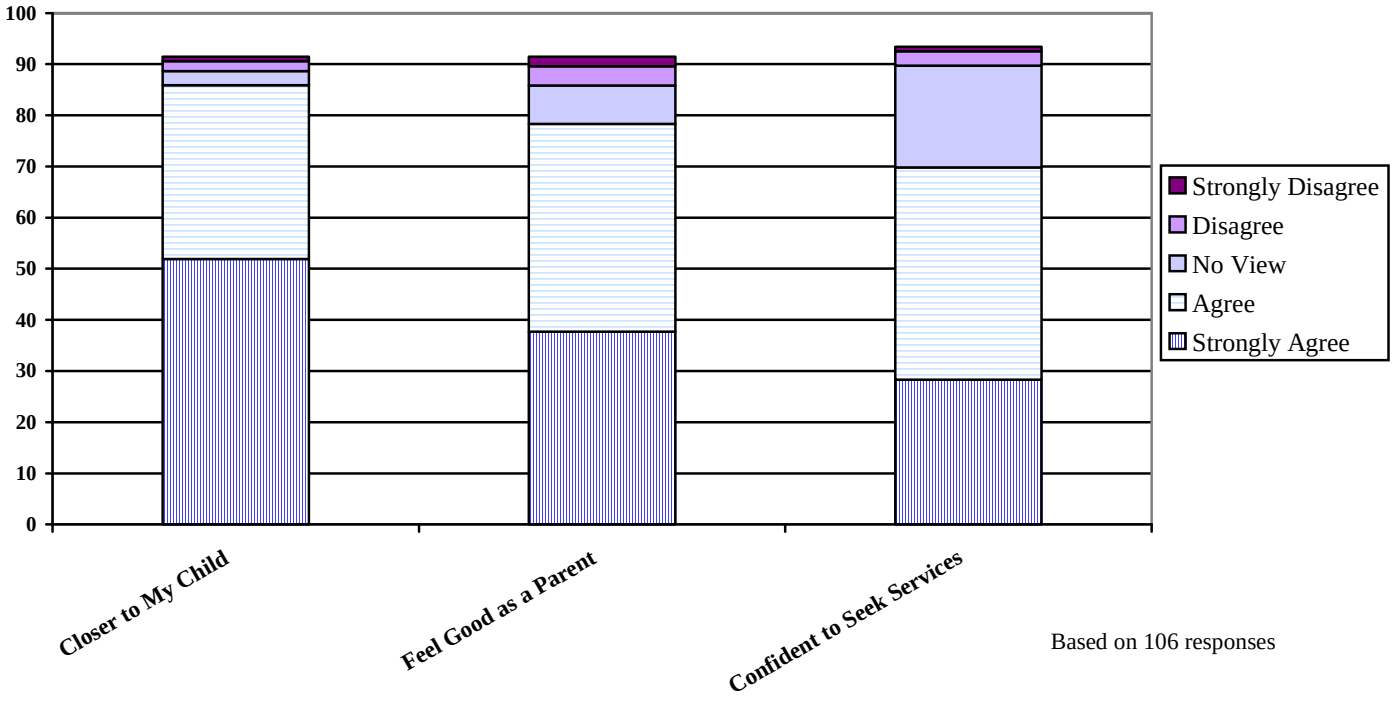
6.3.2 Impact and Outcome Evaluation

i. Improved well-being and parenting outcomes for Mothers

The post-project survey revealed that respondents clearly felt that the Project had improved aspects of their parenting and attachment (see: fig iv):

- 85.9% (n=91) indicated that the TtLG Project helped them to feel closer to their child, with 51.9% (n=55) strongly agreeing this was the case;
- 78.3% % (n=83) indicated that the Project helped them to feel good about themselves as parents (37.7%, n=40 indicating 'strongly');
- 69.8% (n=74) felt more confident looking for other services and supports for their family since being on the Project (28.3%, n=30 indicating 'strongly').

Fig iv: Likert Scale findings concerning Improved Parenting



Few respondents provided negative responses regarding these aspects with three of the five parents who indicated they disagreed that they felt more confident looking for services also disagreeing that they felt good about themselves as parents:

- 91.6% (n=97) learnt more about parenting and attachment, with 77.4% (n=82) indicating 'yes, definitely';

- 89.7% (n=95) are more confident in responding to their child's needs, with 64.2% (n=68) indicating 'yes, definitely';

- 87.8% (n=93) cope better as a parent since taking part in the TtLG, with 53.8% (n=57) indicating 'yes, definitely';

- 90.6% (n=96) have acquired understanding of children's attachment needs, with 83% (n=88) indicating 'a lot more understanding';

- 90.6 % (n=96) have acquired understanding of children's exploration needs, with 80.2% (n= 85) indicating 'a lot more understanding'.

The evidence supports that the TtLG has achieved the objective of empowering parents of young children with the knowledge, awareness, confidence and skills to successfully overcome the barriers to attachment.

'I feel the models provided should be taught to all parents in the community to help them better understand their children and child development and am therefore very grateful to have received the opportunity to participate in this Project';

'Feel much closer to (son) than could have ever thought. Enabled me to understand (son), his behaviour, actions and why I react the way I do';

'I have learnt so much about the way my daughter reacts and why and how to deal with it. In conjunction all this is due to (clinician) and she is truly an asset to this Project and for that I am forever grateful';

'The Project has helped me to understand my child's point of view more and to look at situations, conflicts and challenges from many angles';

'I look at the strategies I have learnt from the looking glass and I am able to meet a lot of my child's needs than what I could before';

'Looking at the world through my child's perspective and learning how to do that was invaluable to me. Even though I am very much struggling with my son still, this course has given me a lot of tools to work with and keep utilizing. I know it's not a quick fix but I'm definitely not giving up on my son or our family'.

These impacts have been sustained since TtLG mothers left the project. The three-month follow-up survey found that most mothers (88%, n=44) reported a lasting positive change in themselves since taking part in the TtLG Project. Mothers described themselves as happier, less stressed and more able to cope.

'I'm happier now… I'm a single parent and really needed a break… the childcare helped me get some timeout';

'I was exhausted at the beginning… at the end I felt on top of everything… getting the feedback from others helped (clinician, co-facilitator and primary caregiver;

'I feel so much better ….I now understand that I'm not the problem… the way (child) behaves is not a result of me… I can now look at it from his side… see what he wants';

'I can cope now …I still get stressed out but I know how to back off'.

Mothers also reported that the project has sustained impacts on their parenting practices:

- 88%, (n=44) described positive changes in the way they do things with their children;
- 88%, (n=44) reported increased responsiveness and ability to read cues;
- 80%, (n=40) reported increased confidence in responding to their children's attachment needs;
- 74%, (n=37) reported getting less frustrated with their child.

All of the mothers contacted in the 16-18 month follow-up survey (100%, n=29) indicated they continued to use information or ideas about attachment acquired from the TtLG project. Mothers reported sustained confidence and competence in parenting, ongoing empathetic understanding and sustained better parenting practices (despite children now being considerably older presenting new challenges).

'She's a toddler now and wants to play I can see that she does things of the circle I can help her when things aren't right. Like when she's tired she can get frustrated with toys and things I know to cuddle her and settle her down';

'I did get more confident as she got older; it's easier when they can tell you what they want';

'made me stop and think more …like thinking about why (child) got upset';
'I knew I could join in with him, I guess that's being more confident';

'We're both confident with (child). It was good to be able to talk about the things I learnt from (clinician)';

'Can be a challenge sometimes but I understand that he needs to learn things';

'Yes it helped me to find out about how children need you in different ways';

'I feel better about (child's) behaviour; it made me stop getting angry with (child)';

'I'm more confident because there aren't as many arguments with the (children)';

'Yes it's just so different it's made a big difference to how I feel as a mother';

'I am confident with (child) it's different now he is very active but I can support him';

'I think I can understand (child) better and so there isn't as much stress';

'I am feeling better with (child) now';

'I know I am doing better now, it's important for (child) to develop in her own way';

'I think that they are better because I can anticipate what they will be wanting to do, I know that (child 1) needs more quiet times away from her brother';

'I guess now I just can stop their fights starting ...like I can see when one of them is getting upset and I can sort of get in and fix it up first so they don't really get going'; 'I think she is happy because we feel happy about it all and we're OK about just being with her'.

ii. Positive Child Well-being Outcomes

Mothers also reported improved positive child behaviour on completing the project with 76.4% (n=81) perceiving that their child's behaviour had improved. Again this impact appears to be lasting and probably reinforced by more positive parenting practices. The three-month follow-up survey confirmed sustained changes in improved child behaviour, with 88% (n=44) of responding mothers reporting lasting positive changes in their children's behaviour since taking part in the TtLG Project.

'Major changes… he is coming out of himself…looks to new people in our life…..he is happier';

'He is more confident. I let him explore and follow his lead. I don't try to always make a game for him I follow him and no longer say don't do this';

'(Child) used to be clingy now she's happy and goes to kindy 4 days a week she's turned into a real social creature and wants to go more days'.

Given that the children of mothers surveyed in the 16-18 month follow-up interviews were significantly older than they were during the intervention (with many moving from being babies to toddlers), mothers indicated that they found it difficult to attribute their child's long term behaviour change to the project. However, many mothers indicated sustained improvement in family functioning; many felt they could do more with their children, enjoyed parenting, were better able to cope and felt they were better parents as a result of the project. Many reported that their children were happier as a result:

'I think we are both happier and more confident';

'I think it's more that I understand him better. I can join in with him better';

'He is changing all the time doing more things for himself …it's me that's changed I am less stressed about doing the right with him';

'I think there isn't as much stress with us';

'Going to the course made me see that (child) was really being just a normal toddler, it's more that I have changed';

'I think I'm better at organising things, like remember to think about things from their point of view , understanding that sometimes they are just tired and winging and not really playing up';

'I can see more about why (child) is doing things and I think that he is more confident about doing things for himself';

'I think it made us both good parents';

'I'm different with (child) better than before and I know that I am a better mother when I look after myself';

'I think I am better at things with (child) and that makes it better at home';
'Yes it's just something that I feel good about I know that I can give (Child) what he needs';

'Really it was by changing how I looked at things with the (children), now I try to think about lots of things from their perspective e.g. like packing up games at night, I try to remind them 10 minutes before they have to instead of just coming in and saying 'do it';

'I am a better parent I enjoy them more';

'I feel happier with myself for learning about how to be a better mother.'

All of the staff interviewed universally reaffirmed the findings acquired from mothers, that the impacts of the project have been profound for children, parents and families. This has had a very positive effect on the staff who participated:

'You look at the child before and after the project and you just can't believe it's the same child';

'Absolutely fantastic to see the way the children develop and change. I can honestly say I've never seen such a dramatic improvement in the toddlers. It's just a wonderful project'.

'It's been amazing and totally rewarding. A fantastic experience to see the progress of the mums and children'.

'One little boy just didn't speak at all. And his mum was clearly having great problems relating to him and meeting his needs. And now it's completely different, chatting away and his mum's like a different person. It's been wonderful'.

'There've been dramatic changes in parents and children. Amazing changes really'.

'There's been a huge dramatic change for mums involved – much better understanding and lots of improvement in attaching with their children'.

The focus groups of primary care givers testified strongly (and in some cases emotively) to the improvements brought about amongst clients and children by the intervention:

'There was a child with profound behaviour problems… kicking, swearing, biting… his mum wouldn't even talk to him… its completely different now, his mum had acquired the skills to talk more… his behaviour is completely different. I mean it's like he's a completely different little boy. It's just wonderful'.

'This little girl didn't say a word she used to just scream with these high pitched squeals… her language improved and she can actually communicate now and her mum communicates with her'.

'I've seen massive change. Massive changes. There's been children who just wouldn't let go of their mums at first now interacting and playing with other kids. Mother's being much more in control of themselves. Massive changes. Even in the appearance of some mums, their physical appearance, being happier, dressing smarter'.

iii. Overcoming Barriers to Attachment

Staff emphasized that the child parent relationships have been enhanced through project participation; the project has built on existing strengths and helped parents to successfully address the root causes of attachment and parenting struggles:

> *'It's produced much stronger and secure relationships between parents and children and provided a really strong base for the future. Phenomenal success!'*

> *'Exploring the strengths families have and unearthing the problems and strategies to use these to address the causes of difficulties…it's been incredibly rewarding'.*

> *'When Aw started childcare she was very distressed about leaving mum. Recently she left us to go to preschool and we say her on her first day and she was very excited about going to a new place';*

> *'When WC commenced care he would never venture far from his primary caregiver and was distressed when other staff entered the room. He now enjoys spending time exploring the room and loves to have the opportunity to interact with the older children';*

> *'EM has become more creative and her imagination has expanded vastly. She now finds it easier to engage others in her dramatic play by verbalising her needs more confidently';*

> *'AV now is able to more confidently return to her safe base, rather than always staying out exploring'.*

Mothers have shared their learning with others. This was more common whilst TtLG mothers were still engaged in the project, with over eight in ten mothers (n=97) indicating in the post survey that they have shared attachment information with friends and family. More than half of the surveyed mothers in the follow-up survey, (54%, n=27) reported that they had talked about the TtLG Project with other family members and friends in their community. This strongly suggests that project messages are being promulgated by clients some months after they have completed the project:

> *'Sharing attachment knowledge with others some trouble explaining it to others & family but by me doing what I learnt they are picking up and learning'.*

Overall evaluation data indicates that the TtLG Project is fostering and nurturing positive parent and child well being outcomes. For many respondents the experience of the Project has been very positive and valuable:

> *'I feel I have gained an enormous amount of information and much greater understanding of my child and child's needs. The experience was enjoyable and something I looked forward to going to each week';*

> *'Thank you for the opportunity to participate. It has made a big difference to our lives. Thank you also for providing access to childcare. I didn't realize before how desperately I needed a break from the kids so I could function when I was with them'.*

iv. Standardized Instruments: Pre and Post Scores of Cognitive and Behavioural dimensions Measured

The findings obtained from the semi structured interviews and surveys have been reaffirmed through triangulation with the application of the range of standardized instruments selected for the evaluation.

Table 10 presents a summary of the pre post comparisons for each standardized instrument applied for the evaluation. The Instruments selected were:

- Hospital Anxiety and Depression Scales (HADS)
- Parenting Stress Index/Short Form (PSI/SF)
- Emotional Availability (EA) attachment assessment
- Children's Wellbeing and Involvement Observations measures

Table 10: Summary of Statistics from pre-post comparison of scores obtained from the application of standardized instruments using the Wilcoxon Signed Ranks Test with Effect Size calculations.

Instrument / Dimension	Sample Size	Pre-Median Score	Post-Median Score	Ties	Z Score	P Value (1 tailed)	Effect Size (d)
PSI (Stress)	100	107	84	1	-7.420	.000*	0.966
HADS (Anxiety)	108**	11	8	14	-4.958	.000*	0.712
HADS (Depression)	108**	9	5	10	-5.184	.000*	0.748
Wellbeing	87	3	4	5	-6.578	.000*	0.942
Involvement	87	3	3.9	6	-6.938	.000*	1.079
Child Responsiveness to Parent (EA)	96	5	6	16	-4.903	.000*	0.572
Child Involvement with Parent (EA)	93	5	6	18	-5.148	.000*	0.604
Parent Sensitivity (EA)	96	6	6.5	30	-4.554	.000*	0.521
Parent Structuring (EA)	96	4	4.5	31	-4.567	.000*	0.536
Parent Non-Intrusiveness (EA)	96	5	5	60	-1.563	.118	0.162
Parent Non-Hostility (EA)	96	5	5	57	-1.680	.093	0.173

* Significant at the 0.05 level
** Two clients who left the project prematurely completed the HADS test.

Using the Wilcoxon Signed Ranks Test, significant improvements were detected across all but two dimensions.

The hypothesis that the Project would reduce levels of anxiety and depression was supported in both cases ($p<0.01$). Using Cohen's prescriptions for interpreting effect size[21], in both anxiety and depression the effect was approaching a 'large one' (denoted as $d>0.8$). Over the duration of the project, the number of mothers experiencing 'moderate' to 'severe' anxiety and depression (scoring between 11-21 on the HADS), more than halved; from 52 to 25 (anxiety) and from 37 to 13 (depression). Conversely the numbers

[21] Cohen, J. (1988). Statistical power analysis for the behavioural sciences (2nd Ed) Hillsdale, NJ: Erlbaum.

acquiring a 'normal' score more than doubled for anxiety (from 21 in the pre measure to 44 in the post) and was 60% higher for depression (from 42 to 67 respectively).

Similarly, 'stress in the parent child system' as measured by the PSI recorded median score changed from 107 to 84. Again the alternative hypothesis that the Project would reduce stress levels is supported ($p<0.01$) with a large effect size recorded.

Child's wellbeing and involvement observation ratings also yielded positive findings: the median score for wellbeing rose from 3 to 4 and for involvement from 3 to 3.9. The change in scores was significant at the 0.01 level with large effect sizes recorded in both cases.

The Emotional Availability attachment assessments based on the scores recorded by professional independent assessors yielded significant improvements ($p<0.01$) across four of the six domains assessed: 'Child Responsiveness to Parent', 'Child Involvement with Parent', 'Parent Sensitivity' and 'Parent Structuring' all improved with effect sizes being moderate to large. Interestingly, two domains measured through the assessment, 'Parent Non-Intrusiveness' and 'Parent Non- Hostility' did not demonstrate significant improvement and had an effect size less than 'small' using Cohen's criteria; However, these areas were not specifically addressed in the TtLG Project.

v. Impact of TtLG on Fathers

The project has been less successful in formally engaging fathers in organised group sessions. Reasons for this include the high proportion of single and separated mothers recruited to the project and work and time commitments of fathers. The PCG approach has encouraged father engagement with individual child care workers but further engagement has in most sites been restricted to ad hoc information giving exercises. The except here is the Gowrie Adelaide centre at Thebarton where a more detailed program has been run (See: Appendix E2).

A total of twenty four fathers have attended one or more sessions run from the Thebarton Center (including seven fathers of mothers engaged with the il nido center). Evaluation forms were obtained from fourteen fathers. Whilst there may be a degree of self-selection bias in this small sample, fathers surveyed clearly gained greater understanding of their child's attachment needs:

- All responding fathers (n=14) reported an understanding of the Circle of Security attachment model with 78.6% (n=11) reporting a lot of understanding;

- All respondents indicated that participation in the fathers session had given them an understanding of children's attachment needs, with 57.1% (n=8) having a lot of understanding.

Fathers identified project benefits to their families in terms of it helping them to feel closer to their children and positively influencing their children's behaviour changes. Moreover, these sessions were identified impacting on fathers' parenting skills:

- 92.8% (n=13) agreed that their family's participation in TtLG had helped their child's behaviour (35.7%, n=5 strongly agreed)

- 78.6% (n=11) agreed that they felt closer to their child as a result of their family's participation in TtLG (35.7% n=5 strongly agreed)
- 78.6% (n=11) agreed that participation in the fathers program improved their parenting skills (14.3%, n=2 strongly agreed)

Whilst these findings are tentative, there is a clear indication that exploring additional ways of formally engaging fathers in group sessions could add value to the benefits already gained for mothers and their children.

vi. Summary

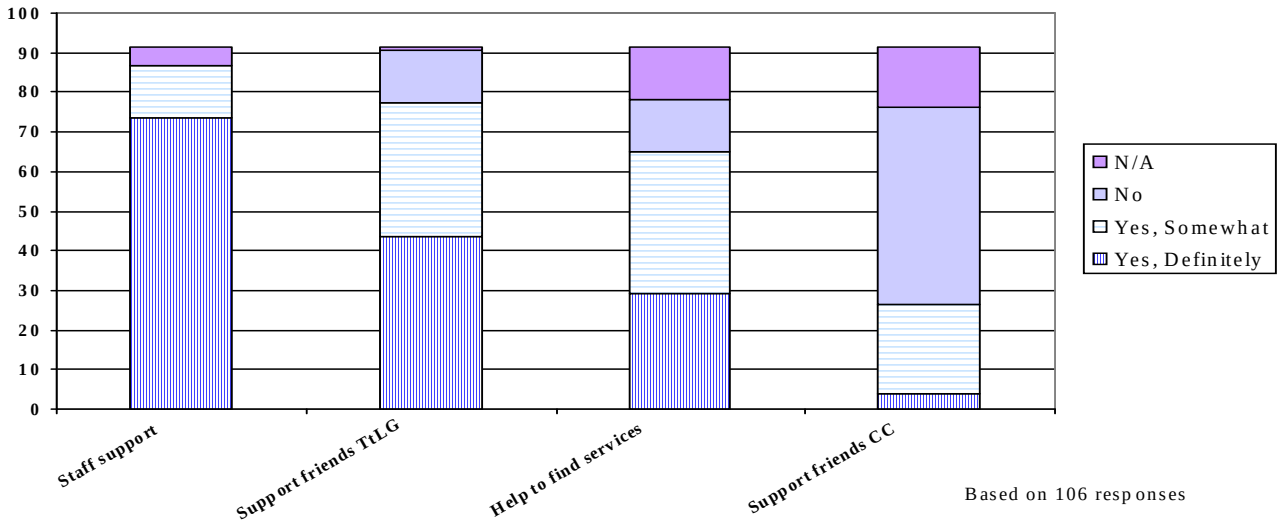
Clearly the project has improved parent competence and style and improved family functioning. Mothers have increased their knowledge competence and awareness to overcome barriers to attachment, are less stressed, depressed and anxious and better able to cope as parents. Many report better parenting practices, better engagement with their children and improved child behaviours which they attribute to the project. For many parents these impacts have been sustained since leaving the project. These findings provide clear evidence that the project has addressed the national 'Invest to Grow' priority areas of: 'Improved family functioning', 'Improved parent competence and style' and 'Improved child social and emotional development'.

6.4 Objective 4:

To develop and enhance social support /friendship networks for the target group

Fig v presents findings from the post questionnaire regarding support received by mothers engaged with the TtLG project:

Fig v: Likert Scale findings concerning social supports received



- 86.8% (n=92) indicated that staff respected and supported their family, 73.6% (n=78) indicating 'yes, definitely';
- 77.4% (n=82) indicated that they had developed supportive friendships with other TtLG project mothers, with 43.4% (n=46) indicating 'yes, definitely';
- 65% (n=69) indicated they had received help to find other services for their child or their family from the project, with 29.2% (n=31) indicating 'yes, definitely';
- 26.4% (n=28) indicated they had developed supportive friendships with other mothers attending the center who were not part of the TtLG Project, with 50% (n=53) indicating they had not.

Most mothers have received help to find services through their engagement with the project, and this was confirmed by project staff. However, this often occurred through informal contacts, networks and channels as the project has not specified the establishment of formal referral pathways as an objective. Clients who may have more long standing acute problems might benefit from this being included (See: Section 6.5.3).

Forty one percent (n=12) of mothers in the 16-18 month follow-up survey retained the confidence to access other services; however, 59% (n=17) indicated that they felt no need to access services. This may reflect improvements recorded in their well-being, parenting and family life.

Clearly, the majority of mothers had developed friendships with peers whilst engaged with the project although this was not as evident with regard to friendships with mothers who were not on the project. However this still occurred in some degree for over a quarter of respondents.

Staff confirmed that many mothers had formed lasting social support and friendship networks through engagement with the project. These appear to be more successful, but are not exclusive to, where parents have retained connection with the child care centre and its services. Factors which militate against sustained friendship networks were usually logistical; where mothers lived far away from each-other, started work or moved house, the friendships were not as lasting.

TtLG families were encouraged to participate with their families in social and community events offered at their childcare centre including:

- Christmas Party at the end of the year;
- Easter Party;
- Family tea evening meetings other parents;
- Teddy bears picnic;
- New Parents Morning Tea;
- Sessions for the fathers of those participants who had an active dad.

Supportive friendships endured for over half of the TtLG mothers surveyed in the three-month follow-up (54%, n=27). These friendships made during the Project were most frequently with other mothers who had children the same age. Examples of on-going friendships included meeting for coffee, attending children's birthday parties and maintaining phone contact. Good group dynamics was seen to support the development of friendships rather than any specific TtLG activity.

Some mothers (26%, n=13) also reported on-going participation in their local community since the project, taking up activities such as: joining a playgroup (n=7), commencing part-time work (n=7) and returning to study (n=5). Establishing netball teams, client organized group meetings and shopping outings were also cited:

> *'I enjoyed the social contact and sharing experiences & seeing what others do and knowing we all share the similar highs and lows of children';*

'Friendships from group members priceless I feel that this group was life changing, helping me when I was at my most lowest point. Congratulations for such a wonderful Project';

'The contact with other mothers from similar backgrounds was extremely beneficial in not feeling alone and their feedback was invaluable'.

The 16-18 month follow-up survey revealed that 28% (n=8) had kept in contact with others met through the project. The mothers who did not maintain contact with other group participants from the TtLG Projects cited reasons such as not living in close proximity to other families or their own work commitments. A number of mothers stated that whilst they were no longer in contact with others from the project, this did not reflect negatively on the relationships formed at the time of their engagement.

Clearly social support / friendship networks have been established through the project which for a sizable minority has endured over an extended period. This demonstrates that the project has been addressing the national Invest to Grow priority of supporting child friendly communities.

6.5 Objective 5:

To develop and promote the uptake of a 'best practice' model for services working with mothers and fathers and children around issues of attachment

6.5.1 Professional Stakeholder Assessment of the Efficacy of the model

A survey of professionally engaged stakeholders across all five sites was conducted on completion of Wave 4 (a summary report of this appears in Appendix E12). The interviews with CEOs (or their delegated manager), clinicians and co-facilitators were semi-structured to include summative scales in order to gain a quantitative assessment of the impact of the project from their perspective. However, the interviews were largely qualitative in nature to enable and encourage an open exploration and critique if the project model. This work was supplemented by two focus groups of PCGs from all project sites (with the exception of Perth) the findings from which appear in a Appendix E13.

Eighteen stakeholders were interviewed (either face-to-face or over the telephone) with interviews lasting between 30 – 90 minutes.[22]

Thematic analysis was conducted on the qualitative findings to identify areas which were generic to the project across two or more sites. The analysis was conducted in tandem with the fieldwork and was iterative; as themes emerged these where subsequently addressed in upcoming interviews using procedures established from Grounded Theory approaches. This analysis has informed the findings pertaining to model refinement considerations below.

[22] . One clinician from Perth was not interviewed as she had left the project; she was replaced by a manager who had worked with the co-facilitator.

Stakeholders were very satisfied with the overall outcomes achieved by the Project with 72% (n=13) indicating 'fully satisfied' and 28% (n=5) indicating 'mostly satisfied'. Satisfaction was expressed largely in terms of the impacts achieved for Project clients.

55% (n=10) thought that the overall goal of the Project had been 'fully achieved', and 28% (n=5) 'mostly achieved'. Two indicated 'partially achieved' and one did not know. For those who did not indicate 'fully' the remaining need for the model to be adopted and on-going was highlighted.

Fig vi: Project Staff Assessment of Extent to which Stated Objectives have been achieved

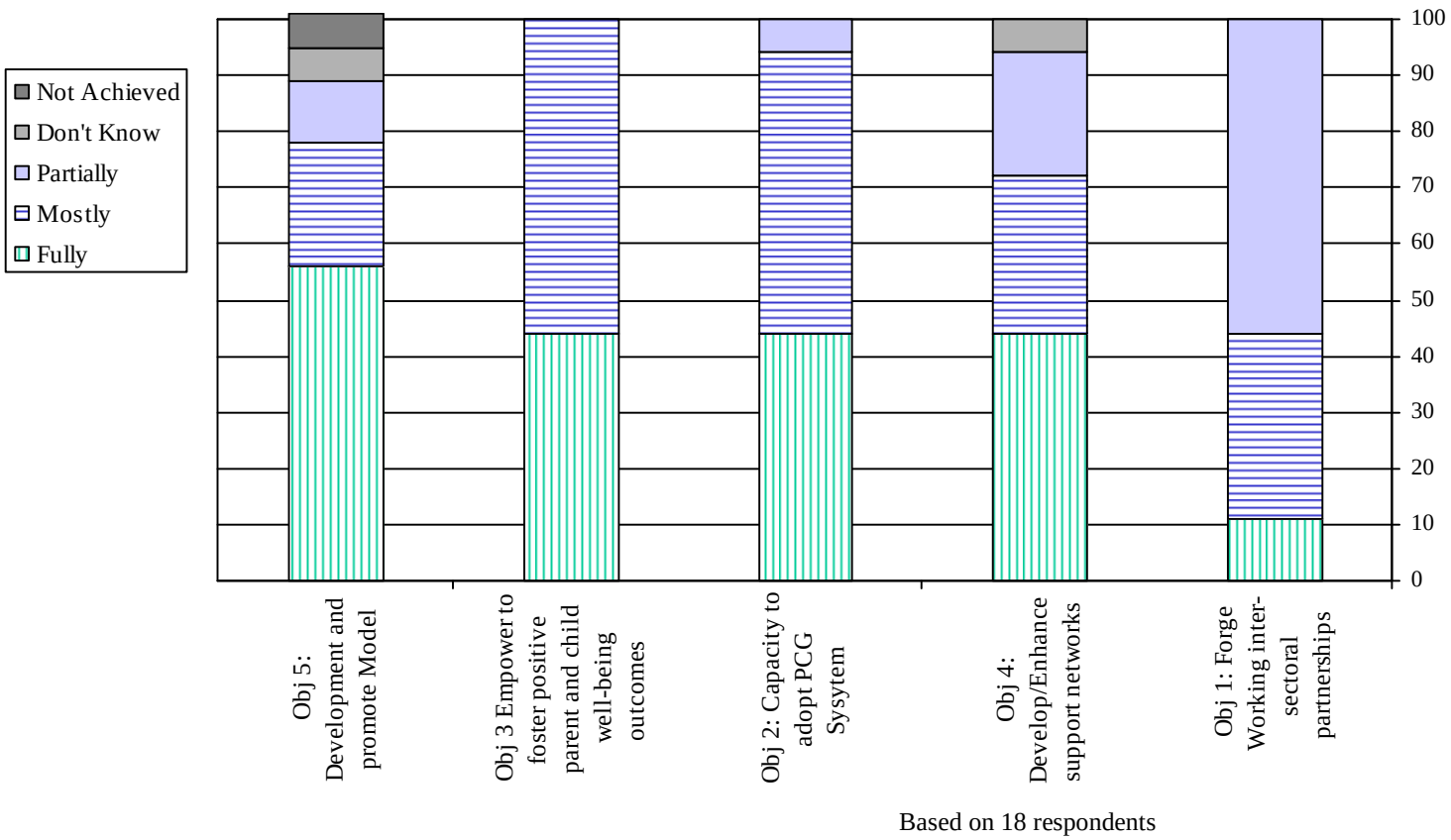


Fig vi presents the summation of the Child Care Centre project staff (broadly defined as the site managers/CEOs, project managers, clinicians and co-facilitators) assessment of the extent to which each of the TtLG project's objectives have been achieved. Nearly all staff who had engaged with the project to some degree indicated that the project had achieved all of its stated objectives to some extent. The most successfully achieved objectives were Objectives 2 and 3 where all but one respondent indicated the objectives

had been 'fully' or 'mostly' achieved. For the Child centre staff the impacts for clients and their children and the extent to which the project has built a sustainable PCG capacity in participating child care centers have been substantial:

> *'It's been absolutely fantastic for the families who've been involved';*
>
> *'You see mum's who took no interest in themselves or their appearance, who can't communicate to their children and are deeply depressed totally transform. It's just amazing';*
>
> *'I've seen children completely change… a truly remarkable experience';*
>
> *'Children who were clearly having real communication problems, one kept biting… one didn't hardly speak at all… they've become like completely new kids!'*

To a lesser degree, the project has developed and enhanced parent support networks, but this was still viewed as being fully or mostly achieved by 72% (n=13) respondents. This has taken several forms including retaining contact with the center, its staff and/or activities, retaining friendships acquired with other project mothers and in some cases engaging with local established groups. Where this did not occur a number of reasons were postulated (see: Section 6.4). Some respondents indicated they were only partially aware of the sustainability of networks and so answered 'partially achieved' for this objective.

> *'A lot of the friendship network stuff really depends on the mothers who come along in a particular Wave – I mean some live miles from each other so the chance of them carrying on their friendships are pretty slim given the demands of kids. Others work, or start work etc etc. So this has varied a lot between waves'.*

78% (n=14) felt that the higher order objective 5 'to develop and promote the uptake of a 'best practice' model…' had been 'fully' or 'mostly' achieved (56%, n=10 indicating 'fully'). This is a notable finding given that (in the view of those staff engaged with the project) the least achieved objective was the 'lower order' Objective 1. Whilst 44% (n=8) respondents indicated this had been 'fully' or 'mostly' achieved, 56% (n=10) indicated it had only been 'partially' achieved. This was explained in terms of partnerships not being fully established across project sites (see below); within each site sustainable integrated partnerships were viewed as having been established through the project. There was also comments made about the lack of ownership and partnership from other sectors.

> *'It's been great in terms of our own centre and the partnerships formed between the child care workers and the clinician. And we've worked well with Gowrie Thebarton around training. But we've really not had much to do with the other centers'.*
>
> *'There's not really been the ownership across sectors that I would have liked to see. This has made it much more difficult to get people to take up and run with the project'.*

6.5.2 Model Sustainability

The potential of the model to meet client needs in a sustained way is supported here and the benefits for families with attachment issues of 'rolling out' the model would be substantial.

i. The Adoption of Primary Care Giving (PCG) Child Care Practice

Staff were broadly enthusiastic about the changes in professional practice and subsequent improvements in the quality of care precipitated by the implementation of the PCG approach. Staff felt better equipped with the skills and knowledge to practice child care in a more effective, insightful, reflexive and ultimately more rewarding way. The changes were profound for many staff across the centers, extending to working practices with clients and children, relations between staff and between staff and management, managerial practices, and for some influencing personal social relationships. Practice has become more holistic, orientated toward 'emotional needs' and relationship focused. This has enabled staff to interpret child behaviour differently and engage more intensively with families accessing the centre.

There has been a 'cultural shift' in working practices precipitated by the project, away from behaviorist models such as the 'Positive Parenting Practice' approach toward the wholesale adoption of PCG[23]. The approaches were almost universally viewed as benefiting children, families, parents and staff. These changes in skills, learning, philosophical orientation and professional practice are strong legacies from the implementation of the project. However, for some staff, concerns were also expressed about the extent to which PCG was fully understood and implemented; the need for regular review, an on-going training and support in reflective practice was subsequently asserted.

ii. Systemic Changes at the Policy Level

The project has precipitated systemic changes amongst participating Centers. This has varied in degree as each has separate policy development procedures. However, in all cases attachment theory and PCG is being embraced at the policy level.

The implementation of these approaches in professional practice through the TtLG project has preceded and prompted the broader policy changes. PCG is now part of induction and 'refresher' programs for new staff across several participating sites.

iii. Expanding the Project

The project is extending to other Lady Gowrie sites. A presentation of the TtLG Project and the evaluation findings took place in Caboolture, Queensland in February 2008, and Caboolture plans to adopt the project later in the year. The project is also conducting consultations with Aboriginal communities to identify how the project might encourage greater participation and meet the needs of Indigenous families.

[23] Whilst several sites had adopted aspects of PCG prior to the project the extent of this varied greatly; it was universally asserted that PCG implementation had been substantially enhanced and improved through the Project.

iv. Continued use of Project Resources

The 'Circle of Security' poster has been enthusiastically adopted as a symbolic and practical guide for staff and families using the centers[24]. Many of the written resources (including books and articles concerning attachment theory) have been compiled within each site and are utilized as needed. Other resources developed through the project have been taken up including the development of a DVD 'The Father/Child Journey' specifically for fathers of families accessing the services[25].

The project Manual was generally well received amongst those staff members who had seen it. The manual was viewed as essential for the initiation of key players in the project (clinician, co-facilitator and managers) and was referred to often in the early waves of the project and by new staff. All aspects of the manual were viewed as useful but clinicians tended to be selective, referring to the manual occasionally as a 'refresher' once they had become familiar with the materials.

Co-facilitators outside of South Australia seldom used the manual being guided more by the formal training and materials received. However, those located in one of the three locations within South Australia tended to access materials from the manual more regularly. The manual was viewed as a supporting resource and not a replacement for practical training.

v. Impacts on Clients

Impacts on mothers and children have been found to be sustained over time (See: Section 6.3).

vi. Capacity Building Benefits for Staff

Staff have clearly been up-skilled through the project. Many have reported changes in career pathways and seeking further formal training in related child care areas (See: Section 6.2).

Sustaining the model through Lady Gowrie would be impossible without the funding needed to support the employment of the project manager and clinicians at each site. Moreover, removing the 'gap' fee for child care covered by the funding is likely to have a deleterious effect on the recruitment of families to the project, particularly given the proportions of clients who are single mothers and/or are receiving Government benefit support. The need for an on-going Government sponsored implementation of the model possibly through State Government agencies was strongly championed by management.

