- the tertiary level residential child and family health service cater for families who are experiencing non acute postnatal depression;

- strong links between the tertiary level residential family care centre and inpatient psychiatric units be developed; and

- programs be developed to address behavioural difficulties in children under three years of age.

In the 1996 financial year Service Agreement [5] between ACT Government Health Directorate and CMS it was clearly articulated that CMS would run a tertiary level Child and Family Health Service utilising a primary health model of care from July 1997 in the purpose built facility in Curtin. Guided by the principles and practices of primary health care this service was to be integrated into the public community based primary health program. CMS was to manage the tertiary primary health service and the ACT Government Health Directorate would manage the primary and secondary primary health services.

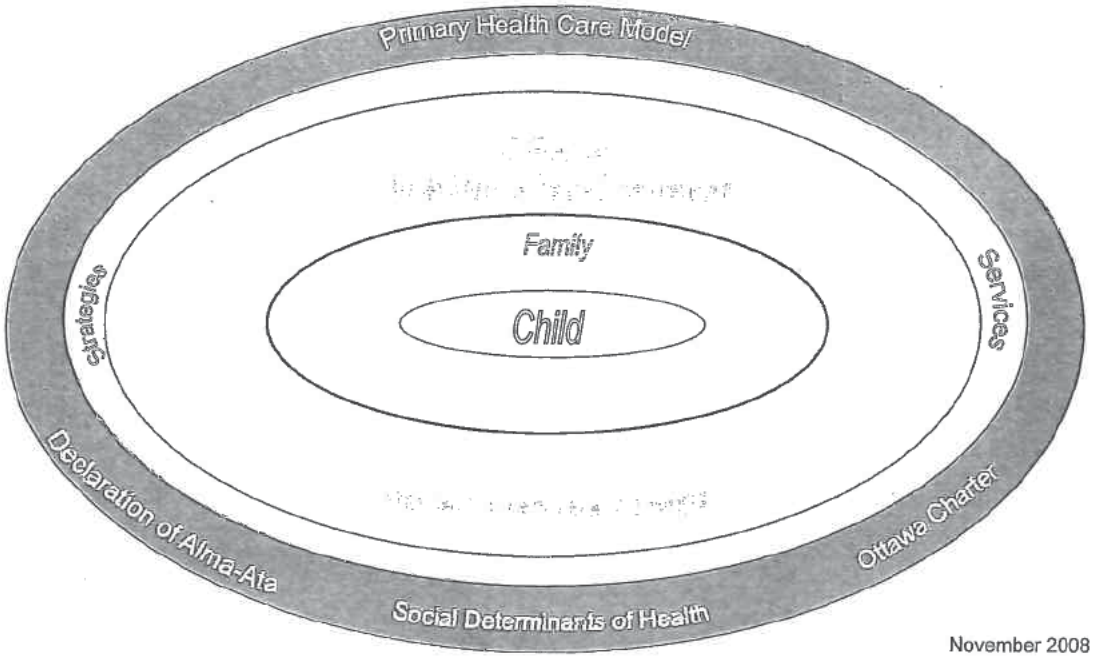
3.0 Service Delivery Model

The reason for QEII's existence and the evidence and research available, increasingly validates the work at QEII with families with young children. The dynamic social, cultural and political climate all contribute to the sense of challenge and the imperative to keep abreast of new and emerging evidence.

One-size-fits-all approaches fail to adapt to the needs of particular children, families and communities, and are therefore less effective [6]. Effective services seek to build partnerships with parents, children and communities. When service providers and families work as partners to determine what action should be taken, there is greater probability that the desired outcomes will be achieved[7].

Building on the evidence base and the strategic focus, QEII's primary health care Service Delivery Model and C-Frame platform for the delivery of care, underpin the work of the organisation. This enables practice to be built on a strong foundation and facilitate a language for interdisciplinary team work. Our aim is that the resulting consistency of approaches directly impact on outcomes for clients using QEII services.

QE II Service Structure



November 2008

Working in partnership with families, QEII seeks to maximize positive health outcomes for primary carers, babies and young children and for all family members, while strengthening and promoting healthy physical, social and emotional development.

QEII's principal aims are to provide and promote programs that help families develop their own resources to enjoy a fulfilling family life. The purpose of QEII is to assist families with young children who need support and advice, to confidently manage the challenges of early parenting. Some of the common presenting issues related to the long-term physical and mental health outcomes for babies and young children include: sleep; breastfeeding; diet and nutrition; attachment; child development; living with chronic mental health and drug or alcohol issues; disability; and the management of behaviour.

Families vary greatly in their personal levels of education, and confidence. Effective services take account of this, beginning with the parents own perceptions and experiences of their situation, and basing service on what parents are capable of contributing. It is important that QEII takes these factors into consideration, so that engagement of families occurs. Effective services also start where families are at developmentally [8]. When service providers and families work collaboratively to identify family goals and priorities, services are more likely to address the families' most salient needs. When professionals determine what the goals of an intervention should be, the issues that are most important for families and have most impact on their lives may be overlooked[9].

There has been a significant shift in service delivery to families and individuals over time, from a deficit based focus on problems to a competency-based, health-oriented approach that recognises and highlights strengths and family resources [10]. This shift has partly come about as a result of research interest in the concept of resilience, which focuses on strengths forged within the context of adversity, rather than less realistic, problem-free models of family health. Many factors have been proposed that contribute to resilience at an individual, family and community level, and it is now considered by many practitioners and researchers to be a key concept in health service delivery [11].

Strengths-based approaches to practice focus on what is working well and encourage families in crisis to identify their strengths, and how they have previously overcome challenges [12]. Recent research has helped by studying "successful" families and individuals, so as to isolate the key characteristics of strong relationships and use these to inform service delivery [7]. This strengths-based approach, however, mainly operates in a service environment where people are accessing help for difficulties they are already experiencing. While this approach has obvious merit, the "missing link" is encouraging people to access support and help prior to problems occurring, in a preventative effort to increase strengths and offset future difficulties [13].

QEII has a platform for the delivery of care called C-Frame (Connect, Collaborate, Change) which facilitates consistent practice across the organisation. There are key professional practice approaches inherent within the use of C-Frame. The QEII Service Delivery Model and platform for the delivery of care C-Frame offers a unique and complementary service to existing services available to children and families and the communities of the ACT. A blend of services underpinned by theoretical evidence which focus' on the early years of life, the principles and practices of primary health care and

health promotion complemented by strength-based approaches that aim to enhance the health and wellbeing of families with young children. These services are provided for individuals and groups and use universal and targeted strategies within the scope of care.

There is a concerted effort to provide QEII services geographically throughout ACT. The QE II Family Centre is located in the geographical centre of Canberra at Curtin and community developmental programs are run as close as possible to the recipient community as can be arranged.

The QEII Service Delivery Model places the child, family and community as central to the model. This approach required structural and personnel changes to develop QEII's strategic focus and document the service model to a point that clarifies the way forward and then become a 'work in progress'. For the past twenty years, QEII has stepped outside of the model of traditional acute clinical service delivery and developed ways of work that include community development, collaboration and partnerships. This document outlines CMS' strategic approach to the Service Delivery Model, which is inclusive of social determinants of health and the principles and practices of health promotion, and the platform for the delivery of care - C Frame.

3.1 Primary Health Care

3.1.1 Element I: Our philosophical approach

At the International Conference on Primary Health Care in 1978 the Declaration of Alma-Ata [14] was made expressing the need for all governments, all health and development workers, and the world community to protect and promote the health of all people. The Declaration of Alma-Ata has ten principal statements of which statement V11 defines Primary Health Care. The Declaration was later ratified in Bangkok in 2005 and in the World Health Report (WHO) 2008 *Primary Health Care: Now More Than Ever*[16] WHO confirmed that the values that informed the Alma-Ata Declaration in 1978 had been tested and remain true.

Primary Health Care is characterised by an holistic understanding of health as well being, rather than the absence of disease. The presence of good health is dependant upon multiple determinants. The health status of communities is both a function of and a reflection of development in those communities. The locus of control is important in primary health care and health services should reflect local needs and involve communities and individuals at all levels of planning and provision of services. Services and technology should be accessible, affordable and acceptable to communities. Through health promotion and preventative care, primary health care aims to eliminate causes of ill health. Equity is a crucial part of primary health care and health services must strive to address inequity and prioritise services to the most needy. Finally, primary health care should be based upon social, biomedical and health services research in order to provide effective health care.