6.5.3 Model Promulgation

Several formal presentations promoting aspects of the TtLG model have been delivered by TtLG Project staff on specific Project components / activities. These have been summarised in Table 11. In addition, the Gowrie Adelaide CEO, Project Manager and local evaluator presented findings from the TtLG evaluation on three occasions to South Australian Government Departments in early 2008.

[24] The diagram appeared in several rooms in the four sites visited by the evaluators.

[25] A list of project resources appears in Appendix C

Roll out of the model would benefit from a greater period of preparation at the hosting agency. The Project Manager reported that a longer planning and training period prior to taking in the first wave of TtLG participants would have enhanced project implementation. This would have enabled individual sites and staff members to identify what extra training would be required to develop the capacity of the site and staff to support TtLG families. An action plan for each year could then have been developed earlier.

Table 11: Conference and Workshop activities Promulgating Learnings from the TtLG Project

Date/Venue	Event	Activity Description
Sept 2005 /Brisbane	Early Childhood Australia Kaleidoscope- National Conference 'Changing Images Of Childhood'	Presentation of the TtLG Project
Oct 2005 / Newcastle	Fathers Inclusive Practice Forum	Presentation: 'Through the Looking Glass Project -Involving Fathers'
May 2006 / Adelaide	Parenting Imperatives Conference: "New Perspectives, New Directions, New Connections"	A work shop session ' TtLG-Using Video in Working With Families'
Sept 2006 / Darwin	Early Childhood Australia Conference 'Together In Partnership' State Conference	Two Presentations: 'The TtLG Project, An Attachment Parenting Intervention Based In Child Care' and 'Primary Care Giving as an Approach'
Nov 2006 / Melbourne	QEC Biennial Conference 'Early Childhood-Evidence Into Practice'	Presentation: 'Through the Looking Glass Project- An Integrated Approach To Supporting Parenting' Workshops: 'Primary Care giving- Integrating Attachment Theory Into Child Care Practice' 'Reflective Practice- Integrating Reflection Using Videotaping'
Dec 2006 / Hong Kong	5th International Conference on Social Work in Health and Mental Health	Presentation ' Using Video in working with Families'
Oct 07 / Sydney	Australian Association for Infant Mental health Conference	Staff from all five sites attended. 2 presentations delivered addressing: Engaging Fathers and Primary Care giving Approach in Child Care
Feb 2008 / Caboolture, Queensland	Presentation of TtLG project and Evaluation	The local evaluator, Thebarton CEO and project manager presented the project to promote its adoption in Caboolture.
March 08 / Perth	World Congress of Health Professions	Staff from the Perth site attended. Presented TtLG program intervention
April 08 / Newcastle	Family Strengths Conference	Attended by one staff member presented learning from the TtLG project
Sept 08 / Perth	Australasian Evaluation Society Conference	Evaluating a Multi-Site Longitudinal Intervention for families with attachment issues – Blending epistemologies? - Arguing for a participatory action research approach.

6.5.4 Promoting the Primary Care Giving Philosophy

The Adelaide Gowrie site currently engages in training activities across the child care sector. Given the amount of training and capacity built in the area of PCG and attachment through the project and the benefits of adopting these child care approaches, extending the reach of these training activities was broadly supported. This might include further staff 'visits' to Adelaide to observe, shadow or be mentored in the practices of PCG. These opportunities were available during the project and were clearly valued by staff from other states.

The need to link some 'post project' families experiencing acute or enduring issues with supporting agencies raised some questions from staff concerning continuity of care and the extent to which the referred to agency's philosophy and practice mirrors that of the referred agency. Promoting the PCG philosophy and raising awareness of the approach across appropriate sectors and agencies was advocated as a means to help address this.

There is a large potential for the trained project staff to provide training services in a range of areas (e.g. PCG, attachment, Circle of Security, group work) to other agencies. The example of co-facilitators being able to deliver group facilitation training was cited as potential inter-sectoral training activity. The delivery of training would also promote stronger linkages and partnerships. There is evidence of this happening with the Brisbane site currently engaging with Queensland Health's 'Seeds' project, working with them for the adoption of the Circle of Security. Dissemination of the approaches used has also been enacted by Gowrie Adelaide, through presentations of the model and evaluation findings at TAFE colleges and South Australian health and education government departments.

Expanding this external training role was also viewed as helping to raise the profile of Lady Gowrie and present potential opportunities to generate funding to help retain the clinician role when the TtLG project finishes. The need to explore ways in which trained TtLG staff might further apply their skills (and optimize the considerable investment made in skills development) when the project ends was also championed.

The need to promote and build capacity in PCG across the child care sector was strongly advocated by those engaged with the project. The potential to link training in PCG to formal courses run through the TAFE and University sector was also highlighted and championed.

7 DOCUMENTATION OF THE PROJECT MODEL

The TtLG model is detailed on the Lady Gowrie web site at:

http://www.throughthelookingglass.org.au/cms/about

The model is presented in Section 1 of this report with the project Manual contents and project resources provided in Appendix C. The project Manual may be requested form Lady Gowrie Adelaide.

7.1 Model Development

The Project Manager in collaboration with clinicians and members of the Reference Group has developed a TtLG project manual which also details the project model.

Clinicians reported that each group of families had a different dynamic with individual families having diverse needs. This complexity and diversity required clinicians to be flexibly responsive and employ the use of a range of activities and resources during the weekly group sessions. Information and resources successfully used with families were identified and systematically adopted and included in the manual. The manual has therefore evolved over the duration of the project and has become a reservoir of resources which complement its set of guidelines for the implementation of the TtLG Project. The contents of the Manual and resources compiled have been provided by the Lady Gowrie Project Manager and are summarized in Appendix C.

There have been few changes in the original model since its conception in the project proposal. An exception was the inclusion of the modified 'strange situation' technique in Gowrie Adelaide, reflecting the interest and expertise of their particular clinician. This was implemented following Reference Group discussions as a means of further exploring child parent attachment, and was used to complement the range of established model techniques. However, management has expressed some concerns that the technique may sway what is a multifaceted model away from the social/community elements and more toward therapeutic aspects; it has not been integrated into the model at other sites.

Given the contextual differences between sites drawing conclusions about optimizing the 'best practice' model is problematic; a number of issues have been identified which were specific to the context of individual sites. Other issues relate to the nature of the TtLG Project being conducted nationally across sovereign bodies with their own managerial and accountability structures (See: Section 6.1.3). This impeded the establishment of a coherent set of working, reporting and accountability procedures across the five engaged sites. These difficulties have also been exacerbated by staff turnover and geographical distance, notably with the Perth site which ended its involvement with the project after the fifth wave. However, all sites (including Perth) have expressed strong wishes to continue with the project in some form.

7.2 Adjustments made to the Model

Whilst the essential elements of the model have been retained throughout the project, the evaluation has revealed a number of difficulties encountered in its implementation across the five sites. These have revolved around the more generic difficulties of

establishing an efficient functioning 'multi-disciplinary' team which have been confounded by the need to do this across 'independently managed' bodies:

- Complexities of reporting and accountability[26];
- Ambiguities concerning professional boundaries between clinicians, child care workers and co-facilitators;
- Blending the project with the objectives and priorities of individual child centre sites;
- Promoting the adoption of a different paradigm of collaborative working.

There were also initial managerial concerns about the possibility of clinicians feeling 'isolated' given that their role distinguishes them from other child centre employees. Measures were subsequently taken to link clinicians to colleagues located in other sites. Paradoxically, the emergence of the TtLG clinicians as a mutually supportive group across the project sites, whilst strengthening collegiality and facilitating sharing of learning and information which has contributed to resource development, appeared to have emphasized the boundaries between their professional roles and those of other TtLG service providers. This created difficulties to implementing aspects of the model and inhibited the project logic; the efforts required to blend existing norms and preferred practices which have been reified in this group with the requirements and application of the TtLG model were underestimated. Two examples have emerged: difficulties in persuading clinicians to reduce home visits; difficulties in persuading clinicians to assess video film of client child/parent interaction collegially with the primary care givers.

A series of recommendations were identified and addressed at the management level:

- Greater staff engagement with the Reference Group (through staff representation) to allow more open dialogue;
- Establishing a program of national meetings of TtLG staff which had a 'dialogue' focus across staff groups and sites;
- Establish an on-going training program in attachment and its mechanisms to monitor its application in working practice;
- The introduction of staff appraisals for clinicians;
- On-going revision of the Manual to clarify job specifications, roles, the applied nature of primary care giving, reporting procedures and the TtLG vision;
- Formalising procedures for raising staff concerns;
- Supporting open and effective two way communication between directors and clinicians in order to achieve optimal implementation of the TtLG Projects in centers;
- Reviewing the co-facilitator's role and responsibilities and investigating additional ways that the co-facilitator can work with the TtLG family;
- Clarifying the childcare centre director's role and responsibilities in supporting centre staff working with TtLG families. In particular the TtLG family's relationship with the primary caregiver and any consequent demands on the primary caregiver.

[26] Clinicians are currently accountable to three bodies: the TtLG Project Manager, the Child Centre Director and their professional supervisor

The above areas have been addressed, and have been documented in the project Manual. Service delivery 'Action Plans' for each individual site for Years 2006-07 and 2007-08 were also developed; these appear in Appendix B.

As clinicians became more embedded in their centers the barriers identified gradually eroded; this was assisted by staff changes in which some clinicians were recruited who were known to have experience with child care work, or who were more willing to embrace the new paradigm.

7.3 Areas for Potential Model Refinement Identified by Professional Stakeholders

Following wave 4, professional stakeholders identified a number of areas where the model and project might be refined or adapted. Several of these are discussed earlier in this report under the specific objectives to which they relate. Additional areas identified by professional stakeholders are presented below. These should be generally be viewed as considerations for those seeking to implement the model rather than stipulations as there will inevitably be contextual and staff differences in different site locations.

A full itemization of all areas for potential refinement is presented in Section 7. 4

i. Optimising Multi-Disciplinary Teams

The need to 'balance' the contributions of the varied expertise brought to the project through the multi-disciplinary team was a challenge for the project. The unique service provided through the TtLG project was embodied in the fusing of therapeutic (clinician) and early intervention (child care) approaches; these were conceived as traditionally having separate allegiances and identities. Ensuring an integrated approach in the model was made more difficult by the organizational and managerial differences across sites.

Bringing together all staff earlier in the project and more frequently to address issues and share learning experiences would have encouraged a more coordinated 'team' approach. Instigating more professional development activity at the team level earlier would also have promoted the progression of a working team culture within sites.

Having participated in the project since its instigation, some of the PCGs consulted in the evaluation had worked with more than one clinician and co-facilitator. These workers provided a particular insight to factors which helped promote the optimization of the multi-disciplinary team within the child care setting. The discussion was steered toward aspects which might inform the best practice model and several suggestions were highlighted. There was evidence presented of these measures being successfully exercised in different sites:

- Where more than one locality was used by a given center, the need for the clinician to be available across these localities;
- The benefits of a clinician having some background in child care provision including the day-to-day difficulties encountered by child care workers;
- The need for clinicians to hold the personal qualities of being: non-judgmental, respectful of other's expertise, and empathetic;

- Incorporating periods of time when clinicians can interact with child worker staff;
- Incorporating time when 'new' clinicians can work with staff in the child care rooms and observe their working with children in their care;
- Adopting the use of a 'Communication Folder' in the event of the clinician being unavailable, to enable staff to record issues of concern to be addressed later;
- Clarifying times when the clinician would be available for consultation with the PCGs.

Conducting 'open nights' at the community centre in which the clinician could speak to all parents about the project was also valued as this was viewed as helping to address any pre-existing sense of stigma.

ii. Adjusting for client demands on PCG time

Client demands on primary care givers' time was identified as an issue but one which could be accommodated. The potential for PCGs to be removed from attending to children was successfully addressed by identifying a second member of staff to act as a 'secondary care giver' in their absence. For sites where this was applied it worked well.

Time demands from parents were also alleviated by forward planning of meeting times; parents and PCGs agreed convenient set times early in the project when their PCG would be available for meetings. This procedure should therefore be incorporated into the best practice model.

> *'Finding the time for the parents was sometimes hard for me especially if I had some children to be looking after';*
>
> *'(Agreeing available time) Worked really well for us… It wasn't carved in stone but it meant that everyone was clear about when the PCG was available…'*

iii. Suitability of the Project for 'Acute' Cases

A small minority of families were experiencing acute problems at a level of severity the project could not fully address. Whilst this raises questions concerning stricter definitions of eligibility for recruitment in order to filter out clients who may require more intensive therapeutic intervention, there were some disagreements amongst professional stakeholder groups regarding the exclusion of these clients. Clinicians and co-facilitators felt that excluding more acute cases would deny them the considerable benefits to be gained from the project. PCGs asserted that substantial and rewarding benefits were achieved for these families. For these stakeholders, it was felt that identifying a willingness to try to engage with the project was a more important factor than severity of condition. However, two managers expressed concerns regarding disruptive difficulties experienced with specific families. Four potential strategies emerged around this issue:

1. 'screening' mothers to ensure a willingness to engage with the project, be reflective and seek underlying solutions to attachment issues;

2. 'linking in' specialized concomitant support with other agencies for specific cases if required;
3. extending the engagement period for families who need it;
4. establishing a more formalized 'referral pathway' for families who may need further help;

Strategy 1 presents challenges which may only be possible to address individually through the professionally informed impressions of the clinician. However, given the holistic family centered and personalized approach adopted by the model, the flexibility to embrace strategies 1-3 on a case by case basis was viewed as feasible; these measures could potentially be accommodated in the current model. With regard to strategy 4, in several sites, referring specific clients to new services occurred where linkages to external agencies were already established. As the model stands, whilst the project seeks to empower clients to seek appropriate external support services as part of objective 3, there is currently no formal strategy to develop referral pathways to appropriate services for those clients who may require further therapeutic help. Whilst there was evidence of this happening on a less formal basis, incorporating this formally would help to ensure that 'post project' cases identified as requiring it, receive that additional support. There may be a case for extending project linkages and partnerships with suitable 'follow-up' agencies to enable this to happen. This may also yield benefits in terms of external agencies directing additional suitable 'recruits' to the project.

The benefit of locating the project at Centers for Early Development and Learning was highlighted as these will embrace a range of easily accessible services at the same venue and potentially optimize multidisciplinary service delivery.

iv. Engaging Aboriginal families and fathers

The project has not recruited ATSI families. At the time of writing this report, an extensive consultation with Aboriginal communities from urban and rural areas is being conducted using TtLG project funding. It is hoped that this will lead to modifying TtLG to produce a culturally appropriate model which will encourage uptake from Indigenous families.

The engagement of fathers has varied across the different sites. Given the high number of single mums and the work/time demands for families with fathers, this has been problematic. Where this has occurred it has been largely through information giving sessions and informal liaison with the PCG. This has been beneficial in helping to establish relationships with families. Formal group activity with fathers has yielded positive impacts (See: Appendix E2). Means of extending this activity to engage more fathers should be further explored.

7.4 Overview of further Potential Model Refinement Areas

Potential refinements to the model have been unearthed more recently as the staff who engaged with it from the various sites have become more familiar and experienced. A comprehensive list of these is presented below. A number of these areas are currently being addressed for inclusion in the project Manual.

i. Position descriptions roles and partnerships:

- *The model would benefit from further establishing clearer position descriptions of the working roles of staff engaged with the project (Clinicians, Co-Facilitators, Managers / Supervisors), taking account of the myriad roles which have been adopted during the TtLG project.*

- *The model would benefit from stipulating the nature and proceedings for the provision of PCG staff support (including emotional 'debriefing') and the Clinician role in this.*

ii. Implementation of the model:

- *The model would benefit from a longer period of staff induction and site preparation prior to recruiting clients. This will allow PCG practices to be established as a firm base for the project and encourage clinicians to be more embedded in the child care center. Given the learning acquired through this project, this preparation period should be no less than two months.*

- *The model would benefit from establishing protocols for communication between PCGs and clinicians which may include time-tabling meetings and/or adopting the use of a 'communication folder'.*

- *PCGs and clients would benefit from negotiating agreed times for consultations early in the project to avoid parental demands impeding PGC time with children; establishing a secondary care giver for support has also been identified as a best practice in this regard.*

- *The model may benefit from establishing formal linkages with service agencies in order to link them to clients with acute problems.*

- *Consideration be given to extending the project for the small number of families who need it; the flexibility to extend the project for these families would need to be incorporated in the model.*

iii. Implementation of the model specifically across several sites / agencies:

- *Where the model is applied across sites, more regular meetings of all staff to share and explore experiences of the team approach would contribute to the more effective functioning of the multi-disciplinary approach.*

- *The model would benefit from the development of MOUs for all participating sites which clarify ownership, accountability procedures, roles and responsibilities of management and staff (including position statements for clinicians, co-facilitators, PCGs). Establishing agreed procedures for managing conflict/disagreement could usefully be included.*

iv. Establishing procedures for clients leaving the project:

- *The model would benefit from developing in plain English a client 'exit strategy' which includes clarifying the role of the PCG for parents no longer engaged with the TtLG project.*

- *The model would benefit from developing more formal linkages and pathways to suitable external agencies to address specific identified client need where appropriate.*

v. Training / Staffing issues:

- *The model would benefit by including multi-disciplinary team training as early as possible within sites to enhance functionality; this should include time/ measures to familiarize clinicians with child care workers and their professional practice through observation and interaction.*

- *The model would benefit from formally identifying specific staff as PGC/TtLG trainers, and ensure they are equipped with the pedagogical skills to deliver capacity building sessions for other workers as required. These sessions might supplement or replace PCG training currently delivered as part of staff induction.*

- *The model would benefit from including the requirement of extending regular professional staff appraisal to identify staff training needs.*

- *Incorporating measures to retain trained staff (e.g. accreditation and financial remuneration) into the model would enhance efficacy and continuity of service delivery*

vii. Future Directions:

- *Consideration should be given to further expanding the training role of Gowrie centers across the sector in order to raise awareness of and build capacity in PGC. The promotion of PCG in formal training provided through TAFE and Universities should be explored further.*

- *Avenues to utilize the new skills acquired by clinicians and co-facilitators through engaging them in cross-sector capacity building activity should continue to be explored; this would potentially promote further beneficial post-project outcomes.*

- *The model would benefit from continuing to engage in dialogue with Aboriginal communities to inform its cultural appropriateness for Indigenous families.*

- *The model should continue to provide information sessions to fathers and encourage exploration of flexible ways to greater engage with fathers where possible.*

8 DISCUSSION OF EVALUATION METHDOLOGY

This evaluation report addresses findings from Waves 1-5 of the TtLG Project for the period July 2005 to April 2008. The project is currently completing a sixth Wave the findings from which will be included in an evaluation summary report to be submitted to Lady Gowrie Adelaide.

The participatory action research approach has allowed on-going feedback throughout the project; it has clearly informed the identification of project implementation issues and inhibiters to the project logic. This has encouraged action with regard to training and discussion, and unearthed a range of process issues which were addressed as the project progressed. The approach has also facilitated the application of a broad range of triangulated methods to gather data from the range of stakeholders engaged with the project over time. Some of these methods have only been possible to implement with the collaboration of project staff as evaluation partners.

The procedures employed in the evaluation have been more elaborate than was initially envisaged and have required considerable planning and organisation to enact (notably the collection of video footage and its professional assessment pre and post each implemented Wave). This has been largely brought about by the absence of any one psychometric instrument to measure parent/child attachment and related dimensions. This has also necessitated training in evaluation and the application of evaluation tools utilised here. The speedy implementation of the project prior to the procedures for data collection being formalised led to some missing data in Wave 1. However the application of the tools recommended by the Reference Group has allowed the spectrum of impacts to be specifically measured, and the procedures established have been ethically endorsed and were acceptable to project clients. Data collection improved as the project progressed and is of an acceptable standard. Standardised data has been complemented by qualitative approaches which have allowed causality to be addressed, the experiences of staff and clients to be explored, pertinent model aspects to be unearthed and sustainable impacts to be identified.

Following the first three waves, the evaluation has continued to collect, analyse and present findings from clients. However, in seeking to address the higher order objectives, the evaluation conducted semi-structured (but largely qualitative) interviews with all staff across all sites who had engaged with the project (CEOs, managers, clinicians and co-facilitators) and conducted focus groups with Primary Care Givers following Wave 4. During conclusions about the model from the broad range of contextually specific accounts generated in this process was problematic. However, a number of areas have subsequently been identified regarding optimisation of the implementation of the model which have been discussed with project management and will be further explored with the project Reference Group. These refinements have been included in this report.

The evaluation addressed project impacts over time for clients largely through a three-month follow-up interview of all mothers from waves 1-3. The findings obtained were highly positive and provided strong evidence of sustained impacts. This raised questions concerning longer term outcomes for clients and the local evaluator proposed implementing a longer term follow-up to address this. The selection of clients and the period of time for follow-up were largely governed by the parameters of the funding period and the evaluation resources available. With the endorsement of management and the Reference Group, evaluation resources were shifted from the three-month to a fifteen month follow-up (which, given the logistics of tracing some clients became an eighteen month follow-up in some cases). All clients from Waves 2 and 3 were surveyed and interviewed for this. The findings from this work are included in this report.

8.1 Consideration of a Control Group

The PAR design of this evaluation was informed by the need apply a methodology which embraced and informed project evolution and development over time. The evaluation rejected establishing a control group for a number of practical, ethical and design reasons. The potential need for modification to the project model in the light of evaluation findings would reformat the intervention reducing any comparisons with a control to snapshots of the model at that particular developmental phase. Moreover, the model was multifaceted and applied across different site contexts with a degree of flexibility in each case.

Ethical difficulties were recognised by the local evaluator in that the control would deny the intervention to parents identified as being in need. Logistical barriers were also identified including: identification and recruitment of enough subjects for the control group, problems of applying the standardised measure in an appropriate way with control group recruits (particularly the videoing of parent interactions with their children in their homes on 'pre' and 'post' occasions, and the infeasibility of setting up scenarios for the 'wellness and involvement' scales to be applied), and the increase in costs (including training, travel and incentives) of doing so with enough numbers of geographically spread parents for robust comparisons to be made.

However on concluding Wave 3 it became evident that place restrictions had generated lists of eligible parents at two specific sites who could not be accommodated into the project. Given that the model had matured by this time, and that its nature had not modified greatly from the initial application, the external evaluator revisited the question of establishing a control group using these eligible parents which he raised with the Reference Group. The advantages of using a control group primarily rest on strengthening the case for causal attribution.

The local evaluator subsequently calculated effect sizes generated by the application of the pre and post standardised tools to calculate the size of the control group required for robust comparisons to be made. Since the control group is expected not to change over time, the effect size for the pre-post difference in the project group was used as an estimate of the difference between the project group and the control group. Sample sizes to achieve at least an 80% power were calculated for each of dimensions addressed by the standardised tools. A selection of these is presented in Table 12.

There are however persisting issues with establishing a control group for this evaluation:

1. Incentives and raising expectations amongst control group recruits. The lists of eligible people identified are not part of an official 'waiting list' and may not be taken onto the project if other more 'needy' cases are identified following their participation. Given the sensitivity of issues to be addressed suitable incentives would have to be identified. However, there was an ethical need to emphasis the possibility of being denied access to the project; this might also alleviate Hawthorne Effects on control subjects 'post' responses.
2. Possible selection bias. If project subjects were systematically selected according to perceived 'need' this creates differences based on need between the control and project groups.
3. Costs of accessing eligible subjects in their homes, and additional costs of training and data analysis.
4. The need to restrict recruitment to those two areas that have identified contactable and eligible subjects; given the contextual differences between sites conclusions would be restricted to specific site(s).
5. Objections from clients concerning home videoing. Preliminary work conducted early in the project uncovered a strong reluctance amongst clients who were no loner part of the Project to be video taped at home with their children. This may also amplify a latent selection bias in the control group.
6. Related to 4, the demands of the Well-being observations notably the need to establish familiarity between children and researcher raises issues of feasibility.
7. The need for ethical approval given the change in evaluation design

Given the sample sizes required and the particular difficulties that video taping presents, use of the Emotional Availability scale is highly problematical. The Well-being observations were not feasible given the need to pre-establish relationships with control group children (and their parents).

However, the possibility of establishing a 'Comparison Group' in SA, and applying pre and post measures of the PSI and HADS was considered. Such an endeavor would have required establishing a clear, sensitive and ethically accep2protocol which clarified subject involvement with the project and provided adequate incentives to participate. Control subjects would have had to be matched with project subjects to avoid selection bias. This would have incurred considerable additional costs.

These issues were raised with the Reference Group and project management. Given the problems and the costs involved and the current triangulated methodology which explored causality qualitatively using multiple sources and methods, establishing a comparison group was rejected.

Table 12: Control Group Sample Size Calculations for Measures registering significant pre/post differences

Standardised Measure	N	Power
1.PSI (stress)	20	0.987
2.HADS (Anxiety)	35	0.841
3.HADS (Depression)	20	0.897
4.Wellbeing	20	0.993
5.Involvement	20	0.999
6.EA Child Responsiveness to Parent	105	0.810
7.EA Child Involvement with Parent	65	0.818
8. EA Parent Sensitivity	60	0.806
9. EA Parent Structuring	20	0.795

9 CONCLUSIONS AND RECOMMENDATIONS

The evaluation has demonstrated a range of sustainable impacts for mothers, children and individual staff engaged with the project. A cultural shift in the working practices toward the fuller implementation of PCG and continued training in this area has occurred across all participating centers and this has been ingrained through developments at the policy level. This has led to a change in the responsibilities of child-care workers who have acquired a broader range of beneficial skills in the process. Resources and skills developed or compiled for the project continue to be utilized. Approaches developed in the project (notably the use of video recording to help parents and staff reflect on their practices) have also been adopted in some sites as part of on-going practice. Further project implementation will occur in at least one new site in Queensland and work has commenced to explore adapting the project for Aboriginal communities.

The main difficulties to emerge from this project were related to the issues generated through enlisting a multidisciplinary approach to service provision and in attempting to manage it across geographically dispersed sovereign and autonomous agencies with independent managerial structures, differing missions and policies. In the former case the difficulties were overcome through nurturing understanding and experiences of the contributions and expertise available from the professional participants. A number of strategies to enhance this have been identified. Coordinating the various sites proved a greater challenge and one which may have been eased by the early establishment of MOUs and documented project management/accountability procedures. However, embedding the project in organizations with established managerial and accountability structures would alleviate this issue.

The degree of training and capacity building achieved by the project has been substantial and represents a considerable investment which has subsequently generated profound outcomes for vulnerable families and their children. Clearly, the roles of the clinician and co-facilitator are not sustainable without funding to support these positions. There have been some moves made toward promoting the project in an attempt to secure funding at a State level including several formal presentations of interim findings, but these have not to date led to a continuation of the project. There is potential for expanding the training role of centers across the sector and engaging clinicians as central to this work; this has the possibility of acquiring funding for the role through this source. However, the extent to which this would be sustainable, and the degree to which these activities might impinge on the operations of an extended TtLG are unknown.

In the light of the evidence presented through this evaluation, there is an overwhelming case to perpetuate the project in order to build on the investment and continue to provide an intervention which has clear multiple positive impacts and sustainable benefits for Australian families. A number of potential model refinement areas have been identified and are currently being considered. Whilst there are areas of the service model which may be subject to on-going context specific revision, the project demonstrates its flexibility to adapt to and be adopted by different child center practices and contexts and generate a range of successful outcomes for service providers and their clients.

Appendix A.

Evaluation Plan Matrix

Evaluation Plan Matrix: Through the Looking Glass – A Community Partnership in Parenting – Paul Aylward (External Evaluator)

Goal: To develop and pilot a model of collaborative early intervention and prevention for targeted parents to improve secure attachment outcomes for young children in five selected child centre sites across Australia.

	Objective	**Strategies**	**Process Indicators**	**Data Collection Methods**	**Impact/Outcome Indicators**	**Data Collection Methods**
1.	**To forge working and sustainable inter-sectoral partnerships across Australia (childcare, health , education and consumer) overseeing and informing the development and management of the Project.**	Establish a committed Project Reference Group of partnering agencies and parents Engage five suitable child centre sites to the Project Recruit an experienced Project Officer to liaise with mothers and fathers, education and health professionals in order to develop inclusive education resources and activities Develop an inclusive program of activities for the Project	Number and range of Health and Education Professionals and parents contributing to the development of the Project and its resources Health and Education Professionals and parent satisfaction with processes of engagement Health and Education Professionals and mothers and fathers value the Project and are committed to the partnership (participation) Health and Education Professionals satisfaction with resources/activities developed and structure of the Project Parent satisfaction with participation, resources/activities developed and structure of the Project Partnerships identified and viewed as useful and appropriate by service providers and parents	Document Review E Mail survey of contributing Health and Education agencies (Reference Group members) In-Depth Interview: Project Officer In-Depth Interview: Project Manager Semi Structured personal/telephone interviews: clinicians, co-facilitators, managers (after Wave 4).	Partnering Agencies /stakeholders meet regularly and are committed to the Project Inclusive Project developed Evidence of on-going partnership (new initiatives, linkages, activities, project involvement)	Document Review E mail survey of contributing Health and Education agencies (Reference Group) In-Depth Interview: Project Officer In-Depth Interview: Project Manager Semi Structured personal/telephone interviews: clinicians, co-facilitators, managers (after Wave 4).

	Objective	Strategies	Process Indicators	Data Collection Methods	Impact/Outcome Indicators	Data Collection Methods
2.	**Build capacity of participating Childcare Centres to develop and adopt a sustainable integrated primary care-giver system**	Liaise with Reference Group to organise design and delivery of program of training Engage five Project sites in partnership to implement attachment model Deliver a two day training workshop to recruited project staff (clinicians, co-facilitators and site managers**)** Embrace an action learning/research approach to coordinate, deliver, evaluate, refine and provide on-going support for training program in the five Project sites across Australia to childcare centre front-line and project staff.	Inclusive program of training developed – Health and Education professional stakeholders and mothers and fathers satisfaction with training program and process of its development Recruitment of range of childcare centre staff service providers across five sites to participate in training / project No' of workshops delivered, training provided and refinements made No' and nature of staff attending training Attendee satisfaction with training content, delivery, timing and venue Perception of appropriateness and usefulness of training amongst workshop attendees Model used in training viewed as useful and appropriate by service providers (i.e. Marvin's 'Circle of Security' attachment model)	E Mail survey of contributing Health and Education agencies (Reference Group) Self completion evaluation questionnaire of childcare centre front-line staff Document Review Self completion evaluation questionnaire for clinicians on completion of 2 day training. Follow up telephone interview of clinicians In-Depth Interviews with Trainers In-Depth Interview with PO Telephone Interview Childcare Centre Managers and Clinicians Semi Structured personal/telephone interviews: clinicians, co-facilitators, managers (after Wave 4). Focus group – Child care staff not directly engaged with TtLG (after Wave 4)	Childcare service providers gain increased awareness and knowledge of attachment model and are equipped with skills and confidence to implement it Childcare service providers value participation in the Project and identify capacity building benefits Childcare service providers (plan to) incorporate model and learnings in Professional practice Evidence of systemic change for adoption of primary care-giver system and integration of attachment model (MOUs, policy, planned activities, professional development programs etc)	E mail surveys of project workers each year, and 3 months after completion of Project Telephone Interview Childcare Centre Managers and Clinicians Self completion evaluation questionnaire for clinicians on completion of 2 day training. Follow up telephone interview of clinicians Semi Structured personal/telephone interviews: clinicians, co-facilitators, managers (after Wave 4) Focus group – Child care staff not directly engaged with TtLG (after Wave 4) Document Review Rapid Reconnaissance

	Objective	Strategies	Process Indicators	Data Collection Methods	Impact/Outcome Indicators	Data Collection Methods
3.	**3.1 To equip and empower a range of parents of young children with the knowledge, awareness, confidence and skills to successfully overcome the barriers to attachment** ↓ **3.2 To foster and nurture positive parent well-being outcomes** ↓ **3.3 To foster and nurture positive child well-being outcomes**	Engage groups of seven parents from each project site to commit to the six –month Project Provide a 'safe space' for clients and families to interact, socialise and express their issues. Implement integrated Project strategies: • Individual counselling • Childcare provision • Psycho-social Group work sessions (involving child care worker, social worker, nurse) • Father sessions	Parents recruited across five sites and retained throughout the Project No and timing of strategies delivered – information and activities provided staff engaged (including resources) Number and characteristics of recruited mothers and father's (, ethnicity, disablement / retained and not retained) Number of client sessions conducted / uptake of quality childcare provision Clients feel the setting is safe, they enjoy using the venue, feel relaxed there and can freely socialise and express their issues Client satisfaction with project strategies (including childcare provision) content, timing, delivery, venue Staff satisfaction with project strategies, content, timing, delivery, venue.	Document Review Census of parents in each of wave x 6 using a self-Completion Evaluation In-Depth Interview: Project Officer In-Depth Interview: Project Manager Telephone Interview Childcare Centre Managers and Clinicians Semi Structured personal/telephone interviews: clinicians, co-facilitators, managers (after Wave 4). Focus group – Child care staff not directly engaged with TtLG (after Wave 4) Rapid Reconnaissance	Mothers and fathers report increased knowledge, awareness, confidence, skills attributable to the Project (*parenting competence and style) Parents are less depressed and anxious, and better equipped to manage/cope (*parenting competence and style, improved parenting competence and *improved family functioning) Parents are equipped to overcome barriers to attachment and report greater bonding attributable to the project (*improved family functioning) Parents are motivated and confident to seek appropriate service support (* parenting competence and style) Parents report improved parenting practices and activities support (*parenting competence and style) Parents report improved positive child behaviour (*Improved child social and emotional development) Parents share learning with others (*parenting competence and style) Children exhibit increased levels of involvement and engagement precipitated by the project (*Improved child social and emotional development) * Invest to Grow Priority Area outcomes	Census of parents, in each of wave x 6 using a self-completion Evaluation Questionnaire Parents receive battery of Standardised psychometric instruments (pre / post project) x 6: Application of standardised child wellbeing and involvement observation scales pre and post measures: Wellbeing Observation Instrument (Winter) The Leuven Involvement Scale for Toddlers (LIS-T) In-Depth Interview: Project Officer In-Depth Interview: Project Manager Telephone survey of clients 3 months after completion of project (first three Waves) Longitudinal qualitative interviews (Waves 2 and 3) 16-18 months after completing the TtLG project Semi Structured personal/telephone interviews: clinicians, co-facilitators, managers (after Wave 4) Focus group – Child care staff not directly engaged with TtLG (after Wave 4)

	Objective	Strategies	Process Indicators	Data Collection Methods	Impact/Outcome Indicators	Data Collection Methods
4.	**Develop and enhance social support /friendship networks for the target group**	Liaise with Project site staff and clients to identify suitable existing or new community events, networks, group meetings where project activities / clients can be included Integrate project activities into existing community health promotion and social events Facilitate and encourage client participation in formal and informal social events (and their families) located at participating sites Encourage family members to attend attachment sessions	Number and range of events conducted, resources distributed / project messages integrated Attendance and participation of project clients, families, wider community, staff. Staff and client Satisfaction with event involvement, content, timing, delivery, venue.	Document Review Telephone survey of clients 3 months after completion of project (first three Waves) Longitudinal qualitative interviews with clients (Waves 2 and 3) 11-18 months after completing the TtLG project Semi Structured personal/telephone interviews: clinicians, co-facilitators, managers (after Wave 4) Focus group – Child care staff not directly engaged with TtLG (after Wave 4)	Clients report development/enhancement of social support networks (*Inclusive communities) Support networks are valued, sustained and strengthen client community embeddedness, connectedness and resilience (*Inclusive communities) * Invest to Grow Priority Area outcomes	Telephone survey of clients 3 months after completion of project (first three Waves) Longitudinal qualitative interviews with clients (Waves 2 and 3) 16-18 months after completing the TtLG project Semi Structured personal/telephone interviews: clinicians, co-facilitators, managers (after Wave 4) Focus group – Child care staff not directly engaged with TtLG (after Wave 4)

	Objective	Strategies	Process Indicators	Data Collection Methods	Impact/Outcome Indicators	Data Collection Methods
5.	**To develop and promote the uptake of a 'best practice' model for services working with mothers and fathers and children around issues of attachment**	Adopt an action research approach to the evaluation of the Project which informs the on-going inclusive development of the Model Disseminate learning, findings and best practice derived from the Project: Media releases Promotional Launch Poster / Conference presentations Publications (journal, web, periodicals) Compile a comprehensive staff-development program detailing the model and its implementation in order to encourage uptake of model across the sector	Evidence of integration of action research evaluation into project planning and development Stakeholder satisfaction with processes adopted Stakeholder satisfaction with model developed Dissemination activities and audience reach	Document Review Telephone Interview with Project site managers In-Depth Interview: Project Officer In-Depth Interview: Project Manager Semi Structured personal/telephone interviews: clinicians, co-facilitators, managers (after Wave 4)	Production of an approved inclusive 'Best Practice' model Evidence of systemic change for adoption of primary care-giver system and integration of attachment model (MOUs, policy, planned activities, professional development programs etc) beyond Project sites.	Document Review E-Mail survey / In-Depth Interview Reference Group Telephone Interview with Project site managers In-Depth Interview: Project Officer In-Depth Interview: Project Manager Semi Structured personal/telephone interviews: clinicians, co-facilitators, managers (after Wave 4) Critical Feedback – model refinement Reference Group

Appendix B.

TtLG Action Plans 2006-2007 all sites

THROUGH THE LOOKING GLASS PROJECT
ACTION PLAN JULY 06-JUNE 07

1. PROJECT SITE: Adelaide

	Adelaide		
	ISSUE	**ACTION**	**PRIORITY**
1	Support the full integration of health and education creating a single team of staff working in a *partnership* approach Strengthen relationships between staff, increase access and opportunities to meet. • Clinician, co facilitator and director • clinician and co facilitator, • clinician and PCG's • clinician and other CC staff	Encourage Sally to access the Underdale site to establish relationships with staff. Provide a consultation space at Underdale so that Sally can meet with families for 1:1 as well meet with staff to support project objectives.	HIGH HIGH
2	Support the development of expertise and the trial of integrating the modified Strange Situation Procedure into the EA taping and the COSI	Work with Mary Hood to support Sally to incorporate the SS procedure into the EA taping with her supervision	MED
3	Maintain and build on attachment knowledge of staff as per agreed training calendar	Schedule a review session for all staff to revisit Attachment and COS concepts Schedule a session to introduce staff to the concept of 'state of mind' building on from the COS. Circulate articles of interest on the topic of attachment and other TtLG related concepts to support further learning. Expose staff to external forums / conferences at the local level that are attachment focused. Send staff with agreement to report back on their learning to all of the team.	HIGH MED LOW MED
4	Increase staff competence and confidence in applying the Children's Well Being and Involvement Scales for all children at the centre Utilize the expertise and leadership of Cecilia and Nikki with team leaders of all rooms	Schedule a review session to revisit the Children's Well being and Involvement Scales with an implementation plan to build a team of staff with high level competence to support all staff to apply the tool with confidence using Cecilia and Nikki's expertise	HIGH
5	Improve video editing skills enabling the task of creating the You Are So Beautiful tape to be done by Sally	Utilize Brian or a person at the local level with video editing skills who can share their knowledge skills with Sally so that both are able to do the task	LOW

	Adelaide		
	ISSUE	**ACTION**	**PRIORITY**
6	Ensure social capital building opportunities are routinely available for TtLG participants to access	Create a calendar of events so that there is at least one event happening each wave that the participants can be invited to	MED
7	Co facilitator availability to develop partnership with clinician, participants, PCG and other CC staff Strengthen relationships between staff, increase access and opportunities to meet. • co facilitator , clinician and director • co facilitator and clinician • co facilitator and PCG's • co facilitator and room team leaders • co facilitator other CC staff	Release Cecilia for a minimum of 2 x 4 hours a week to follow up on project tasks. To support • the application of the Children's Wellbeing and Involvement Scales • plan sessions with Jen • prepare for facilitating sessions • support the PCG • to create video footage • support the writing of Learning Stories • support CC staff practices.	HIGH
8	Budget allocation and accountability for expenditure. Budget allocation for 2006-07 set	Implement process to invoice Gowrie Adelaide TtLG Project for specific costs associated with the project implementation in Perth. Invoicing including the detail of expenditure on a quarterly basis.	HIGH
9	Increase staff confidence in building secure attachment relationships with their primary care groups / all children in care.	Revisit the COS graphic and introducing staff to apply in rooms to their primary care group. Introduce video taping to observe own relationships and reflection on. Introduce staff to sharing their learning with peers.	HIGH MED LOW

THROUGH THE LOOKING GLASS PROJECT
ACTION PLAN JULY 06-JUNE 07

PROJECT SITE: il nido

	il nido		
	ISSUE	**ACTION**	**PRIORITY**
1	Support the full integration of health and education creating a single team of staff working in a *partnership* approach Strengthen relationships between staff, increase access and opportunities to meet. • Clinician, co facilitator and director • clinician and co facilitator, • clinician and PCG's • clinician and other CC staff	Encourage and support staff to meet with Sally to support their work with families both within the project and out.	LOW
2	Support the development of expertise and the trial of integrating the modified Strange Situation Procedure into the EA taping and implement the COSI.	Work with CAMHS and Sally to book families into the CAMS venue to undergo the taping and interview	HIGH
3	Maintain and build on attachment knowledge of staff as per agreed training calendar	Circulate articles of interest on the topic of attachment and other TtLG related concepts to support further learning. Expose staff to external forums / conferences at the local level that are attachment focused. Send staff with agreement to report back on their learning to all of the team.	MED MED
4	Increase fathers involvement	Utilize the male worker within the local area, 'fathers worker' within community agencies who may be able to partner Sally and Kerry to deliver the 3 TtLG sessions to dads	MED
5	Improve video editing skills enabling the task of creating the You Are So Beautiful tape to be done by Kerry	Utilize Brian or a person at the local level with video editing skills who can share their knowledge skills with Kerry so that both Sally and Kerry are able to do the task	MED
6	Ensure social capital building opportunities are routinely available for TtLG participants to access	Create a calendar of events so that there is at least one event happening each wave that the participants can be invited to	MED

	il nido		
	ISSUE	**ACTION**	**PRIORITY**
7	Co facilitator availability to develop partnership with clinician, participants, PCG and other CC staff Strengthen relationships between staff, increase access and opportunities to meet. • co facilitator , clinician and director • co facilitator and clinician • co facilitator and PCG's • co facilitator and room team leaders • co facilitator other CC staff	Release Kerry for a minimum of 2 x 4 hours a week to follow up on project tasks. To support • the application of the Children's Wellbeing and Involvement Scales • plan sessions with Jen • prepare for facilitating sessions • support the PCG • to create video footage • support the writing of Learning Stories • support CC staff practices.	HIGH
8	Budget allocation and accountability for expenditure. Budget allocation for 2006-07 set	Implement process to invoice Gowrie Adelaide TtLG Project for specific costs associated with the project implementation in Perth. Invoicing including the detail of expenditure on a quarterly basis.	MED
9	Increase staff confidence in building secure attachment relationships with their primary care groups / all children in care and reflective practice using video taping as the medium	Introduce video taping to observe own relationships and reflection on. Introduce staff to sharing their learning with peers.	MED MED

THROUGH THE LOOKING GLASS PROJECT
ACTION PLAN JULY 06-JUNE 07

PROJECT SITE: Salisbury

	Salisbury		
	ISSUE	**ACTION**	**PRIORITY**
1	The clinician position to support the project is a .50 FTE and new to child care.	Orientate Jude to the child care site and practices.	HIGH
2	Support the full integration of health and education creating a single team of staff working in a *partnership* approach Strengthen relationships between staff, increase access and opportunities to meet. • Clinician, co facilitator and director • clinician and co facilitator, • clinician and PCG's • clinician and other CC staff	Provide a confidential consultation space so that Jude can meet with families for 1:1 as well meet with staff to support project objectives. Plan regular meetings	HIGH
3	Difficulties with accessing the child care site enabling participation in the program	Investigate the possibility of utilizing the centre bus to support families with access difficulties.	HIGH
4	Maintain and build on attachment knowledge of staff as per agreed training calendar	Schedule a review session for all staff to revisit Attachment and COS concepts Schedule a review session for all staff to revisit primary care giving with additional support by Cecilia and Nikki visiting the site to provide follow-up support in rooms. Schedule a session to introduce staff to the concept of 'state of mind' building on from the COS. Circulate articles of interest on the topic of attachment and other TtLG related concepts to support further learning. Expose staff to external forums / conferences at the local level that are attachment focused. Send staff with agreement to report back on their learning to all of the team.	HIGH HIGH MED LOW MED
5	Increase staff competence and confidence in	Schedule a review session to revisit the	HIGH

	Salisbury		
	ISSUE	**ACTION**	**PRIORITY**
	applying the Children's Well Being and Involvement Scales for all children at the centre Utilize the expertise and leadership of Jess and Janine with team leaders of all rooms	Children's Well being and Involvement Scales with an implementation plan to build a team of staff with high level competence to support all staff to apply the tool with confidence using Janine and Jess's expertise	
6	Increase fathers involvement	Utilize the male worker within the local area, 'fathers worker' within community agencies who may be able to partner Jude and Jess to deliver the 3 TtLG sessions to dads	MED
7	Improve video editing skills enabling the task of creating the You Are So Beautiful tape to be done by Evelyn	Utilize Brian or other with video editing skills who can share their knowledge skills with Jude and Jess so that both are able to do the task	HIGH
8	Ensure social capital building opportunities are routinely available for TtLG participants to access	Create a calendar of events so that there is at least one event happening each wave that the participants can be invited to	MED
9	Co facilitator availability to develop partnership with clinician, participants, PCG and other CC staff Strengthen relationships between staff, increase access and opportunities to meet. • co facilitator , clinician and director • co facilitator and clinician • co facilitator and PCG's • co facilitator and room team leaders • co facilitator other CC staff	Release Jess for a minimum of 2 x 4 hours a week to follow up on project tasks. To support • the application of the Children's Wellbeing and Involvement Scales • plan sessions with Jen • prepare for facilitating sessions • support the PCG • to create video footage • support the writing of Learning Stories • support CC staff practices.	HIGH
10	Budget allocation and accountability for expenditure. Budget allocation for 2006-07 set	Implement process to invoice Gowrie Adelaide TtLG Project for specific costs associated with the project implementation in Salisbury. Invoicing including the detail of expenditure on a quarterly basis.	MED
11	Increase staff confidence in building secure attachment relationships with their primary care groups / all children in care.	Revisit the COS graphic and introducing staff to apply in rooms to their primary care group. Introduce video taping to observe own	HIGH

	Salisbury		
	ISSUE	**ACTION**	**PRIORITY**
		relationships and reflection on. Introduce staff to sharing their learning with peers.	MED LOW

THROUGH THE LOOKING GLASS PROJECT
ACTION PLAN JULY 06-JUNE 07

PROJECT SITE: Brisbane

	Brisbane		
	ISSUE	**ACTION**	**PRIORITY**
1	LAUNCH of the project	Investigate the possibility of having the launch in Brisbane to support building links to services.	HIGH
2	Support the full integration of health and education creating a single team of staff working in a *partnership* approach Strengthen relationships between staff, increase access and opportunities to meet. • Clinician, co facilitator and director • clinician and co facilitator, • clinician and PCG's • clinician and other CC staff	Provide a consultation space so that Lisa can meet with families for 1:1 as well meet with staff to support project objectives at both CC sites.	MED
3	Support the development of expertise and the trial of implementing the modified Strange Situation Procedure and COSI.	Identify a space where these activities might be possible. Work with Lisa and her local level clinical supervisor to support implementation.	MED
4	Maintain and build on attachment knowledge of staff as per agreed training calendar	Schedule a review session for all staff to revisit Attachment and COS concepts Schedule a review session for all staff to revisit primary care giving with additional support by Cecilia and Nikki visiting sites to provide follow-up support in rooms. Schedule a session to introduce staff to the concept of 'state of mind' building on from the COS. Circulate articles of interest on the topic of attachment and other TtLG related concepts to support further learning.	HIGH HIGH MED LOW

	Brisbane		
	ISSUE	**ACTION**	**PRIORITY**
		Expose staff to external forums / conferences at the local level that are attachment focused. Send staff with agreement to report back on their learning to all of the team.	MED
5	Increase staff competence and confidence in applying the Children's Well Being and Involvement Scales for all children at the centre Utilize the expertise and leadership of Lisa P. with team leaders of all rooms	Schedule a review session to revisit the Children's Well being and Involvement Scales with an implementation plan to build a team of staff with high level competence to support all staff to apply the tool with confidence using Lisa P's expertise	HIGH
6	Increase fathers involvement	Identify a male worker within the local area, 'fathers worker' within community agencies who may be able to partner Lisa and Lisa to deliver the 3 TtLG sessions to dads	MED
7	Improve video editing skills enabling the task of creating the You Are So Beautiful tape to be done by Lisa P	Identify a person at the local level with video editing skills who can share their knowledge skills with Lisa so that both are able to do the task	MED
8	Ensure social capital building opportunities are routinely available for TtLG participants to access	Create a calendar of events so that there is at least one event happening each wave that the participants can be invited to	LOW
9	Promotion of the project, building relationships with referring agencies.	Deliver a consistent message for referring agencies. TtLG intervention has multiple components group, 1:1 and child care. It's a package. Promote what is unique about TtLG and why it is successful using hard evidence. Identify opportunities for presenting the project at forums to promote across health education and welfare raising others awareness to support referrals	HIGH
10	Co facilitator availability to develop partnership with clinician, participants, PCG and other CC staff	Plan the release Lisa for a minimum of 2 x 4 hours a week to follow up on	HIGH

	Brisbane		
	ISSUE	**ACTION**	**PRIORITY**
	Strengthen relationships between staff, increase access and opportunities to meet. • co facilitator , clinician and director • co facilitator and clinician • co facilitator and PCG's • co facilitator and room team leaders • co facilitator other CC staff	project tasks. To support • the application of the Children's Wellbeing and Involvement Scales • plan sessions with Jen • prepare for facilitating sessions • support the PCG • to create video footage • support the writing of Learning Stories • support CC staff practices. Plan ahead regular release as standard with scheduled backfill as routine.	
11	Budget allocation and accountability for expenditure. Budget allocation for 2006-07 set	Implement process to invoice Gowrie Adelaide TtLG Project for specific costs associated with the project implementation in Perth. Invoicing including the detail of expenditure on a quarterly basis.	HIGH
12	Increase staff confidence in building secure attachment relationships with their primary care groups / all children in care.	Revisit the COS graphic and introducing staff to apply in rooms to their primary care group. Introduce video taping to observe own relationships and reflection on. Introduce staff to sharing their learning with peers.	HIGH MED LOW

THROUGH THE LOOKING GLASS PROJECT
PRIMARY CAREGIVING ACTION PLAN
JULY 07-JUNE 08

PROJECT SITE: PERTH

	Perth			
	ITEM	**ACTION**	**RESPONSIBLE PERSON**	**TIME FRAME**
1	To gain an increased understanding of primary caregiving as an approach and ideas for supporting the implementation process	Arrange for Virginia to visit the Adelaide Gowrie for observation of Primary caregiving in rooms and to meet with Kaye Colmer and or Bec Heath at il nido CCC to discuss the implementation of the approach, history of their sites journey and to gain support for addressing challenges	Virginia in partnership with Kaye and Pam	Aug 07
2	To build a sound foundation of attachment knowledge that underpins primary caregiving as an approach supporting the development of 'champions' at the site to lead staff change	Arrange for Virginia Sarah and Michelle to visit Adelaide to attend the 2 day training with Kent Hoffman in August	Virginia Sarah Michelle in partnership with Pam	
3	Invitation for Perth Gowrie staff to join with Nikki and Cecilia on a journey	Letter to be sent to staff form Nikki and Cecilia inviting them to join them on a journey over the coming year with a focus on discussing and reflecting on attachment concepts and application to the child care setting to support establishment of primary caregiving	Nikki and Cecilia in partnership with Perth Team	July 07
4	Mentoring support to Perth Gowrie staff delivered by Nikki and Cecilia supporting the Primary caregiving approach establishment Cecilia to support Kewdale Nikki to support Karawarra in a coordinated approach	Staff to be invited to keep a journal for recording reflections Monthly or 6 weekly contacts through emails to Discuss as an email group questions that are focused to create reflection on specific child care activities that meet the needs of children Share reflections through email Share experiences of changing from a behaviouralist approach to a relationship based approach through email Provide specific action learning activities that can be provided to staff to implement in the centre that can provide further discussion points at	Nikki and Cecilia in partnership with Perth leadership team and Perth CC staff	July 07-June 08

	Perth			
	ITEM	**ACTION**	**RESPONSIBLE PERSON**	**TIME FRAME**
		staff meetings Provide discussion points / ideas for team leaders so that team leaders of rooms can discuss them with staff in their rooms and lead change within their room and link to an activity within the staff meeting Topics to be explored may include: 1) COS Top Half: Secure Base, support my exploration Watch Over Me, Delight in Me, Help Me, Enjoy with me What does each of these mean? What do they look like? Examples of within the rooms, different ages What's the child's specific cues that indicate each need? How do we need to respond within a primary caregiving approach? Share What's my personal experience of this 2) COS Bottom Half: Safe Haven Welcome my coming to you, Comfort Protect Me, Comfort me, Delight in me Organize my feelings What does each of these mean? What do they look like? Examples within the rooms, different ages What's the child's specific cues that indicate each need? How do we respond within a primary caregining approach? Share What's my personal experience of this 3) COS Hands: Taking Charge What does this mean? When it is required? What does it require? What's the cues? How to respond and where does it fit in a primary caregiving approach Examples of 4) Bigger Stronger Wiser and Kind, being Emotionally Available		

	Perth			
	ITEM	**ACTION**	**RESPONSIBLE PERSON**	**TIME FRAME**
		What does this mean? Being both sides of the circle for all the children within my primary care giving group and within my room What does it mean to working as a primary caregiver in a primary caregiving system within a room Teamwork, Others supporting me and my relationships 5) Wellbeing and Involvement Link How it all fits together 6) In Their Shoes, experience of care from the place of the child Child experiences of care, of feeding, sleeping, toileting, learning / playing, exploring within a primary caregiving approach Relationship based care		
5	Provide follow up training session to staff in Perth	Nikki and Cecilia to revisit Perth in 2008 and provide a further session building on the foundation and spend time with staff within the rooms supporting the change	Nikki and Cecilia in partnership with Perth Project Team	Early 08

Appendix c.

TtLG Manual Contents and Resources

TtLG Manual Contents and Project Resources

CONTEXT	
The importance of the early years	Brain development hard wiring Early relationships matter Infant mental health Attachments
INTRODUCTION	
Project overall aims	
Theoretical underpinnings	Early intervention Social Capital Multi disciplinary team Partnerships & Collaboration Attachment theory
PROJECT COMPONENTS	
Key ideas/ concepts	Childcare and Primary Caregiving Clinician and child care staff link Group program and goals
Program staff	Primary caregiver Co-facilitator - childcare worker Clinician Centre Director/Manager
Program Weekly group sessions	Weekly sessions 1 – 18 insert program information Group attendance Group functioning – problems and solutions
Individual counselling and support	Setting goals with parents Home visiting Staff guidelines: vehicle use, mobile phones
Video work	Guidelines
Fathers involvement	Rationale 3 specific sessions
Learning Stories	Childcare PCG stories for TtLG families
Social Capital Building	
Training	Foundation training modules Ongoing training
POLICY & PROCEDURES	
Partnerships	Identifying agencies Forming agreements
Referrals	Processes for recruiting families to program
Selection	Assessment Process Selection Process: criteria for inclusion Families not offered a place
Records	Guidelines for case conferencing Confidentiality (Child protection) Documentation: assessment and genogram; Social mapping circles diagram
Professional Development	Clinical supervision Communication Case Review
Childcare Centre	Procedures
HR ISSUES	
Recruitment Processes	Developing Job Descriptions

	Identifying and recruiting staff with specific expertise Identifying and recruiting Child Care Centres Advertising
Roles and Responsibilities	Childcare centre Manager/ director Clinician Co Facilitator Primary Caregivers Performance Management Processes Supervision
Induction	Staff Induction Processes, to child care, to project Orientation of Families to childcare
APPENDICES	Forms 1. Broad program outline 2. Circle of Security Graphic 3. Circle of Repair Graphic 4. Evaluation forms 5. Promotional Flyer Brochure 6. Referral Form 7. Selection Criteria 8. Letter of confirmation 9. Contract of understanding 10. Consent from for use of video 11. Consent form for audio taping 12. Parent(s), PCG, Clinician Interview outline forms

PROJECT RESOURCES

TtLG families		
Resources		Source
Handouts graphics	Circle of Security (COS) Circle of Repair (COR) Attachment handouts	COS project USA
	COS fridge magnet	TtLG project
DVDs	'Shark Music'	COS project USA
	'Zoe-Brain-Repair'	COS project USA
	'You Are So Beautiful'	TtLG project
	'The Fathers / Child Journey'	Gowrie Adelaide and CYWHS
Books	Series of children's books on feelings (Angry, Lonely, Sad, Kind, Scared & Happy)	Author: Trace Moroney
	'I Love My Mummy' children's book	
	'Ourselves in Their Shoes'	Author: Anne Stonehouse
Cue cards	NCAST cue cards (feelings/emotions) Messages from childhood cards	NCAST USA
Posters	Parenting and Relationship posters	Anne Stonehouse
Videos/DVDs	Movies supporting group discussions: Finding Nemo Riding in Cars with Boys American Beauty Kenny	
Toys	Purpose: For use during parent-child dyad taping	
Cameras	Purpose: Photo Voice Activity by parents	

Childcare staff		
Resources		
Videos	Primary caregiving Secure attachments Parent partnerships Play that's real Video training with Robyn Dolby	Gowrie Adelaide
Handouts graphics	Circle of Security (COS) Circle of Repair (COR) Attachment handouts	COS project USA
Video cameras	Purpose: Taping parent-child dyads	

Appendix D.

Evaluation Toolset:

1. Evaluation summary sheets Clinicians and TtLG families
2. Client consent form & evaluation information
3. Client demographics form
4. Hospital Anxiety Depression Scale (HADS)
5. Parenting Stress Index (PSI)
6. Emotional Availability Scales
7a. Children's Wellbeing Observation Measure
7b. Children's Involvement Observation Measure
8a. Mothers post-program questionnaire
8b. Fathers post-program questionnaire
9. Mothers (three month) follow-up telephone interview schedule
10. Reference Group email survey
11. Co-facilitators email survey
12. Program managers interview schedule
13. Focus Groups of Primary Care Givers (PCG) – Topic Guide
14. Survey of TtLG Site Professional Stakeholders: Managers (CEOs), Clinicians and Co-Facilitators
15. Mothers (16-18 month) follow-up telephone interview schedule

Appendix D.1

TtLG Evaluation Summary Sheets family and clinician

FAMILY SUMMARY SHEET
INSTRUCTIONS: √ = Yes X = No Relevant Scores to be recorded.
Please send a copy of this form into TtLG evaluation Thebarton by Week 6. Summary sheet to be sent in at the completion of TtLG program.

FAMILY CODE:	

FAMILY NAME: _____

Mother's name: _____

Contact phone no. _____

Evaluation consent form	Demographic information	Post program evaluation questionnaire

PARTNER	Attended Fathers Sessions	Father's session evaluation form

MOTHER Treatment of depression*	Receiving clinical treatment	Taking medication	Attending other program or agency	Using alternative therapies
*information collected in assessment process				

MOTHER

PSI		HADS				Videotaping for EA Score	
		Anxiety		Depression			
Pre	Post	Pre	Post	Pre	Post	Pre	Post

CHILDREN Details & name of PCG			WELL-BEING		INVOLVEMENT	
Name	Age	Sex M/F	Pre score	Post score	Pre score	Post score
1						
PCG*						
2						
PCG						

Continued with childcare after TtLG	Withdrew from TtLG program	Reasons:

PLEASE MAKE ANY COMMENTS ON THE REVERSE SIDE OF THIS PAGE

TtLG Clinician Evaluation Summary Sheet

Site details _____ **Wave No.** _____ **Start date** _____ **Finish date** _____

Clinician name: _____ **Qualifications:** _____

Co-facilitator name: _____ **Qualifications:** _____

Number of families STARTING: **Number of children in child care:**

Number of families FINISHING: _____ **Number of children continuing in child care:** _____

Evaluation Data Collection Tasks

Each family has a 1 page evaluation summary sheet. This provides a checklist of the key evaluation data that project workers will be required to collect from participating families. As the tasks are completed please tick or cross the boxes or record the relevant score. The key tasks are summarised below:

1. Obtain Informed **Consent** from clients for evaluation questionnaires and follow-up telephone survey.

2. Collect **demographic information sheet and assessment information re: treatment for depression**

3. **Application of Standardised tools** for clients:
   - Parenting Stress Index (**PSI**) tests - pre and post program
     (Forms to be sent back to Margaret at Gowrie Thebarton for scoring)
   - Hospital Anxiety and Depression Scale (**HADS**) pre and post
   - Videotaping for Emotional Availability scores (**EA**) – pre and post program.

4. Collection of pre and post scores for **children's well-being and involvement**– standardised tools to be administered by co-facilitator/ primary caregiver.

5. Maintain a **reflective journal** – thoughts, concerns, issues etc. to assist with evaluation feedback.

6. Within 4 - 6 weeks of the program commencing please send a copy of each family's evaluation summary sheet to Evaluation assistant at Thebarton. This will assist with the data collection and analysis.

7. Return family summary sheets and evaluation forms at the completion of each wave, together with this cover sheet.

Thankyou for your help with the evaluation, if you have any questions please contact:

Margaret O'Neill
T: 08 8352 5144
F: 08 8234 1217
E: margareto@gowrie-adelaide.com.au

Lady Gowrie Child Centre
39a Dew Street
Thebarton SA 5031

Appendix D.2
Client consent and information forms

THROUGH THE LOOKING GLASS PROGRAM

CONSENT FORM FOR PARTICIPATION IN THE EVALUATION

I ….....

being over the age of 18 years hereby consent to participate as requested in the evaluation of the Through the Looking Glass Program.

1. I have read the evaluation information sheet provided.
2. Details of evaluation activities have been explained to my satisfaction.
3. I am aware that I should retain a copy of the Evaluation Information Sheet and Consent Form for future reference.

4. I understand that:
   - I may withdraw at any time from the evaluation without disadvantage and am free to decline to answer particular evaluation questions.
   - The privacy and confidentiality of any information I provide will be safeguarded as explained in the Evaluation Participant Information Sheet.
   - While the information gained in this evaluation study may be published I will not be identified, and individual information will remain confidential.
   - Whether I participate or not, or withdraw after participating, will have no effect on any service that is being provided to me.

5. Are you willing to take part in a follow-up evaluation phone call 3 to 4 months after you have completed the Through the Looking Glass Program?

Circle your response: YES NO. If agreeing to a phonecall please record your phone details:…….

Participant's signature…… Date……...

I certify that I have explained the evaluation study to the Through the Looking Glass client and consider that she/he understands what is involved and freely consents to participation in the evaluation research.

Name…….……

Signature…….. Date…….

NB. Two signed copies should be obtained (client and evaluator)

Through the Looking Glass Evaluation Information

The *Through the Looking Glass* is part of the Stronger Families and Communities Strategy, an Australian Government initiative that provides funding for early childhood programs and resources. As a requirement of this funding local programs, such as *Through the Looking Glass,* have to collect evaluation information on how the program is working for parents.

Evaluation is an important process. It can identify how effective a program is and what factors influence program activities and why. Your feedback is a very valuable part of this process. Data from the evaluations will be used to further develop the *Through the Looking Glass* programs that will follow on after your program has finished. The evaluation findings will be collected by myself, as the local evaluator. I am keen to find out what things worked well for you and also what you would like to have done differently.

As part of the evaluation you will be asked to fill in a range of different forms at the start and also the end of the program. This is an important evaluation strategy as it helps to show any changes that occur as a result of your participation in the *Through the Looking Glass* program. The evaluation questions will ask about your level of satisfaction with the different activities of the Through the Looking Glass program and your awareness and understanding of the Through the Looking Glass program. There will also be some demographic questions that are required by the National Evaluation of the Stronger Families and Communities Strategy.

There are no right or wrong answers to any of the questions on the evaluation forms. The idea is to simply find out how you are feeling at the beginning and the end to the program. I would also like to contact you to ask a few questions, over the phone, a few weeks after you finish the program. This will be an opportunity for you to talk about your participation in the *Through the Looking Glass* program and describe how it has influenced your parenting.

Participants maybe contacted at a later date to invite them to take part in a focus group discussion about their experiences. The focus group will be an opportunity to talk about the longer term impacts of taking part in the Through the Looking Glass program.

Your participation in the evaluation is voluntary and you may withdraw at any time without disadvantage. There is no payment for participation in the evaluation study. Your answers will be treated in the strictest of confidence. There will be no names or means of identification in any write up of the evaluation findings. Your information will remain confidential except in the case of a legal requirement to pass on personal information to authorized third parties. This requirement is standard and applies to information collected in both research and non-research situations. Such breaches of confidentiality are rare, however we have an obligation to inform you of this possibility.

This evaluation study has been approved by the Children, Youth & Women's Health Service Research Ethics Committee, Adelaide SA. The Secretary of the Committee, Ms Brenda Penny, can be contacted by telephone on 08 8161 6521.

Your contribution is very much valued and I hope that you enjoy your time with the *Through the Looking Glass* program. Please contact me if you have any questions.

Margaret O'Neill	Lady Gowrie Child Centre	Phone: 08 8352 5144
Evaluation	39a Dew St	Email: margareto@gowrie-adelaide.com.au
assistant.	Thebarton SA 5031	

Appendix D.3

Client demographics form

DATE _____ **TtLG Code:** _____

*Clinician to insert

Through the Looking Glass (TtLG) Program Family information

Please tick √ the appropriate box or write your answers in BLOCK LETTERS.

1 What is your age? _____ **years**

2 Please answer the following questions in relation to your child/ children in TtLG childcare

Child 1	**Male** ❑	**Female** ❑	**Age**	_____	**yrs**	_____	**months**
Child 2	**Male** ❑	**Female** ❑	**Age**	_____	**yrs**	_____	**months**
Child 3	**Male** ❑	**Female** ❑	**Age**	_____	**yrs**	_____	**months**

3 How are you related to your child/children who is part of the Through the Looking Glass program?

❑ Mother ❑ Grandparent

❑ Father ❑ Other *(please specify* _____

4 In which country were you born? Australia ❑ Other *(please specify)* ❑ _____

5 Do you speak a language other than English at home? Yes ❑ No ❑

Other language *(please specify)* _____

6 Are you of Aboriginal or Torres Strait Islander origin? Yes ❑ No ❑

7 What is the highest level of education that you have completed? *(mark one only)*

❑ University degree
❑ Certificate or diploma from TAFE or College
❑ School Year 12 or equivalent
❑ School Year 11 or equivalent
❑ School Year 10 or equivalent
❑ School Year 9 or lower
❑ Never attended school
❑ Other (please specify) _____

8 Which of the following best describes your current employment status? *(mark one only)*

❑ In full-time work
❑ In part-time work
❑ In casual work
❑ On leave from paid work
❑ Unemployed and looking for work
❑ Retired
❑ Not working (but not looking for work and not retired)
❑ Studying
❑ Full-time parent
❑ Other *(please specify)* _____

9 What is your main source of income? *(mark one only)*

❑ Wages or salary earned by you or your partner
❑ Government benefit, pension or allowance
❑ Child support
❑ Other *(please describe)* _____

Thankyou for your time and effort in completing this form.

Appendix D.4

Hospital Anxiety Depression Scale and Scoring sheet

Date: Pre Post CODE

Office Use Only

This questionnaire is designed to help the Through the Looking Glass facilitators understand how you are feeling. Please read each statement and underline the reply which comes closest to how you have been feeling in the past week.

Don't take too long over your replies. Your immediate reaction to each statement will probably be more accurate than a long thought out response.

1 I feel tense or 'wound up'

a Most of the time

b A lot of the time

c From time to time, occasionally

d Not at all

2 I still enjoy the things I used to enjoy

a Definitely as much

b Not quite so much

c Only a little

d Hardly at all

3 I get a sort of frightened feeling as if something awful is about to happen

a Very definitely and quite badly

b Yes, but not too badly

c A little, but it doesn't worry me

d Not at all

4 I can laugh and see the funny side of things

a As much as I always could

b Not quite so much now

c Definitely not so much now

d Not at all

Please continue over the page

5 Worrying thoughts go through my mind

a A great deal of time

b A lot of the time

c From time to time but not too often

d Only occasionally

6 I feel cheerful

a Not at all

b Not often

c Sometimes

d Most of the time

7 I can sit at ease and feel relaxed

a Definitely

b Usually

c Not often

d Not at all

8 I feel as if I am slowed down

a Nearly all the time

b Very often

c Sometimes

d Not at all

9 I get a sort of frightened feeling like 'butterflies' in the stomach

a Not at all

b Occasionally

c Quite often

d Very often

Please continue

10 I have lost interest in my appearance

a Definitely

b I don't take as much care as I should

c I may not take quite as much care

d I take just as much care as ever

11 I feel restless as if I have to be on the move

a Very much indeed

b Quite a lot

c Not very much

d Not at all

12 I look forward with enjoyment to things

a As much as ever I did

b Rather less than I used to

c Definitely less than I used to

d Hardly at all

13 I get sudden feelings of panic

a Very often indeed

b Quite often

c Not very often

d Not at all

14 I can enjoy a good book or radio or TV programme

a Often

b Sometimes

c Not often

d Very seldom

Thankyou for answering these questions. Please hand the completed form back to your facilitator

HADS Scoring Sheet Instructions

Please circle the number corresponding with the parent's response, sum the items and then record total scores for each Anxiety and Depression subscale. For the purposes of the TtLG program evaluation the HADS will be given to each client pre and post program delivery. HADS scores are to be recorded on the Evaluation Summary Sheet.

Each item is scored from 0 to 3. The total scores range from 0 to 21 for the Anxiety Subscale (Q 1,3,5,7,9,11,13) and also the Depression subscale (Q. 2,4,6,8,10,12,14).

The score ranges can be classified 'normal' (0-7); mild (8-10); moderate (11-14) and severe (15-21).

Date	**Pre**	**Post**	**Name/code**
Anxiety			**Depression**
1 a 3 b 2 c 1 d 0			**2** a 0 b 1 c 2 d 3
3 a 3 b 2 c 1 d 0			**4** a 0 b 1 c 2 d 3
5 a 3 b 2 c 1 d 0			**6** a 3 b 2 c 1 d 0
7 a 0 b 1 c 2 d 3			**8** a 3 b 2 c 1 d 0
9 a 0 b 1 c 2 d 3			**10** a 3 b 2 c 1 d 0
11 a 3 b 2 c 1 d 0			**12** a 0 b 1 c 2 d 3
13 a 3 b 2 c 1 d 0			**14** a 0 b 1 c 2 d 3
SCORE			

Appendix D.5

Parenting Stress Index

Abidin RR, (1995) Parenting Stress Index Professional Manual (3rd ed). PAR Psychological Assessment Resources, Inc. Florida. www.parinc.com

Forms to be purchased from registered supplier.

Parenting Stress Index (PSI) short form is only available from TtLG project manager

Appendix D.6

Emotional Availability Scales

Emotional Availability Scales

Reference:

Biringen, Z., et al., (1998). The Emotional Availability Scales, (3rd ed.), Attachment and Human Development, 2, 256-270.

PARENT DIMENSIONS	Range	Criteria
• **Sensitivity**	1-9	1 Highly insensitive 3 Somewhat insensitive 5 Inconsistently sensitive 7 Generally sensitive 9 Highly sensitive
• **Structuring**	1-5	1 Non-optimal structuring 3 Inconsistent structuring 5 Optimal structuring
• **Non-intrusiveness**	1-5	1 Intrusive 3 Somewhat intrusive 5 Non-intrusive
• **Non-hostility**	1-5	1 Markedly & overtly hostile 3 Somewhat intrusive 5 Non-intrusive
CHILD DIMENSIONS	**Range**	**Criteria**
• **Child responsiveness to parent**	1-7	1 Clearly non-optimal in responsiveness 3 Somewhat non-optimal 5 Moderately optimal 7 Optimal
• **Child involvement with parent**	1-7	1 Clearly non-optimal involving behaviour 3 Somewhat non-optimal 5 Moderately optimal 7 Optimal

Appendix D.7a

Children's Wellbeing Observation Measure

TtLG Family code		**Centre**		**Date**	
Child's name		**Age**		**Sex**	
Observer's name					
OVERALL WELLBEING SCORE	……	**Pre …….**	**or**	**Post ……..**	

The **Through the Looking Glass (TtLG**) evaluation requires two overall wellbeing observations scores for each child participating in the program:

1. **Pre-score** recorded within 4 weeks of the child starting at the childcare centre (allow time for child to settle, at least 4 sessions eg 2 mornings + 2 afternoons)
2. **Post-score** recorded sometime during the last 2 weeks of the mother's participation in the TtLG program.

TtLG co-facilitator to record the scores on the family evaluation summary sheet.

The Wellbeing Observation **instrument is designed to help identify the quality of the curriculum measured through** 3 dimensions of wellbeing (with 12 signals)*.