CMS is deeply influenced by the Declaration of Alma-Ata and later ratifications as well as the Ottawa Charter on Health Promotion [15] and its philosophy of Primary Health Care that incorporates:

- an holistic understanding of health;
- recognition of multiple determinants of health;
- community control over health services;
- health promotion and disease prevention;
- equity in health care;
- research based methods; and
- the use of accessible, acceptable and affordable technology.

3.1.2 Element II: A set of strategies

Our Service Delivery Model involves a set of strategies aimed at creating health care which is consistent with the underlying philosophy. Education is a key strategy in primary health care as through education communities and individuals gain understanding of and control over health problems. Intersectoral cooperation and coordination is also a significant part of primary health care. This requires cooperation at all levels, from government planning through to local implementation and across traditional departmental boundaries. Primary health care services require balance between health promotion, preventative care and illness treatment. This is best achieved through the use of a team drawn from a variety of disciplines.

In its commitment to exemplifying best practice in the delivery of primary health care services to families of young children CMS utilises the following specific set of strategies:

- needs based planning;
- education;
- intersectoral coordination and cooperation;
- balance between health promotion, prevention and treatment; and
- a multidisciplinary health care team.

3.1.3 Element III: Level of service provision

To successfully implement a primary health care service it is critical to clearly describe the kind of service, both as a set of activities and as a level or model of service provision. The service must be the first level of health care and which is readily accessible to individuals and communities. This means that effective primary health care must be locally based and be universally accessible. They must also be free from financial barriers. As the first level of health care service, primary health care services need to be well integrated with the secondary and tertiary health care sectors, in order to provide continuity of care for people throughout all levels of the health care system. This involves cooperation and communication. Primary health care services require cooperative efforts from a team of health care providers drawn from a range of disciplines. Finally primary health care should offer a range of services in health promotion, illness prevention, illness treatment and rehabilitation.

Since 1996 CMS has had a Service Agreement [6] with its primary funder, the ACT Government, for the provision of the integrated tertiary level service of its primary health care services, with primary and secondary primary health care services being provided by the ACT Government Women, Youth and Child Health Program. The service operated by CMS is an integrated primary health care residential postnatal and early childhood service for families of young

children experiencing complex health and behavioural difficulties at the Queen Elizabeth II Family Centre. The Service Agreement is congruent with the ACT Governments commitment to the provision of integrated primary health care services and CMS' philosophy of and commitment to the provision of primary health care services.

As defined in our contract with the ACT Government Health Directorate and reflected in the Strategic and Operational Plans the provision of services at QE II are in their approach are:

- locally based;
- affordable and accessible;
- well integrated;
- delivered by a health care team;
- reflective of health promotion principles and practises;
- disease preventative;
- engaged in illness treatment; and
- rehabilitative.

3.1.4 Embedded in elements in primary health care:

3.1.4.1 Health promotion

Health promotion is the:

> *"process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyle to wellbeing"*[15].

The Ottawa Charter for Health Promotion[15] emphasises the importance of promoting health at a global level. There are six key action areas which QEII is particularly committed to:

- building healthy public policy;
- creating supportive environments;
- strengthening community action;

- developing personal skills;
- reorienting Health Services; and
- providing adequate and appropriate education and opportunities for skills development so that people can influence their communities to make local decisions for effective use of resources in order to attain health.

Health Promotion encompasses a range of approaches and activities and, as such, is an umbrella term. Health Promotion activities can be at a local, national, and/or global level and include preventative health services, health education, social marketing, community development and engagement, organizational development, policy development, community based work, environmental health measures, and economic and legislative activities. CMS recognises that no single activity is more important than another; however, the greatest successes have come from combining approaches through comprehensive and integrated programs [17].

3.1.4.2 Social determinant of health

Considerable literature exists that supports the association between an individual's social environment and health outcomes throughout an individual's life span which are independent of individual risk factors [18]. These social determinants of health include:

- **the social gradient** refers to the researched and documented phenomenon that an individual's life expectancy and exposure to diseases and illness increases the further down the individual is on the social ladder. This holds true for all societies whether in developed countries or developing countries;
- **stress** - exposure to stressful events which causes anxiety and feelings of not coping or being in control, damage an individual's health. This is also true for work and personal environments. It is well documented that people who have control over their work have better health. The social organisation of work, management styles and social relationships in the work place all impact on health as does feelings of job insecurity;
- **early life experiences** include the period before birth and therefore refers to the support and care pregnant mothers receive;
- **social exclusion** refers to racism, discrimination, stigmatisation, hostility, unemployment and poverty, whether the poverty be relative (i.e. this means being much poorer than most people in a particular society or country) or absolute poverty (i.e. the lack of basic material necessities of life). Ethnic minority groups, refugees, people with disabilities and homeless people are most at risk;
- **addiction** – an individual's abuse of alcohol and drugs is influenced by the wider social setting – addiction is both a response to social breakdown (offers an escape from reality and stress) but also

contributes to making an individual's problems and inequalities of health worse;

- **unemployment** - being unemployed has both psychological consequences and financial implications. Unemployed people and their families suffer increased poor health outcomes and increased risk of premature death;
- **social support** - individuals fare best when they experience friendship, good social relationships and strong supportive networks. The amount of social, emotional and practical support individual's experience varies by social and economic status and poverty in particular may contribute to social exclusion and isolation;
- **food** - in order to achieve optimal health, individuals need a healthy diet and an adequate supply of nutritious foods as a lack of variety and food causes malnutrition and deficiency diseases and oversupply also causes serious disease and morbidity. Access to good affordable food has a far greater impact on health outcomes than health education. The supply of food is influenced by global market trends and as such is a political rather than an individual issue;
- **transport** - the low use of public transport and an over reliance on private transport has resulted in poorer health outcomes due to lack of exercise, increased air pollution and decreases in social contact. The issue of transport not only has public transport policy implications but also involves urban planning policies. Conversely another issue regarding access to public transport affects disproportionately more lower income families than higher income families who can afford private transport and who are able to afford to live in more centrally situated environments.

Social circumstances and the environment do affect the health of individuals. Brunner and Marmot have developed a model that describes:

> "*how factors in the environment, acting through the central nervous system, could influence biology to cause ill-health*" [19].

The model links social structure to health and disease via material, psychosocial and behavioural pathways. Genetic, early life and cultural factors are further important influences on population health [18]. The above authors claim that social structure influences well-being and health via three main pathways:

> "*Material circumstances are related to health directly, and via the social and work environment. These in turn shape psychological factors and health-related behaviours. Early life experiences, cultural, and genetic factors also exert influences on health* [18]".

Within each of the Program areas, CMS is mindful of how the social determinants of health can and do impact on the well-being of families that access QEII services. Therefore individual family members are viewed in a holistic manner and any negotiated action plan takes these into account. In addition, QEII practitioners are involved in external organisations, advisory and

reference groups with the aim of influencing government policies with regard to the importance of the early years, strategies to combat social exclusion and the importance of individual, family and community support for families.

3.2 Platform for the delivery of care:

C-Frame

During 2003, QEII adopted C-Frame, a parenting skills development framework which is a practice focus with families and with each other. The name C-Frame encapsulates the three action c-words embedded in the framework: to connect, collaborate and change [20]. This framework provides a process and tools for practitioners to connect with families and work collaboratively with them towards positive change, and also to connect with colleagues and work collaboratively towards positive change with an increase in skills in the work place.

The historical background to the development of C-Frame is as follows: QEII together with Tweddle Child and Family Health Service (Vic), The Parenting Research Centre (Vic), Tresillian Family Centre (NSW) and Ngala (WA) collaborated and developed the C-Frame evidence based framework to guide professional staff in their interactions with parents.

The rationale for C-FRAME is as follows [20]:

- children depend upon parents to meet their basic needs;
- children are vulnerable to a range of health and psychosocial problems when their parents are unable to adequately meet their physical, cognitive and emotional needs;
- significant reduction in children's psychosocial and health problems can be achieved by providing timely, effective and accessible early intervention programs;
- the most effective way of achieving long term positive outcomes for young children is to enhance the quality of parenting they receive;
- emphasis is placed on resourcing and empowering parents to create positive and nurturing environments for their children. This is done by maximising small successes to motivate ongoing positive change;
- the success of parenting intervention is determined by the ability of practitioners to effectively engage parents in a process of personal behaviour change; and
- positive change occurs for children when their parents change positively.

C-Frame provides a process and tools for practitioners to connect with families and work collaboratively towards positive change.