1 ***Happiness and satisfaction***
- ***Confidence and self esteem***
- ***Sense of self***
- ***Vitality***
- ***Enjoyment/Sense of humour***
- ***Ability to rest and relax***

2 ***Social functioning***
- ***Social initiative***
- ***Assertiveness***
- ***Coping/flexibility***
- ***Positive attitude towards warmth and closeness***

3 ***Dispositions***
- ***Openness and receptivity/ Pleasure in exploring***
- ***Pleasure in sensory experiences***
- ***Persistence/ robustness***

*(signals adapted from Mayr and Ulich 1999; Laevers 1997)

INSTRUCTIONS

- **Make 8 observations of 5 minutes each over 4 hours for each child**
- **Make 4 observations in the MORNING and 4 in the AFTERNOON**
- **In each observation focus on one child's behaviour, their activities and the educators' and other children's interactions with them**
- **After each 5 minute observation, take time to make notes and ratings on the 12 signals outlined in the following table (pg 2-3).**
- **Record the occurrence of specific behavioural signals by checking the indicator according to the predominant phenomenon**
  - ✔ **IF POSITIVE**
  - **X** **IF NEGATIVE**
  - **-** **IF NOT OCCURRING THROUGH MISSED OPPORTUNITY**
  - **O** **IF NO OPPORTUNITY TO OBSERVE**
- **After each observation summarise the score for each of the 3 dimensions of wellbeing as: l (low), m (medium) or h (high)**
- **Describe the context**
- **Judge an overall wellbeing score between 1 and 5 for each observation, refer to table on pg4**
- **Record an OVERALL WELLBEING SCORE by calculating the average of the 8 observation scores (see page 7).**

This instrument was adapted from a wellbeing schedule originally developed by Pam Winter, itself an adaptation of the work of Mayr and Ulich (1999). Children's well being is one of the most important indicators of quality for educational settings and processes and is a complex physical and psychological state and disposition. It includes good physical health and feelings of happiness, satisfaction and successful social functioning and interactions in the environment.

Domains and signals of wellbeing	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
1. HAPPINESS AND SATISFACTION								
Confidence, self esteem								
Trusts (biological needs are satisfied without anxiety – feeds, settles, toilets calmly)								
Expresses wants, needs, ideas, feelings								
Tries out things, risking the possibility of being unsuccessful								
Recovers from unsuccessful attempts relatively quickly								
Looks for/creates realistic challenges for self								
Asks for help when needed								
Initiates and engages in interactions, social and pretend play								
Sense of self								
Recognises and begins to regulate own needs, wishes, feelings								
Confidently expresses wishes, preferences, opinions								
Shares the joy and success of self and others								
Accepts verbal and non verbal attention from others								
Vitality								
Is alert and active								
Is spontaneous								
Has lively posture and movements								
Enjoyment/sense of humour								
Demonstrates pleasure in authentic experiences and ways								
Enjoys fun, jokes, humour								
Engages in experiences with enthusiasm								
Ability to rest and relax								
Signals need for rest, retreat								
Regulates rhythms of activity and rest (retreats when tired)								
Has periods of calmness								
2. SOCIAL FUNCTIONING								
Social initiative								
Reaches out to others								
Is receptive and responds to the stimuli/suggestions of others								
Attracts other children								
Negotiates								

2. SOCIAL FUNCTIONING cont'd	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Assertive								
Has a sense of own space								
Is not unduly pressured by claims of others								
Objects when personal rights are threatened								
Wants to be considered								
Asks for help/comfort								
Coping /flexibility								
Is flexible, accepts help/support when needed								
Recovers from distress/ excitement/ confusion/ frustration								
Can be comforted								
Calms/quietens (using own strategies)								
Can be distracted if appropriate								
Remains 'accessible' when distressed								
Cooperates								
Accepts bottom lines/boundaries								
Positive attitude towards warmth and closeness								
Enjoys being close/cuddles								
Reaches out for physical contact								
3. DISPOSITIONS								
Openness and receptivity/pleasure in exploring								
Is alert, open, direct body language								
Is aware of those around								
Tries new and unmastered activity positively								
Takes time to wonder and experiment								
Is curious, questions, actively seeks out things to investigate/explore								
Considers alternatives								
Pleasure in sensory experiences								
Enjoys meals								
Enjoys smelling things								
Enjoys movement								
Listens to music and nature's sounds								
Visually tracks and observes attentively								
Uses expressive materials with enjoyment eg dough, sand, paint								
Persistence/robustness								
Tries again when faced with a problem								
Persists with optimism								
Not easily distracted when concentrating								

WELLBEING DIMENSIONS

Summarise the score for each of the 3 wellbeing dimensions as l=low, m=medium or h=high, based on notes and ratings of the 12 signals of wellbeing

1. Happiness and satisfaction l m h
2. Social functioning l m h
3. Dispositions l m h

OVERALL WELLBEING LEVELS

Judge an overall wellbeing level for each observation

Level	Description
1	Emotionally uncomfortable, displays of negative symptoms eg crying, hurting, withdrawn, unhappy, tense, easily overwhelmed
2	Seldom displays enjoyment, signs of level 1 about half the time, alternating with neutral and some positive signals, may take pleasure in disrespectful ways eg hurting others
3	Occasional signs of emotional discomfort, generally appears 'quite happy', reasonable self confidence and enjoyment without intensity
4	High level generally happy with few signs of emotional discomfort, adequately succeeds in meeting their needs
5	Extremely high secure attachment patterns, radiates vitality and self esteem, shows initiative, curiosity and pleasure in activities; receptive, communicative, self guided and flexible, lots of positive interactions

Please circle O scores

MORNING OBSERVATIONS

Observation 1 Time: am			
Context description (eg With what, why, where, how was child engaged? Who was with them?)			
Wellbeing dimensions	**Score**	**Overall wellbeing level**	**Comment about any factors influencing observation.**
Happiness and satisfaction	**l m h**		
Social functioning	**l m h**	**1 2 3 4 5**	
Dispositions	**l m h**		

MORNING OBSERVATIONS

Observation 2 **Time:** **am**			
Context description (eg With what, why, where, how was child engaged? Who was with them?)			
Wellbeing dimensions	**Score**	**Overall wellbeing level**	**Comment about any factors influencing observation.**
Happiness and satisfaction	**l m h**		
Social functioning	**l m h**	**1 2 3 4 5**	
Dispositions	**l m h**		

Observation 3 **Time:** **am**			
Context description (eg With what, why, where, how was child engaged? Who was with them?)			
Wellbeing dimensions	**Score**	**Overall wellbeing level**	**Comment about any factors influencing observation.**
Happiness and satisfaction	**l m h**		
Social functioning	**l m h**	**1 2 3 4 5**	
Dispositions	**l m h**		

Observation 4 **Time:** **am**			
Context description (eg With what, why, where, how was child engaged? Who was with them?)			
Wellbeing dimensions	**Score**	**Overall wellbeing level**	**Comment about any factors influencing observation.**
Happiness and satisfaction	**l m h**		
Social functioning	**l m h**	**1 2 3 4 5**	
Dispositions	**l m h**		

AFTERNOON OBSERVATIONS

Observation 5 **Time:** **pm**			
Context description (eg With what, why, where, how was child engaged? Who was with them?)			
Wellbeing dimensions	**Score**	**Overall wellbeing level**	**Comment about any factors influencing observation.**
Happiness and satisfaction	**l m h**		
Social functioning	**l m h**	**1 2 3 4 5**	
Dispositions	**l m h**		

Observation 6 **Time:** **pm**			
Context description (eg With what, why, where, how was child engaged? Who was with them?)			
Wellbeing dimensions	**Score**	**Overall wellbeing level**	**Comment about any factors influencing observation.**
Happiness and satisfaction	**l m h**		
Social functioning	**l m h**	**1 2 3 4 5**	
Dispositions	**l m h**		

Please continue over the page for observations 7 and 8.

AFTERNOON OBSERVATIONS

Observation 7 Time: pm			
Context description (eg With what, why, where, how was child engaged? Who was with them?)			
Wellbeing dimensions	**Score**	**Overall wellbeing level**	**Comment about any factors influencing observation.**
Happiness and satisfaction	**l m h**	**1 2 3 4 5**	
Social functioning	**l m h**		
Dispositions	**l m h**		

Observation 8 Time: pm			
Context description (eg With what, why, where, how was child engaged? Who was with them?)			
Wellbeing dimensions	**Score**	**Overall wellbeing level**	**Comment about any factors influencing observation.**
Happiness and satisfaction	**l m h**	**1 2 3 4 5**	
Social functioning	**l m h**		
Dispositions	**l m h**		

OVERALL WELLBEING LEVEL SCORE = average score of all observations									
Observation	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Total**
Score									
Average of 8 observations =	***Please record this score on the front page***								

Any extra comments can be written on the reverse of this page

Appendix D.7b

Children's Involvement Observation Measure

TtLG Family code		**Centre**		**Date**	
Child's name		**Age**		**Sex**	
Observer's name					
OVERALL INVOLVEMENT SCORE	……	**Pre …….**	**or**	**Post ……..**	

The **Through the Looking Glass (TtLG**) evaluation requires two overall involvement observations scores for each child participating in the program:

3. **Pre-score** recorded within 4 weeks of the child starting at the childcare centre (allow time for child to settle, at least 4 sessions eg 2 mornings + 2 afternoons)
4. **Post-score** recorded sometime during the last 2 weeks of the mother's participation in the TtLG program.

TtLG co-facilitator to record the scores on the family evaluation summary sheet.

INSTRUCTIONS

- Make **8 observations of 2 minutes each**, at a minimum of **15 minute intervals** with **4 observations** in the **morning** and **4 observations** in the **afternoon**
- Judge a score of l=low, m=medium or h=high for each of the following **signals of involvement** (see appendix notes for more information on signals of involvement).
    - ✓ ***concentration***
    - ✓ ***energy***
    - ✓ ***persistence***
    - ✓ ***expression/posture***
    - ✓ ***reaction time***
    - ✓ ***language***
    - ✓ ***creativity/complexity***
    - ✓ ***satisfaction***
- Judge an **overall involvement level for each observation** according to the following table (see appendix notes for more information on levels of involvement).

Levels of Involvement		
1.	**No activity**	**aimless, absent minded**
2.	**Interrupted activity**	**tinkering/dreaming**
3.	**More or less maintained activity**	**busy but routine actions without much devotion, few signals of involvement**
4.	**Activity with intense moments**	**strong involvement but not all signals**
5.	**Maintained intense activity**	**involved with essential signals**

- **After all observations are completed please calculate an overall involvement score by averaging the 8 observation scores.**

MORNING OBSERVATIONS

Observation 1: Time	**am**		
Description			
Signals of involvement		**Involvement level**	**Comments**
Concentration	**l m h**	**1 2 3 4 5**	
Energy	**l m h**		
Persistence	**l m h**		
Expression/posture	**l m h**		
Reaction time	**l m h**		
Language	**l m h**		
Creativity/complexity	**l m h**		
Satisfaction	**l m h**		

Observation 2: Time	**am**		
Description			
Signals of involvement		**Involvement level**	**Comments**
Concentration	**l m h**	**1 2 3 4 5**	
Energy	**l m h**		
Persistence	**l m h**		
Expression/posture	**l m h**		
Reaction time	**l m h**		
Language	**l m h**		
Creativity/complexity	**l m h**		
Satisfaction	**l m h**		

Observation 3: Time	**am**		
Description			
Signals of involvement		**Involvement level**	**Comments**
Concentration	**l m h**	**1 2 3 4 5**	
Energy	**l m h**		
Persistence	**l m h**		
Expression/posture	**l m h**		
Reaction time	**l m h**		
Language	**l m h**		
Creativity/complexity	**l m h**		
Satisfaction	**l m h**		

Observation 4: Time	**am**		
Description			
Signals of involvement		**Involvement level**	**Comments**
Concentration	**l m h**	**1 2 3 4 5**	
Energy	**l m h**		
Persistence	**l m h**		
Expression/posture	**l m h**		
Reaction time	**l m h**		
Language	**l m h**		
Creativity/complexity	**l m h**		
Satisfaction	**l m h**		

AFTERNOON OBSERVATIONS

Observation 5: Time	**pm**		
Description			
Signals of involvement		**Involvement level**	**Comments**
Concentration	**l m h**	**1 2 3 4 5**	
Energy	**l m h**		
Persistence	**l m h**		
Expression/posture	**l m h**		
Reaction time	**l m h**		
Language	**l m h**		
Creativity/complexity	**l m h**		
Satisfaction	**l m h**		

Observation 6: Time	**pm**		
Description			
Signals of involvement		**Involvement level**	**Comments**
Concentration	**l m h**	**1 2 3 4 5**	
Energy	**l m h**		
Persistence	**l m h**		
Expression/posture	**l m h**		
Reaction time	**l m h**		
Language	**l m h**		
Creativity/complexity	**l m h**		
Satisfaction	**l m h**		

Please continue over the page for observations 7 and 8

Observation 7: Time **pm**			
Description			
Signals of involvement		**Involvement level**	**Comments**
Concentration	**l m h**	**1 2 3 4 5**	
Energy	**l m h**		
Persistence	**l m h**		
Expression/posture	**l m h**		
Reaction time	**l m h**		
Language	**l m h**		
Creativity/complexity	**l m h**		
Satisfaction	**l m h**		

Observation 8: Time **pm**			
Description			
Signals of involvement		**Involvement level**	**Comments**
Concentration	**l m h**	**1 2 3 4 5**	
Energy	**l m h**		
Persistence	**l m h**		
Expression/posture	**l m h**		
Reaction time	**l m h**		
Language	**l m h**		
Creativity/complexity	**l m h**		
Satisfaction	**l m h**		

OVERALL INVOVLEMENT LEVEL SCORE = average score of all observations									
Observation	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Total**
Score									
Average of 8 observations = ***Please record this score on the front page***									

Appendix D.8a

Mothers post program questionnaire

Office use only

FAMILY CODE_____

Through the Looking Glass Post Program - Mothers.
The following questionnaire has been developed by the Independent Evaluator to find out what you thought of the Through the Looking Glass Program. **Please do not write your name on the questionnaire**. Your answers are strictly confidential - no one will see this completed questionnaire other than the external evaluator. Once you have completed the questionnaire seal it in the accompanying envelope and return it to the clinician. Please tick √ the box that best describes your level of agreement with each statement or write your comments in BLOCK CAPITALS.

1. Please indicate your level of agreement with the following statements

		Strongly Disagree	**Disagree**	**No view**	**Agree**	**Strongly Agree**
a	The program has helped me feel closer to my child	❑	❑	❑	❑	❑
b	I enjoyed the weekly group sessions	❑	❑	❑	❑	❑
c	The timing of the sessions was <u>not</u> convenient for me	❑	❑	❑	❑	❑
d	The information materials used were clear and easy to understand	❑	❑	❑	❑	❑
e	I felt comfortable with the project workers	❑	❑	❑	❑	❑
f	It was difficult to find transport to and from the childcare centre	❑	❑	❑	❑	❑
g	The childcare arrangements were satisfactory	❑	❑	❑	❑	❑
h	There were not enough opportunities to discuss my experiences of being a parent	❑	❑	❑	❑	❑
i	This program has helped me feel good about myself as a parent	❑	❑	❑	❑	❑
j	I feel more confident looking for other services and supports for my family since being on the program	❑	❑	❑	❑	❑
k	It was easy to get along with my child/ children's primary child carer	❑	❑	❑	❑	❑
l	I felt relaxed and safe at the centre	❑	❑	❑	❑	❑

Please write any comments you would like about your answers:

-

2. While participating in the Through the Looking Glass Program have you found that …..

		Yes definitely	Yes Somewhat	No	Does not apply
a	You developed supportive friendships with other mothers in the Through the Looking Glass program	❑	❑	❑	❑
b	You developed supportive friendships with other families at the child care centre	❑	❑	❑	❑
c	Your child/children's behaviour improved	❑	❑	❑	❑
d	You have become more confident in responding to your child/children's needs	❑	❑	❑	❑
e	You were able to get help in finding other services that might help your child or family	❑	❑	❑	❑
f	You have learned more about parenting and attachment issues	❑	❑	❑	❑
g	You have shared your learning about children's attachment needs with other people in your family or community	❑	❑	❑	❑
h	Staff in the child care centre supported and respected your family	❑	❑	❑	❑
i	You can cope better as a parent since attending the program	❑	❑	❑	❑

Please write any comments you would like to make about your answers:

3. Please indicate your level of understanding of the following:

		No understanding	A bit of understanding	A lot of understanding
a	Children's exploration needs	❑	❑	❑
b	Children's attachment needs	❑	❑	❑
c	Childcare centre's primary care giving practices	❑	❑	❑

Please write any comments you would like to make about your answers:

4. To what degree have the following activities and things helped you to understand about your child's attachment needs?

		No help	A bit of help	A lot of help	Don't know
a	Explanation about the Circle of Security model	❑	❑	❑	❑
b	Explanation about the Circle of Repair model	❑	❑	❑	❑
c	Talking about the video 'You are so Beautiful'	❑	❑	❑	❑
d	Discussion about the Shark Music video	❑	❑	❑	❑
e	Individual sessions with the clinician	❑	❑	❑	❑
f	Talking with other mothers in the group about parenting	❑	❑	❑	❑
g	Your child's Learning Stories	❑	❑	❑	❑
h	Reflecting on the videotape of your interaction with your child	❑	❑	❑	❑
i	Talking about the book 'I Love my Mummy'	❑	❑	❑	❑
j	Group reflection on individual family videos	❑	❑	❑	❑

Please write any comments you would like to make about your answers:

_____

_____

_____

5. During the Through the Looking Glass Program you were asked to complete some questionnaires about parenting. Could you please describe how you felt while completing these forms and how carefully you answered them? (*please remember your answers are strictly confidential*)

_____

_____

_____

_____

_____

_____

_____

6. What aspects of the program were most beneficial to you and why?

---

7. Can you suggest anything that could have been done better?

---

8. Please make any other comments you believe would be helpful to the organisers of the sessions:

---

9. Have you had any difficulty understanding or answering this questionnaire?

Yes ❑ No ❑

(Please describe)

Appendix 8b

Fathers post progam questionnaire

Office use only

FAMILY CODE_____

Through the Looking Glass Post Program - Fathers.

The following questionnaire has been developed by the Independent Evaluator to find out what you thought of the Fathers sessions that you have attended. Your feedback will be very much appreciated and will assist in the further development of the Fathers program. Please tick √ the box that best describes your level of agreement with each statement or write your comments in BLOCK CAPITALS. Your answers are confidential. Once you have completed the questionnaire please return it to the clinician in the accompanying envelope.

1. Please indicate your level of agreement with the following statements

		Strongly disagree	**Disagree**	**No view**	**Agree**	**Strongly Agree**
a	I enjoyed the Fathers sessions	❑	❑	❑	❑	❑
b	The timing of the sessions was inconvenient for me	❑	❑	❑	❑	❑
c	The information materials used were clear and easy to understand	❑	❑	❑	❑	❑
d	I felt comfortable when two female project workers were conducting session 1	❑	❑	❑	❑	❑
e	It was useful to have the Fatherhood project worker present	❑	❑	❑	❑	❑
f	I understand what my partner's group does in the Through the Looking Glass program	❑	❑	❑	❑	❑
g	I feel closer to my child because of the program	❑	❑	❑	❑	❑
h	I would like more information about attachment	❑	❑	❑	❑	❑
i	There were not enough opportunities for me to discuss my experiences of being a father	❑	❑	❑	❑	❑
j	Participating in the Fathers sessions has improved my parenting skills	❑	❑	❑	❑	❑
k	I support my partner's involvement in the program	❑	❑	❑	❑	❑
l	Our family participation in the Looking Glass program has helped to improve our child's behaviour or development	❑	❑	❑	❑	❑

Please write any comments you would like to make about your answers:

-

2. Please tick all the Fathers sessions that you have attended.

	DATE ***ACTIVITIES***
❑	Session 1
❑	Session 2
❑	Session 3

3. Please indicate your level of understanding of the following components of the Through the Looking Glass program:

		No understanding	**Some understanding**	**A lot of understanding**
a	Circle of Security model	❑	❑	❑
b	Circle of Repair model	❑	❑	❑
c	Children's exploration needs	❑	❑	❑
d	Children's attachment needs	❑	❑	❑
e	Childcare centre's primary care giving practices	❑	❑	❑

Please write any comments you would like to make about your answers:

---

4. To what degree have the following things helped you understand the Through the Looking Glass program?

		No help	Some help	Very helpful	Don't know
a	The video 'You are so Beautiful'	❑	❑	❑	❑
b	Photo voice - your photos	❑	❑	❑	❑
c	The Shark Music video	❑	❑	❑	❑
d	Talking with other fathers in the group about parenting	❑	❑	❑	❑
e	The Circle of Security graphict	❑	❑	❑	❑

Please write any comments you would like to make about your answers:

5. What aspects of the Fathers sessions were most beneficial to you and why?

6. Can you suggest anything that could have been done better in the sessions?

7. Please make any other comments you believe would be helpful to the organisers of the sessions:

8. Have you had any difficulty understanding or answering the questions in this evaluation form?

Yes ❑ No ❑

(Please describe)

Appendix D.9

Mothers' (three month) follow-up telephone Interview schedule

Through the Looking Glass (TtLG)
Followup Telephone survey of Wave ----- mothers Interview Schedule

Family Code	**Mothers name**		**Children**		**Phone number**
Site					
Phone call	**Date**	**Time - Start**	**Finish**	**Duration**	**Outcome***
1					
2					
3					
4					

*

Introduction

1. Introduce myself as evaluation assistant, with a reminder re: clinician talking about evaluation and getting in touch after the program.

2. This is only a phone call, no forms to fill in.

3. The idea is simply to find out how they are feeling some weeks after the TtLG program has finished.

4. Highlight importance of their feedback and evaluation (It can identify how effective the TtLG program is and what factors/things can influence the program activities and why)

5. All answers are confidential and no person will be identified in any write up of evaluation findings

6. Ask if we can have telephone interview should take about 15 minutes

7. If not convenient then ask for a day and time that is suitable for mother.

8. Check if child ---------- is still in childcare.

Introduction/explanation
These first few questions look at how you felt while taking part in the TtLG and using the childcare centre / satisfaction/

1. <u>Overall,</u> how (satisfied) did you feel with the approach /activities of the TtLG
(*childcare, content of the program, timing, way the program was delivered etc)*

Can ask why /link to following questions
very satisfied
satisfied
no view –
dissatisfied
very dissatisfied

Q2. What for you were the most useful things about being involved in the TtLG
what things worked well for you

(childcare, Primary Care Giver, content of the program, timing, way the program was delivered etc)

Q3. What were the least useful things about the program?

(childcare, content of the program, timing, way the program was delivered etc)

Q4. Is there anything you would like to change about the TtLG program ?

Q5a. How did you feel about coming to the childcare centre for the TtLG?
(Prompts was it relaxing, did you feel safe, could you freely express your issues/concerns.)
*5b If **relaxing** - what things/activities made you feel relaxed?*
*5c If **NOT relaxed** - what things/activities bothered you?*
What would have made you feel more safe/relaxed?
Q6. Did you think the amount (length) of time for the TtLG program was about right?
(Or did the length of time work for you?)

Could you explain that …..

LOOKING AT THE WEEKLY SESSION

Q7. What activities were most useful in helping you understand more about your child's attachment needs?

(the following list can be used as a prompt)

- Circle of Security model
- Circle of Repair model
- The Video 'You are so beautiful'
- Discussion about the Shark Music video
- Talking with other mothers in the group about parenting
- Reflecting on the videotape of your interaction with your child
- Talking about the book ' I love Mummy'
- Your child's Learning Stories
- Cue cards (faces)
- Group Reflection on individual family videos
- Child's PCG

Any other activities

Q8. Do you feel more confident now in responding to your child's attachment needs, since attending the TtLG?

If **NO** (*Talk to see if participation in the TtLG has increased their knowledge of attachment but at the same time this new knowledge has made them less confident in responding to their child's attachment needs*)

Q9. Have there been any changes in the way you do things with your child (parent/ or relate to your child/ren) as a result of taking part in the TtLG?

NB ask for some examples……..?

Q10. Have you seen any changes in your child's behaviour since you have taken part in the TtLG?

*10b If **YES** ….could you describe these changes*

*10c If **NO**……why do you think that there has been no change?*

Q11. Can you describe any differences in yourself now compared to when you started the TtLG program

(Feel happier, etc)

Q12. How did you find mixing with other parents in the program (good or bad experience)?

Q 13. Do you feel you made some friendships/networks while taking part in the TtLG?
Prompt (Do you still see any other parents who attended)
*b If **YES** ….could you describe these networks*
What activities of the TtLG do you think helped?

Q14. Have you used/gone to any other services/supports since attending TtLG?

b. If YES …. Did the program help you do this in any way /or how?
*c. if NO …. Ask why/reasons/ no needs***?**

Q15. Have you started doing any more things in the community since finishing with the TtLG? (playgroup etc, craft, study etc
b If YES …what sort of things
c If NO …..ask/ any reason

Q16. Would you recommend the program to other people?

Q17. Have you told any other parents about things you learnt in the TtLG program?

b If YES… what kinds of things

Q18. Would you like to make any other comments?

Conclusion
Briefly review and confirm responses
Ask if there is anything that they would like to add
Thank for their time and thoughts
Re-confirm confidentiality

Appendix D.10

Reference Group Email Survey

Through the Looking Glass: a Community Partnership in Parenting

I am seeking your views, as a member of the Reference group, on the design and structure of the Through the Looking Glass (TtLG) program. Your feedback will enable any changes to the program to be considered in the early stages of the project implementation.

Your responses will be treated in confidence by the local evaluators, and no names will appear in any subsequent report. Please feel free to say as much or as little as you wish. There are 9 questions and the questionnaire should take between 5 -10 minutes.

INSTRUCTIONS

1 Please type your answers to the questions below (or check by mouse clicking on appropriate boxes provided). Explanation boxes will expand to fit any comments that you wish to write.

2 Save and return the file as a Word attachment to the e-mail address below. If you are not sure how to do this, instructions are provided at the end of the questionnaire. I appreciate you taking the time to complete the questionnaire. Please submit your replies by **Friday 7th October 2005** to: margareto@gowrie-adelaide.com.au

3 If you prefer you may print the questionnaire, complete and return via mail to:

Lady Gowrie Child Centre

TtLG Evaluation Att: M O'Neill

39a Dew St

Thebarton SA 5031

Thanks for your help and cooperation.

Paul Aylward TtLG Evaluation Manager

1) To what extent are you satisfied with the way in which you were recruited to the TtLG project Reference group?

a) Fully satisfied	☐
b) Partially satisfied	☐
c) Not satisfied	☐

Please explain your answer here:

2) Overall to what extent are you satisfied with the Reference group meeting processes?

a) Fully satisfied	☐
b) Partially satisfied	☐
c) Not satisfied	☐

Please explain your answer here:

3) Please indicate your level of agreement with the following statements regarding Reference group activities.

		Strongly Agree	Agree	No View	Disagree	Strongly disagree
a)	Meeting times are convenient	☐	☐	☐	☐	☐
b)	Meeting venue facilities are adequate	☐	☐	☐	☐	☐
c)	Meetings should be held less often	☐	☐	☐	☐	☐
d)	The meetings are run efficiently	☐	☐	☐	☐	☐
e)	The Evaluation Plan is appropriate for the TtLG program	☐	☐	☐	☐	☐
f)	The well-being of clients is adequately considered during meetings about the project	☐	☐	☐	☐	☐
g)	Demands on program staff are adequately considered during selection of program activities	☐	☐	☐	☐	☐
h)	I am clear about the role of the Reference Group	☐	☐	☐	☐	☐

Please comment specifically on any of the above areas or any other aspects of the Reference group which you feel should be mentioned

4) How clear is your understanding of the following aspects of the TtLG program?

	Clear understanding	Partially clear understanding	No clear understanding
a) Program objectives	☐	☐	☐
b) Circle of Security attachment model	☐	☐	☐
c) Structure of the TtLG program for parents	☐	☐	☐
d) Integration of primary care giving model into staff work practices	☐	☐	☐
e) Evaluation Plan	☐	☐	☐

Please comment specifically on any of the above areas or any other aspects of the TtLG program which you feel should be clarified

5) For the purposes of the TtLG project evaluation how satisfied are you with the application of the following standardised tools?

	Fully satisfied	Partially satisfied	Not satisfied
a) Parent Stress Index (PSI)	☐	☐	☐
b) Hospital Anxiety Depression Scale (HADS)	☐	☐	☐
c) Videotaping (to be used with Emotional Availability Scales)	☐	☐	☐
d) Child's Wellbeing Observation Instrument	☐	☐	☐
e) Child's Involvement Scale	☐	☐	☐

Please comment specifically on any of the above areas or any other aspects of the evaluation which you feel should be mentioned

6) Overall how satisfied are you with the progress of the TtLG project?

a) Highly satisfied	☐
b) Partially satisfied	☐
c) Not satisfied	☐

Please explain your answer here:

7) In terms of your professional working role and responsibilities how would you rate the value of your partnership with the TtLG project?

a) Highly valuable	☐
b) Partially valuable	☐
c) Not valuable at all	☐

Please explain your answer here:

8) Are there any specific areas you feel should be changed in the project?

Please type your answer here:

9) If there is anything else you would like to add about the TtLG program, please write it here.

THANK YOU FOR COMPLETING THE QUESTIONNAIRE.

Please email your responses back to us by 7th October 2005**, as a word attachment to: margareto@gowrie-adelaide.com.au**

- When you have finished the questionnaire, simply click: File and Save As…
- You can then save the questionnaire with your answers in any folder you choose.
- When you reply to the Email, please attach the file you have saved to ensure we get the questionnaire with your answers back.

Margaret O'Neill
Evaluation Assistant
T: 8352 5144
E: margareto@gowrie-adelaide.com.au

Lady Gowrie Child Centre
39a Dew Street
Thebarton SA 5031

Working days: Tuesday and Friday.

Appendix D.11

Co-facilitators email survey

Through the Looking Glass: a Community Partnership in Parenting

I am seeking your views, as a co-facilitator, on the design and structure of the Through the Looking Glass (TtLG) program. Your feedback will enable any changes to the program to be considered in the early stages of the project implementation.

Your responses will be treated in confidence by the local evaluators, and no names will appear in any subsequent report. Please feel free to say as much or as little as you wish. The questionnaire should take between 5 -10 minutes.

INSTRUCTIONS

1. Please insert your answers to the questions below by mouse clicking on the appropriate boxes provided. You may also comment on your responses by writing in the space below each question. The shaded explanation boxes [ ] will expand to fit any comments that you wish to write.

2. Save and return the file as a Word attachment to the e-mail address below. If you are not sure how to do this, instructions are provided at the end of the questionnaire. I appreciate you taking the time to complete the questionnaire. Please submit your replies by **Tuesday 7 February 2006**: margareto@gowrie-adelaide.com.au

3. If you prefer you may print the questionnaire, complete and return via mail to:

Lady Gowrie Child Centre

TtLG Evaluation Att: M O'Neill

39a Dew St

Thebarton SA 5031

Thank you for your help and cooperation. Please contact me if you have any questions,
Margaret O'Neill ***margaret0@gowrie-adelaide.com.au***

T: 8352 5144 (working days Tuesday and Friday)

1) To what extent are you satisfied with the way in which you were recruited to the role of co-facilitator in the TtLG project?

a) Fully satisfied	☐
b) Partially satisfied	☐
c) Not satisfied	☐

Please explain your answer here:

2) Overall to what extent are you satisfied with your role in the TtLG program?

a) Fully satisfied	☐
b) Partially satisfied	☐
c) Not satisfied	☐

Please explain your answer here:

3) How clear is your understanding of the following aspects of the TtLG program?

	Clear understanding	Partially clear understanding	No clear understanding
a) Program objectives	☐	☐	☐
b) Structure of the TtLG program for parents	☐	☐	☐
c) The co-facilitator's role and responsibilities	☐	☐	☐
d) The clinician's role and responsibilities	☐	☐	☐
e) The primary carer giver's role and responsibilities	☐	☐	☐

Please comment specifically on any of the above areas or any other aspects of the TtLG program which you feel should be clarified:

4) Please indicate your level of satisfaction with the training you have received for the following components of the TtLG Program.

	Fully satisfied	Partially satisfied	Not satisfied	Not applicable
a) Circle of Security attachment model	☐	☐	☐	☐
b) The Child's Wellbeing Observation process	☐	☐	☐	☐
c) The Leuven Involvement Scale	☐	☐	☐	☐
d) Primary care giving	☐	☐	☐	☐
e) Videotaping	☐	☐	☐	☐
f) Co-facilitating group meetings	☐	☐	☐	☐
g) Reflective journal writing	☐	☐	☐	☐

Please comment specifically on any of the above areas or any other components of the TtLG program which you feel should be clarified

5) Please indicate your level of agreement with the following statements

	Strongly Disagree	Disagree	No View	Agree	Strongly Agree
I felt confident assisting the clinician with the weekly group sessions	☐	☐	☐	☐	☐
It was difficult to manage my co-facilitator tasks given my other work responsibilities at the child care centre	☐	☐	☐	☐	☐
Co-facilitating the TtLG program has increased my knowledge and skills regarding attachment and children	☐	☐	☐	☐	☐
I felt comfortable working with the clinician	☐	☐	☐	☐	☐

Please comment specifically on any of the above areas or any other components of the TtLG program which you feel should be clarified

6) Are there any specific areas of the TtLG project that you feel should be changed?

Please write your answer here:

7) If there is anything else you would like to add about the TtLG program, please write it here.

8) What is the highest level of education that you have completed? *(mark one only)*

a) A university degree	☐
b) A vocational certificate or diploma, at TAFE or college	☐
c) School Year 12 or equivalent	☐
d) School Year 9 or equivalent	☐
e) None of the above	☐

THANK YOU FOR COMPLETING THE QUESTIONNAIRE.

Return Instructions: **Please email your responses back by** Tuesday 7th February 2006**, as a word attachment to: margareto@gowrie-adelaide.com.au**

- When you have finished the questionnaire, simply click: File and Save As…
- You can then save the questionnaire with your answers in any folder you choose.
- When you reply to the Email, please attach the file you have saved to ensure we get the questionnaire with your answers back.

Alternatively you can mail your completed questionnaire to:

Lady Gowrie Child Centre,
TtLG Evaluation
39a Dew St
Thebarton SA 5031.

Appendix D.12

Program managers interview schedule

Qualitative Interview. TtLG Lady Gowrie Management.

Topic Guide.

1. **Briefly describe your role in the Project**
2. **What have been the main strengths of the project so far?**
3. **Have there been any unexpected benefits or outcomes resulting from the project?**
4. **What have been the greatest Challenges to the project? How have these been addressed? Are there any issues which require on-going or new attention (staffing, fathers, C&LD + Indigenous)?**
5. **Have there been any new partnerships or activities resulting from the Project?**
6. **What kind of systemic / organisational changes have resulted or been precipitated by the project?**
7. **Have there been adaptations to the model in the light of experience? If the project were starting again, are there any contingencies or preliminaries you would put in place before implementation?**
8. **Have there been any differences in how the model has evolved compared to how you originally perceived it? Do you predict any further changes?**
9. **Can the model (elements) be sustained after the funding period – what can be done ?**
10. **Have there been any unintended benefits?**
11. **Have there been any (other) unexpected problems – how addressed?**
12. **Is the model suitable for broader role out? (Cost effectiveness / other programs in competition)**
13. **Is there anything else you'd like to add?**

Appendix D.13

PCG Child Care Workers Focus Group – Topic Guide

Primary Care Giver Child Care Worker Focus Group

1) Overall to what extent were you satisfied with the outcomes achieved by the project?

Post-It Note Task:

2) What have been the most beneficial aspects of the project?

(prompts: For the mothers who participated / Service provision / professional development)

Has participation in the project been valuable?

3) In what ways do you think the project could have been improved?

(prompts: different or additional strategies? Involvement of other stakeholders? Training? Resource development?

Show Overhead.

4) Overall how would you summarise the extent to which this project has met its Goal:

To develop and pilot a model of collaborative early intervention and prevention for targeted parents to improve secure attachment outcomes for young children in five selected child centre sites across Australia.

5) The project specified a number of Objectives with which I know you are familiar. I shall read these out individually. Please indicate the extent to which (in your view) each has been achieved: (Prompt: categories)

Show overhead:

1. To forge working and sustainable inter-sectoral partnerships across Australia (parents, health and education agencies) overseeing and informing the development and management of the Project.
Why have you given this assessment?

2. Build capacity of participating Childcare Centres to develop and adopt a sustainable integrated primary care-giver system
Why have you given this assessment?

3. 3.1 To equip and empower a range of parents of young children with the knowledge, awareness, confidence and skills to successfully overcome the barriers to attachment

3.2 To foster and nurture positive parent well-being outcomes

3.3 To foster and nurture positive child well-being outcomes

Why have you given this assessment?

4. Develop and enhance social support /friendship networks for the target group

5. To develop and promote the uptake of a 'best practice' model for services working with mothers and fathers and children around issues of attachment

6) Have you attended any of the training provided as part of the TtLG project (PCG?, Well-being observation training)

- **What did you find most Useful? – Used in Practice?**
- **Do you think other staff members would benefit from this training/ In what ways?**
- **What did you find least useful.? Why? (delivery, timing, venue, content, appropriateness)**
- **Any additional training needed? (Clarity about the PCG role?)**

7) Have you seen the project manual?

- **What are the strengths of the manual?**
- **Weaknesses?**
- **What aspects are most useful?**
- **What aspects are least useful?**

8) Can you tell me about:

The procedures for communicating with the TtLG clinician
The procedures for communicating with the TtLG co-facilitator
Management support for your role as a TtLG PCG

Prompt: How did this work? Could it be made better? What worked best? What made this work?

9) Has the project generated any lasting outcomes? (Prompt:)

Prompt:

- **professional agency changes/practices**
- **Future utilisation of resources**
- **Continued project activities – related activities – incorporation of attachment model, primary care giver system / learning into professional practice**

- **Consumer impact evidence**

10) Have there been any unintended outcomes from the project?
Prompt: - negative: staff demands, space, confidence
- positive: feel more valued, confident, competencies

Degree of on-going support for families after finishing TtLG?

11) If there is anything else you would like to add about the project?

Prompt:

- **Anything you would have liked me to ask that I haven't?**
- **Anything you're glad I didn't ask?**
- **Anything you were uncomfortable about answering? – Why?**

Focus Group Overhead.

To develop and pilot a model of collaborative early intervention and prevention for targeted parents to improve secure attachment outcomes for young children in five selected child centre sites across Australia.

Objectives of the Through the Looking Glass Project

1. To forge working and sustainable inter-sectoral partnerships across Australia (parents, health and education agencies) overseeing and informing the development and management of the Project.

2. Build capacity of participating Childcare Centres to develop and adopt a sustainable integrated primary care-giver system

3. To equip and empower a range of parents of young children with the knowledge, awareness, confidence and skills to successfully overcome the barriers to attachment

- To foster and nurture positive parent well-being outcomes
- **To foster and nurture positive child well-being outcomes**

4. Develop and enhance social support /friendship networks for the target group

5. To develop and promote the uptake of a 'best practice' model for services working with mothers and fathers and children around issues of attachment

Appendix D.14

Professional Stakeholder Semi-Structured Questionnaire:

Telephone / Interview Survey of Site Clinicians, Co-Facilitators, and Managers

Survey of TtLG Site Stakeholders: Managers (CEOs), Clinicians and Co-Facilitators

1) Overall to what extent were you satisfied with the outcomes achieved by the project?

a) Fully satisfied	☐
b) Mostly satisfied	
c) Partially satisfied	☐
d) Not satisfied	☐

Please explain your answer:

2) In your view, what have been the most beneficial aspects of the project?
(prompts: For the mothers, fathers, kids who participated / Service provision / professional development)

Has participation in the project been valuable?

3) In what ways do you think the project could have been improved?
(prompts: different or additional strategies? Involvement of other stakeholders? Training? Resource development?

4) Overall how would you summarise the extent to which this project has met its

Prompt: goal `To develop and pilot a model of collaborative early intervention and prevention for targeted parents to improve secure attachment outcomes for young children in five selected child centre sites across Australia.` **Would you say…**

a) The project has fully met the goal	☐
b) The project has mostly met the goal	☐
c) The project has partially met the goal	☐
d) or The project has not met the goal at all	☐

Please Explain Your Answer:

5) The project specified a number of Objectives with which I know you are familiar. I shall read these out individually. Please indicate the extent to which (in your view) each has been achieved: (Prompt: categories)

	Fully Achieved	Mostly Achieved	Partially Achieved	Not Achieved at all	Don't Know / No comment
1. To forge working and sustainable inter-sectoral partnerships across Australia (parents, health and education agencies) overseeing and informing the development and management of the Project.	☐	☐	☐	☐	☐

Why have you given this assessment?

5) Continued…

	Fully Achieved	Mostly Achieved	Partially Achieved	Not Achieved at all	Don't Know / No comment
2. Build capacity of participating Childcare Centres to develop and adopt a sustainable integrated primary care-giver system	☐	☐	☐	☐	☐

Why have you given this assessment?

5) Continued…

	Fully Achieved	Mostly Achieved	Partially Achieved	Not Achieved at all	Don't Know / No comment
3.1 To equip and empower a range of parents of young children with the knowledge, awareness, confidence and skills to successfully overcome the barriers to attachment 3.2 To foster and nurture positive parent well-being outcomes 3.3 To foster and nurture positive child well-being outcomes	☐	☐	☐	☐	☐

Why have you given this assessment?

5) Continued…

	Fully Achieved	Mostly Achieved	Partially Achieved	Not Achieved at all	Don't Know / No comment
4. Develop and enhance social support /friendship networks for the target group	☐	☐	☐	☐	☐

Why have you given this assessment?

5) Continued…

	Fully Achieved	Mostly Achieved	Partially Achieved	Not Achieved at all	Don't Know / No comment
5. To develop and promote the uptake of a 'best practice' model for services working with mothers and fathers and children around issues of attachment	☐	☐	☐	☐	☐

Why have you given this assessment?

6) Have you attended any of the training provided as part of the TtLG project?

- **What did you find most Useful? – Used in Practice?**
- **Do you think other staff members would benefit from this training/ In what ways?**
- **What did you find least useful.? Why? (delivery, timing, venue, content, appropriateness)**
- **Any additional training needed?**

7) Have you seen the project manual?

- **What are the strengths of the manual?**
- **Weaknesses?**
- **What aspects are most useful?**
- **What aspects are least useful?**

8) Has the project generated any lasting outcomes? (Prompt:)

Prompt:

- **professional agency changes/practices**
- **Future utilisation of resources**
- **Continued project activities – related activities – incorporation of attachment model, primary care giver system / learning into professional practice**
- **Consumer impact evidence**

9) Have there been any unintended outcomes from the project?

10) If there is anything else you would like to add about the project?

Prompt:

- **Anything you would have liked me to ask that I haven't?**
- **Anything you're glad I didn't ask?**
- **Anything you were uncomfortable about answering? – Why?**

Appendix D.15

Mothers (16-18 month) follow-up telephone interview schedule

MOTHERS SIXTEEN-EIGHTEEN MONTH FOLLOWUP INTERVIEW SCHEDULE

It has been over a year since you completed the TtLG program and I am following up to ask how the program worked for you and ……..CHILD'S NAME.
(What worked best and what things did not work)

Q1 Are you continuing to use any of the information/ ideas about attachment that you received during the TtLG program?

Prompts:

- *Doing things differently with (USE CHILD'S NAME)*
- *Feeling more attached with ……*
- *More able to deal with situations (child's needs/behaviour etc)*
- *CHILD'S NAME) behaviour has improved as a result of the TtLG program*

If YES	**If NO**
Ask for examples: Prompts: Have there been any changes in the way you do things with …….CHILD'S	Explore why not: (reasons)

Q2. What parts of the TtLG program were most helpful to you and …CHILD? and How have these things helped you and …CHILD'S NAME?

Prompts:

- *16 week course (multiple components e.g. Circle of Security (COS), video reflection, group discussion with other mothers, 1:1 time with clinician)*
- *Provision of childcare & relationship with primary caregiver (PCG)*

If YES program helpful	**If NOTHING helpful**
Ask for examples:	See Q3

Q3. What things were not helpful or did not work for you in the TtLG program? and Why?

Any suggestions/ideas for how things could have been done differently?

Q4. On completion of the program did your confidence in responding to ……. CHILD'S NAME attachment needs increase?

YES	**NO**
Do you still feel more confident in responding to …….CHILD"S NAME	Explore why not and ask for suggestions/ ideas for ways the program could be adapted to support an increase in confidence

Q5. Did …….CHILD'S NAME behaviour change as a result of taking part in the program?

YES	**NO**
Ask for examples Has this change continued?	Explore why not and ask for suggestions/ ideas for ways the program could be adapted to support …CHILD'S NAME

…

Q6. Do you still keep in contact with any other people you met during the program (other mothers from the group, the childcare primary care giver, other families from the child care centre etc) *Any sustained networks with other mothers/families in the TtLG or the childcare centre*

YES	**NO**
Ask for examples	Explore why not and ask for any suggestions/ ideas for ways the program could be sustain social networks

Q7. On completion of the program did your confidence in accessing/contacting services for yourself and also ……CHILD'S NAME increase

YES	NO
Did the TtLG project influence you?	Explore why not and ask for suggestions/ ideas for ways the program could be adapted to support an increase in confidence

Indicate the phonecall is wrapping up

Q8. Suggestions any ideas or advice you would give to someone setting up a similar program for parents and children?

Q9 Can you sum up for me the extent to which the program has influenced your parenting or your relationship with …….CHILD'S NAME in the longer term?

If YES a longer term influence	If NO longer term influence
Probe for some examples of how parenting and/or relationship with child has changed as a result of participating in TtLG	Explore why not and ask for suggestions/ ideas for ways the program could be adapted to support a longer term influence

Q.10 And has there been a lasting difference in yourself since attending the program?

Prompts: *confidence, stress, emotional state, coping better etc*

If YES	If NO
Probe for examples if differences/changes	Explore why not and ask for suggestions/ ideas for ways the program could be adapted to support a lasting difference

Q9. Any other comments or things you'd like to add about the program

Thanks for taking the time to talk about the TtLG.

Appendix E.

Evaluation Summary Reports:

1. Mothers (three month) follow-up telephone interview summary
2. Fathers sessions summary
3.Childcare worker training series
4.Training workshop July 2005
5.Training workshop August 2006
6.Training workshop February 2007
7.Reference group email survey
8.Clinicians evaluation summary
9.Co-facilitator email survey
10.Directors evaluation summary
11. Rapid reconnaissance site report
12. Survey of TtLG Site Stakeholders: Managers (CEOs), Clinicians and Co-Facilitators
13. Focus groups of PCGs
14. Mothers (16-18 month) follow-up telephone interview summary

Appendix E.1

Mothers' (three month) follow-up telephone interview summary: Waves 1, 2 & 3.

Through the Looking Glass (TtLG)
Follow-up Telephone Interviews surveys Evaluation Summary
Waves 1, 2, and 3.

Sixty one mothers completed the TtLG program across Waves 1, 2, and 3. Consent for a follow-up telephone call was received from 60 of these mothers. One mother with a hearing impediment did not provide consent. The follow-up telephone interviews were made approximately 3 months after the mothers had completed the TtLG programs. Fifty mothers from Waves 1, 2, and 3 participated in the survey, a response rate of 83%. An average of 3 phone calls was made to each participant in order to book in and complete the telephone interview. The average length of a phone interview was 25 minutes.

Table 1: Follow-up telephone survey participation (n=50)

Site	Wave 1	Wave 2	Wave 3	Total
Thebarton SA	7	3	4	14
Salisbury SA	3	4	3	10
il nido SA	3	3	3	9
Perth	1	5	4	10
Brisbane	1	3	3	7
Total	15	18	17	50

The telephone interview was designed to elicit information about each mother's experience of the TtLG and to assess longer term outcomes of mothers' participation in the TtLG program. A semi-structured interview schedule of questions was developed as a guide, so that consistent information could be collected about the TtLG strategies and activities. Mothers were given the opportunity to describe in their own words their experience of the TtLG program. Data analysis identified themes corresponding to the relevant TtLG program objectives:
3a. To equip and empower a range of mothers of young children with the knowledge, awareness, confidence and skills to successfully overcome the barriers to attachment.
3b. To foster and nurture positive parent well-being outcomes
3c. To foster and nurture positive child well-being outcomes
4. To develop and enhance social support and friendship networks for the target group

Mothers' perceptions of the overall TtLG program
Mothers (98%, n=49) were clearly satisfied with their experiences of the TtLG program, with 72% (n=36) indicating they were highly satisfied with the way in which the program helped them feel closer to their child. The following quotes highlight the satisfaction that mothers expressed:

> *' All the people were wonderful there, the whole thing was about getting in touch with little brains'IL014*

> *'You know how you wake up sometimes and don't want to go to work, well I never felt like that with this (TtLG) I was happy to go to be there and share my experiences it was wonderful' S060314*

'very satisfied…it made me look at childrearing in a different light'IL004

'satisfied ..it made me feel happier meeting other people like me''T050805

'really satisfied with it, all activities worked, (clinician) made you feel comfortable'B060302

'wonderful ..it should be compulsory for all mothers leaving hospital, they shouldn't be without this information'IL009

The one mother who was not satisfied with the overall TtLG program commented that she felt the approach to discipline was too 'softly, softly'. However she also responded that she felt comfortable with the staff and other mothers and could see positive changes in the other mothers in her group (T050802).

Parental wellbeing

Most mothers (88%, n=44) reported a positive change in themselves since taking part in the TtLG program. Mothers described themselves as happier and less stressed.

'I'm happier now… I'm a single parent and really needed a break… the childcare helped me get some timeout'IL004

'I was exhausted at the beginning… at the end I felt on top of everything.. getting the feedback from others helped (clinician, co-facilitator and primary caregiver)T050805

'I feel so much better ….I now understand that I'm not the problem… the way (child) behaves is not a result of me.. I can now look at it from his side.. see what he wants.'P050802

'I can cope now …I still get stressed out but I know how to back off'B051103

Six (12%) mothers reported an increased ability to cope with their child's needs only while they were participating in the TtLG program. Their capacity to cope was short term and did not continue after they had completed the TtLG program. They would like to be able to continue to follow-up with the TtLG program staff after the program finishes.

Parenting competence and style

Mothers clearly felt that the participation in the TtLG program increased their ability to respond to their child's attachment needs by improving their parenting competence and style.

Confidence

- Most mothers (80%, n=40) reported increased confidence in responding to their children's attachment needs.

'Yes more confident……..before when S was crying all the time I felt I couldn't do anything….now I talk with her..the way I talk is different ….like when she's teething I say I know your teeth are sore but they'll get better I know how she's feeling. Before I didn't feel anything ..no mother-daughter bond but now I feel really close ..it'll be like that for a long time' S060110

'I have more understanding of his needs before if he was crying I would have said 'dumb….serves you right' now I am more empathic. Before if he was upset I'd try and rationalise with him now I just take control and have time in…I've got ideas in my toolbox that can calm him down and change the situation.' IL008

'Yes definitely I'm more in tune with (child's) emotions I'm more aware of things he needs I can see it more …I can be patient.. we're doing more things together ..playing together' T060305

Yes more confident… feel more confident in myself as a parent.. I can see (child's) point of view…(an example) I understand you don't want to take off your shoes, let me give you a cuddle…he needs me to organise the situation for him, he needs this cuddle….. Before my expectations were too high now I can let him verbalise his feelings. I can still get distressed he is a poor sleeper and can be exhausted but it doesn't escalate.. I can start to organise his feelings' B060301

All (20%, n=10) mothers who reported no change in their level of confidence in responding to their children's attachment needs described difficulties in their relationship with their child, such as sleep issues.

Parenting knowledge, skills and awareness of attachment needs

Most mother (88%, n=44) described changes in the way they do things with their children. Multiple answers were given by some mothers. The key changes in parenting styles identified included:

- Increased responsiveness and ability to read cues (88%, n=44)

  'Little things I can go out now with no screaming he's more relaxed .. I can leave him with someone if I give him a kiss and a cuddle say goodbye he can understand it' S060113

  Now give (child) more personal space. The video showed me there were opportunities to do this. It helped me pick up on her feelings.'T050807

  'I used to want them (children) to tell me what they wanted now I can read their cues and anticipate what they might be wanting' S050702

  'I can now see things from (child's) perspective. The Circle of Security helps.. previously I was quite unforgiving but now I respond differently…(described an example).. I no longer battle over the choice of clothes, I'll let (child) choose her

own clothes to wear if they're inappropriate I'll hold her and speak with her and suggest something different … we are closer… I no longer smack' T050806

'I'll take time during the day to sit on the floor and play with them, before this (TtLG) I'd just be too stressed to play.. now I can enjoy them'B05113.

'I can see (child's) point of view…(example) I understand you don't want to take off your shoes, let me give you a cuddle…he needs me to organise the situation for him, he needs this cuddle….. Before my expectations were too high now I can let him verbalise his feelings. I can still get distressed he is a poor sleeper and it can be exhausting but it doesn't escalate.. I can start to organise his feelings' B060301

- Less frustration (74%,n=37)

  'I can now accept that he wants to do things himself before I would be organising most things'P060201

  'now I realise that when the kids whinge and grizzle and cry, they're not doing anything wrong, it's just something they do and I can try and look at it from their eyes'S050807

  'COS helped me to understand about the things children do, I'm not as frustrated now, I can see where he is exploring'T060804

  'if he's being naughty I stop and think 'he's just a kid' and try and not get upset with him and try and help him. Time in helps, I can hold him and try and help him'B60901

  'I've learnt from the Circle of Repair it showed how if we did something we did not want to do, like go from 0 ..to ..10 (anger levels) in frustration it's OK I can apologise and acknowledge we're only human and make sure the kids know that we're sorry.. apologise' IL008

Clients share learning with others

More that half the mothers (54%, n=27) reported that they had talked about the TtLG program with other family members and friends in their community. The concepts most frequently shared focused on:

- the need to understand children's behaviour
- seeing things from the child's perspective
- reading children's cues and
- picking up on children's feelings.

Understanding Attachment Needs

When asked which aspects of the TtLG program were most useful in helping to understand their child's attachment needs all mothers interviewed (n=50) identified some

aspect of the TtLG program as being helpful. Some mothers (n=14) described multiple components of the program. The most frequently reported useful activities were:

- The Circle of Security (COS) model (84%, n=42)

  '*COS good, easy to understand and all the examples helped'T050803*

  '*COS…I liked learning about exploration and organising feelings'IL015*

  '*COS is a good model but you need time to understand this idea, it takes a while'P060201*

  '*COS helped me understand what the children were doing and I keep going back to it'S060113*

- The individual family video (78%, n=39)

  'The videotaping helped me see what was going on behind my back.. I could be preoccupied with (child1) and it helped me see (child2) and be aware of what they needed.'S060114

  'watching the video makes you more aware…you can see the obvious that you just don't realise you are doing'T050803

  '*the video helped me to see myself objectively I really am doing OK. It was good to see the change in the 2 videos* (pre and post)'B060301

  '*Video review – showed me that I did have attachment with (child) I didn't think I did…looking at us from the outside showed it' S060110*

- Clinician and co-facilitator support (78%, n=39)

  '(Clinician) and (co-facilitator) were amazing, talking with them helped me so much ….they made me more confident. The one on one time with (clinician) really helped me understand about (child's) needs'

  '(Clinician) listened to our (mothers) ideas and talked about our experiences. This all helps you understand your child' IL009

- Group reflection on videos (70%, n=35)

  'watching other mothers' videos helped…it was obvious what was happening…this helped me see what could be done for my child' IL009

  '(child) is only a baby but is she changing quickly ….watching the other mothers helped. I learnt a lot from their family videos … it's good to know these things as she is growing up'T050807

- Group discussions with other mothers (70%, n=35)

  '*comparing notes gave me more information and ideas of things to do with (child)' P060909*

'our group interaction helped me as a first time mother. I got an understanding of the other mothers' experiences and what they did. This really helped me' T050807

'talking with the other mothers helped make me feel happier..like I wasn't the only one with problems with their child'S060816

- Primary Caregiver (PCG) (50%, n=25)

(PCG) was reassuring ..the Learning Stories she did showed (child) doing things with other children, that made me feel good' T050807

'The childcare worker's stories helped….. it was good to know that (child) was happy in the childcare' IL013

'*We have a good carer and good Learning Stories, it makes you feel good' T060802*

The Primary Caregiver relationship with the family is important as one mother highlighted

'*We had a great relationship with the first carer, she wanted to talk and know about us, but she left and the next one was not interested in our family' IL006*

- 'Shark music' (30%, n=15)

The 'Shark Music' concept represents a metaphor for 'the painful state of mind (feelings and memories initially unconscious) of the caregiver and/or child that emerges when certain needs on the Circle are evoked' (Marvin, Cooper, Hoffman & Powell, 2001). The video demonstrates the power of the state of mind in relation to the parent's relationship with their children and the struggles they may have. The 'Shark Music' video provides a platform for reflecting on mothers own childhood relationship experiences.

'a new idea but understood what it was and how it happens for me'

'the idea of recognising shark music very valuable, it helps you understand why some things make you react'T050804

'very helpful..I now realise that I have a mixture of things (experiences) from both parents and I am only just recognising the long-term effect of these things' S050807

- 'You are so beautiful' video (14%, n=7). Mothers described this video showing parent- child interactions as 'emotional', 'heart rendering' and 'touching'.

Child Wellbeing

Most mothers (88%, n=44) reported positive changes in their children's behaviour since taking part in the TtLG program.

'Major changes… he is coming out of himself…looks to new people in our life…..he is happier' T060301

'He is more confident I let him explore and follow his lead. I don't try to always make a game for him I follow him and no longer say don't do this' IL008

'(Child) used to be clingy now she's happy and goes to kindy 4 days a week she's turned into a real social creature and wants to go more days' IL009

'Little things, I can go out now with no screaming he's more relaxed .. I can leave him with someone if I give him a kiss and a cuddle say goodbye he can understand it, he knows I'll come back'S060113

Mothers identified a range of TtLG activities as being helpful in contributing to positive behaviour changes including:

- Childcare (70%, n=35)
  'Childcare teaches (child) things I wouldn't have thought of and I really needed the break we're both a lot happier' S060815

  'he now mixes with other children ,the childcare helped us with that'P060805

  'she was quite clinging… now confident and independent…childcare helped'T060804

  'she loves child care and is really happy there B060302

  'childcare helped her grow up… she knows that I am coming back' T050802

- The Circle of Security (COS) model (70%, n=35)
  'I am responding to him differently and he's happier. I can see what he wants and the COS helps me with that before I would be organising things my way and he would have to do that but now I can let him go and sort out play things and I'll follow him'T060301

  '*the COS helps me understand her better' S060816*

  The COS it was all about learning about (child) feelings, reading what he was trying to tell me. I use it all the time, I'm always looking at the fridge magnet'IL008

  '*The COS helps me see she is able to rely on me…I've got a more relaxed approach to calming her down'T060802*

Client's satisfaction with project strategies

Childcare setting

Most mothers (88%, n=44) reported that the childcare centre provided a 'safe space' for their families. They felt relaxed and could freely talk about their issues.

‘ (children) were clingy and I was anxious about them, but I could watch them play through a window and this made me feel better’B051103

‘everybody was welcoming not like other places I’ve had to go to with our issues’T050807

‘good place.. childcare workers are friendly I could ask his carer any questions’IL001

‘meeting in the childcare centre was relaxing for me I looked forward to Tuesdays was a great experience’ P050802

‘Hard at first ….I wasn’t working and then I believed that if not working you should look after your own kids…have now changed my mind some parents need their own time…I do ….(child) still goes to care’ S060110

One parent who described the childcare setting and staff as friendly qualified her response saying the location was difficult for her to reach using public transport. Two mothers reported that they found it difficult to ‘relax’ as they could hear children crying and this made them feel anxious about their own children in care.

Program timing

The length of the TtLG programs ranged from 16 to 18 weeks**,** varying across the sites due to the number of mothers in each wave. The majority of mothers (78%, n=39) were satisfied with the program timing.

‘Good length..this time reinforced things.. I built a rapport with the other women and could relax’T050803

‘Perfect, better than a short program I had time to think and ask questions’IL014

‘Long term helps with trying to change practices you have been using for a long time’S060314

Six mothers would have like the program to run for a longer period of time, primarily for the ‘social’ aspect of the weekly meetings.

Five mothers suggested the program be condensed into fewer weeks with longer session times, suggesting that this would be a more practical option for people with time constraints such as work commitments.

Social and Community Networks

The majority of mothers (84%, n=42) reported that they were comfortable mixing with other mothers in the group. However five (10%) mothers felt that their groups were too small.

Over half the mothers (54%, n=27) reported some level of ongoing friendships were made during the program, most frequently with other mothers who had children the same age. Examples included meeting for coffee, attending children's birthday parties and phone calls. Good group dynamics was seen to support the development of friendships rather than any specific TtLG activity. The mothers who did not maintain contact with other group participants from the TtLG programs cited reasons such as not living in close proximity to other families or their own work commitments.

Some mothers (26%, n=13) started to participate in their local community. Taking up activities such as:
Joining a playgroup (n=7)
Commencing part-time work (n=7)
Returning to study (n=5).

Least useful activities
When asked to identify any aspect of the TtLG program that was not useful most mothers (70%, n=39) reported that all the activities had been useful. The remainder of mothers (n=11) identified the following aspects of the TtLG program as being of little use to them, some gave multiple responses:

- The volume of paperwork, including questionnaires (14%, n=7)
- The 'daunting' and 'invasive' videotaping of parent-child interactions (10%, n=5)
- Group discussions that were lacking in focus (10%, n=5)
- Ineffective relationships with primary caregiver (10%, n=5)
- Location and transport difficulties (4%,n=2).

Mothers' suggestions
Ten mothers (20%) identified aspects of the TtLG that they would like to change. Four mothers gave multiple responses:

- More information on the Circle of Repair (20%, n=10)
- More 1:1 time with the clinician (18%, n=9)
- More videos (not of group members) maybe professional videos showing parent-child behaviours in different settings. This could help group discussions (10%=5)
- Group discussions to be more focused and less random talking (10%, n=5)
- Photos of attachment moments as a memento (10%, n=5)
- More people in the group (4%, n=2)
- Non-verbal cue session to be held earlier in the program, would help in understanding child's attachment needs (2%, n=1)

Summary
Findings from the follow-up telephone survey 3 months after mothers have completed the program indicate that the TtLG project is achieving sustainable long term impact with mothers reporting increased confidence in parenting and understanding of their child's attachment needs.

Appendix E.2

Fathers sessions summary

Through the Looking Glass (TtLG)
Fathers Session Evaluation Summary

A formal 3 part group program for fathers has been developed by TtLG staff at Lady Gowrie Child Centre, Thebarton Adelaide. This program is designed to facilitate fathers' involvement in the broader TtLG program that targets mothers as the primary carer.

Attachment information programs for fathers were delivered by TtLG staff at Lady Gowrie Child Centre Thebarton during Waves 1, 3, 4 and 5. The programs were offered after hours to partners of the mothers attending at Thebarton and in Waves 4 and 5 partners from TtLG families at il nido Childcare Centre Paradise were also included. Initially the fathers' program was delivered over 3 sessions however in response to fathers' feedback the programs for Wave 4 and 5 were expanded to 4 sessions

The Fathers program consists of 3 group sessions that co-ordinate with the information being presented in the mothers' weekly group program. Key activities include:

- presentation of the Circle of Security and Circle of Repair models.
- 'Photo voice' activity, in which fathers use disposable cameras to take photos of their children that capture key concepts of the Circle of Security. These photos can provide a discussion focus at group sessions.
- video taping of interactions between fathers and their child/ren, which is incorporated into the 'You are so Beautiful' video to provide a discussion focus.

A total of 24 fathers from TtLG families participated in the programs, with 17 fathers from Thebarton and 7 fathers from il nido Childcare Centre Paradise. Fourteen fathers completed evaluation forms (response rate of 58%).

Evaluation Findings
The father's views were positive about the TtLG program and their participation in the fathers' information programs:

Understanding of TtLG project

- 82.8% (n=13) agreed that as a result of participating in the fathers session they understood their partners involvement in the TtLG (42.9%, n=6 strongly agreed)
- 92.8% (n=13) found the information materials clear and easy to understand (28.6%, n=4) strongly agreed)

Understanding of Attachment

- All responding fathers (n=14) reported an understanding of the Circle of Security attachment model with 78.6% (n=11) reporting a lot of understanding.
- All respondents indicated that participation in the fathers session had given them an understanding of children's attachment needs, with 57.1% (n=8) having a lot of understanding.

Session Impacts for Fathers

- 92.8% (n=13) agreed that their family's participation in TtLG had helped their child's behaviour (35.7%, n=5 strongly agreed)
- 78.6% (n=11) agreed that they felt closer to their child as a result of their family's participation in TtLG (35.7% n=5 strongly agreed)
- 78.6% (n=11) agreed that participation in the fathers program improved their parenting skills (14.3%, n=2 strongly agreed)

Most beneficial aspects of Fathers sessions (Spontaneous)

Thirteen fathers (92.9%) identified beneficial aspects of the Fathers' Sessions. The most frequently cited (n=12) benefit was the opportunity to talk with other fathers and share their stories.

- *Able to share and listen to other fathers' views*
- *Communicating with other fathers & realising others feel similar. A nice feeling of community*
- *I learnt so much from hearing other fathers stories*
- *Discussing real situations*
- *Fatherhood project worker a great help, good to discuss real life experiences, good to talk with fathers*
- *Group discussions and getting more understanding of how my wife benefits from the course*
- *Group discussions other dad's views in relation to interaction with the children*
- *Just talking was good The Fatherhood project worker (SS) had a major influence on the outcome of the meetings*
- *Learning a new way of being a parent and talking about ideas and feelings in an open environment*
- *Meeting other male partners*
- *Listening to other fathers talk about their situations with families, which I could relate to with my children and family*
- *Knowing that we aren't the only ones having problems with kids*
- *COS magnets are great, simple and easy to understand, you realise 'of course'*
- *'Communicating with other partners and realising others feel similar, a nice feeling of community'*
- *'Group discussions with others, views expressed by the dads in relation to their interaction with the children'*
- *'Just the chance to talk about ideas and feelings in an open environment, but mainly learning a new way of being a parent'*

Suggestions to improve future programs

Six fathers suggested a range of possible improvements for future fathers' programs:

- *Explore more real life scenarios within attachment theory e.g. constructive discipline techniques*
- *More male influence with male project workers*
- *More sessions and have partners together for at least one session*

- *We could as fathers have more than 3 sessions I felt I was just touching the surface of issues I would like to go deeper into*
- *A reminder call might have helped me get organised. Email would be good as I look at it often*
- *Suggest getting down on the ground to our children's level*

Overall Summary

- *Fantastic experience, some of the theory talk a bit intimidating*
- *Well organised and very caring program. Thank you*
- *The sessions were excellently run*
- *Quite happy with session*
- *'I enjoyed communicating with my partner after each of her sessions, our conversations are valuable'*
- *'My wife's participation has helped our family'*

Appendix E.3

Childcare worker training series

Through the Looking Glass (TtLG)
Childcare worker training Evaluation Summary
Wave 1

Training workshops on Attachment Theory and Primary caregiving were delivered to childcare staff during Wave 1 of the TtLG program. The training sessions were delivered by staff from Lady Gowrie Child Centre, Adelaide, Ms Sally Watson, TtLG clinician and Ms Cecilia Ebert, TtLG co-facilitator.

Eight training workshops for frontline childcare workers were conducted across the 5 participating TtLG childcare sites, during Wave 1, between the period 19th July to 8th November 2005.

1. Lady Gowrie Child Centre, Thebarton, Adelaide (n=32)
2. il nido Child Care Centre, Paradise, Adelaide (n=12)
3. Salisbury Highway Child Care Centre, Salisbury Downs, Adelaide (n=35)
4. Lady Gowrie Child Centre, Brisbane (n=15)
5. Lady Gowrie Child Centre, Perth (n=11)

Evaluation responses were received from 105 training participants. Overall respondents' feedback was positive:

- 88% (n=92) rated the quality of training as good (38%, n=40 extremely good)
- 80% (n=84) rated the training as useful (40%, n=42 extremely useful)

90% (n=94) respondents described multiple examples of how they would implement the training into their work practices. The most frequently reported implementation strategies involved the childcare worker:

- becoming a secure base for the children in their care (secure base as in the Circle of Security model) (n=78)
  'thinking about the child first and focus on feelings not behaviours'

  'I will be more understanding, listening to children, 100% available ..not just being there'

  'I will be more understanding, more realising the child's reaction is from their unexplained feelings and emotions not just their attitude'

- working as a team to implement primary caregiving (n=71)
  'I will continue to work as a team, communicate, support and reflect on primary care'

- using reflective practices (n=63)
  'I will reflect more on my own feelings and thoughts, will be bigger, wiser and kinder'

88% (n=92) respondents described how the training will benefit families at their centres. The most frequently reported examples were:

- More secures attachments with children in care (n=92)
- Parents will feel more secure leaving children in care (n=80)

'children will feel safe that you're there for their needs. Parents will feel secure leaving their children with people that understand them'

'better attachments, better understanding of what parents feel as they drop off their child'

'building trusting relationships, using knowledge and applying it to parents with secure base wording about attachment theory'

'forming relationships to give a sense of security and comfort...families will have an understanding of our involvement with their child and I will have a better understanding of their child'

'improved transitions in and out of our room…assisting parents understanding of enrollment'

33% (n=35) respondents reported suggestions for improving training sessions, 12 respondents made multiple suggestions. Most frequent suggestions:

- More opportunities for group discussions (n=27)
- More role-playing (n= 22)

49% (n=51) respondents identified further training needs, 21 respondents made multiple suggestions. The most frequent suggestions:

- Continued on-going training (n=36)
- More information on primary caregiving including case studies (n=30)
- Information on setting professional boundaries (n=12)

Through the Looking Glass Training Evaluation
Primary caregiving and attachment theory

Site: Date:

1. How do you rate the usefulness of this training (please circle response)
   - Extremely useful
   - Very useful
   - Useful
   - Of little use
   - Not useful

2. How do you rate the overall quality of this training (please circle response)
   - Extremely good
   - Very good
   - Good
   - OK
   - Poor

3. What did you find most helpful in the training?

4. Do you have any suggestion for improving this session?

5. How will you use the information you acquire in the training in your work?

6. What do you feel will be the benefits for the children and their families in your service form this information?

7. What further information/training do you need to feel confident about being part of the TtLG?

Thank you for taking the time to fill in this evaluation form.

Appendix E.4

Training workshop July 2005

Through the Looking Glass (TtLG)
Training workshop Evaluation
Lady Gowrie Centre, Thebarton, Adelaide SA.
21st – 22nd July 2005

A two-day Through the Looking Glass (TtLG) training workshop was delivered at the Lady Gowrie Centre in Thebarton, Adelaide in July 2005. The workshop was attended by 26 staff members from the five TtLG childcare centres across Australia:

1. Lady Gowrie Child Centre, Thebarton, Adelaide
2. il nido Child Care Centre, Paradise, Adelaide
3. Salisbury Highway Child Care Centre, Salisbury Downs, Adelaide
4. Lady Gowrie Child Centre, Brisbane
5. Lady Gowrie Child Centre, Perth

At the completion of the training workshop an evaluation questionnaire was distributed (Appendix 1). Twenty attendees returned evaluation questionnaires (77% response rate). This survey measured participants' satisfaction with the workshop format, program and organisation, and their levels of understanding and confidence in implementing TtLG strategies. Overall responses were positive with participants reporting on:

- valuable opportunities to network and discuss concerns, strategies and thoughts
- informative training sessions

"Good overall, very informative, lots of opportunities for discussion" (id 5)

" All areas covered at high level, great to meet other co-workers for discussion, great to be able to contact people for assistance and help" (id 9)

" *Energy levels in group were high and very positive*" (id 15).

Workshop activities

1 Benefits

Attendees reported positive benefits from attendance at the workshop with many people (75%, n=15) listing multiple benefits. Some staff (30%, n=6) reported that all sessions were beneficial.

The most frequently reported beneficial aspects of the workshop training were:

- specific training sessions for child care staff and clinicians, covering particular role responsibilities such as the child's wellbeing and involvement assessment tools and videotaping (65%, n=13)\
- networking and learning about other workers' experiences (65%, n=13)
- reviews of primary care giving and attachment theory (25%, n=5)
- evaluation training (25%, n=5).

2 Least beneficial aspects

Few aspects of the workshop were reported as being of little benefit to participants. Half of the respondents (50%, n =10) wanted to understand more about the standardized evaluation tools that would be used in the TtLG program. Some staff (20%, n=4) suggested less time could be spent on evaluation theory.

One person described the review of primary care giving as not being relevant to their role as a clinician.