Being effective in providing support to families, requires from the outset partnerships that are constructive and helpful to ensure child safety and wellbeing throughout the stages of child and parenting development. In all kinds of parenting support, from the briefest contacts to extended interventions, professionals and primary carers come together in a unique relationship. Very different from informal social relationships, this relationship has a specific focus (the child), purpose (helping the parent, or other primary carer, achieve desired changes), and structure (parameters are placed around the nature and frequency of contacts). Primary carers strengths and life experiences are utilised in the process in order to motivate them towards positive changes they themselves seek. An underlying principle is that it is the primary carer themselves that need to initiate and maintain behaviour change. Therefore the relationship between the professional and primary carer is critical to the process.

The framework consists of four main phases which are not necessarily all used or used in any particular order except for the fact the Phase 1 (connecting with the primary carer or the colleague) is obviously the first step in the process:

- Phase 1: creating a collaborative relationship;
- Phase 2: developing a commitment to change;
- Phase 3: contextual analysis; and
- Phase 4: negotiating change and intervention.

Embedded in C-Frame is the requirement that practitioners utilise professional practices approaches that are congruent with the principles and practice of primary health care and the C-Frame platform for the delivery of care at QE II.

The Circle of Security Parenting Program, is a relationship based parenting program which is grounded in Attachment Theory. Clinical staff complete the Circle of Security Parenting Program providing an approach for operationalising Attachment Theory at QEII.

3.3 Professional practice approaches

3.3.1 Reflective practice

Reflective practice incorporates an umbrella term which is about how QEII approaches the work of the organisation. The processes can be formal or informal. Reflective practice can be defined as a process in which a group of people come together to help each other to learn from their experience [21]. Reflective practice is a process by which change and understanding can be pursued at the one time. It is usually described as cyclic, with action and crucial reflection taking place in turn. The reflection is used to review the previous action and plan the next action.

In reflective practice, each participant draw different learning's from different experiences. Utilising this approach a team of people draw collective learning from a collective experience. Reflective practice and action learning may be compared to experiential learning. As usually described, it is a process for drawing learning from experience. The experience can be something which is taking place, or is set up for the occasion by a trainer or facilitator.

Reflective practice intends to reaffirm positive practice and introduce some change into practices that could be improved; action learning uses some intended change as a vehicle for learning through reflection. In each, action informs reflection and is informed by it. The reflection produces the learning (in action learning) or research (in action research). In both, the action is changed as a result of the learning, and leads to more learning [22].

3.3.2 Community based services

QEII's programs are based on a developmental approach to working with families on the assumption that people's needs are best met when services are provided as close to, or in their, their local environment as possible. Central to the model are values of self determination and empowerment. Service activities continually evolve and change in keeping with the developmental approach and the changing nature and needs of the various communities they serve. The development of this framework continues to evolve and will build upon the work commended by CMS in the 1990's.

3.3.3 Parenting education

The National Agenda for Early Childhood report [23] defined parenting education as the broad process of providing parents with specific knowledge, child rearing skills and strategies in order to strengthen their abilities with regard to:

- assisting their children attain developmental skills
- manage behaviour issues
- enhance their child's developmental opportunities through play and social interaction.

QEII's parent education programs are based upon the same theoretical underpinnings as has been highlighted within the Service Delivery Model. Residential program client education sessions are attended by primary carers who wish to increase their knowledge with regard to a range of parenting, primary health care and child safety and development issues. Community development education sessions have targeted prospective parents with aim of alleviating anxiety by achieving a smooth transition into their new roles as parents. QEII responds to parental requests and community group requests by developing additional evidence based workshops.

3.3.4 Interdisciplinary team

An interdisciplinary team is a team of professionals represents several different disciplines, and this Service Delivery Model is dependent on the team functioning as a cohesive group of people. By this, it is expected that they share a common philosophy of practice, recognise and freely exchange knowledge and recognise discipline specific and common skills thereby work effectively together for the achievement of a set of common goals.

For an effective interdisciplinary team to develop it is necessary for individuals to understand each others' professional frames of reference. They need to be able to define for each other their specific expertise and the usefulness of this in the assessment and delivery of programs to families. Roles and responsibilities can be accorded to team members on the basis of this understanding.

There is also some need to have a degree of fluidity in boundaries, based on the sharing and evolution of knowledge and skills, and in addition, an emphases on cooperation as an essential means of fulfilling one's own professional role and functions as well as meeting the needs of clients. Joint decision making does not mean, however, that the individual can abdicate professional responsibility for client care and standards of service delivery. Scope to exercise this professional responsibility is incorporated into team's procedures.

3.3.5 Cultural inclusion

Cultural inclusion means that CMS is committed to the social inclusion agenda and has a desire to focus on ways to be inclusive of people experiencing both disadvantage and discrimination. CMS acknowledges Australia's history that included a period of time when aboriginal children were cared for in an 'out of home care' context and children were also adopted from institutions like QE II. CMS acknowledges this past and the contribution it may have made to the sadness of stories heard from families and children who were 'stolen' in any way from their families or origin. We acknowledge that this past is often a barrier to families having trust in mainstream services like ours today. Along with many Australians, QEII would like to reconcile this history and look forward to how engagement and problem solving can move to respectful and effective ways of work with Aboriginal families.

QEII is currently working with Aboriginal and CALD communities in the ACT and surrounding regions. Relationships with these communities have been allowed to develop over time. QEII considers the community and extended family as integral parts of the building blocks for healthy children, and employs a culturally sensitive process of working with families from diverse cultural backgrounds.

4.0 Service focus

4.1 The enhancement and protection of children

Child abuse and neglect is a complex social issue. Sometimes it occurs when parents have insufficient parenting knowledge and skills and rely on inappropriate discipline to manage their children's behaviour. Sometimes children are harmed because parents/carers are isolated and challenged beyond their capacity to cope, especially during periods of crisis or in caring for a child with particular needs. Sometimes harm stems from the serious emotional and psychological problems of parents. Dorothy Scott (2007) at a parental substance abuse and child protection national forum stated that *"the child protection system is under pressure and it can become a dangerous place for children*[25]*"* she pointed out that one of the reasons for the high number of notifications relates to changes in reporting laws, but a key factor is the increase in, and interrelatedness of, parental substance dependence, domestic violence, and parental mental illness.

Various key reports and the current ACT legislation *Children and Young People Act 2008* have been instrumental in helping to shape CMS' approach to caring for and protecting children. We support the view that the protection of children from abuse and neglect is a whole of community responsibility [26]. Within the community the roles may differ, but working in partnership, with a shared understanding of the rights of children, the need to support vulnerable families and take actions when necessary, can build a safety net for children. All staff working at QEII play a vital role in supporting parents to care for their children. Relationships are built with parents who enable the facilitation of valuable insight into the challenges they face as parents. There is a pivotal role in linking vulnerable families to support services that can assist to overcome personal and social stresses that may lead to family breakdown and the possible abuse and neglect of children.

4.2 Early brain development

The basic architecture of the brain is constructed through an ongoing process that begins before birth and continues into adulthood. Like the construction of a home, the building process begins with laying the foundation, framing the rooms, and wiring the electrical system in a predictable sequence and it continues with the incorporation of distinctive features that reflect increasing individuality over time. Brain architecture is built over a succession of 'sensitive periods' each of which is associated with the formation of specific circuits that are associated with specific abilities. The development of increasingly complex skills and their underlying circuits builds on the circuits and skills that were formed earlier. Through this process, early experiences create a foundation for lifelong learning, behaviour, and both physical and mental health. A strong foundation in the early years increases the probability of positive outcomes and a weak foundation increased the chance of later difficulties [28].

Attachment, the potent bond or relationship an infant has with his/her primary caregiver, is necessary for optimal brain development and ultimately emotional

regulation [29, 30, 31]. Research suggests that if babies are not responded to in an effectively attuned manner, many of their brain cells in the orbital frontal cortex are thought to develop differently by the end of the first year. QEII has a key role to promote the importance of early brain development throughout its programs due to the fact that most parents who access QEII services have children in the 0 – 3 year age range.

4.3 The importance of the early years

QEII's early years focus is based on the underpinning philosophy that the early years of children's lives have a significant impact on their physical, behavioural and social development later in life. QEII considers that many common problems faced by children are preventable or can be improved if they are recognized and effective intervention begins early.

There is substantial national and international evidence [32, 33, 34, 35] that comprehensive prevention and early intervention programs for children and their families have long term benefits for physical and mental health, educational achievement and emotional functioning. Key points from the literature indicate:

- brain development in the period from conception to six years sets a base for subsequent learning, behaviour, relationships/attachments and health over the life cycle;
- biological embedding of early life experiences contributes to socioeconomic gradients in health and wellbeing outcomes and affects subsequent responses to stressful circumstances;
- low birth weight and poor infant nutrition are associated with chronic disease later in life;
- social disadvantage has a detrimental effect on health throughout the lifespan;
- children who are better nurtured in early life are healthier and do better in adult life;
- health problems in children reflect a complex interaction between children and their family as well as their social, environmental, cultural and economic circumstances; and
- early childhood development programs appear to reduce a range of risk factors (or enhance a range of protective factors) and have the potential to influence outcomes related to physical health, child abuse, crime, drug use and mental health problems.

A number of reports have considered summaries of the known risk and protective factors for children [36, 37, 38]. Key risk factors include:

- low birth weight,
- abuse or neglect,
- family instability and
- socioeconomic disadvantage.

Key protective factors preventing adverse outcomes include:

- social skills,
- breastfeeding,
- small family size and
- positive social networks.

These factors form part of a preventative and an early detection system with complementary intervention programs aimed at reducing risk factors and increasing protective factors for child health and wellbeing.

Ongoing development of effective programs and tools are being identified so that there is a clear relationship between each activity and resulting interventions. There have been a number of papers and reports in relation to early childhood interventions [36, 39, 40] that highlight common characteristics of successful and effective interventions which include:

- comprehensive, intersectoral and flexible;
- community based and within the context of family and community;
- a balance of interventions across the service continuum, including balance between population based and targeted services;
- are based on prevention and are planned for the long term;
- adequately resourced and take account of capacity building for sustainability; and
- maximize continuity of care/services through interdisciplinary teams.

Supporting parents in understanding the physical, social and emotional needs of key transition periods is critical. Evidence at these times suggest that families and children are most vulnerable or at risk. Preventative and early intervention strategies prevent long term impacts in a number of domains.

Evidence shows that the key transition periods in the early years, are:

- immediately following birth and the first year;
- transition from infancy to toddler;

- transition from toddler to preschool years; and
- preparation and transition to school.

4.4 Parenting and influencing factors

Parenting is a socially constructed role that is influenced by a wide range of personal and contextual factors interacting in complex ways. The approaches to parenting information, education and support need to acknowledge this complexity, and the variation that occurs from family to family. Given the multiple needs of today's families, it is important that QEII provide a range of professionals with different disciplines who together work with individuals, groups and communities, in varying locations and contexts.

Some parents because of social or personal circumstances need more resourcing and education than others. As well as strategies to broaden the range of parenting skills available that focuses on personal coping strategies, how to establish and maintain positive social supports, and how to work effectively with the service system are also covered in the services offered by QEII.

Effective intervention will address those things that are a barrier to parents learning through their own experience, such as anxiety or a lack of personal sense of efficacy. Importantly, parenting intervention should aim to enable parents to solve problems for themselves.

Parenting is not only adult driven, but is actively shaped by children in their interactions with their parents. Sensitivity and responsiveness to the cues given by children is therefore critical for effective parenting. Knowledge of child development is important, particularly where parents have unrealistic expectations of, or incorrect attributions for, a child's development and behaviour; however, this knowledge alone may not be sufficient when other factors impinge upon parents' ability to put knowledge into practice.

There is no universal standard of effective parenting, and in considering the effectiveness of parenting, it is appropriate to examine the function of the behaviour for the child rather than its form. Parenting practices that result in positive outcomes for children can take many forms and are influenced by many factors, such as the child's temperament, environmental circumstances, culture, social expectations, parents' gender, and parent's own experiences of being parented.

Parenting is more likely to be effective when parents adapt their practices to meet their children's changing needs, are responsive to them, and flexible in this responsiveness. Many factors can affect a parent's capacity to do this, creating vulnerability. What is helpful will vary according to the factors that lead to the circumstance. Where a child's behaviour is challenging and parents lack ideas on appropriate strategies to manage the situation, there is a need for training in parenting skills. Where personal or social adversity factors predominate, the emphasis may most appropriately be placed on addressing

these factors. Where there are multiple risk of adversity factors, a multi-faceted approach is indicated[41].

4.5 Infant mental health and parent-child attachment

John Bowlby elaborated a theoretical basis for understanding how babies develop emotional relationships, known as "attachment theory" [42]. He surmised that babies create an inner working model of all human relationships on the basis of the earliest relationships in their lives. This may be modified gradually in the light of later experiences but, once the template is set, it is more difficult perhaps to change it than it is to 'lay it down' beneficially in the first instance [43].

When parents are emotionally available and sensitively tuned to their infant's needs, a baby is more likely to develop secure attachments which can reliably be measured by the age of one year [44]. Insecure attachments can be observed in about one-third of infants by this age. Follow-up studies suggest that insecure infants are more likely to have behavioural and learning difficulties by the time they commence school they are also at risk of having greater difficulties in interpersonal relationships throughout their lives [45]. Children whose parents have depression and anxiety are more likely to develop these problems themselves.

There are different perspectives within current attachment theory. The key points of agreement include [46]:

- the adult-caregiver/child attachment relationship in the first three years has major consequences for infant functioning and developmental outcomes;
- the level of sensitive and responsive adult care giving behaviour is the key feature of attachment;
- infant attachment may provide the internal working model for later close relationships and development of self-image; and
- infant behaviour involves signals such as crying or smiling aimed at bringing the attachment figure closer and at bringing the child closer to the figure.

4.6 Family mental health in the early years

QEII is well placed to focus on the mental health of young families with the range of services that are offered, both through Centre-based services and the community primary health care and mental health services. Evaluations undertaken by Tweddle (Vic) [47] and Karitane (NSW) [48] found that women being admitted to early parenting centres have poor mental and physical health. The importance on focusing on family mental health from a primary health care perspective is crucial to the health and wellbeing outcomes for children as poor

mental health has implications for the quality of attachment and child developmental outcomes [49].

Infant mental health is a continuum for a child's "strong start" in life and is influenced by multiple factors. Maternal engagement in positive health-related behaviours is beneficial to child health and wellbeing outcomes. It is important that screening opportunities are available for clients to identify both risk and protective factors for perinatal mood disorders. Treatment needs to include the biological, psychosocial and relationship implications.

QEII's scope is that it provides primary health care support for clients, their partners and extended families where applicable. QE II is not an acute mental health service however interventions for unsettled infants are often the entry point into assessment and treatment for a primary carer mood disorder. QEII is also committed to strategies that focus on the parent-infant dyad particularly for those families with multiple needs or following observations of either distant or intrusive interactions with infants. It is also crucial for QEII to work with key services providing perinatal mental health and support services such as the ACT Government Health Directorate Perinatal Mental Health Clinic and public and private acute and community based mental health services.

In situations that involve change and challenges, such as parenthood, it is natural that people experience some anxiety. Anxiety during the perinatal period is often linked to the fear of giving birth and the possibility of having a baby with a disability or serious illness, suffering from a miscarriage or delivering a stillborn [50]. Other related anxieties may include fear about being abandoned, fear about being home alone, fear about not knowing what to do or doing something wrong and that may harm the baby [51]. Severe anxiety and stress over such issues should be a matter of concern as it may affect the health of both primary carer and child, and the family as a whole. There is a wealth of evidence showing that anxiety is common in perinatal depression and women who reported high levels of anxiety after childbirth also reported high levels of anxiety during pregnancy [52].

Parental attunement or, more specifically, parental reflective functioning, refers to a parent's capacity to understand their own and their child's behaviour in terms of intentions (purpose) and underlying internal mental experiences or states such as feelings, thoughts, desires and beliefs. What does reflective functioning (RF) look like in families?

- there is parental awareness of the mental states of themselves and other family members – in particular their child's;
- an explicit effort is made to understand internal states that underlies behaviour;
- recognition by parents that their child's or their own understanding of the world changes over time i.e. it is developmental;

- it is spontaneous and shows awareness that the listener might have a separate experience;
- language is tentative, respectful and doesn't claim inside knowledge of another's mental state;
- shows curiosity about other's attitudes;
- there is an expectant attitude that understanding will be elaborated by what is on another's minds;
- flexible in thinking and not stuck on one point of view;
- playful, with gentle humour being used; and
- emphasis is on problem solving and give and take [53].

The ability of parents to reflect or mirror their child's internal experience is crucial for the development of secure attachment and social development outcomes. It is through this process that a child's understanding of its own self-states occurs [54].

4.7 The perinatal period

The perinatal period is defined as the period from conception to 24 months post-delivery [55]. Affective/mood disorders occurring antenatally and postnatally are part of the spectrum of anxiety, depression and low self-esteem that are lifelong problems for many women [56].