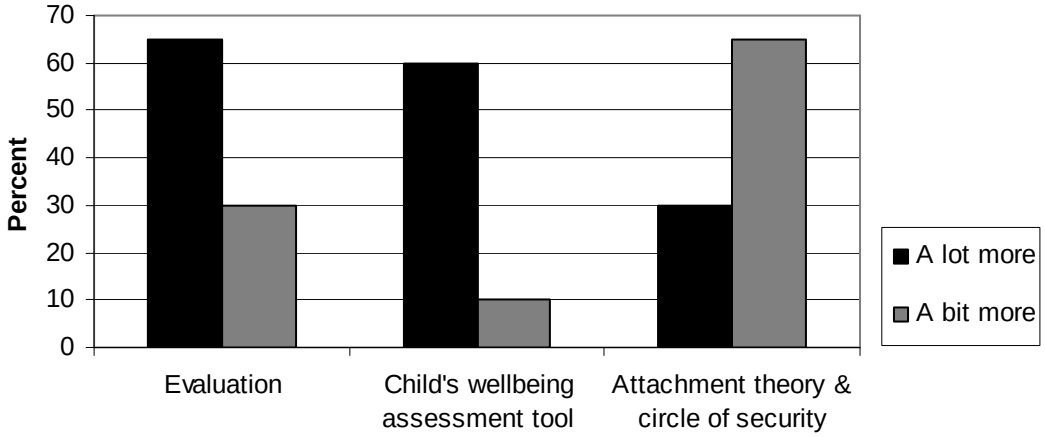
3 Understanding of TtLG program strategies

Most workshop participants reported an improved level of understanding of the Tt LG program strategies (see Table 2). Greatest improvements in understanding were recorded for 'Evaluation', and the 'Child's wellbeing assessment tool' as highlighted in Figure 1.

Table 2: Changes in understanding attributable to Training

Program strategies		No improvement %	A bit more understanding %	A lot more understanding %	Not Applicable %	No Response %
a	Attachment theory and Circle of Security	5	65	30	-	-
b	Child's wellbeing assessment tool	5	10	60	25	-
c	Group Program	10	40	30	5	15
d	Evaluation	-	30	65	-	10
e	Program processes (referrals, assessments etc)	-	50	45	-	5
f	Team processes	-	50	45	-	5

Figure 1: Changes in understanding levels attributable to training



3 Understanding of TtLG program strategies (continued)

The childcare staff training session covering the child's wellbeing assessment tool was run concurrently with the clinicians' training session. However a comment was recorded that clinicians need some exposure to the mechanics of the wellbeing and involvement assessment processes to 'round off the training' (id 16).

Five staff (25%) suggested extra training on specific activities including:

- attachment theory and circle of security (n=2)
- practice with the wellbeing and involvement scales (n=2)
- the development of children's learning stories (n=1).

4 Confidence levels implementing TtLG program strategies

Workshop participants reported high levels of confidence in applying program activities (see Table 3).

Table 3: Confidence levels in applying Program Strategies

Program strategies	Very confident %	Quite confident %	Not confident %	Not applicable %	No response %
Attachment Model	55	30	10	-	5
Children's wellbeing observation tool	50	10	-	30	10
Evaluation data collection	45	45	-	-	10

Additional comments regarding perceptions of confidence were made by 7 workers (35%).

*"As a frontline childcare worker, need more understanding of how the clinician, co-facilitor and primary caregiver work together" (*id 3)

"As a clinician feel confident, just keen to know what we will be using" (id 12)

"Confidence will increase once applied in own setting" (id 13)

"Evaluation data collection - feel that either I will manage it or I feel confident to seek clarification" (id 20*).*

The need for follow up training in the attachment model has been identified for a minority of respondents, although most feel equipped with the skills to apply it in their work (see Table 4 below) Given the need for greater clarification of the standardized instruments to be used in the evaluation, the confidence levels expressed above are encouraging.

5 Workshop training

Overall the workshop training was rated well by attendees. High levels of satisfaction were reported for the workshop format, program and organisation (see Table 4).

Table 4: Satisfaction levels with the TtLG training workshop

Training	Strongly agree %	Agree %	No view %	Disagree %	Strongly disagree %	No response %
Good presentation style	40	55	-	-	-	5
Poor workshop venue	-	-	5	15	75	5
Attachment model is highly appropriate for my work	70	25	-	-	-	5
Training materials were clear and easy to understand	50	40	-	5	-	5
I enjoyed the training	60	35	-	-	-	-
Pace of training was right	45	45	5	-	-	5
I would have liked more training	15	50	20	10	-	5
I feel equipped with skills to use the attachment model in my work	40	45	-	5	-	10

Ten respondents (50%) listed additional comments. Key concerns raised were

- The quality of training materials, in particular overheads and PowerPoint slides (10%, n=2)
  " ..too small print and some with too much information on each" (id 18)

- A need for more training on the Co-facilitor role (10%, n=2)
  "Would have liked more training specifically on the role of the co-facilitor" (id 4).

6 Suggestions

Participants (70%, n=14) recorded aspects of the training activities that could have been done differently:

- more time in role groups of clinicians, co-facilitors and primary caregivers covering specific tasks and responsibilities (n=5)
- an over-view of the different role responsibilities (n=4)
- more opportunities to work through the assessment of families and use of video (n=4)
- a clear description of co-facilitors role, especially in weekly sessions (n=3)
- some exposure to the wellbeing and involvement tools (n=3)
- reading handouts and printouts of presentations to be prepared before hand for easy distribution during training sessions (n=3)

Appendix 1: Training Workshop Evaluation Questionnaire

Through the Looking Glass Training: Evaluation Form

The following questionnaire has been compiled by the Independent Evaluator to evaluate the training that you have just attended. Please take the time to complete the questionnaire and where appropriate tick the appropriate box, or write in BLOCK CAPITALS for legibility. Please put additional comments on the last page of the questionnaire if needed. Your answers are strictly confidential – please do not put your name on the questionnaire.

1. **What aspects of this workshop were most beneficial to you and why?**

2. What aspects of the workshop were least beneficial to you and why?

3. To what degree has your <u>understanding</u> of the following things changed as a result of attending this workshop?

	No Improvement at all	**I understand a bit more**	**I understand a lot more**
a. Attachment Theory and the Circle of Security			
b. Using the Assessment of Child's well being tool			
c. The group program (inc father's sessions, videotaping etc)			
d. The Evaluation (inc Evaluation Plans)			
e. The Processes involved for the project (referrals, assessments etc)			
f. The Team Processes to be used during the Project			

Please comment specifically on any of the above areas where you would like additional training:

4. How confident are you about applying the following in your work:

	Very Confident	**Quite Confident**	**Not confident at all**
a. Implementing the Attachment model			
b. Using the Children's' Wellbeing Observation tool			
c.Collecting the evaluation data			

Please explain your answers here:

5. Please indicate your level of agreement with the following statements regarding the training over the last 2 days:

	Strongly Agree	**Agree**	**No View**	**Disagree**	**Strongly Disagree**
a. The style of presenting was good					
b. This is a poor venue for the workshop					
c. The attachment model is appropriate for my work					
d. The materials used were clear and easy to understand					
e. I enjoyed the training					
f. The training was delivered at the right pace for me					
g. I would have liked more training					
h. I feel equipped with the skills to use the attachment model in my work					

Please explain your answer:

6. Can you suggest anything that could have been done better in the workshop (new areas for inclusion, better presentation etc)?

7. Please make any other comments you believe would be helpful to the organisers of this workshop

Thank you for completing the questionnaire. Please put it in the envelope provided to ensure confidentiality

Appendix E.5

Training workshop August 2006

Through the Looking Glass (TtLG)
Training Workshop Evaluation
Lady Gowrie Child Centre Inc, Thebarton Adelaide SA
2nd – 4th August 2006

Representatives from the five TtLG childcare sites attended a 3 day training workshop in August 2006, held at Lady Gowrie Child Centre Inc, Thebarton Adelaide SA:

6. Lady Gowrie Child Centre, Thebarton, Adelaide
7. il nido Child Care Centre, Paradise, Adelaide
8. Salisbury Highway Child Care Centre, Salisbury Downs, Adelaide
9. Lady Gowrie Child Centre, Brisbane
10. Lady Gowrie Child Centre, Perth

The training workshop was designed to provide participants the opportunity to review and discuss the following key components of the TtLG project:

- TtLG program (manual, forms, session activities)
- TtLG Training plan for childcare sites
- Evaluation plans and activities
- Group facilitation (styles and processes)
- Reflective practice for childcare staff
- Video work with parents

As part of this workshop co-facilitators (n=5) attended a specific group facilitation training program conducted by Relationships Australia.

At the completion of the 3 day workshop an evaluation questionnaire was distributed (see Appendix 1). This evaluation survey measured participants' levels of understanding and confidence in implementing TtLG strategies and their satisfaction with the workshop format, program and organisation.

Evaluation Findings
Fifteen evaluation responses were received:
Clinicians (n=5), Co-facilitators (n=4), Directors (n=3), Manager Community Service (n=1), Manager and co-facilitator (n=1) and Ass. Director (1).

Understanding of the key TtLG components as a result of the training.
TtLG program (manual, forms, session activities)

- 40% (n=6) understood most of it but would like more information
- 20% (n=3) fully understand
- 20% (n=3) partially understand
- 7% (n=1) have no real understanding

TtLG Training plan for childcare sites

- 27 %(n=4) Understand most of it but would like more information
- 20% (n=3) fully understand
- 20% (n=3) have no real understanding
- 13% (n=2) partially understand
- 20% (n=3) not applicable

Evaluation plans and activities

- 67% (n=10) understood most of it but would like more information
- 20% (n=3) fully understand
- 13% (n=2) have partial understanding

Group facilitation (styles and processes)

- 67% (n=10) fully understand
- 20% (n=3) understand most of it but would like more information
- 13% (n=2) partially understand

Reflective practice for childcare staff

- 27% (n=4) understand most of it but would like more information
- 20% (n=3) fully understand
- 13% (n=2) partially understand
- 7% (n=1) no real understanding

Video work with parents

- 27% (n=4) fully understand
- 27% (n=4) understand most of it but would like more information
- 20% (n=3) no real understanding
- 13% (n=2) partial understanding

Additional comments
Eight respondents (53%) made additional comments indicating they would like more information on the manual.

Work shop Rating
Participants were satisfied overall with the training workshop

- 93% (n= 14) indicated the training activities were relevant to their TtLG role (with 67%, n=10 strongly agreeing)
- 60% (n=9) found the training materials clear and easy to understand (with 47%, n=7 strongly agreeing)
- 67% (n=10) agreed the training was delivered at the right pace (with 47%, n=7 strongly agreeing)
- 40% (n=6) agreed the training developed group facilitation skills, while 33%, n=5 indicated this was not applicable to their role.
- 27% (n=4) strongly agreed that the video work discussion will assist clinical work with parents while 52% (n=8) had not view or indicated not applicable

Four respondents (27%) made additional comments indicating that they would like more time to work with their colleagues on the TtLG program components.

Most beneficial aspects of the workshop
All participants (n=15) reported aspects of the training workshop that were beneficial. Key benefits were identified:

- Networking and hearing about other peoples experiences (80%, n=12)
  'Hearing the experiences of the other sites'

'Spending time with other professionals discussing roles and how the other sites operate'

- Reviewing video work (34%, n=5)

- Group facilitation training (27%, n=4)
  'Learnt about myself and tools to use in the program,

Least beneficial aspects of the workshop
Seven responses (47%) were received with five participants indicating that reviewing documents and forms was of no benefit and 2 participants were new to their role and required more information on the evaluation.

TtLG Training Workshop 3rd August 06 Day 1
Evaluation Session Group Whiteboard Exercise
Four key evaluation questions relating to the TtLG project were displayed on a whiteboard:

1. Project success factors
Factors that have contributed to the project success so far (e.g. initiatives, processes, products and/or services generated through the project.
2. Project impacts
How the project has made a difference to local families, communities and children and/or assisted families and communities using the service
3. Area of concerns and/or improvement
Concerns about the project, the directions in which it is heading and/or any improvements which could be made
4. Evaluation questions and comments

Participants were asked to reflect on these questions, record their responses on notes and attach these notes under the relevant question. Twenty eight responses were received and key themes identified.

1. Project success factors
Factors that have contributed to the project success so far (e.g. initiatives, processes, products and/or services generated through the project.

- Training
- Planning
- Team work
- Networks
- Support for mothers/families

2. Project impacts
How the project has made a difference to local families, communities and children and/or assisted families and communities using the service

- Parents and staff have gained new knowledge, skills and an understanding of behaviours
- Genuine relationships with TtLG clients
- "It's what we are" - childcare profession 'mission' to assist families and communities Sustainable continuity of care with families

3. Area of concerns and/or improvement

Concerns about the project, the directions in which it is heading and/or any improvements which could be made

- Information exchange between roles and sites
- Role clarification
- Extending the program reach to other families in childcare centre
- Access to childcare after program
- Time off for staff
- What happens when project ends

4. Comments and questions

- Primary Care Giving (PCG) - is it being implemented and can it be evaluated
- Feedback for clinicians, information on tools
- Children's observation measurements, when and where to apply the tools
- Tension applying standardised tools in non-standardised setting

TtLG Training Workshop
Co-facilitators Group Facilitation Training 3-4 August 2006
Relationships Australia
As part of the TtLG Traiining workshop co-facilitators (n=5) from each childcare site attended a 2 day Group Facilitation workshop conducted by Relationships Australia. Evaluation feedback was provided by Relationships Australia.

1 Training Benefits
Increase in confidence
Personal and professional growth in way of thinking
Significant increase in knowledge of group facilitation
Gained 'huge amount' of knowledge and also personal and professional learning
Knowledge and skills on group work

2 Training program highlights
Exploring and reflecting on task and maintenance concepts
Developing confidence in team skills
Revising learning styles and leadership styles
Learning about questioning techniques
Bonding and feeling part of a team (n=3)
Learning about myself

3 Least positive aspect of program
No comments recorded

4 Recommendations for future programs
More time to explore some concepts (n=1)

Additional comments

5 Group facilitation training course
'Very informative, lots of handouts for future reference'

6 Educator's facilitation of the training
'Fantastic, did not get bored and felt really good about myself'
'Gave us lots of information and gave us time to discuss and process it in a way that was relevant for our program'

7 Relevance of the course content
'Greatly appreciate all the extra handouts'

Table 1: Participants ratings

Training	**Poor %**	**Okay %**	**Excellent %**
Overall rating of the course			100
Educators facilitation of the training			100
Relevance of course content			100
Quality of training handouts			100

Appendix 1

Through the Looking Glass Training Workshop Evaluation

Adelaide 2 – 4 August 2006

INSTRUCTIONS

Please take the time to complete the questionnaire and √ the appropriate box or write your responses in BLOCK CAPITALS for legibility. In order to maintain confidentiality please place the completed form in the envelope supplied. Return the envelope to the local Adelaide TtLG representative who will then forward all forms to the TtLG evaluation team at Gowrie Child Centre, Thebarton SA.

1. What is your role in the TtLG program?

Director □ Clinician □ Co-facilitator □

Other □……

2. Please indicate your degree of understanding around the following components of the TtLG project?

		No real understanding	Partial understanding	Understand most of this but would like more information on some areas	Fully understand this area	N/A
a	**The Evaluation (including the plan and activities)**	☐	☐	☐	☐	☐
b	**Group facilitation (including styles and processes)**	☐	☐	☐	☐	☐
c	**The TtLG group program (including the manual, forms & session activities)**	☐	☐	☐	☐	☐
d	**Video work with parents**	☐	☐	☐	☐	☐
e	**TtLG training plan for childcare sites**	☐	☐	☐	☐	☐
f	**Reflective practice for childcare staff**	☐	☐	☐	☐	☐

***Please comment specifically on any of the above areas where you would like additional training*:**

3. Please indicate your level of agreement with the following statements regarding the Workshop training:

		Strongly Agree	Agree	No View	Disagree	Strongly Disagree	n/a
a	**The training activities were relevant to my role in the TtLG program**	☐	☐	☐	☐	☐	☐
b	**The materials used were clear and easy to understand**	☐	☐	☐	☐	☐	☐
c	**The training was delivered at the right pace for me**	☐	☐	☐	☐	☐	☐
d	**The training equipped me with group facilitation skills**	☐	☐	☐	☐	☐	☐
e	**The video work discussion will assist my clinical work with parents**	☐	☐	☐	☐	☐	☐
f	**Reviewing the TtLG training plan was useful**	☐	☐	☐	☐	☐	☐
g	**I would have liked more training**	☐	☐	☐	☐	☐	☐

Please write any explanations of your answers that you believe would be helpful:

4. What aspects of this workshop that were most beneficial to you and why?

5. What aspects of this workshop that were least beneficial to you and why?

6. Please write any other comments you believe would be helpful.

Thank you for completing this questionnaire.
Please seal it in the envelope supplied and return it to the Adelaide TtLG representative.
All forms will be given to the TtLG evaluation assistant at Thebarton.

Appendix E.6

Training workshop February 2007

Through the Looking Glass (TtLG)
Training Workshop Evaluation
Location: Relationships Australia Centre, Hindmarsh Adelaide SA.
8th - 9th February 2007

A two day TtLG training workshop was delivered in February 2007 at the Relationships Australia Centre, Hindmarsh Adelaide SA. Representatives from all 5 TtLG childcare sites attended:

11. Lady Gowrie Child Centre, Thebarton, Adelaide
12. il nido Child Care Centre, Paradise, Adelaide
13. Salisbury Highway Child Care Centre, Salisbury Downs, Adelaide
14. Lady Gowrie Child Centre, Brisbane
15. Lady Gowrie Child Centre, Perth

Training program

Day 1 Morning - Team Building - TtLG Project Sculpturing Exercise
Facilitators: Catherine Sanders and Lisa Kettler
Afternoon - Reflective Practice, Facilitators: Kaye Colmer and Nikki Edwards

Day 2 Morning - Emotional Availability, Facilitator: Jacqueline Beal
Afternoon - Interpreting Parent Child Dyads, Facilitator: Mary Hood.

Evaluation questionnaires were distributed at the end of each training day. Questionnaires attached as Appendix 1.

Team Building Workshop – Day 1 Morning session

Seventeen participants returned evaluation survey forms:
Co-facilitator (n=5); Clinician (n=4); Director (n=3); Manager (n=2) Primary Caregiver (PCG) (n=2); Other *(not specified)* (n=1).

Most participants reported an increased understanding of TtLG roles and components as a result of attending the Team Building Workshop.

- 59% (n=10) indicated an increase in their understanding of their own role with 35% (n=6) reporting no change as they already had a clear understanding of their role.
- 77% (n=13) increased their understanding of other roles in TtLG with 24 % (n=4) reporting no change as they already had a clear understanding of other roles
- 77% (n=13) increased their understanding of the multiple components of the TtLG with 24% reporting no change as they already had a clear understanding

Workshop rating

Most participants (71%, n=12) found the workshop useful.

- 83% (n=14) agreed the project sculpturing exercise was relevant to their work.
- 83% (n=14) found the presentation style good
- 76% (n=13) agreed the materials were clear and easy to understand.

Additional comments highlighted participants' experiences:
'It was good fun and included everyone to gain insight of all the different roles and pressures that we work with through out the project'.

'I also reflected on how important everyone's role is in TTLG and to ensure effective communication is used to keep everyone feeling valued and 'linked'.

'More focus on empathy for clients would have been good. Also pointing out how hard people found it to act rather than talk. Exercise ended up being a bit laboured.'

Reflective Practice Workshop – Day 1 Afternoon session
An additional person attended this workshop, a childcare centre manager (n=18)
Most participants (89%, n=16) reported an increased understanding of reflective practice.

- 78% (n=14) had an increased understanding of the importance of being emotionally available as a worker.
- 89% (n=16) increased their understanding of the value of co-worker relationships in supporting parents.

All participants (n=18) indicated that the workshop training had increased their confidence in

- Videotaping child-worker interactions as a tool to support reflective practice
- Reflecting with staff teams on videotapes of child-worker interactions

Workshop rating
All (n=18) participants agreed that:

- the workshop was useful
- the presentation style was good
- materials were clear and easy to understand.

However 95% (n=17) reported a need for additional training on the use of videotape as a reflective tool. Some participants made additional comments highlighting the benefits of the reflective practice training:

'It made me think about my own capacity for reflection and to be more emotionally available for parents, children and co-workers.'

'Learning more about using the videotaping as a tool for training - very inspiring!'

'Appreciate the opportunity to think about reflective practice in more depth and Looking at video footage and learning about how the presenters use the footage in staff meetings.'

Emotional Availability (EA) Workshop – Day 2 Morning session
Sixteen participants completed the Day 2 Workshop evaluation survey

The majority of participants (82%, n=13) agreed the EA information was relevant to their work with 88% (n=14) reporting an increase in understanding of:

- The use of EA scales to assess change in parent-child attachment
- The relationship of EA scales to organised and disorganised attachment
- The individual EA dimensions:
    - Maternal sensitivity
    - Maternal structuring
    - Intrusiveness
    - Hostility
    - Child responsiveness
    - Child involvement

However one participant made an additional comment that they *'learnt something and that was useful but it was not useful to my current needs i.e. it is not a priority'.*

Workshop rating

Overall most participants (87%, n=14) rated the EA workshop as useful

- 87% (n=14) agreed the style of presentation was good
- 100% (n=16) agreed the materials were clear and easy to understand.

Additional comments highlight respondents experience of the EA training:
'It was great to get a deeper understanding of EA as well as the perspective from the clinicians work with parents.'

'I had little knowledge apart from articles and experiences as a primary caregiver and this will help me when looking at client videos to be more aware, conscious and understanding of the situation/problem and enable me to work more effectively with my clinician to better the support for the group.'

Parent Child Dyads Workshop – Day 2 Afternoon session

Most participants reported the parent – child dyad training increased their understanding of parent-child attachment concepts. However some participants indicated no change in their understanding as they already had a clear understanding of the concepts: :

- 76% (n=12) reported an increased understanding of attachment concepts, 25%(n=4) already had a clear understanding
- 81% (n=13) increased understanding of parent-child defenses, 13% (n=2) already had a clear understanding
- 50% (n=8) increased understanding of the Circle of Security (COS) graphic, 38% (n=6) had no change as they already had a clear understanding and 13% (n=2) had no increase in understanding.

As a result of the Parent Child Dyad training some participants reported increased competency in:

- Identifying parent-child relationship defences (81%,n=13)
- Applying the COS graphic to videotapes of parent child dyads (76%, n=12)

Workshop rating

Overall most participants (82%, n=12) rated the Parent Child Dyad training as useful

- 94% (n=15) agreed the style of presentation was good
- 86% (n=17) agreed the materials were clear and easy to understand
- 81% (n=13) agreed the information on interpreting videotapes of parent child dyads is relevant for my work
- 75% (n=12) identified the need for additional training on interpreting videotapes of parent child dyads

Additional comments reflect participants rating of the workshop
'Gained a better understanding and good to see application in practical sense.

'I will be able to take the information to my staff. I gained an understanding of interpreting that I did not have before'

'Should be additional training for clinicians as a separate group to explore this at a deeper level in order to support the work we do in the group and the complexities of this especially in relation to sensitivities.'

Additional comments on the 2 Day Workshop

'Overall very informative and added to my own understanding'. (Director)

Discussions in a larger group format work well. To be able to throw out our ideas and interpretations of what we know & what we see & have people challenge this to give us further insight is a technique that I learn from'. (Co-facilitator)

'Day 2 was amazing! I feel inspired and motivated to use some of the ideas i.e. explaining the COS graphic and video clips to train staff at my centre. Some fabulous ideas. I was glad to be part of the training.' (Co-facilitator)

'Excellent - good small and large group work' (Director)

'It would be helpful to have more training for staff team, especially the Primary Caregivers. It would be interesting to spend time at other sites as well as here in Adelaide'. (Co-facilitator)

'Perhaps getting people to move about the room every 30 minutes or so as at times (I) was feeling tired and drained and I believe it was because we were sitting down for long periods of time'. (PCG)

'Make a video and PowerPoint presentation to take back to staff for further training'. (Director)

Appendix 1

Through the Looking Glass Training Adelaide 8th and 9th February 2007 EVALUATION DAY 1

The following questionnaire has been compiled to assist the evaluation of this training. Please take the time to complete the form by ticking √ the appropriate box or writing your responses in BLOCK CAPITALS for legibility.

What is your role in the TtLG program?

Director □ Clinician □ Co-facilitator □ Other □ ***(please specify)*** ……

Day 1 Morning session TEAM BUILDING

1. To what degree has this session increased your understanding of the following aspects of the TtLG project?

		No change already have a clear understanding	No increase at all	Some increase	Increased quite a lot
a	Your role	□	□	□	□
b	Other roles within TtLG	□	□	□	□
c	The multiple components of the TtLG intervention	□	□	□	□

2. Please tick your level of agreement or disagreement with the following statements

		Strongly Disagree	Disagree	No View	Agree	Strongly Agree
a	The team building workshop was useful	□	□	□	□	□
b	The style of presenting was good	□	□	□	□	□
c	The materials used were clear and easy to understand	□	□	□	□	□
d	The project sculpting exercise was relevant to my work	□	□	□	□	□

3. What aspects of this team building workshop were most useful to you and why?

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4. Please make any other comments you believe would be helpful to the organisers.

Day 1 Afternoon session REFLECTIVE PRACTICE

5. To what degree has this session increased your understanding of the following aspects of the TtLG project?

		No change already have a clear understanding	No increase at all	Some increase	Increased quite a lot
a	Reflective practice	□	□	□	□
b	The importance of being emotionally available as a worker	□	□	□	□
c	The value of co-worker relationships in supporting parents	□	□	□	□

6. To what degree has this training session increased your <u>confidence in implementing</u> the following activities?

		No change already confident	No increase at all	Some increase	Increased quite a lot
a	Videotaping child-worker interactions as a tool to support reflective practice	□	□	□	□
b	Reflecting with staff teams on videotapes of child-worker interactions	□	□	□	□

7. Please tick your level of agreement or disagreement with the following statements

		Strongly Disagree	Disagree	No View	Agree	Strongly Agree
a	The reflective practice workshop was useful	□	□	□	□	□
b	The style of presenting was good	□	□	□	□	□
c	The materials used were clear and easy to understand	□	□	□	□	□
d	Reflection on child-worker interaction is relevant for my work	□	□	□	□	□
e	There should be additional training on the use of videotaping as a reflective practice tool	□	□	□	□	□

8 What aspects of this workshop on reflective practice were most useful to you and why?

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9 Please make any other comments you believe would be helpful to the organisers.

Through the Looking Glass Training Adelaide 8th and 9th February 2007 EVALUATION DAY 2

The following questionnaire has been compiled to assist the evaluation of this training. Please take the time to complete the form by ticking √ the appropriate box or writing your responses in BLOCK CAPITALS for legibility.

What is your role in the TtLG program?

Director □ Clinician □ Co-facilitator □ Other □ ***(please specify)*** ……

Day 2 Morning session EMOTIONAL AVAILABILITY

10. To what degree has this session increased your understanding of the following aspects of Emotional Availability (EA)?

		No change already have a clear understanding	No increase at all	Some increase	Increased quite a lot
a	The use of EA scales to assess change in parent-child attachment	□	□	□	□
b	The relationship of EA scales to organised and disorganised attachment classifications	□	□	□	□
	The individual EA dimensions:				
c	Maternal sensitivity	□	□	□	□
d	Maternal structuring	□	□	□	□
e	Intrusiveness	□	□	□	□
f	Hostility	□	□	□	□
g	Child responsiveness	□	□	□	□
h	Child involvement	□	□	□	□

11. Please tick your level of agreement or disagreement with the following statements

		Strongly Disagree	Disagree	No View	Agree	Strongly Agree
a	The EA workshop was useful	□	□	□	□	□
b	The style of presenting was good	□	□	□	□	□
c	The materials used were clear and easy to understand	□	□	□	□	□
d	The EA information is relevant for my work	□	□	□	□	□

12. What aspects of this workshop on Emotional Availability were most useful to you and why?

14. Please make any other comments on Emotional Availability that you believe would be helpful to the organizers

Day 2 Afternoon session PARENT CHILD DYADS

14. To what degree has this session increased your understanding of the following aspects of the TtLG project?

		No change already have a clear understanding	No increase at all	Some increase	Increased quite a lot
a	Attachment concepts	□	□	□	□
b	Parent-child relationship defenses	□	□	□	□
c	The Circle of Security (COS) graphic	□	□	□	□

15. To what degree has this training session increased your <u>competency</u> in the following activities?

		No change already competent	No increase at all	Some increase	Increased quite a lot
a	Identifying parent-child relationship defences	□	□	□	□
b	Applying the COS graphic to videotapes of parent child dyads	□	□	□	□

16. Please tick your level of agreement or disagreement with the following statements

		Strongly Disagree	Disagree	No View	Agree	Strongly Agree
a	The workshop on interpreting parent-child dyads was useful	□	□	□	□	□
b	The style of presenting was good	□	□	□	□	□
c	The materials used were clear and easy to understand	□	□	□	□	□
d	The information on interpreting videotapes of parent child dyads is relevant for my work	□	□	□	□	□
e	There should be additional training available on interpreting videotapes of parent child dyads	□	□	□	□	□

17. What aspects of this workshop on interpreting parent child dyads were most useful to you and why?

18. Please make any other comments about interpreting parent child dyads that you believe would be helpful to the organisers.

OVERVIEW of the 2 DAY WORKSHOP

Day 1	Team Building and Reflective Practice
Day 2	Emotional Availability and Interpreting Parent Child Dyads

19. Please make any comments about the 2 day workshop that you believe would be helpful to the organisers.

Appendix E.7

Reference group email survey

Through the Looking Glass (TtLG)
Reference Group Email Survey Evaluation Summary
September –October 2005

In September 2005 an email questionnaire was distributed to Reference Group members, including program staff (n=11). A total of 10 surveys were returned, response rate of 91%. Six questionnaires were completed on-line and returned by email, the remaining 4 questionnaires were returned by mail.

Overall Reference Group members reported positively on the TtLG program.

- 100% (n=10) respondents were satisfied overall with the progress of the TtLG project (60%, n=6 were highly satisfied)

'Program is having an impact nationally in terms of understanding of the significance of attachment theory. It is contributing to the development of a national Gowrie strategic plan.'

'Very valuable project – delighted to be involved'

1. Recruitment to the TtLG Reference Group
100% (n=10) respondents were satisfied with their recruitment to the TtLG program (80%, n=8 fully satisfied).

2. Reference Group meeting processes
100% (n=10) respondents were satisfied with the reference group meeting processes (50%, n=5 fully satisfied). Additional comments:
'Difficulty with some decisions being changed in subsequent meetings due to changes in attendance at meetings.'

'In the long–term would like to see meetings structured so that there is active engagement of members and their expertise can inform program development, not just a reporting process.'

3. Reference group activities
Respondents clearly felt positive about the organisation of the reference group meetings:

- 100% (n=10) agreed the meeting venue facilities were adequate (40%, n=4 strongly agreeing);
- 90% (n=9) agreed meeting times were convenient, with one respondent reporting 'no view';
- 70% (n=7) agreed that meetings are run efficiently (10%, n=1 strongly agreeing);
- 80% (n=8) agreed that the Evaluation Plan is appropriate for the TtLG program (40%, n=4 strongly agreeing);
- 80% (n=8) agreed that the well-being of clients is adequately considered during the meetings (20%, n=2 strongly agreeing);
- 70% (n=7) agreed that demands on program staff are adequately considered during meetings (20%, n=2 reporting no views)

- 60% (n=6) agreed that they were clear about the role of the Reference Group (20%, n=2 disagreed and 20%n =2 reported no view)
- 80% (n=8) disagreed that meeting should be held less often (20%, n=2 strongly disagreeing);

Additional comments:

'Clinicians need to be consulted about the feasibility of applying all these tools – asked to do a lot of work in addition to the program'

'Important to monitor how well staff are able to keep up with the demands of both the program and the evaluation…outcomes for clients are directly related to the degree to which the program was able to be implemented as designed and maintaining in that way over time'.

4. Level of understanding about TtLG program

Respondents have an overall understanding about key aspects of the program:

- 100% (n=10) respondents indicated they understand the TtLG program objectives (70%, n=7 have a clear understanding);
- 100% (n=10) understand the Circle of Security attachment model (50%, n=5 clearly understand);
- 100% (n=10) understand the structure of the TtLG program for parents (50%, n=5 clearly understand);
- 90%(n=9) understand the Evaluation Plan (60%, n=6 clearly understand);
- 80% (n=8) understand the integration of primary care giving model into childcare staff work practices (40%, n=4 clearly understand).

5. Standardised tools for Evaluation

Overall members were satisfied with the standardised tools that the Reference Group had recommended for the Evaluation of the TtLG program:

- 90% (n=9) were satisfied with the Parenting Stress Index (PSI) (60%, n=6 were fully satisfied);
- 90% (n=9) were satisfied with the Hospital Anxiety Depression Scale (HADS) (50%, n=5 were fully satisfied)
- 90% (n=9) were satisfied with videotaping and Emotional Availability Scales (70% n=7 fully satisfied);
- 80% (n=8) were satisfied with the Children's Wellbeing Observation Measure (60%, n=6 fully satisfied)
- 80% (n=8) were satisfied with the Children's Involvement Observation Measures (50%, n=5 fully satisfied)

Additional comments

'Concerns that PSI and HADS have not been validated for use together as is occurring in TtLG program. There may be issues of survey fatigue and de-motivation when clients answer the tools in this combined manner.'

'Externally assessment of video – taping for emotional attachment, could lead to delays'

'Not really familiar with instruments so don't have an informed view of their value'

'Details regarding the use of these scales needs to be specified – eg how are the EA scales used with infants less than 12 months'

'Some proportion of clients should be involved in gold-standard measurement of attachment between them and their child as a means of assessing whether the program has met its objectives. This will be difficult and that it places additional demands on families, but at the same time, if we are going to ask families to participate in programs such as TtLG into the future, we will want to have good data from this trial to back up our assertions that the program is genuinely beneficial. The more rigour we can put into the research aspect of this, the more likely it is that we will be able to have confidence in the findings that we see from the evaluations overall'

6. Satisfaction with progress of TtLG project

Overall Reference Group members reported positively on the TtLG program:

- 100% (n=10) respondents were satisfied overall with the progress of the TtLG project (60%, n=6 were highly satisfied)

7. TtLG partnerships

In terms of their professional working role and responsibilities Reference group members value their partnership with TtLG:

- **90% (n=9) respondents rated their partnership as valuable (60%, n=6 highly valuable).**

8. Suggestions

Several members suggested aspects of the program that could be further furthered considered

'We need to ensure the dynamic relationship between the clinician and childcare staff.'

'Potentially useful extensions could be made to the program eg adding in other aspects such as dietary education for parents etc (would need to consider staff workloads)'

'May be overloading the parents with questionnaires but evaluation findings will clarify this.'

'Concerned that the sites are not synchronised in the delivery of the program'

Appendix E.8

Clinicians evaluation summary

Through the Looking Glass
Clinicians Feedback Evaluation Summary

Evaluation data has been collected from clinicians during:

1. Informal telephone interviews conducted in September 2005
2. Interview with the clinician's Reference Group representative, Ms Sally Watson, TtLG clinician, at Lady Gowrie Child Centre, Adelaide, 17th May 2005

1. Informal telephone interviews September 2005 summary

All clinicians are employed 0.5 in their role with the TtLG program. During the Wave 1 TtLG program four clinicians had social work qualifications; one clinician was a qualified psychologist.

Telephone interviews were conducted with clinicians from the 5 participating childcare sites

16. Lady Gowrie Child Centre, Thebarton, Adelaide
17. il nido Child Care Centre, Paradise, Adelaide
18. Salisbury Highway Child Care Centre, Salisbury Downs, Adelaide
19. Lady Gowrie Child Centre, Brisbane
20. Lady Gowrie Child Centre, Perth

Clinicians were asked to describe in their own words their experience of the TtLG program, looking at what is working well and what could be changed. Overall clinicians were positive about their involvement with the TtLG but highlighted that the program is still in the early development stages. All clinicians reported that they have a heavy workload to achieve in their part-time role (0.5).

Strengths

The program is working well and clinicians are observing positive benefits for participating families, in particular the mothers are developing friendships and social networks e.g. providing transport to meetings and meeting for coffee.
Child care centres directors and staff are supportive of the TtLG program.

Suggestions for improvements

Clinicians highlighted that the program is still in the early development stages.

Training

Clinicians reported the need for ongoing training focusing on:

- program implementation
- videotaping skills in particular editing and burning of CDs.

Manual

The TtLG manual is still in draft form and clinicians would like more information on activities for the weekly group sessions with mothers. Clinicians are developing their own additional handouts and activities for group sessions. These materials and information will contribute to the ongoing development of the manual.

Client concerns
Clinicians expressed concerns regarding the number of forms that mothers are required to complete at the beginning of the program, including detailed assessment forms and evaluation pre-program forms. All clinicians raised concerns that this may be asking too much of the mothers. There are concerns regarding literacy levels and ESL clients. Two clinicians helped clients fill in the forms – they are concerned that the lack of confidentiality could lead to biased responses from the parents.

Clinicians reported that the mothers are 'vulnerable' having already been assessed at referring agencies. On top of all the assessment and testing the vulnerable clients also have to agree to have a video record of themselves and their children interacting. This can be a very big 'thing' to get thru' especially as some women feel at risk of having their child taking away into care.

Client referrals
The TtLG program has been established at Lady Gowrie Centre Adelaide for 3 years. The TtLG program is new to the other 4 sites. The clinicians from the 4 new sites all reported that it is a challenging process building up local community awareness of the program. Referrals to the program have been slow in the interstate sites of WA and Queensland.

It can be difficult matching up TtLG families with child care spaces (i.e. matching childcare spaces available with the different ages of TtLG children). Clinicians need to work closely with Directors on matching their requirements.

One clinician suggested that Adelaide could have a central referral point e.g. Gowrie Thebarton. This way the child care vacancies and family locations could be more effectively matched. Could also save time from the perspective of the agency person making the referral if they did not have to contact several child care centres.

TtLG roles and responsibilities
Clinicians would like more clarification on the role of the co-facilitator, in particular how and when the co-facilitor administers the child's wellbeing and involvement measures.

Childcare centres
Some child care centres are poorly resourced with office equipment e.g. no photocopier and limited space for clinician's office. This can make it difficult for clinicians when organising forms and handouts for sessions.

Staff development
Clinicians reported the need for support (i.e. professional supervision) especially those clinicians implementing the program for the first time. There is a potential for clinicians to be professionally isolated working on their own in childcare centres. There is an understanding that project manager will organise teleconferencing between the clinicians.

There are currently difficulties organising this because clinicians work different days and there is a time difference with WA and Queensland sites.

Overall clinicians in Wave 1 of the TtLG are satisfied with the TtLG program and their involvement. All clinicians emphasised that the project is in the very early developmental stages and processes are evolving.

2. Interview Clinician's Representative 17th May 2007
Evaluation data was collected during an interview with Ms Sally Watson, clinician at Lady Gowrie Child Centre Adelaide and nominated clinician's representative on the Reference Group.

Satisfaction with TtLG program content and procedures
Clinicians are satisfied overall with the content of the program. However the clinicians perceive that their role is evolving over each wave and there are increasing demands and expectations on their role. The clinician's role in the TtLG program is in the capacity of a health care worker providing clinical and therapeutic support to mothers referred to the program. They are in a unique position, working in an early childhood education setting and as such are required to integrate their professional work practices with their co-workers from early childhood education profession, the co-facilitator and primary caregiver. One clinician described the role of the clinician as being the 'guest' worker in a 'host organisation'.

At times the clinicians have been asked by centre directors to offer support and advice to other childcare centre families not just TtLG families. Clinicians view this as a positive aspect of being co-located in a childcare centre although it can impact on their workload.

All clinicians highly value their clinical supervision that the Project Manager has organised with an independent expert in early childhood and attachment. The Adelaide clinicians receive face to face supervision while the interstate sites have phone access to the clinical supervisor.

Administration
Clinicians are concerned about the number of forms and questionnaires that TtLG mothers are required to read and sign at the beginning of each wave. Clinicians suggested the option of rationalising or consolidating paperwork e.g. activities requiring signed consent to be all listed together on one A4 page instead of multiple pages as is the current situation.

Clinician's mid-wave evaluation with families
Clinicians would like to explore the option of implementing their own midway evaluation with mothers to inform their clinical practice and intervention with the families. This would be conducted in an informal manner by the clinician, accessing if the mothers' individual goals are being met and providing an opportunity to respond to any concerns or issues that the mothers may be experiencing i.e. a formative evaluation informing the later stage of the TtLG intervention.

Clinicians are concerned that some mothers feel daunted by the length of the program, viewing it as a big commitment. An informal midway evaluation involving all members of the TtLG team including the PCG could be a valuable opportunity to renew commitment and enthusiasm to the program.

Communication
Communication can be a complex issue given the different organisational structures across the 5 sites and the range of workers involved in the TtLG program (clinicians, co-facilitators, PCG, centre directors). Clinicians highlight the need to maintain clear, concise communication channels and directives from project management.

Childcare and Primary Caregiving
Clinicians are respectful of the key role that the childcare primary caregivers have in supporting families. They nurture multiple children not just TtLG families.
The quality of primary care giving can be impacted by a range of factors including the level of childcare training and staff turnover. These factors vary across TtLG sites.

There are structural issues around the concept of the primary care giver. The TtLG families need to understand that the PCG may not always be available. They will take leave, have days off, sick leave, lunch breaks etc.

TtLG Manual
The manual is a work in progress.

Clinicians continue to contribute to the development of the TtLG Manual/ Guidelines, building up a range of resources, activities and references for other practitioners. A suggestion was made that advice could also be recorded about when particular activities worked well and when they did not work well and the reasons why.

Clinicians suggest that the manual be designed in the format of 'Guidelines' outlining the principles and themes of the TtLG intervention. There is a need for flexibility in the manual processes so that the clinician can respond to the particular needs of the group and the individual participants. The capacity to adapt the weekly sessions to participants needs is a key requirement of the intervention. Mothers are participating in the program because they have attachment issues with their child and as such may at times present to the weekly group with acute needs that need to be addressed. This may require the clinician to adapt the planned program format.

Assessment criteria
Clinicians have developed a clear set of criteria to use in the assessment of mothers referred to the TTLG program. Categories deemed as not appropriate include:

- Inadequate/ non-existent reflective capacity of the mother
- Some child protection referrals
- Unmanaged mental health issues

- Certain domestic violence and legal situations that may require time involved in legal matters and court attendance

TtLG is a therapeutic group process and participants must have the capacity to contribute to the group.

Overall clinicians are satisfied with their involvement with the TtLG program while at the same time acknowledging the TtLG project is continually evolving and there is the need for ongoing learning and development for all staff working together on the TtLG program.

Appendix E.9

Co-facilitator email survey

Through the Looking Glass (TtLG)
Co-facilitators Evaluation Summary

Background

Co-facilitator role and responsibilities

The co-facilitator is an experienced childcare worker who:

- works with the clinician in the TtLG weekly group session with mothers and
- supports the primary caregivers who work with the individual TtLG children and families.

During the weekly group sessions the co-facilitator contributes expertise from the childcare education perspective, complementing the health and therapeutic perspective of the clinician.

Co-facilitator staff

Three childcare centres have retained their co-facilitators through Waves 1, 2 and 3. However during this period there has been co-facilitator staff turnover at two sites. The Perth based TtLG program has been re-located to different childcare sites for each of the 3 waves and this has resulted in a turnover of co-facilitators. One local Adelaide centre inducted a new co-facilitator for Waves 2 and 3 due to the resignation of the Wave 1 co-facilitator.

Co-facilitator evaluation

Co-facilitator evaluation feedback has been collected from:

- an email survey of Wave 1 co-facilitators
- co-facilitators' group facilitation training August 2006
- an interview with the co-facilitator's Reference Group representative.

Email survey

In January 2006 an email survey was distributed to the Wave 1 co-facilitators based in the
five TtLG childcare sites:

1. Lady Gowrie Child Centre, Thebarton, Adelaide
2. il nido Child Care Centre, Paradise, Adelaide
3. Salisbury Highway Child Care Centre, Salisbury Downs, Adelaide
4. Lady Gowrie Child Centre, Brisbane
5. Lady Gowrie Child Centre, Perth

Three co-facilitators returned questionnaires. Follow-up with the non-responding co-facilitators (n=2) was not achieved due to one co-facilitator leaving the childcare centre and one interstate program being re-located to a different childcare site. Due to the low numbers only raw scores are reported not frequencies.

Email survey findings

Qualifications

Respondents indicate their highest level of education:
University degree (n=2); Vocational certificate or diploma at TAFE or college (1)

Recruitment
All 3 respondents were satisfied with their recruitment to the TtLG co-facilitator role (n=2 strongly satisfied)

Role satisfaction
All 3 respondents were satisfied with their role in the TtLG program (n=1 fully satisfied)

TtLG program
Respondents (n=3) indicated an understanding of key components of the TtLG program:

- program objectives (n=3, clearly understand)
- primary caregiver's role and responsibilities (n=3, clearly understand)
- structure of the TtLG program as it relates to parents (n=3, clearly understand)
- co-facilitator's roles and responsibilities (n=2, partially understand)
- the clinician's role and responsibilities (n=2, partially understand)

Training
Respondents (n=3) indicated an overall satisfaction with the training for key components of the TtLG program:

- Circle of Security (n=2, fully satisfied)
- Children's Wellbeing Observation Measure (n=2, fully satisfied)
- Children's Leuven Involvement Observation Measure (n=2, fully satisfied)
- Reflective journal writing (n=2, fully satisfied)
- Primary caregiving (n=2, partially satisfied)
- Videotaping (n=1, fully satisfied; n=1, partially satisfied)
- Co-facilitating group meetings (n=1, fully satisfied; n=1, partially satisfied)

All respondents (n=3) agreed that:

- co-facilitating the TtLG program increased their knowledge and skills around attachment and children (n=3, strongly agreed)
- they were confident assisting the clinician with the weekly group sessions (n=2, strongly agreed)
- they were comfortable working with the clinicians (n=2, strongly agreed).

All respondents (n=3) disagreed that it was difficult to manage their co-facilitator tasks given their other work responsibilities at the child care centre.

Suggestions
Each respondent suggested specific aspects of the TtLG project that could be changed.

> *'Training at the start of the project outlining roles and responsibilities'*
>
> *'Administration to be more organised, with everyone involved having a clear, concise picture of what is happening'*
>
> *'Change the order of some topics. The first few sessions with COS before videos'*

TtLG Training Workshop
Co-facilitators Group Facilitation Training 3-4 August 2006 (Wave 3)
Co-facilitators (n=5) from each childcare site attended a 2 day Group Facilitation Workshop conducted by Relationships Australia. Evaluation feedback was provided by Relationships Australia.

1.Training Benefits

- Increase in confidence
- Personal and professional growth in way of thinking
- Significant increase in knowledge of group facilitation
- Gained 'huge amount' of knowledge and also personal and professional learning
- Knowledge and skills on group work

2. Training program highlights

- Exploring and reflecting on task and maintenance concepts
- Developing confidence in team skills
- Revising learning styles and leadership styles
- Learning about questioning techniques
- Bonding and feeling part of a team (n=3)
- Learning about myself

3. Least positive aspect of program
No comments recorded

4. Recommendations for future programs

- More time to explore some concepts (n=1)

Additional comments
5. Group facilitation training course
'Very informative, lots of handouts for future reference'

6. Educator's facilitation of the training
'Fantastic, did not get bored and felt really good about myself'
'Gave us lots of information and gave us time to discuss and process it in a way that was relevant for our program'

7. Relevance of the course content
'Greatly appreciate all the extra handouts'

Table 1: Participants ratings

Training	**Poor %**	**Okay %**	**Excellent %**
Overall rating of the course			100
Educators facilitation of the training			100
Relevance of course content			100
Quality of training handouts			100

Co-facilitators Reference Group Representative Interview 15th March 2007

The Co-facilitators Reference Group Representative is based at the Lady Gowrie Child Centre, Thebarton, Adelaide and has worked with the TtLG program since an earlier pilot program which commenced in 2002. During this time the co-facilitator has developed a high level of understanding of the co-facilitator role and delivered numerous training workshops on attachment theory and primary caregiving.

Overall co-facilitators highly value their role in the TtLG program. The co-facilitator representative outlined the co-facilitators' perceptions of their role as:

> *'a bridge between the TtLG project and the primary caregivers, sharing program content with the individual TtLG primary caregivers (PCG) and supporting PCG in their work with TtLG families'*
>
> *'an active participant in the weekly group sessions while at the same time supporting the clinician by being a reflective observer of the group dynamics'*
>
> *'an early childhood knowledge base providing appropriate child development information provision to TtLG parents'*
>
> *'an advocate for the TtLG child, parent and primary caregiver'*

One co-facilitator has commenced a post-graduate Degree in Infant Mental Health. These studies are developing her capacity to better support the participants in TtLG and the primary caregivers.

Further evaluation feedback from individual co-facilitators will be collected during later Waves of the TtLG project.

Appendix E.10

Directors’ evaluation summary

Through the Looking Glass (TtLG)
Childcare Directors Evaluation Summary

Childcare Directors' feedback was collected during a series of short informal interviews (n=3) and open forum discussions at the 2nd - 4th August 2006 Training Workshop and the TtLG Project Day 30th April 2007. These workshops were attended by Directors/managers from the five TtLG childcare sites

6. Lady Gowrie Child Centre, Thebarton, Adelaide
7. il nido Child Care Centre, Paradise, Adelaide
8. Salisbury Highway Child Care Centre, Salisbury Downs, Adelaide
9. Lady Gowrie Child Centre, Brisbane
10. Lady Gowrie Child Centre, Perth

Directors (n=5) described the TtLG project as a 'collaborative' project built on partnerships between their own role as a centre director/manager and the TtLG clinician, co-facilitator and childcare worker roles. These partnerships enable knowledge sharing between the clinician's health profession and the early childhood education profession.

Directors (n=5) reported the need to spend time supporting these partnerships and developing collaboration between the different TtLG staff roles. Directors noted *'it takes a lot of energy to create forums, to take the time to talk and then there's the need for communication lines to be formalised'.*

'there is a need to give up some autonomy in collaboration, it's not just one way, we need to see and respect the differences'

Directors (n=5) identified the 'flow on effect' to other families and staff in their centres as a key benefit of the integration of the TtLG program into their centres. Directors (n=5) reported their centre clinicians support other families in the centre by providing parents with counselling when requested by staff e.g. one centre mother received counselling after a miscarriage. Clinicians support centre staff by sharing parenting information and resources.

Challenges
Directors (n=5) identified a range of concerns regarding the implementation of the individual waves of the TtLG.

- The process of keeping childcare places available for TtLG families can sometimes impact financially on a centre's operation, particularly when a family withdraws from the program at the last minute.

- Finding spaces for the wide age range of children in each TtLG wave can be a challenge. This is particularly difficult when there are number of babies in the program due to tight staffing ratios in a babies room. Directors have identified the need to consult closely with the clinicians in regard to accommodating the

children of TtLG families. Clinicians may need to vary the enrollment of families across different waves depending on the age range of children.

- Many families continue with childcare after they complete the group TtLG program. This can sometimes lead to a 'cumulative' negative impact on staff workload and wellbeing as these families continue to look to childcare staff for support with their child at the same time as 'new' TtLG families join the centre. Directors need to provide additional support to staff in some situations.

- It is sometimes difficult for directors to release staff for TtLG activities due to the shortage of childcare staff. At times there is no staff member available to backfill a vacancy. An overall industry sector shortage of staff impacts on directors' capacity to release childcare workers from the centre rooms.

Overall directors agreed that the TtLG project has valuable outcomes for their centres and the participating TtLG families however at the same time they identified challenges that are experienced as they work to integrate the TtLG project into their childcare centre's work practices and culture.

Appendix E.11

Rapid reconnaissance site report

Through the Looking Glass (TtLG)
Rapid Reconnaissance Evaluation Summary
Site visit il nido 24th October 2006

On 24th October 2006 a 'rapid reconnaissance' visit was conducted at the il nido Community Childcare Centre, Paradise SA.

The visit was planned in advance with phone calls and email communication between the TtLG evaluation assistant, il nido Childcare Centre Director and the TtLG clinician.

Childcare site
Impressions upon arrival at 9:30 am.
The centre buildings and surrounding areas were clean and neat. Premises were easily accessible with off street car parking close to the centre entrance. The arrival area was quiet with 3 families arriving by car to take children to care. No families were walking to centre.

Reception
The centre receptionist was welcoming and friendly, greeting some people by their first name. Parents confidently walked into childcare centre rooms with children. All children arriving appeared to be happy, no child displayed any signs of discomfort upon entering the childcare rooms.

The reception area was made up of a wide hallway/passage leading to a door into the childcare rooms and the reception desk space. The director's office adjoins the reception area. Walls were painted bright blue with wide range of parent information material displayed along walls and counter. Half timber and glass window walls separate reception space from childcare rooms.

Childcare facilities
The clinician was waiting to take the evaluator on a 'tour' of the childcare centre. This was arranged beforehand as the director had a prior commitment. Before entering through the door into the childcare rooms the clinician explained the format of the 'tour' outlining the different areas of the centre that were organised according to the age groups of the children.

Upon entering the childcare rooms a comfortable level of noise was registered. The sounds of children' happy voices were heard. There were no sounds of crying or distress. Children were free to take part in a wide range of activities that were set up on low tables and chairs and carpeted spaces on the floor.

Childcare workers were engaged with children and no children appeared to be isolated. A range of activities were occurring in the centre e.g. a childcare worker was sitting down nursing a child on her lap, with a small group of toddlers sitting around her, listening as she was reading a storybook. Another worker was setting up painting easels and talking with 3 children and involving them in the setting up activities.

The babies' room section was separated from the older children's area by half timber and glass walls. The room was very quiet and calm.

A set of doors opened out to a covered verandah and paved area. The wide doors provided easy access to the outside play area. This area appeared a little dry and dusty due to the ongoing drought conditions. A large number of children were playing outside, some running around actively and while others were involved and concentrating on more stationary activities including playing with plastic boxes.

Two childcare workers were outside with groups of children. The atmosphere was happy and relaxed. The childcare workers were involving children in the setting up of activities. Workers were attentive to all children, regularly looking around and checking on children's whereabouts. Workers spoke to child using their names.

Overall impression of the childcare centre facilities, inside and outside, was of a safe, happy and relaxed space for children.

The clinician introduced each of the childcare workers to the evaluators. Childcare workers were friendly and welcoming. They happily acknowledged the clinician using her first name, indicating they felt comfortable in their relationship with the clinician.

Upon completion of the tour of the childcare facilities the clinician and evaluator moved to a building detached from the childcare centre and located at the end of the carpark. This building provides a large open space area for childcare workers with lockers, kitchen facilities and lounges.

In one corner of the building there was a separate room providing a private space for meetings. This room was set up as the office space for the TtLG clinician and used for the weekly group sessions with the TtLG mothers. This room was a large area, clean, light and bright. The clinician's work space was organised with clear desk space, bookshelves and filing cabinet.

Informal interviews
A series of informal interviews were held during the day with the clinician, co-facilitator, centre director and the TtLG primary caregivers.

Clinician's reflections
TtLG program benefits
Outcomes for families: The combination of individual sessions between the clinician and the mother and the weekly group sessions works well by providing many opportunities for mothers to raise their concerns and issues. The clinician has observed the TtLG mothers confidence in their parenting skills increase through their participating in the program.

Communicating with other TtLG clinicians is valuable. Regular meetings and teleconferencing enable colleagues to share experiences and learnings.

Challenges
Important to build up relationships with co-facilitator, centre director and the primary caregivers. Open communication is vital as there are can be 'challenges' integrating families with high needs into the childcare community. Primary caregivers need support. The clinician consults with the co-facilitator regarding the weekly group activities that the co-facilitator feels comfortable implementing.

Flexibility is required as each wave of families has a different dynamic and also each weekly group session can have a different dynamic. Some weeks a mother may come to the group with immediate concerns that need to be discussed and this requires the clinician and co-facilitator to be flexible and adjust the planned weekly activities.

There is a heavy work load for the part-time position (0.5). This workload includes a high volume of paperwork with many forms to be collected from parents and also completed for project management. The referral processes can be time consuming – assessing people, negotiating their commitment to participate and co-coordinating childcare spaces for the children. The days that childcare is available do not always suit families due to other commitments.

Overall the clinician reported that the TtLG program is evolving with learnings from each wave. e.g Wave 1 mothers did not have a clear understanding of the Learning Stories that the primary caregivers produced to show the child's involvement in activities and the attachment processes that were occurring during this involvement. In subsequent waves the co-facilitator now brings in the Learning Stories to a group session and talks about the stories.

Director's reflections
TtLG program benefits
Outcomes for families: Observing the mothers' confidence increase over time. Many of the mothers 'struggle' at the beginning as they interact with staff and take responsibility for payment of childcare fees. By the end of the program the mothers have become more confident and 'able to talk with us'.

Outcomes for staff: There has been an increase in staff knowledge and confidence e.g Before the TtLG program started at the centre the staff would direct a family in a crisis situation to the centre director. Now staff have the confidence and ability to offer help to a family experiencing difficulties. They regularly talk with the co-facilitor who can often help with advice and referrals to other services.

The clinician's presence in the centre is valuable for all staff and families. The clinician has provided support to non-TtLG families on several occasions. The clinician supports staff with parenting information, books and pamphlets.

The TtLG workshops are valuable and provide opportunities to learn from the other sites.

Challenges
The TtLG primary caregivers (PCG) need a lot of support as they integrate the TtLG children into care. The families often have high level needs and the PCGs need to support both mother and child. Also when a family withdraws from the program the staff need support to reflect on the situation and to acknowledge that this is not a reflection on the PCG.

Three waves of the TtLG program have been conducted and many TtLG families are continuing to keep their children on in care. This has had an unexpected outcome of increasing pressure on staff as they work with new and 'old' TtLG families. Staff need support especially those staff who have supported families in all 3 waves.

Administration can be a challenge. The project management billing process for the TtLG families can be complex. Then there are issues when spaces are kept free for prospective TtLG families and the family decides at the last minute not to take part in the program. This is 'lost' income for the centre.

There is pressure organising staff availability around the day of the week that the group session is held. The director needs to have backfill staff to release the co-facilitator for her responsibilities in organising and participating in the group session.

It can be a challenge organising childcare spaces for the TtLG families. It is particularly hard to find spaces in the babies' room. The director has negotiated with the clinician that in each wave there can only be a maximum of 3 babies.

Overall the centre's involvement in the TtLG project is valuable with many positive outcomes for staff and families. However there is an ongoing need for clear communication between project management, the clinician and the director in order to manage the challenges that are involved in implementing a complex program into a childcare setting.

Co-facilitator reflections
TtLG program benefits
The co-facilitator has established a very supportive working relationship with the clinician and is confident working with the TtLG families.

Participation in the TtLG program has increased the co-facilitator's knowledge of attachment theory and primary caregiving. She has now commenced post-graduate studies in Infant Mental Health. The co-facilitator supports peer learning with the other childcare workers and is able to share her knowledge and understanding of the TtLG families needs.

There are many positive changes in the TtLG families e.g watching mothers develop friendships and become more confident in their interactions at the childcare centre.

Challenges
There is a need to clarify the role and responsibilities of the co-facilitator upfront at the beginning of the project. The workshops with other co-facilitators are valuable, providing opportunities to learn from peers.

TtLG primary caregivers (PCG) reflections
Informal discussions were held with six primary caregivers of TtLG children.
Benefits
The TtLG training in primary caregiving and attachment theory has flow-on benefits to all children in the centre not just TtLG families.

All primary caregivers have observed TtLG mothers building up attachment relationships with their children. They report that childcare has a valuable role in supporting families as they develop secure attachment relationships. Childcare provides parents with some 'timeout' and also the child has time out in a secure and supportive environment. PCGs observe TtLG children coming into the centre as often 'timid and shaking' and over time they become happy and confident to play with friends.

The PCGs observe the TtLG families building up trust with the childcare staff. The group meeting between the TtLG mother, the clinician and the primary caregiver is very important in building trust. Valuable information is shared between the group and provides an understanding of the families needs.

Challenges
Some TtLG families have very high needs and look to the PCG for 'solutions'. In these cases the support of the clinician and the co-facilitor is very valuable. They are able to provide information about a wide range of early childhood and parenting issues e.g one child had a hearing problem and they were able to arrange hearing aids and referrals to a specialist hearing centre.

Some mothers have high levels of anxiety when leaving their children in care, particularly if the PCG has not yet started their shift. The PCGs now have communication books in which mothers can record any concerns or matters that they would like the PCG to be aware of during the day.

All PCGs reported that the Wellbeing and Involvement Observation measurement tools are time consuming.

The primary caregivers reported that their involvement in the TtLG program has both professional benefits as they increase their knowledge and skills while at the same time the TtLG families benefit as the PCGs support the development of secure attachment relationships between mothers and children.

Appendix E.12

Survey of TtLG Site Stakeholders: Managers (CEOs), Clinicians and Co-Facilitators

Survey of TtLG Site Stakeholders:

Managers (CEOs), Clinicians and Co-Facilitators

1. Background

A survey of professionally engaged stakeholders across all five sites was conducted on completion of Wave 4. The interviews with CEOs (or their delegated manager), clinicians and co-facilitators were semi-structured including summative scales to gain an assessment of the impact of the project from their perspective but focusing largely on qualitative feedback to critique and further refine the practice model. Eighteen stakeholders were interviewed (either face-to-face or over the telephone) with interviews lasting between 30 minutes to an hour. One clinician from Perth was not interviewed as she had left the project; she was replaced by a manager who had worked with the co-facilitator. This work was supplemented by two focus groups of PCGs from all project sites (with the exception of Perth) the findings from which appear in a separate report.

Given the contextual differences between sites drawing conclusions about optimizing the 'best practice' model is problematic; however this has also provided a potential opportunity to optimize its transferability. Thematic analysis was conducted on the qualitative findings to identify areas which were generic to the project across two or more sites. The analysis was conducted in tandem with the fieldwork and was iterative; as themes emerged these where subsequently addressed in upcoming interviews using procedures established from Grounded Theory approaches. Findings were summarized and discussed with the Project Manager and CEO at the host site. A summary of potential areas of model improvement will be submitted to the Reference Group for discussion and final ratification.

Whilst the impacts of the model for staff and clients have been substantial and are discussed elsewhere in the evaluation, there are areas identified here where refinement of the best practice model would optimize its outcomes and enhance its implementation and functioning.

2. Quantitative Findings

Stakeholders were very satisfied with the overall outcomes achieved by the Project with 72% (n=13) indicating 'fully satisfied' and 28% (n=5) indicating 'mostly satisfied'. Satisfaction was expressed largely in terms of the impacts achieved for Project clients.

55% (n=10) thought that the overall goal of the Project had been 'fully achieved', and 28% (n=5) 'mostly achieved'. Two indicated 'partially achieved' and one did not know. For those who did not indicate 'fully' the remaining need to produce a final model of service delivery was highlighted.

Fig i: Project Staff Assessment of Extent to which Stated Objectives have been achieved

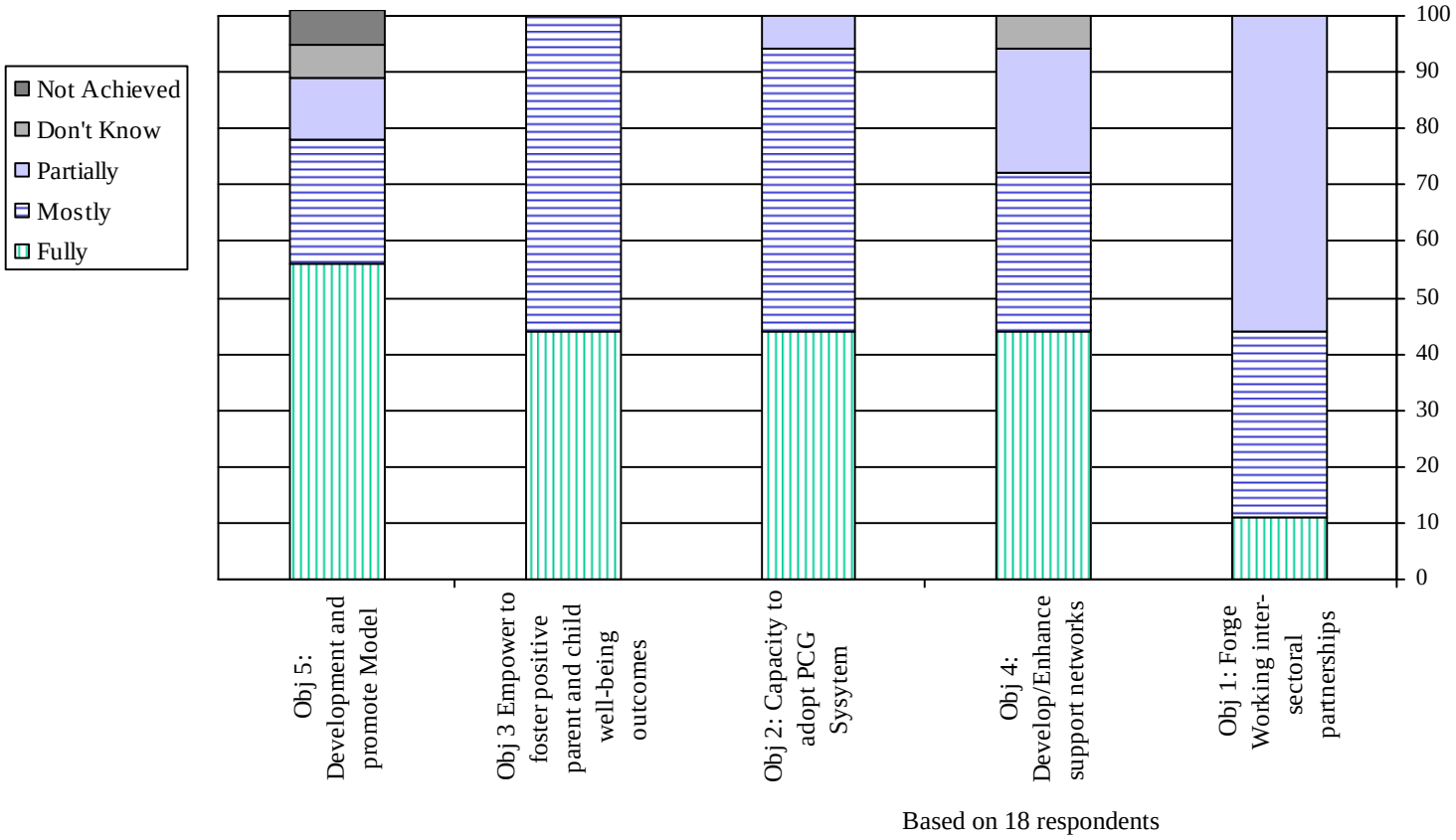

Fig i presents the summation of the Child Care Centre project staff (broadly defined as the site managers/CEOs, project managers, clinicians and co-facilitators) assessment of

the extent to which each of the TtLG project's objectives have been achieved. Nearly all staff who had engaged with the project to some degree indicated that the project had achieved all of its stated objectives to some extent. The most successfully achieved objectives were Objectives 2 and 3 where all but one respondent indicated the objectives had been 'fully' or 'mostly' achieved. For the Child centre staff the impacts for clients and their children and the extent to which the project has built capacity amongst staff have been substantial:

'It's been absolutely fantastic for the families who've been involved';

'You see mum's who took no interest in themselves or their appearance, who can't communicate to their children and are deeply depressed totally transform. It's just amazing';

'I've seen children completely change… a truly remarkable experience';

'Children who were clearly having real communication problems, one kept biting… one didn't hardly speak at all… they've become like completely new kids!'

To a lesser degree, the project has developed and enhanced parent support networks, but this was viewed as being fully or mostly achieved by 72% (n=13) respondents. This has taken several forms including retaining contact with the center, its staff and/or activities, retaining friendships acquired with other project mothers and in some cases engaging with local established groups. Where this did not occur the reasons postulated where: geographic distance between mothers in particular waves; the severity of issues held by particular mothers in a given wave. Some respondents indicated they were only partially aware of the sustainability of networks and so answered 'partially achieved' for this objective.

A lot of the friendship network stuff really depends on the mothers who come along in a particular Wave – I mean some live miles from each other so the chance of them carrying on their friendships are pretty slim given the demands of kids. Others work, or start work etc etc. So this has varied a lot between waves.

78% (n=14) felt that the higher order objective 5 'to develop and promote the uptake of a 'best practice' model…' had been 'fully' or 'mostly' achieved (56%, n=10 indicating 'fully'). This is a notable finding given that (in the view of those staff engaged with the project) the least achieved objective was the 'lower order' Objective 1. Whilst 44% (n=8) respondents indicated this had been 'fully' or 'mostly' achieved, 56% (n=10) indicated it had only been 'partially' achieved. This was explained in terms of partnerships not being fully established across project sites (see below); within each site sustainable integrated partnerships were viewed as having been established through the project. There was also comments made about the lack of ownership and partnership from other sectors.

'It's been great in terms of our own centre and the partnerships formed between the child care workers and the clinician. And we've worked well with Gowrie Thebarton around training. But we've really not had much to do with the other centers'.

There's not really been the ownership across sectors that I would have liked to see. This has made it much more difficult to get people to take up and run with the project.

3. Summary of Themes identified From Qualitative Findings

3.1 Stakeholder Roles

3.1.1 The role of the Clinician

The clinicians' role was central to the delivery and running of the project at each site. In practice, this extended beyond direct responsibilities relating to the participating mothers and children. Additional roles identified in this evaluation have included:

- training and induction of staff in the primary care giving approach and project processes;
- promoting the project and approach ("marketing the project") in the community;
- Supporting the emotional needs of PCG staff that have engaged, and formed close relationships with project families (through debriefing sessions).

It is noteworthy that the additional roles identified above were not envisioned as clinician responsibilities in the project model. Taking on these roles required the development of new skills in addition to re-orientating to the PCG philosophy and becoming familiar with the TtLG procedures. Moreover, the need to engage with the range of data collection activities for the evaluation added to workload. This was particularly demanding for clinicians in the early stages of the project which would have benefited from more preparation time. Subsequently, the implementation of the project was viewed as being too hasty; staff were broadly of the view that the first Wave of clients were recruited too early and that they were not fully equipped to handle the tasks required early on. The project would have benefited from the acquisition of a fuller understanding of attachment theory, the initiation of PCG procedures and established changed management processes prior to implementing the project.

Whilst clinicians were expected to network with peers and other agencies in helping to identify potential coordinated options for clients in need (including recruitment and potential follow-up after the project), broader promotion rested with each participating Director.

PCG promoted the development of close relationships with mothers, children and families who were experiencing (sometimes profound and on-going) personal problems; subsequently there was a potential to cause a degree of empathetically nourished emotional distress in PGCs. Whilst the well-being of staff resides with the site manager,

the expertise of the clinicians and their centrality to the project precipitated their allocation to or adoption of the staff support role. Clarification of this role and the procedures for its enactment varied across sites and has not been stipulated in the model.

The need for more time to embed clinicians in their respective child care sites was also evident. Many of the clinicians were from welfare backgrounds and did not have prior experience working collegially with child care workers. Certainly the extent to which PCG was operationalised was unfamiliar territory for staff operating at some sites. For other sites PCG had already been established. However, for all sites, more preparation time prior to the first Wave of clients would have helped to establish the practices and collegial working environment encouraged by the project.

3.1.2 The role of the Co-Facilitator

Co-facilitators acted as two-way conduits between the clinician and PCGs. Good relations between clinicians and co-facilitators were viewed as crucial to the project working at an optimal level. Contextual differences were evident across the sites. In Queensland, the 'grass roots' experience of the clinician was viewed as providing the advantage of greater understanding of the complexities and pressures experienced by PCGs. Here, the co-facilitator was also a director at one of the Brisbane sites which was viewed as having an 'equalizing' status effect with the clinician, but also provided more impetus to disseminating information about the project and encouraging the uptake of staff training.

The need to clarify roles and responsibilities of co-facilitators and clinicians was evident early in the project; disagreements here were deleterious to the efficient functioning of the multi-disciplinary team approach. These issues were resolved over time (and in some cases after staff changes had occurred).

3.1.3 Implications for the model of best practice:

The model would benefit from establishing clear position descriptions of the working roles of staff engaged with the project.

The model would benefit from stipulating the nature and proceedings for the provision of PCG staff support and the Clinician role in this.

Where the model is applied across sites, more regular meetings of all staff to share and explore experiences of the team approach would contribute to the more effective functioning of the multi-disciplinary approach.

3.2 Optimising Multi-Disciplinary Teams

The need to 'balance' the contributions of the varied expertise brought to the project through the multi-disciplinary team was a challenge for the project. The unique service provided through the TtLG project was embodied in the fusing of therapeutic (clinician) and early intervention (child care) approaches; these were conceived as traditionally having separate allegiances and identities. Ensuring an integrated approach in the model was made more difficult by the organizational and managerial differences across sites (see below).

Bringing together all staff more frequently to address issues and share learning experiences would have encouraged a more coordinated 'team' approach. Professional development activity at the team level would also have contributed more to the development of a working team culture across sites.

3.2.1 Implications for the model of best practice

The model would benefit from a longer period of induction and preparation prior to recruiting clients. Given the learning acquired through this project, this preparation period should be between two-four months.

The model would benefit by including multi-disciplinary team training to enhance functionality

3.3 Staff Training

Staff turnover across a number of sites emphasized the need for on-going training in PGC and the procedures of the project (see below). Given the centrality of the clinician and co-facilitator to the project and their intensive engagement with it, they are well placed to play a central role in training staff in these areas. Elements of the project Manual contribute to this. It is also the case that other child-care staff have also become skilled in these areas and could potentially take on training responsibilities. Additional the need for more professional staff appraisal procedures to identify training needs was identified.

Given the profound re-orientation toward PCG needed in some centers, this training activity is crucial. Both clinicians and co-facilitators have been happy to take on this role both through formal training and informal mentoring activities. However, currently neither clinicians nor other staff have received training in practical capacity building skills, the "how to" procedures of running workshops.

3.3.1 Implications for the model of best practice

The model would benefit from identifying specific staff as PGC/TtLG trainers, and ensure they are equipped with the pedagogical skills to deliver capacity building sessions for

other workers as required. These sessions might supplement or replace PCG training delivered as part of staff induction.