For women and their partners, childbirth brings emotional upheaval and a total change to their lives. Feelings of distress may adversely affect women's adaptation to motherhood. Studies on maternal role development enable increased understanding of how women respond to the difficulties of motherhood over time. Services need to provide greater support for mothers by recognising the challenges of childbearing and the intensity and demands of motherhood, as well as fostering social support [57]. Best practice approaches for perinatal mental health are described in the WA Guidelines for Perinatal Depressive and Anxiety Disorders[59] and developed by National Beyond Blue [58]. Early identification through screening and assessment of risk factors, management and referral, are described.

The involvement of the partner is important (whenever possible) when working with women who have perinatal depression or anxiety related issues. A range of approaches can be considered within service delivery and a plan available for how QEII will implement strategies. The transition to parenting for the partner can also be difficult, commencing in the pregnancy [60] and there can be a degree of depression in some partners. In a UK study one in twelve fathers had depressed mood, and lower mood was associated with negative infant temperament [48].

Evans et al, [62] from the Avon Longitudinal Study of Parents and Children (ALSPAC; a large cohort study) reported that symptoms of depression were as common and severe antenatally (11.8% at 18 weeks of pregnancy), as postpartum (9.1% at 8 weeks). Green and Murray, [51] using a higher threshold for antenatal scoring, reported 12% antenatally and 14% postnatally. Pooling of international studies usually estimates the rate of postnatal depression as 12-15% [48].

In urban situations, significant depression has been reported in 25% of British mothers with school-aged children and 40% of working-class mothers. A Melbourne study suggested that 35% of multi-ethnic, low socioeconomic status mothers with infants less than 12 months old had significant depression, especially mothers who were recent immigrants [64].

Longer term effects are consistently reported. Murray, who has followed up on a cohort of children whose mothers experienced PND, reported an adverse and "enduring influence on child psychological adjustment [65]". They also noted that "the child's relationship with the mother appeared to be mediated by the quality of the infant attachment at 18 months". The relationship between mother and child is clearly affected by maternal mood.

Barnett et al [66] noted that mothers with high trait anxiety levels reported more problems and distress and less confidence in their parenting and their social supports when their child was aged one year and five years. They judged their child to have more social/behavioural problems and their partners agreed with this assessment. In another ALSPAC pager, O'Connor et al [67] reported significant links between antenatal maternal anxiety and behavioural/emotional problems in boys and girls at age four years. This antenatal prediction did not seem to be mediated by a link between antenatal and postnatal anxiety and depression.

Studies suggest that wherever possible the involvement of the male partner in any supportive strategies for the women can contribute to the well-being of the whole family. Giving partners a clear role to play in the psychological care of women can facilitate their helpful involvement [68].

4.8 Help seeking behaviour

Parent help-seeking can be thought of as the full range of actions parents take to inform and improve their parenting behaviour [68]. Understanding what parents seek help about, who they go to, and how they feel about help-seeking, is an important aspect of being able to support and assist parents.

It has been shown in multiple studies that there is a level of shame and/or embarrassment that parents sense when seeking help. A paper presented by the Australian Childhood Foundation suggests that up to 39% of all parents reported this fear and this has implications for children living in "at risk" situations [69].

It is also clear that men are much less likely to seek assistance because this is seen as a failure or weakness. Information from the health area suggests that stoicism and suppression of emotion are values often associated with masculine gender role socialisation [70].

There is also an ambiguity for many families around who to approach for assistance and this adds to the stress of attempting to seek help. Some families report that they don't recognise that the family situation in fact is normal and can be managed. There is also the need to deal with the issues of conflicting advice from families and friends which interferes with the motivation to seek help beyond the immediate family circle.

4.9 The importance of involving fathers

Over the past decade an interest in fathers and their contributions to family stability and children's healthy development has heightened the attention paid within health and welfare services, early parenting services and research institutions [71]. Early parenting and child health centres have been at the forefront of fathers and early parenting work [72] and there is now a range of information available on key national websites to assist fathers [73]. Children with highly involved fathers are characterized by increased cognitive competence, increased empathy, and less sex-stereotyped beliefs. Such children are also likely to exhibit less externalizing behaviours during the preschool years, less problematic and delinquent behaviours as they grow older, a greater degree of emotional stability and demonstrate more internal focus of control [74].

This growing awareness of the benefits of paternal involvement has lead to greater recognition of the support needs of men during their transition to fatherhood from the antenatal period through to early childhood, and beyond. The Research report prepared by Fletcher et al, 2000 [75] includes a literature review of:

> *"13 identified barriers for fathers/male carers to access family-related services:*
>
> 1. *attitudes of health professionals and educators;*
> 2. *lack of skills of engagement of staff;*
> 3. *lack of appropriate models of male service delivery;*
> 4. *mothers as gatekeepers;*
> 5. *lack of information and resource materials'*
> 6. *lack of knowledge about men;*
> 7. *medical education versus fathering education;*
> 8. *fathers' attitudes to services;*
> 9. *timing of childcare and parenting classes;*
> 10. *the format and staff of childcare and parenting classes;*
> 11. *failure to recognize fathers in family service settings;*
> 12. *perception of men as a threat to children; and*
> 13. *socio-cultural attitudes".*

Based on findings from a large survey of new fathers and community services in NSW [75], it was found that fathers are unlikely to utilize family-related services. This project recommended 4 key strategies to increase father involvement:

1. Promote the involvement of fathers in family-related services;
2. Increase service providers' knowledge of research on fathers and of strategies to recruit and engage fathers;
3. Support the creation and distribution of resources to assist in involving fathers; and
4. Develop capacity of family-related services to utilize male staff and volunteers in the engagement of fathers.

Father inclusive practice occurs when the needs of fathers (biological and social) are responded to through the planning, development and delivery of services. For services aiming to support families, bringing fathers into everyday activities is a crucial part of inclusive practice. This recognises families as a system, and acknowledges a balance between the needs of fathers and the family as a group [76].

Researchers and educators have only relatively recently acknowledged the important influence fathers have on the development of their child/children[77]. Father inclusive practice:

- recognises the diverse circumstances, strengths and interests of fathers
- takes a positive approach to the diversity of men, their needs and expectations, and
- encourages men and service providers to openly celebrate and value fathering [76].

Activities and education sessions undertaken at QEII ensure the respectful and effective inclusion of men. In practical terms, this means scheduling where possible, the workshops at times that are convenient for bother parents to attend. Recommendations made include offering separate sessions for mothers and fathers and training of practitioners and facilitators to recognise the differing characteristics of male and female participants.

QEII recognises the importance of the "parenting" team and the need to ensure that all primary carers have access to information in ways that are easily accessible. We know that men consume information differently and often need different access points to information and support networks. This is predicated on differing social constructs around masculinity and the roles of men within family spaces. QEII is aware of the need to provide services at father friendly times.

Much of the success of the organisation depends on the use of inclusive language and intent needs to be reflected in all spoken and written language

throughout the organisation. It is this sense of congruence and authenticity that reinforces with all primary carers that the organisation is truly father inclusive.

The importance of encouraging men to feel welcomed into the workspace and perceive it as "their space" cannot be underestimated. It is important that CMS look at their recruitment practices to ensure that properly qualified and philosophically sound personnel are employed. Visual representations of parenting must be crafted in such a way that they reflect the feelings of all primary carers rather than the more stereotypical notions of families and parenting.

5.0 Social and cultural issues

5.1 Ecological view

Bronfenbrenner's conceptual model [78] has stood the test of time by describing the connection between a child and the different variables in their environment that influence their development, health and wellbeing. Microsystems are contained within a mesosystem. An ecological view sees children as an integral part of their various environments, (home, childcare, school, and neighbourhood settings in which children spend their everyday lives) actively constructing their own experiences and their own unique perspectives of the world, shaped by both their makeup and the social settings of both internal and external factors.

QEII's underlying philosophy and practice frameworks fully embrace the ecological model. This is evidenced by QEII's ongoing work in communities, the networking of families who attend centre based services, to their local communities and supports, and the partnerships QEII has built with organisations and agencies throughout the ACT.

5.2 Indigenous families

The 2007 Close the Gap report[79] highlights the prevalence and burden of social and emotional difficulties in aboriginal children and young people. The accumulation of risk factors for health and well-being not only creates impoverishment of the financial wherewithal to raise children, but also compromises the very basis of human, psychological and social capital which forms the wider pool of resources essential for child growth and development, including their social and emotional wellbeing. The impoverishment across all the resource domains is accompanied by a reduction in the choice, capacity and flexibility of carers, families and communities to meet the demands and challenges of daily living. This is a recipe for accumulative stress.

A national workshop on parenting in Australia [80] emphasized that parenting interventions for indigenous families need to acknowledge and accommodate the role of extended family and kin. Family obligations may take priority over the interest of individuals, and decision-making about children is typically shared with extended family members and elders. Grandparents, aunts and uncles play an active role in childcare, and grandparents play an important role in transmission of cultural knowledge and customs. Programs also need to cater for the relatively younger age of Indigenous mothers. Parenting support cannot be divorced from the context of health, housing, education, and other areas of disadvantage.

The Memmot et al Aboriginal Child Health Survey [81] discussed the evidence around Aboriginal family function needs to be understood in the context of extreme diversity, both in terms of family structure and geographic location. Aboriginal families are generally more mobile than other families, with complex mobility patterns particularly in rural and remote areas [83]. The Gordon Enquiry [83] outline of models for future service delivery as being ones that emphasise the importance of paying attention to building the strengths and capacities of

individuals, families and communities. Other important factors highlighted by this report include:

- sensitivity is required when initiating contact with Aboriginal people;
- the importance of building trust with Indigenous families;
- services and programs need to be culturally appropriate and supportive of the needs of families and children;
- workers supporting families need to focus and pay attention to the environment of the child, family and community and ask the question what is missing in this environment that is necessary for normal growth and development of the child; and
- the importance of good governance and the development of community capacity as a means of alleviating social problems.

In July 2008 the Coalition of Australian Governments (COAG) announced Indigenous Reform – Closing the Gap. Leaders have agreed to sustained engagement and effort by all governments over the next decade and beyond to achieve the Closing the Gap targets for Indigenous people. The National Partnership is based on evidence that improvements in indigenous child mortality require better access to antenatal care, teenage reproductive and sexual health services, child and maternal health services and integrated child and family services.

5.3 Culturally and linguistically diverse families

Research conducted by the Department of Family and Community Services in 2004 on the Information Needs of Parents from CALD Communities [85] found that overall, parents from CALD communities who participated in the research had similar information needs to other parents. There was, however a greater emphasis among parents from CALD communities on the following areas:

- appropriate child discipline;
- child health and nutrition; and
- coping as a parent in the absence of extended family support.

The research found that two key overarching factors affected the ability of parents from CALD communities to obtain the information they needed. These factors concluded language barriers, compounded by the limited availability of interpretation services, and cultural factors, particularly cultural norms to access information from family rather than from external sources within their community.

Other factors that can impact on parents from CALD communities obtaining information they need may include social isolation which can impact on a

parent's confidence and self esteem, and other immediate priorities of the parent such as finding a job. QEII is aware of the need to be flexible given that the priorities for these families may be more about connecting with preschools and education, and not necessarily about early parenting matters.

The research also found that parents who had established connections to their broader communities through associations and support groups generally felt that these links were of significant value. Parenting education and family support, in its broadest sense, is needed in the general community due to the loss of extended family, the advents of smaller families, the greater mobility of the population and changes in family structure. For many families, the net effect of these phenomena is social isolation and lack of confidence. These things are perhaps even more apparent in CALD and new and emerging communities given smaller family and support networks whilst trying to integrate into and raise their families in new social and cultural systems.

5.4 Separation and divorce

CMS recognises that the rate of divorce and separation has stayed approximately the same according to the Australian Bureau of Statistics information even though the rate of marriage has increased. This has implications for children and their sense of safety and security. There is a real risk that "adults business" can become "children's business" and it is important that policies and practices focused on the best interests of the child and don't get caught up in this parental negotiation cycle.

There is an evidence base growing around the potential benefits to many separated parents of engaging in a focused dispute resolution forum that assists them to hear and consider their children's experiences and needs within a brief, therapeutic medication process [86]. A study [87] found that improving the mutual regard of both parents and their emotional availability to their children often resulted from the child inclusive intervention. This had important flow-on effects for the emotional wellbeing of their children up to one year after intervention.

5.5 Step families and blended families

The Australian Bureau of Statistics [88] defines stepfamilies as, ".....those formed when parents re-partner following separation, and where there is at least one step child of either member of the couple present".

This definition does not include families in which children reside in the household part-time, or stepfamilies where the non-resident parent has re-partnered [89]. The ABS also distinguishes between stepfamilies and blended families. A blended family contains a stepchild, but also a child born to both parents [88]. Stepfamilies are increasing in number with a corresponding rise in complexity of relationships when the family is formed. It is desirable that practitioners become familiar with stepfamily issues in order to facilitate adjustments in surviving loss and change the experience of stepfamily living [90].

5.6 Grandparents or alternative carers

While many grandparents provide temporary child care for grandchildren, some are the primary carers of their grandchildren. The reasons grandchildren come to live with their grandparents are varied, but often include trauma of some kind, such as a parent's drug or alcohol abuse, relationship breakdown, mental or physical illness, imprisonment or death [91 92 93]. As primary care providers, grandparents assume responsibility for their grandchildren's emotional, structural and financial support[91].

Grandparents differ from other adults caring for children. They are often retired or planning retirement, and, compared with younger parents, on average have lower financial resources and less physical stamina. They may face difficulties resuming parenting at an older age, difficulties accessing assistance, or legal costs. This situation, combined with their own ageing, can result in unexpected social, financial and health problems [94].

Grandparent families differ from other families in the domains of [95]:

- age (In 61% of grandparent families, the youngest grandparent was aged 55 years and over);
- family type (almost half (47%) of grandparent families were lone grandparent families, with (93%) of these lone grandmothers caring for grandchildren);
- Income and cost of living (the transition to being a grandparent primary carer may be sudden, and associated with high initial costs related to accommodating children. The ongoing cost may not have been planned for and may affect the sustainability of the grandparent's retirement income. In 2003, one or both grandparents were employed in only one third (34%) of grandparent families. In keeping with this, around two-thirds (63%) of grandparent families relied on a government pension, benefit or allowance as their main source of income); and
- area of usual living (Grandparent families tend to live in regional areas, more so than other families. In 2003, a similar proportion of grandparent families lived in the major cities of Australia as lived in regional areas of Australia (48% compared with 45%).

5.7 Parents affected by alcohol or other drugs

The negative health and social consequences of drug and alcohol use for individuals, communities and families are widely acknowledged. Drug and alcohol use does not occur in isolation and it has been linked to poor mental and physical health, social disadvantage such as lack of education, unemployment, homelessness, social exclusion and poverty. The link between social disadvantage and drug use, particularly alcohol is most evident within the Indigenous population [96]. One study [88] highlighted the use by parents of drugs and alcohol as a contributing factor in 57% of cases of care and

protection applications. Research shows that people aged 18-35 are the group most likely to be addicted to illicit drugs and also the most likely to bear children. Drug use has a significant negative impact on the ability of parents to be available to their children and provide safe care and an outcome of this is the entry of children into out-of-home care. The impact of parental drug use on the extended family can also not be overlooked, with many grandparents finding themselves raising their grandchildren at a time when their advancing age and declining health present its own challenges.

5.8 Families in rural and remote contexts

It is well documented that the health status of rural and remote Australian is an ongoing challenge [88]. Up to 36% of clients attending the QE II Family Centre come from the surrounding regions of rural and remote NSW [89]. Health outcomes, as exemplified by higher rates of death, tend to be poorer outside major cities. The main contributors to higher death rates in regional and remote areas are coronary heart disease, other circulatory diseases, chronic obstructive pulmonary disease, motor vehicle accidents, diabetes, suicide, other injuries and some cancers such as lung cancer. These higher death rates may relate to differences in access to services, risk factors and the regional/remote environment. This also reflects higher proportions in those areas who are Aboriginal or Torres Strait Islander. Overall, death rates for Indigenous people tend to be much higher than for non-indigenous people.

There are clear differences in health service usage between areas. There are, for example, lower rates of GP consultations and generally higher rates of hospital admission in regional and remote areas than in major cities. There are also inter-regional differences in risk factors: for example, people from regional and remote areas tend to be more likely than their major cities counterparts to smoke and drink alcohol in harmful or hazardous quantities. It is also likely that environmental issues such as more physically dangerous occupations and factors associated with driving play a part in elevating accident rates and related injury death in country areas.

Whilst there are positives in terms of lifestyle for people living in rural areas there can be difficulties for young families associated with rural and remote access to support services. Women now have to move out of smaller towns to either regional centres or Canberra to have their baby. This occurs at a stressful transition time for the family [88]. QEII is committed to achieving timely referral pathways for families and professionals residing in areas with limited support services available.