3.4 Formalising a Client Exit Strategy

Many mothers retained the child care services after leaving the project and were subsequently still in regular contact with their PCG. The project has promoted the development of greater understanding between PCG and client informed by 'inside' knowledge of family circumstances; in some cases personal circumstances have been exchanged in a reciprocal process of trust development and the forging of friendships. Whilst this was viewed as highly positive, the nurturing of close relationships during the project created the potential for further working demands for staff from clients who had completed it. There was evidence of some need for further guidance or an 'exit strategy' which clarified the professional aspects of the nature of the relationship post project for all agents.

3.4.1 Implications for the model of best practice

The model would benefit from developing in plain English a client 'exit strategy' which includes clarifying the role of the PCG for parents no longer engaged with the TtLG project.

3.5 Project Sustainability Issues

3.5.1 The Adoption of Primary Care Giving (PCG) Child Care Practice

Staff were broadly enthusiastic about the changes in professional practice and subsequent improvements the quality of care precipitated by the implementation of the PCG approach. Staff felt better equipped with the skills and knowledge to practice child care in a more effective, insightful, reflexive and ultimately more rewarding way. The changes were profound for many staff across the centre, extending to working practices with clients and children, relations between staff and between staff and management, managerial practices, and for some influencing personal social relationships. Practice has become more holistic, orientated toward 'emotional needs' and relationship focused. This has enabled staff to interpret child behaviour differently and engage more intensively with families accessing the centre.

There has been a 'cultural shift' in working practices precipitated by the project, away from behaviorist models such as the 'Positive Parenting Practice' approach toward the wholesale adoption of PCG[1]. The approaches were almost universally viewed as benefiting children, families, parents and staff. These changes in skills, learning,

[1] Whilst several sites had adopted aspects of PCG prior to the project the extent of this varied greatly; It was universally asserted that PCG implementation had been substantially enhanced and improved through the Project.

philosophical orientation and professional practice are strong legacies from the implementation of the project. However, for some staff, concerns were also expressed about the extent to which PCG was fully understood and implemented; the need for regular review, an on-going training and support in reflective practice was subsequently asserted.

3.5.2 Systemic Changes at the Policy Level

The project has precipitated systemic changes amongst participating Centers. This has varied in degree across the participating States as each has separate policy development procedures. However, in all cases attachment theory and PCG is being embraced at the policy level.

The implementation of these approaches in professional practice through the TtLG project has preceded and prompted the broader policy change. PCG is now part of induction and 'refresher' programs for new staff across several participating sites.

3.5.3 Expanding the Project

The project is also extending to other Lady Gowrie sites. A presentation of the TtLG Project and the evaluation findings took place in Caboolture, Queensland in February 2008. Caboolture plans to adopt the project later in the year. The project is also conducting consultations with Aboriginal communities to identify how the project might encourage greater participation and meet the needs of Indigenous families.

3.5.4 Continued use of Project Resources

The 'Circle of Security' poster has been enthusiastically adopted as a symbolic and practical guide for staff and families using the centers[2]. Many of the written resources (including books and articles concerning attachment theory) have been compiled within each site and are utilized as needed. Other resources developed through the project have been taken up including the development of a DVD 'The Father/Child Journey' specifically for fathers of families accessing the services.

The Manual was generally well received amongst those staff members who had seen it. However, the majority of PCG centre staff had not seen the manual, and those that had read it tended to use it early in the program. The manual was viewed as essential for the initiation of key players in the project (clinician, co-facilitator and managers) and was referred to often in the early waves of the project and by new staff. All aspects of the manual were viewed as useful but clinicians tended to be selective, referring to the manual occasionally as a 'refresher' once they had become familiar with the materials.

[2] The diagram appeared in several rooms in the four sites visited by the evaluators.

Co-facilitators outside of South Australia seldom used the manual being guided more by the formal training and materials received. However, those located in one of the three locations within South Australia tended to access materials from the manual more regularly. The manual was viewed as a supporting resource and not a replacement for practical training.

3.5.5 Impacts on Clients

All of the staff, and key players interviewed reaffirmed the findings acquired from mothers, that the impacts of the project have been profound for children, parents and families. This has had a very positive effect on the staff who participated:

> *'You look at the child before and after the project and you just can't believe it's the same child';*
>
> *'Absolutely fantastic to see the way the children develop and change. I can honestly say I've never seen such a dramatic improvement in the toddlers. It's just a wonderful project'.*
>
> *'It's been amazing and totally rewarding. A fantastic experience to see the progress of the mums and children'.*
>
> *'One little boy just didn't speak at all. And his mum was clearly having great problems relating to him and meeting his needs. And now it's completely different, chatting away and his mum's like a different person. It's been wonderful'.*
>
> *'There've been dramatic changes in parents and children. Amazing changes really'.*
>
> *'There's been a huge dramatic change for mums involved – much better understanding and lots of improvement in attaching with their children'.*

Child parent relationships have been enhanced through project participation; the project has built on existing strengths and helped parents to successfully address the root causes of attachment and parenting struggles:

> *'It's produced much stronger and secure relationships between parents and children and provided a really strong base for the future. Phenomenal success!'*
>
> *'Exploring the strengths families have and unearthing the problems and strategies to use these to address the causes of difficulties…it's been incredibly rewarding'.*

Staff confirmed that many mothers had formed lasting social support and friendship networks through engagement with the project. These appear to be more successful, but are not exclusive to, where parents have retained connection with the child care centre. Factors which militate against sustained friendship networks were usually logistical;

where mothers lived far away from each-other, started work or moved house, the friendships were not as lasting.

3.5.6 Building Capacity and Professional Development

The training received by staff through the project has been extensive. Staff across the board expressed profound impacts in the ways they interpret and respond to child behaviour, the adoption of PCG in professional practice, the utilization of new skills in early childhood education. Several staff indicated that the training had been a revelatory insight to the human condition, and had informed relations between staff, staff and clients, staff and management and social and personal relationships outside the workplace. Managerial practices had also been influenced.

The Kent Hoffman training was specifically highlighted as the most substantial impact for clinicians and co-facilitators[3]. The 'Marte Meo' training (again utilizing video methods) was also cited as particularly beneficial. Training of less use was the 'sculpturing' exercise and team gatherings which had been, according to some stakeholders, mislabeled as 'training'.

A caveat here was that in promoting the PCG approach, there was a danger of devaluing existing staff skills. However, this pitfall was successfully avoided. The strategy of promoting and explaining the PCG rather than critiquing existing practices was well recognized. Having received training in the approach, seen it in action and practiced it professionally, staff were convinced of its benefits and relished the opportunity to engage with it. The training has also promoted an awareness of the need for and a desire to continue with on-going learning in PCG. The experiences have in this sense set several staff on a new educational pathway:

> *'I've been studying infant mental health and I'm now doing a Masters… this was totally influenced by the project'.*

3.5.7 Sustainable impacts generated by the Multi Disciplinary Approach to Child Care

The application of a multidisciplinary approach to child care provided new ways of working which benefited staff by enabling access to a range of expertise and through promoting an appreciation and raised awareness of the insights and skills of contributing stakeholders. Stakeholders felt that the project has subsequently helped to raise the profile of child care expertise and the professional recognition of child-care staff.

[3] It is notable that several key players applauded the training sessions received in evaluation. Whilst this is consistent with the findings from self-completion a survey, given the evaluator was conducting the interviews a degree of 'Hawthorne effect' cannot be excluded. However in two cases stakeholders affirmed that the learning acquired through the evaluation training had been applied in other projects ran from the center.

Several clinician and co-facilitator staff have indicated profound influences on their professional development through engagement with the project. This has been mirrored in reports of changes in career pathways:

- *Its put me on a completely different career path ,*
- *For me, I've discovered a whole new pathway in my career… I want to keep working with families and kids, not just as a child care worker;*

At the management level, the learning acquired through establishing and managing a multi-site project involving the complexities of multi-disciplinary team-work was highly valued.

The engagement of the Reference group was also valued. An unexpected outcome from this was the embedding of two research students at Gowrie in South Australia engaging with related projects:

- 'Secure and insecure attachment relationships in a preschool, long day care setting'. Masters thesis, School of Psychology, University of Adelaide, 2006
- 'The attachment relationships between toddlers and their caregivers in child care'. Sophie Mumford , Honours thesis, School of Psychology, University of Adelaide, 2007

The project has also promoted staff collaboration across the Lady Gowrie sites for the first time. Clinicians and managers from outside of South Australia have been keen to point to the support and training supplied by the Adelaide Thebarton Centre. This centre has also acted as an example of a working model for others and staff benefited from visiting the centre and seeing the project operating first hand. However the extent of collaborative relationships varied across sites; Perth questioned the need for inter-site collaboration given its differing mission and community development focus

3.6 Suitability of the Project for 'Acute' Cases

A minority of families were experiencing acute problems at a level of severity the project could not fully address. Whilst this raises questions concerning stricter definitions of eligibility for recruitment in order to filter out clients who may require more intensive therapeutic intervention, there were disagreements amongst key players and staff regarding the exclusion of these clients. Clinicians and co-facilitators felt that excluding more acute cases would deny them the considerable benefits to be gained from the project. Several asserted substantial and rewarding benefits were achieved for these families. It was felt that a willingness to try to engage with the project was more important. However, two managers expressed concerns regarding disruptive difficulties experienced with specific families. Four potential strategies emerged around this issue:

1. 'screening' mothers to ensure a willingness to engage with the project, be reflective and seek underlying solutions to attachment issues;

2. ‘linking in’ specialized concomitant support with other agencies for specific cases if required;
3. Extending the engagement period for families who need it;
4. establishing a more formalized ‘referral pathway’ for families who may need further help;

Strategy 1 presents challenges which may only be possible to address through professionally informed impressions. However, given the holistic family centered and personalized approach adopted by the model, the flexibility to embrace strategies 1-3 on a case by case basis was viewed as feasible; these measures could potentially be accommodated in the current model. With regard to strategy 4, in several sites, referring specific clients to new services occurred where linkages to external agencies were already established. As the model stands, whilst the project seeks to empower clients to seek appropriate external support services as part of objective 3, there is currently no formal strategy to develop referral pathways to appropriate services for those clients who may require further therapeutic help. Whilst there was evidence of this happening on a less formal basis, incorporating this formally would help to ensure that ‘post project’ cases identified as requiring it, receive that additional support. There may be a case for extending project linkages and partnerships with suitable ‘follow-up’ agencies to enable this to happen. This may also yield benefits in terms of external agencies directing additional suitable ‘recruits’ to the project.

3.6.1 Implications for the model of best practice

The model would benefit from developing closer linkages and pathways to suitable external agencies to address specific identified client need where appropriate.

The benefit of locating the project at Centers for Early Development and Learning was highlighted as these will embrace a range of easily accessible services at the same venue and potentially optimize multidisciplinary service delivery.

3.7 Project Management across disparate sites

The TtLG project was applied across three states; each Lady Gowrie agency operated autonomously and had their own policy statements and managerial structure. This generated some difficulties with regard to accountability and responsibility.

Whilst the project was managed and funded through Gowrie Adelaide at Thebarton, the clinicians, being located at specific sites were also subject to managerial requests and structures germane to those sites[4]. This caused some difficulties which may not have occurred had the project been run across sites which were accountable to a single organizational management structure.

[4] Clinicians also reported to their clinical supervisors.

Whilst these difficulties were circumvented where there was a keen commitment to the TtLG project at the managerial level and good communications and relations with Gowrie Adelaide (e.g. Brisbane), these were less evident in the Perth site, and disagreements arose regarding the implementation of the project, reporting requirements and adaptations to the model. Staff turnover amongst key players and management exacerbated this and Perth prematurely left the project on completion of Wave 5. It is notable that all the key players interviewed from the Perth site were very positive about the project and regretted its ending. Certainly, the Perth sites are currently formalizing PCG and seeking to retain other elements of the project in their practice. Establishing MOUs for all participating sites, stipulating the reporting and implementation requirements of the project and the roles of participants and supervisors may have helped to alleviate these problems.

3.7.1 Implications for the model of best practice

The model would benefit from the development of MOUs for all participating sites clarifying ownership, roles and responsibilities of management and staff (including position statements for clinicians, co-facilitators, PCGs). Establishing agreed procedures for managing conflict/disagreement could usefully be included.

3.8 Staffing Issues – Retention and Recruitment

Difficulties of recruiting and retaining suitable staff in the child care sector have been raised (see: Interim Evaluation Report p.15). The implementation of the first waves of the TtLG project required an intensive training program, which whilst being well received and beneficial, nonetheless generated additional workloads for staff engaged with the project. In the early stages the staff were grappling with the project whilst awaiting training in specific areas. There was some anecdotal evidence that initial increased workload may have contributed to staff turnover early in the project. A longer period of induction prior to taking on TtLG clients would have helped to address this (see above).

The evolution of a PCG culture in the workplace has alleviated staff workload as the project progressed; the practice is no longer seen as 'additional' to existing work, but has become "*the way things are done here*". However some staff whilst highlighting the rewarding professional and personal benefits have also pointed out the additional emotional demands the PCG approach generates, the "*Ying and Yang of the circle of Security*".

The amount of training required by the project was comprehensive and intensive and has developed a more capable, skilled workforce. These factors have raised questions concerning staff remuneration:

- *We're better trained and provide a better more intensive service than anywhere else in the sector, so I think we should be rewarded for that in some way.*

Whilst sites could accommodate individual staff changes, where several staff needed to be replaced, a lull in project activity was inevitable whilst new staff are inducted. The preferred option was to take measures to retain project staff.

A potential suggested solution to optimizing staff retention and recruitment is to establish a form of accreditation for those who have undergone training. A potential paradox here is that gaining qualifications/credentials from involvement with the project may broaden employment options elsewhere and hinder staff retention. Linking accreditation with a specified period of practice experience might alleviate this. Improving financial remuneration would also help to retain staff. Given the considerable investment in training, and the additional expense of training new staff, this option should be given serious consideration.

3.8.1 Implications for the model of best practice

Incorporating measures to retain trained staff (e.g. accreditation and financial remuneration) into the model would enhance efficacy and continuity of service delivery

3.9 Providing Cross-Agency Training in PCG and related areas

The Adelaide Gowrie site currently engages in training activities across the child care sector. Given the amount of training and capacity built in the area of PCG and attachment through the project and the benefits of adopting these child care approaches, extending the reach of these training activities was broadly supported. This might include further staff 'visits' to Adelaide to observe, shadow or be mentored in the practices of PCG. These opportunities were available during the project and were clearly valued by staff from other states.

The need to link some 'post project' families experiencing acute or enduring issues with supporting agencies raised some questions from staff concerning continuity of care and the extent to which the referred to agency's philosophy and practice mirrors that of the referred agency. Promoting the PCG philosophy and raising awareness of the approach across appropriate sectors and agencies was advocated as a means to help address this.

There is a large potential for the trained project staff to provide training services in a range of areas (e.g. PCG, attachment, Circle of Security, group work) to other agencies. The example of co-facilitators being able to deliver group facilitation training was cited as potential inter-sectoral training activity. The delivery of training would also promote stronger linkages and partnerships. There is evidence of this happening with the Brisbane site currently engaging with Queensland Health's 'Seeds' project, working with them for the adoption of the Circle of Security. Dissemination of the approaches used has also been enacted by Gowrie Thebarton, through presentations of the model and evaluation findings at TAFE colleges and South Australian health and education government departments.

Expanding this external training role was also viewed as helping to raise the profile of Lady Gowrie and present potential opportunities to generate funding to help retain the clinician role when the TtLG project finishes. The need to explore ways in which trained TtLG staff might further apply their skills (and optimize the considerable investment made in skills development) when the project ends was also championed.

The need to promote and build capacity in PCG across the child care sector was strongly advocated by those engaged with the project. The potential to link training in PCG to formal courses run through the TAFE and University sector was also highlighted and championed.

3.9.1 Implications for the model of best practice

Consideration should be given to expanding the training role of Gowrie centers across the sector in order to raise awareness of and build capacity in PGC. The promotion of PCG in formal training provided through TAFE and Universities should be explored further.

3.10 Engaging Aboriginal families and fathers

The project has not recruited ATSI families. At the time of writing this report, an extensive consultation with Aboriginal communities from urban and rural areas is being planned using TtLG project funding. It is envisaged that this will lead to modifying TtLG to produce a culturally appropriate model which will encourage uptake from indigenous families.

The engagement of fathers has varied across the different sites. Given the high number of single mums and the work/time demands for families with fathers, this has been problematic. Relatively few fathers have been engaged across the five sites. Where this has occurred it has been largely through information giving sessions and informal liaison with the PCG. This has been beneficial in helping to establish relationships with families.

3.10.1 Implications for the model of best practice

The model would benefit from engaging in dialogue with Aboriginal communities to inform its cultural appropriateness for Indigenous families.

The model should continue to provide information sessions to fathers and encourage exploration of ways to greater engage with fathers where possible

4.0 Conclusion

The evaluation has demonstrated a range of sustainable impacts for mothers, children and individual staff engaged with the project. A cultural shift in the working practices toward the fuller implementation of PCG and continued training in this area has occurred across all participating centers and this has been ingrained through developments at the policy level. This has led to a change in the responsibilities of child-care workers who have acquired a broader range of beneficial skills in the process. Resources and skills developed or compiled for the project continue to be utilized. Approaches developed in the project (notably the use of video recording to help parents and staff reflect on their practices) have also been adopted in some sites as part of on-going practice. Further project implementation will occur in at least one new site in Queensland and work has commenced to explore adapting the project for Aboriginal communities.

The main difficulties to emerge from this project were related to the issues generated through enlisting a multidisciplinary approach to service provision and in attempting to manage it across geographically dispersed sovereign and autonomous agencies with independent managerial structures, differing missions and policies. In the former case the difficulties were overcome through nurturing understanding and experiences of the contributions and expertise available from the professional participants. A number of strategies to enhance this have been identified. Coordinating the various sites proved a greater challenge and one which may have been eased by the early establishment of MOUs and documented project management/accountability procedures. However, embedding the project in organizations with established managerial and accountability structures would alleviate this issue.

The degree of training and capacity building achieved by the project has been substantial and represents a considerable investment which has subsequently generated profound outcomes for vulnerable families and their children. Clearly, the roles of the clinician and co-facilitator are not sustainable without funding to support these positions. There have been some moves made toward promoting the project in an attempt to secure funding at a State level including several formal presentations of interim findings, but these have not to date led to a continuation of the project. There is potential for expanding the training role of centers across the sector and engaging clinicians as central to this work; this has the possibility of acquiring funding for the role through this source. However, the extent to which this would be sustainable, and the degree to which these activities might impinge on the operations of an extended TtLG are unknown.

In the light of the evidence presented through this evaluation, there is an overwhelming case to perpetuate the project in order to build on the investment and continue to provide an intervention which has clear multiple positive impacts and sustainable benefits for Australian families. Whilst there are areas of the service model which may be subject to on-going context specific revision, the project demonstrates its flexibility to adapt to and

be adopted by different child center practices and contexts and generate a range of successful outcomes for service providers and their clients.

Appendix E.13

Focus Groups of PCGs – Summary Findings

Focus Groups of PCGs – Summary Findings

Two focus groups of PCG staff were conducted on completion of Wave 4. The first focus group comprised of five PCGs in the Brisbane site (s) conducted in situ at Lady Gowrie Brisbane in March 2008. The second focus group was comprised of two PCGs from each of the three south Australian sites (n=6) and was conducted in early April 2008. The workers were experienced with four having worked in child care for twelve or more years. All participants had acted as primary care givers on the TtLG project.

The workers were reminded that the contexts of each site and their experienced with the project would be different and that the evaluator wished to hear from each site. Several elicitation techniques were used in the focus group including 'secret pooling' were by participants anonymously recorded their views on paper and the moderator took responsibility for raising them for group discussion. However, as the group progressed it became clear that its dynamic encouraged a free flow of ideas and every member contributed.

Summary Findings:

Client Impacts

All primary care givers testified strongly (and in some cases emotively) to the improvements brought about amongst clients and children by the intervention:

There was a child with profound behaviour problems… kicking, swearing, biting… his mum wouldn't even talk to him… its completely different now, his mum had acquired the skills to talk more… his behaviour is completely different. I mean it's like he's a completely different little boy. It's just wonderful.

This little girl didn't say a word she used to just scream with these high pitched squeals… her language improved and she can actually communicate now and her mum communicates with her.

I've seen massive change. Massive changes. There's been children who just wouldn't let go of their mums at first now interacting and playing with other kids. Mother's being much more in control of themselves. Massive changes. Even in the appearance of some mums, their physical appearance, being happier, dressing smarter.

Professional benefits and Working Practice Improvements

Workers recognised some need for some of their peers to be persuaded initially to consider the PCG approach as changing work practices took time and some motivation, and in some cases they alluded to colleagues who had yet to fully adopt it. However, all were convinced that once established PCG became irreplaceable, and highly valued by its adopters. The need to ensure that 'this is how we do things here' through policy, training and the professional practice of all workers underpinned this. Where this became established, the practice of PCG and working in child care generally was viewed as became easier:

When something new comes along, you always get some people who are reluctant to change at first unless they have to. But there's no doubt in my mind that once this has happened, and people start to see the benefits it then comes easier.

Yes, when you start practicing it and seeing how it works, you just want to learn more about it and experience it more. Its changed how I work. You just start thinking differently and reacting differently. Using the circle of Security. Much better.

I'd say that child care work's been made easier by PCG. Your working more with the family and it makes child care a much more positive and growing experience for everyone.

When you see how the project effected some of the children and mums, you know its made working life easier because some of these mums we'd be seeing anyway… The bond you make with the children and the family

It was a bit daunting at first, and a bit stressful. But no, its got easier and easier. Once you have it (PCG) and its established you'd never go back.

Its made work more pleasant and positive. There's actually less pressure and stress than before the project now.

The cultural change in ways of working has benefited service provision for other children attending the centers:

The project has really equipped us to handle all kinds of difficulties. You get past the behaviour and start addressing underlining causes I suppose. Its really helped us in working with all kids at the centre.

The professional benefits gained and the benefits for child care practice generally has led the primary care givers to champion and advocate for the more whole sale adoption of the PCG approach in the sector:

We need to promote primary care giving generally and the project in particular. I just couldn't work any other way now. It's just so much better than before and has mad the job so much more enjoyable and rewarding. Its been a pleasure to come into work!

We need a broad change so that all child care centers adopt the approach.

The professional impact of the approach on those engaged with the project has been profound and influenced career paths for PCG staff:

Its been fantastic for me; its really changed the work I work and what I want to do in the future work wise. I want to do more of this. Its been an absolute joy to see the real differences you can make in people's lives.

I've decided to try and take things further and to do some post-grad studies in this area.

I originally thought of the job as a bit of a stop-gap thing really, although in my case its lasted longer than I intended. But this project and the primary care giving approach and the training and everything, well its just blown me away. I can definitely see a future in working in this area now… yes, I shall look to develop my career in this area now.

Difficulties Encountered and Solutions

Client demands on primary care givers' time was identified as an issue but one which could be accommodated. The potential for PCGs to be removed from attending to children was successfully addressed by identifying a second member of staff to act as a 'secondary care giver' in their absence. For sites where this was applied it worked well.

Time demands for parents were also alleviated by forward planning of meeting times; parents and PCGs agreed convenient set times early in the project when their PCG would be available for meetings. This procedure should therefore be incorporated into the best practice model.

Finding the time for the parents was sometimes hard for me especially if I had some children to be looking after.

(Agreeing available time) Worked really well for us… It wasn't carved in stone but it meant that everyone was clear about when the PCG was available...

Working as part of a Multidisciplinary Team

Having participated in the project since its instigation, some of the had worked with more than one clinician and co-facilitator. These workers provided a particular insight to how the role of the clinician might be optimised and most effective in the child care setting. The discussion was steered toward aspects which might inform the best practice model and several suggestions were highlighted:

- The need for the clinician to be available for all Child Centre Sites;
- The benefits of a clinician having some background in child car provision and the day-to-day difficulties encountered;
- The need for personal qualities of being: non-judgmental, respectful of other's expertise, and empathetic;
- Incorporating periods of time when clinicians can interact with child worker staff;
- Incorporating time when 'new' clinicians can work with staff and observe their working with children in their care;
- Adopting the use of a 'Communication Folder' in the event of the clinician being unavailable, to enable staff to record issues of concern to be addressed later;
- Clarifying times when the clinician would be available for the PCGs.

Conducting 'open nights' at the community centre in which the clinician could speak to all parents about the project was also valued as this helped to break down any pre-existing sense of stigma.

Continued Use of Project Resources

The PCGs asserted that they would continue to use resources compiled by the project in their everyday practices including:

- Video
- The Circle of Security
- The involvement and well-being scale
- Fathers DVD

I'll keep using the involvement scale, but it will be a cut down version.

The PCGs praised the Involvement and Well-Being Scale in terms of its usefulness but with the caveat that its implementation and scoring took a great deal of time:

It was really useful for me, but it took too long to do really… About a full day for one child!

Appendix E.14

Mothers (16-18 month) follow-up telephone interview summary

Mothers (16-18 month) follow-up telephone interview summary

In 2006 the TtLG program was implemented in 2 waves across all 5 participating sites. Wave 2 was delivered during the period January to June and Wave 3 from July to December 2006. Forty mothers completed the TtLG program in these 2 waves. In early 2008 (January – April) these mothers (n=40) were contacted by telephone and invited to participate in a follow-up survey. Twenty nine mothers who completed Waves 2 and 3 participated in the 2008 longer-term phone follow-up survey. A response rate of 72.5%.

The aim of the follow-up survey was to identify the longer term impacts/outcomes of the mothers' and participation in the TtLG program.

Table1: Long-term telephone follow-up survey Waves 2 & 3 (n=mothers)

Site	Wave 2 2006 mothers	Wave 2 2008 follow-up	Wave 3 2006 mothers	Wave 3 2008 follow-up	Waves 2& 3 Total mothers Follow-up
Thebarton SA	4	**4**	5	**3**	**7**
Salisbury SA	3	**3**	3	**1**	**4**
il nido SA	4	**3**	3	**2**	**5**
Perth	6	**3**	5	**3**	**6**
Brisbane	3	**4**	3	**3**	**7**
Total	21	**17**	19	**12**	**29**

The telephone interview was designed to elicit information about each mother's experience of the TtLG and to assess longer term impacts/outcomes of mothers' participation in the TtLG program. A semi-structured interview schedule of questions was developed as a guide, so that consistent information could be collected about the impact of the mothers' participation in the TtLG program. Mothers were given the opportunity to describe in their own words their experiences of the TtLG program. Data analysis identified themes corresponding to the relevant TtLG program impact/outcome indicators (3)

- 3.1. Parents report increased knowledge, awareness, confidence, skills attributable to the Project (*parenting competence and style)
- 3.3 Parents are equipped to overcome barriers to attachment and report greater bonding attributable to the project (*improved family functioning)
- 3.5 Parents report improved parenting practices and activities support (*parenting competence and style)
- 3.6 Parents report improved positive child behaviour (*Improved child social and emotional development)

Parents report increased knowledge, awareness, confidence, skills attributable to the Project (*parenting competence and style)

Longer-term attachment relationships between mothers and children, knowledge and awareness of children's attachment needs

All mothers (n=29) who responded to the 2008 follow-up phone survey reported that they have continued to use the children's attachment information and ideas that they received during their participation in the TtLG program. These mothers described a range of ways in which they use apply their knowledge of children's attachment needs:

> *'Always …..learning about it while (child) was a baby really helped me understand him now, he's at that time where he is non-stop going for everything but I know he's just trying things for himself', (IL008)*

> *'Yes being part of that group with my baby helped me feel good about being a mother', (S060112)*

> *'It helped all our family, we started doing more things with all of the children, it got easier as they got older', (B060302)*

> *'I learnt that I needed to do things a bit differently with (children). They've got different personalities and I had to accept that they want me in different ways so you could say that I'm using the attachment info in different ways with each of them…they both like lots of cuddles but (child 1) wants to pick out her own books and things but (child 2) wants me to help more', (P060403)*

> *'Yes (child) is at school now …the course really helped me understand that (child) wasn't being naughty but just trying out new things ….the idea of the circle and the need to be there for them helped me a lot to accept that sometimes he had to be allowed to try things for himself', (P060409)*

> *'It helped with both (children). Now I can accept that they need to do the exploring, e.g I let them pick out the clothes they want to wear, before it would be a battle I wanted them to wear the things I picked out. There is less arguing about things I realised that letting them make the choices is part of them growing up', (T060801)*

Confidence in responding to child's attachment needs

Twenty three mothers (79%) reported that they felt confident in responding to their child/rens' attachment needs as a result of their participation in the TtLG and program activities.

> *'Yes (clinician) really made me see I was doing things OK and I could sort out what they (children) need me to do', (IL010)*

'I did get more confident as she got older, it's easier when they can tell you what they want', (S060110)

'We're both confident with (child). It was good to be able to talk about the things I learnt from (clinician)', (B060302)

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'We're both confident with (child). It was good to be able to talk about the things I learnt from (clinician)', (B060302)

'I know I am doing better now, it's important for (child) to develop in her own way', (P061012)

'I am confident with (child) it's different now he is very active but I can support him', (B060902)

The remaining six mothers indicated that they felt confident when they finished the program however as their child became older, they did not feel as confident in 'understanding' and responding to their child's attachment needs.

'I was more confident when we finished, it's harder now (child's) older and it's just me to doing it all', (T060301)

'I'm fine but it's always lots of learning as (child) gets older', (B060303)

'Can be a challenge sometimes but I understand that (child) needs to learn things', (P060201)

3.3 Parents are equipped to overcome barriers to attachment and report greater bonding attributable to the project (*improved family functioning)
3.5 Parents report improved parenting practices and activities support (*parenting competence and style)

Parenting skills
All participating mothers (n=29) reported that their participation in the TtLG program had positively influenced their parenting skills, overall mothers indicated that they had more understanding of their child/rens' needs, they were.

'It gave me more patience', (T060305)

'I think it made me be able to enjoy him see him as a separate person with his own way of doing things', (IL008)

'It's helped me not to get as upset and be more slower with him, I can play with him better...I guess before I always wanted him to do things with me, I wanted him to play with the things that I got him', (S060314)

'I think it was very valuable it really helped me to understand (child's) need to have cuddles it wasn't just about (child) being clingy', (B060301)

'It has made me think about (children's) perspective more', (P060403)

Mothers' feelings since completing TtLG

Most mothers (n=25, 86%) reported some lasting 'changes' in themselves since they had completed the TtLG Program. Overall these mothers reported that they felt happier, calmer and enjoyed their role as a mother and interacting with their child/ren.

'I feel happier with myself for learning about how to be a better mother', (P061012)

'I guess I know that I can be a good mother to him, it just makes you understand things better about helping your child', (IL008)

'Yes it's just something that I feel good about I know that I can give (child) what he needs', (S060112)

'I know that I can be a good mother for (child)', (B060303)

'Really it was by changing how I looked at things with the (children), now I try to think about lots of things from their perspective e.g like packing up games at night, I try to remind them 10 minutes before they have to instead of just coming in and saying do it',(P060403)

Social networks

Some mothers (n=8) reported that they 'kept in touch' with at least one other mother from their TtLG groups. Theses mothers met for coffee, shopping or joint children's activities such as birthday parties. Overall most mothers (n=21, 72%) did not establish long term friendships with other group members. Eleven of these mothers identified factors making it difficult to maintain longer-term friendships, including:

- mothers' working commitments (n=5)
- children being in different age groups (n=4)
- families not living in close or convenient locations (n=2).

'Just one sometimes see the others at the shops or school and say hello', (IL010)

'No lots of commitments with work and other things', (P060403)

Confidence in accessing other services
Most mothers (n=16, 55%) reported they had no need to access other services. The remaining mothers (n=13) reported that they felt confident in accessing other services. These mothers commented that the TtLG clinician and/or staff at the childcare centres had provided information and support to access services such as local playgroups or child health support agencies.

> *'(Clinician) was good there were some things I need to sort out', (T060306)*

> '*Yes there's lots of information at the centre', (IL008)*

> '*Yeah, (clinician) told me about some other groups, another playgroup I could walk to', (S060110)*

> *'There's always help if you need it' (P061012)*

3.6 Parents report improved positive child behaviour (*Improved child social and emotional development)

Changes in child's behaviour as a result of the TtLG
Overall most mothers (n=26, 90%) reported positive aspects of their children's' behaviour as result of their families' participation in the TtLG.

> '*Well he's really grown up now and it's different childcare helped him he's confident loves playing with kids', (IL008)*

> *'She's a toddler now and wants to play I can see that she does things of the circle I can help her when things aren't right. Like when she's tired she can get frustrated with toys and things I know to cuddle her and settle her down', (S060110)*

> *'I can see more about why (child) is doing things and I think that he is more confident about doing things for himself', (P060201)*

> *'They don't pest(annoy) me as much, I think I'm better at organising things, like remember to think about things from their point of view , understanding that sometimes they are just tired and whinging and not really playing up', (P060403)*

Some mothers (n=11) highlighted that the changes in their child/rens' behaviour were a result of themselves 'seeing' their child's behaviour through a different lens or 'looking glass'.

> *'I don't think he changed it was me knowing more about him', (T060305)*

'I think it's more that I understand him better...I can join in with him better', (S060314)

'Going to the course made me see that (child) was really being just a normal toddler, it's more that I have changed', (P060602)

Most helpful parts of the TtLG program

All mothers (n=29) identified aspects of the TtLG program that helped them to understand their child/rens' attachment needs. Most mothers (n=26, 90%) provided multiple responses, with 5 mothers emphasizing that all parts of the program were helpful. The most frequently reported aspects were:

- Video reflection of mother and child's interaction (n=17, 59%)
- Talking with the clinicians and co-facilitators (n=16, 55%)
- Circle of Security information (n=13, 45%)
- Group discussions with other mothers (n=7, 24%)
- Child-care providing time out for mothers (n=7, 24%)

Least useful or helpful activities

Overall mothers reported positively on the TtLG program however some mothers (n=13, 45%) identified aspects of the TtLG program that were not useful or helpful, including:

- group discussions sometimes needed to have more focus (n=5)
- overall length of program made it difficult to attend every session due to other commitments (n=3)
- program was not available close to mothers homes, resulting in long traveling times (n=2)
- the requirement for child to be in childcare difficult, as child was already attending kindy (n=1)
- partner/father would have benefited from attending the program as he is the stay at home parent (n=1)
- group size was too small for effective discussions (participant's group had only 3 members due to some mothers withdrawing at the last minute) (n=1)

Mothers' suggestions for future programs

Some mothers (n=16, 55%) made suggestions for future implementations of the TtLG program or similar to TtLG. These suggestions included:

- Attachment information programs available to all parents, even before babies are born (n=4)

  'Maybe all mothers should be given this information before they have their baby. It would help to know about the circle before you need it', (S060112)

- Follow-up sessions available some time after the program is completed (n=3)

  'It would be good to have an update session, you've got different questions when your child is older', (B060303)

- Specific information for families with more than one child, ideas for responding when there are several children needing a mother's support (n=3)

  'Maybe some more information about dealing with brothers and sisters … as they get older they want your attention more…sometimes you're not sure about who needs you more', (IL009)

- Written material to refer back to when no longer attending childcare centre (n=3)

  'It would be good to have some book or something to read again they grow so quick and you have to do things differently', (T060301)

- Programs available in more convenient locations, closer to families homes (n=2)

  'The location was an issue, loved the course but it wasn't convenient', (IL015)

Summary

Findings from the follow-up telephone indicate that the TtLG project is achieving sustainable long term impact with most mothers reporting continued confidence and improvements in their parenting skills and understanding of their child's attachment needs.

Families participation in the TtLG program has provided mothers with a framework and strategies to understand and support their children's' attachment needs.

'Use it all the time with both (children). It's just so good having a framework that helps you understand their feelings. (Clinician) showed me how important it is to see things from your child's perspective, when you do this so many things are easier to understand. Things that people would say are naughty can actually have a very clear reason behind them. …. when (partner) was away I used to think they (children) were being more difficult but now I'd sit with them and we'd talk about how we all miss him when he is away and those times are much easier at home', (IL015)

'I wish I had known this stuff when he was baby. It made a huge difference for me. Learning about the security circle made me realise that I had to help (child) to understand his feelings when he got angry. He likes to try lots of things and sometimes he's impatient but now I can sit with him and calm him down instead of getting angry back at him', (P060805)

'I know my purpose as a mother and that it's important to meet my needs and wants and this makes me a better mother to (child). I've got more patience with her and like I understand that she needs me to help her get through how she's feeling. Before I just didn't really think about how we've both got different needs it was more of a battle. She can be strong willed and want to do things for herself …if there's time I let her dress herself and do her hair I know it doesn't have to be perfect it doesn't make me a bad mother if she gets out looking fun and hair not combed', (P061012)