5.9 Partners working away from home

There are a number of occupations which take a parent away from their family for periods of time. Many of these occupations in the ACT are through the military, mining and government service industries and the increase in the fly-in-fly-out (FIFO) worker. There are a number of studies internationally which document the social impact of this, and particularly on the family [90]. A WA

study [91] revealed that the FIFO lifestyle for parents with children under 5 years was the greatest, particularly for the impact on their life and relationship. Another WA study interviewed FIFO families from a strengths based perspective to find out how they managed their parenting and concentrated work schedules. What became apparent as a result of the study was the importance of social supports the importance of negotiating parenting tasks and the ability to keep the emotional presence within the family unit of the parent that was away at work.

5.10 Parents with a disability or a child with a disability

About 1% of Australians have an intellectual disability. For those who are parents, it can be lack of suitable support services, rather than their disability, which make it hard to cope. It is thought that approximately 1-2% of families with children aged between 0-17 years include at least one parent with learning difficulties. People with an intellectual disability can have a lot more difficulty than others in understanding ideas, solving problems, concentrating, remembering and learning new things. Intellectual disability can result from damage to the brain before or after birth, through either genetic causes or by external (environmental) factors.

Parents with a physical disability often experience undue hardship because:

- there is not enough respite or home help and a lack of support services within the community to meet their day-to-day needs;
- people working in the care sector don't understand the needs of disabled parents; and
- family relationships are interrupted when children are removed or cared for by others when their parents are hospitalised, ill or having difficulty.

4% of Australian children aged 0-4 years have a disability including chronic illness, intellectual or physical disability. The percentage is higher in Indigenous communities. Most parents adapt successfully to parenting a child with a disability and see their child as a positive contributor to the family and a source of happiness. Depending on the severity of the disability, the pressure and the sense of isolation that can accompany high levels of care can place a lot of emotional stress on parents, and might affect the parental relationship or the family's ability to cope financially. Because of these stresses, emotional disturbances such as anxiety or depression are more common than usual among parents of children with disabilities.

5.11 Family violence

Over the past thirty years there has been increasing recognition that domestic violence is a significant public issue, and not merely a 'domestic' or a private matter between two individuals. This shift in perception has, in turn, led to an

acknowledgement that the responsibility for addressing domestic violence belongs to the whole community. This includes employers and workplaces [91].

One of the most common forms of violence against women is that perpetrated by a husband or an intimate male partner [97]. Over three quarters (76%) of the violence against women is perpetrated by someone they know, with over one quarter (25%) of women reporting that the violence was perpetrated by a partner.

Partner violence can affect the physical, mental and reproductive health of those who experience it [97]. This impact can go beyond the wellbeing of individuals, affecting families, particular communities or society as a whole. Violence that occurs between partners may also affect children living with them [97]. 60% of women who had experienced partner violence in the last five years had children in their care. Just over two-thirds of these women said that the children had witnessed the violence. There is increasing concern about the impact of domestic violence on children and understanding of the frequent co-existence of domestic violence and child abuse [98, 99].

6.0 CMS' strategic focus and governance

6.1 Vision

Towards Healthy Families [103]

Ija Mulanggari, goodtha Mulanggari

Thriving Mothers, Thriving Babies

Ngunnawal meaning

6.2 Mission

The ACT community knows, values and supports CMS

Expand programs

Maintain and develop existing programs

Strengthen links with government/non-government sectors

6.3 Values

As a major stakeholder in child and family health for the ACT and surrounding region the Canberra Mothercraft Society at the Queen Elizabeth II Family Centre holds values and vision.

In relation to children and families we place a high value on:

- promoting the physical, emotional and psychosocial wellbeing of children and their families and strengthening family resilience;
- enhancing confidence and infant health; and
- achieving effective outcomes.

In relation to service provision we place a high value on providing a safe, caring and supportive environment that:

- respects individual and cultural differences;
- promotes equity, access and empowerment;
- enables staff to achieve the highest professional standards that reflect best practice and research;
- promotes cooperation and collaboration with other service providers; and

- advises government on health needs of families with young children.

6.4 CMS Board

The CMS Board is made up of eleven members[100] - ten members from the community and one honorary medical officer position. The Board consists of:

- the president and four office bearers;
- six ordinary Board members; and
- one Honorary Medical Officer.

6.5 Key result areas

To achieve their mission CMS aims for results in these areas[102]:

- program development;
- community and public relations;
- finance and audit; and
- governance.

6.5.1 Program Development

- service development;
- research; and
- staff development.

6.5.2 Community and Public Relations

- media relations;
- sponsorship; and
- involvement in community and government activities.

6.5.3 Finance and Audit

- short term viability; and
- long term viability.

6.5.4 Governance

- contemporary best practice governance;

- diverse membership base; and
- sound leadership by a skilled board.

6.6 Governance

6.6.1 The legal entity

The Canberra Mothercraft Society Inc. (CMS) is incorporated as an association membership based, not for profit non government organisation. CMS is a registered charity. The Society has a Constitution[100] in which the objects describe the purpose and role of the Society in the provision of primary health care and community development programs to families in the ACT and Greater Southern Region of NSW.

CMS has a Board of management whose powers are to control & manage the affairs of the Society & to govern in the best interest of CMS. The Board is comprised of members of the Society and is representative of the community it serves. The Office Bearers of the Board [100] are the:

President;

Vice-president;

Treasurer; and

Secretary.

In support of the effectiveness of the Board the backgrounds of Board members include expertise in: law; financial management; medicine; early childhood education; nursing; midwifery; health service management; speech pathology; textile art; counselling; parenting; & disability services.

6.6.2 Limitations model of governance

The Boards governance role is characterised by the processes and systems used by the Board to set organisation direction and priorities, identify risks and create policies to manage these, set management performance expectations and monitor achievements against these and to report to these. In 1999, CMS formally adopted a limitations model of governance with Governance Policies [101] that are annually reviewed and establish the criteria for delegations, accountability and performance of the Board and the Director of Nursing & Midwifery/Executive Officer (DON&M/EO). CMS has a DON&M/EO whose role it is to: lead in the operationalising of the strategic directions established by the Board; provide strategic advice and support to the Board; communicate its directions to staff; communicate on behalf of staff to the Board; and to represent the Board and CMS to government and other agencies [101].

The purpose of the governance model is so that the CMS Board can achieve enough control so that it can exercise its duty of care and enough freedom so that the DON&M can achieve the best possible outcomes. The Board add value to the operations of the Society by: helping the DON&M/EO and senior staff to: determine what matters most; bringing the wisdom of the Board members to organisational decision making; think strategically; monitor progress; and challenge assumptions and the value of achievements; and creating and modelling the desired culture. This occurs at Board Meetings, Committee Meetings and weekly meetings between the President and the DON&M/EO. The DON&M/EO is employed by the Board as a body. Aspects of the relationship between the Board and the DON&M/EO are delegated to the President who always acts in accordance with Board policy. The Board has no managerial relationship with the CMS staff, this being the sole preserve of the DON&M/EO.

6.6.3 Setting and monitoring the strategic direction

The Board is responsible for providing strategic leadership and determines CMS's strategic direction by developing the strategic results to be achieved[101]. The Board regularly monitors the achievement of the strategic results at its monthly meetings. CMS has a cyclical strategic planning process in place that is understood by staff and the Board. In the development of the 5 year Strategic Plan CMS is informed by: CMS Constitution; contracts with key stakeholders; ACT Health Strategic Plan; demographic data; feedback from clients; feedback from key stakeholders; service reviews; staff; research; contemporary thinking about practice; evaluation and achievements against the previous strategic plan. The intent of the plan is that identifies goals and priorities that are recognised and have meaning across the organisation and the plan is realistic in relation to available resources and it informs the way resources are allocated. The Strategic Plan is used to inform the Operational Plan.

6.6.4 Board committee structure

The Board has a committee structure [101] to support the work of the Society. The Board uses committees sparingly and only in response to its own job. The Board Committees do not conflict with the Boards delegation to the DON&M/EO. The Board Committees are:

Board

DON&M/EO Compliance Committee;

Finance & Audit Committee;

Community & Public Relations Committee;

Program Development Committee; and

Board Policy Making Committee.

All Committees have Terms of Reference and report to the Board. Key members of staff, including the: DON&M/EO; Clinical Manager; Operations Manager; Counsellor/Community Development Officer; and the Finance Officer, if members, are equal members of the Committees. The DON&M/EO, Finance Officer and Operations Manager also attend the Board meetings.

6.6.5 Compliance

On behalf of the Board the DON&M/EO ensures that CMS complies with all statutory requirements, its Constitution [100] and contractual agreements in relation to financial and performance reporting requirements with funding bodies. CMS is committed to transparency in all of its activities and publishes a comprehensive Annual Report [103], complete with a full copy of the Auditors Report, on its website and hard copy to all members, stakeholders and interested individuals and organizations.

6.6.6 Operationalising the Strategic Plan

Operational assessment, planning, implementation and evaluation are the responsibility of the DON&M/EO [101]. The DON&M/EO, in consultation with staff and the Board during planning sessions, develops biennial Operational Plans in order to achieve the Strategic Plan. Monitoring is evidenced by the monthly reports provided to the Board. Monthly reports are written against the strategic directions and performance outcomes identified in the Strategic Plan:

- program development;
- community and public relations;
- finance and audit; and
- governance

All staff participate in the Professional Development Evaluation Program where the achievements and the future needs of the individual and the organisation are discussed and an individual development plan made. Operational Policies are developed and regularly reviewed to inform and support staff. Policies [104, 105] reflect compliance with relevant legislation. To achieve the strategic directions the style of management is adaptive to meet the individual staff needs, the ever changing health care environment and the dynamic needs of CMS. The organisation has well prepared and well qualified leaders:

- DON&M/EO;
- Clinical Manager;
- Operations Manager;
- Counselor/Community Development Officer; &
- Educator.

All staff members qualifications are published in the Annual Report[103]. The organisational structure and position descriptions devolve responsibility and

authority. Staffing levels are continually monitored and remain adequate to meets the needs of both clients and staff. All staff are supported with study leave and financial support to obtain appropriate qualifications and continuing professional development to suit this scope of practice.

Staff are encouraged and supported to be active participants as the organisation evolves to meet contemporary needs of our clients. Clinical staff have also been supported to develop coding skills and analyse that data for service improvements.

6.6.7 Financial management

CMS has a budget that reflects the priorities of the Strategic Plan and financial performance is closely monitored and analysed at monthly Board meetings where the Board is provided with detailed financial reports with an analysis of key trends and issues. Budgets are developed for specific programs or projects. In its Strategic Planning CMS considers long term financial viability and sources of income. All long term liabilities are fully covered by contractual arrangements and in reserves. The DON&M/EO works within clear financial delegations and authority. The organisation utilises accrual accounting system and the annual audit[103] reflects that financial management systems meet accepted accounting standards. Members of the Finance & Audit Committee undertake internal controls and checks and this is reported to the Board. The entity is a going concern.

7.0 Scope of care and linkages

7.1 An integrated approach

Services need to be effective and efficient and aimed at improving outcomes for the whole population, as well as addressing those most in need. An important consideration is to ensure that children and families have timely access to the types of services they need.

Universal approaches aim to target the whole population of births in ACT. Research[33] from Canada describes services being available and accessible to all children. The research validates a population approach because the vast majority of children up to age 6 that are considered at risk of not reaching their full potential fall in two-parent, middle-income families. Programs need to focus on all children, not just those in poverty or with special needs. The report emphasizes that programs must incorporate early identification of problems and has the capacity to adapt the setting to meet the individual needs of the child. This requires specialized expertise and resources and good links with specialized services and the health care system.

Providing a universal service for child health and wellbeing means that an early coordinated response can occur for those children with risk factors and those referrals and interventions can be commenced prior to entering the school system. Offering universal programs to all families is essential so that families who are vulnerable or at risk are not stigmatized. Preventative strategies at the earliest stages of life are more likely to be most effective and successful than later stage interventions when family issues have escalated. Studies [106] have shown that investing resources into the early years is both cost effective and can have significant health and wellbeing outcomes into adulthood.

Primary health care services are the first point of contact for families in the ACT and surrounding regions of NSW service systems. QEII is committed to developing key local contact points for families with young children in the ACT and surrounding regional and rural areas. Often services provided locally operate in isolation from each other. QEII seeks to improve interagency collaboration by recognizing that for a coordination infrastructure it requires specific resourcing independent from service delivery. This role includes setting up consultation processes with the community about the changing needs of families with young children, encouraging families to participate in programs to support them in their parenting role and assessing the barriers to service accessibility. A flexible developmental approach is required locally which demands rigour and accountability.

The universal primary and secondary primary health care services are provided by ACT Government Health Directorate Women, Youth & Children Health Program. Through their commitment to primary health care principles and practices and an experience for clients of seamless services ACT Government Health Directorate and CMS have since 1997, provided an integrated Primary Health Care Service. QE II is the tertiary Primary Health Care service in the ACT and is integrated with the WY&CP in the provision of

those services. This creates for the client continuity of care and a single entry point for referral providers such as GP's, mental health, community allied health and child protection, alcohol and drug services, maternity hospitals and a range of non government organisation or referral providers.

The tertiary primary health care service at QEII is specifically targeted at early intervention provided for complex health and behavioural issues that cannot be resolved by community based services and parents with increased vulnerability. This service is able to be targeted because there is a universal system already in place which acts as a springboard by which at risk and vulnerable individuals and families are identified as requiring targeted services.

A number of collaborative strategies, entrenched in the CMS Agreement with ACT Government Health Directorate, and partnerships exist to assist work with the primary and secondary care systems. The ACT primary health care services of the WY&CH Program and CMS provide direct community and residential services to children and families with challenges and conditions that are mild or moderate or chronic, complex and severe. An integrated approach has the capacity to respond to emerging problems and conditions, rather than waiting until problems become so entrenched and severe that they require attention in the acute care sector [107].

Particular efforts need to be made to develop ways of engaging and retaining contact with the most marginalized and vulnerable families, and making all aspects of the service system more equitable and inclusive [108, 109, 110]. Through the single client intake system offered by ACT Health QE II clients move from one contact point to the next without repeated registration procedures. This seamlessness is enabled by an inter-disciplinary service focus where the client's needs are assessed in totality and holistically. There are waiting periods for QE II services, and a triaging system is in place to ensure timely access according to clients needs.

Integration for QEII has four essential components:

1. professional staff from QE II and the WY&CHP are enabled and encouraged to work together in an integrated way built around the needs of children and families;

2. within QEII there are common processes which are designed to create and underpin joint working';

3. a framework exists which brings together ACT Health WY&CHP and CMS, supported by the pooling of resources as appropriate, and ensures key priorities are identified and addressed; and

4. a strong interagency governance arrangement, in which shared ownership is coupled with clear accountability [111].

7.2 Partnerships

Community and intersectoral partnerships, are seen to be an effective way for a range of stakeholders in any given community, to come together and work towards achieving common goals, using the strategies that are most appropriate to their local contexts. A strong motivating factor for adopting a partnerships approach for the delivery of services is recognized because the environment in which we live is a challenging and rapidly changing one, and this is creating a need for new ways to engage and families with their transitions through life, learning and work roles. It also found that delivering this support requires a co-ordinated response, which is able to address the unique needs of families, in the specific settings and circumstances in which they live.

Another driving force in developing strong effective partnerships is the financial reality of funding resource restraints. When looking at partnership approaches there are some key messages:

- all stakeholders in the community are responsible for working in partnership to support young families to make decisions about their futures, and in their specific life transition;
- local solutions to local problems are effective because they can be designed to suit the local context. Local ownership of initiatives also encourages participation and commitment;
- partnerships work best if they have clearly stated, shared and agreed goals, strategies, outcomes and accountability requirements, with all stakeholders working together to achieve common objectives;
- bringing about change at the local level requires flexible guidelines in government-funded initiatives, with the provision of assistance, support and ideas for those communities that need it; and
- effective partnerships include families and children in decision-making processes [112].

Working with other sectors to improve health and wellbeing is not always straightforward; it can be complex, difficult and takes time. Strategies must be guided by strong leadership and supported by varied collaborative efforts across all relevant sectors in order for progress to be made[113]. Planning time is needed for new partnerships to develop relationships with services/organisations that will enhance sustainability. Collaboration will guarantee the establishment of priorities and also ensure diverse and innovative approaches. A structured approach with adequate management support is needed.

Stehlick [114] considers the mutual benefits of partnering with industry. In the development of partnerships that build social capital, the activities themselves become part of the process of trust building. The industry's investment in this

proves is then viewed as a positive commitment by the community, which in turn leads to potential social capital growth, both within the community and with the industry partner. CMS' clinical and community development services work in partnership with a diverse range of health, social service and educational agencies.

8.0 Organisation of Services