then the Territory in consultation with the Organisation must reasonably determine the amount of any overpayment of the Funding Amount and that amount must be repaid to the Territory in accordance with the terms of this Agreement or if this Agreement is continuing, and at the Territory's discretion, the next payment due to the Organisation may be temporarily or permanently reduced by the amount overpaid. ~~Partially agree~~

Commented [ACTGS90]: The Territory agrees with this amendment.

Item 4. INDEXATION

The Territory will pay the Organisation in respect of each financial year of the Agreement Period, the Funding Amount as indexed by:

(1) An **EBA adjustment** that matches the ACT Public Sector Nursing Agreement (noting that the agreement title may change). This adjustment will be based on the FTE profile provided by the Organisation, and will be calculated based on the date of effect of the award increase. ~~Agree~~

(2) A **CPI adjustment** on the non-salary component of the Agreement Funding Amount, at the rate advised by the ACT Department of Treasury, in the ACT Budget Papers as the "Community Sector Funding Rate Consumer Price Index". ~~Agree~~

Item 5. SUPPLEMENTATION

(1) On 30 June of each year of the Agreement Period, up to and including 30 June 2019, the Organisation may be entitled to a supplementation to the Funding Amount to cover any deficit the Organisation has incurred as a result of meeting any emerging long term unfunded leave liabilities, directly related to the provision of the Services (**Deficit Amount**).

(2) If a Deficit Amount is agreed to exist, the Territory will provide a supplement to the Funding Amount according to the following:

(a) o~~O~~n 30 June 2018, the supplement payable by the Territory will be no more than 75% of the Deficit Amount; and

(b) o~~O~~n 30 June 2019, the supplement payable by the Territory will be no more than 50% of the Deficit Amount.

(3) In requesti~~ang~~ supplementation to the Funding Amount, the Organisation must provide to the Territory evidence that the Funding Amount was not sufficient to cover any Deficit Amount, by providing copies of the following:

(a) financial records with details of how the Funding Amount was acquitted by the Organisation in accordance with this Agreement;

(b) evidence that the Funding Amount, including any indexation under Item 4, was not sufficient to meet the Deficit Amount; and

Commented [ACTGS91]: As outlined above, it is no longer Territory policy to include a supplementation provision as a standard in its agreements. The Territory is of the view that the Funding Amount should reasonably cover all relevant costs by the Organisation for the services. In addressing your concerns, and in good faith, the Territory will allow for a transitioning supplementation provision, that ultimately phases out the supplementation over the Agreement Period. However, to meet the Territory's reporting requirements in relation to expenditure of public monies, the Territory will require evidence to supplement the Funding Amount.

Commented [KM(92]: Do not agree. The funding amount should reasonably cover all relevant costs. This is not supplementation this is core funding that has never been including in the funding amount. The funding amount does not and never has covered all reasonable costs. The funding amount has never included long term liabilities and that is why the provision has been in the Agreement since 2000. The only reason the service does not r a loss is because the service has been able, on most occasions, the funding gap from savings to the Territory from private ins. revenue. Canberra Mothercraft Society would rather the Territo, provide a funding amount that covers all reasonable costs – including long term liabilities. This clause is not an act of good faith on the part of the Territory. This clause only mitigates the underfunding risk to the Society and the Territories obligation to cover all reasonable costs. Funding limited to 75% or 50% coverage and time limited to 2019 is completely unacceptable.

(c) any other information that the Territory requests in order to reasonably determine the Deficit Amount.

(4) The Organisation acknowledges that supplementation by the Territory will only be payable if the Organisation has provided to the Territory sufficient evidence that a Deficit Amount has occurred and directly relates to the Services being provided under this Agreement.

(5) If the parties cannot reach agreement on the Deficit Amount within 30 days of 30 June of each relevant year a supplementation may be payable, **clause** 11 will apply.

~~(1)~~(6) The parties agree that no supplementation will be payable for any period following 30 June 2019.

SCHEDULE 5

SPECIAL CONDITIONS

Item 1. CHANGE OF CONTROL

Not used.

Item 2. PERSONAL INFORMATION

(1) Notwithstanding **clause 8**, if the Organisation is not prohibited under government legislation from transferring Personal Information to a third party, then if

(a) the Territory instructs the Organisation to provide any Personal Information to another organisation, and

(b) either the Territory or Organisation has contacted Service Users to notify them of all legal obligations for dealing with the Personal Information, including notifying the third party of the obligations under **clause 8**,

the Organisation will ensure that:

(c) the transfer of or give access to Personal Information is in accordance with the relevant government legislation (including a TPP Code) or notified policy; and

(d) the Personal Information is provided directly by the Organisation to the third party, unless the Territory otherwise instructs.

(2) Personal Information may only be shared by the Organisation if the Service User has previously provided his/her relevant consent at the time that the Organisation first collected the Personal Information, and for the purposes of ensuring the better management of Services for the Service User.

Item 3. ASSETS

Commented [ACTGS93]: Please consider amendments to this provision.

Commented [KM(94)]: Suggest (a) & (b) are superfluous.

(1) The following Assets, and any others as notified and funded by the Territory during the Agreement Period, remain the property of the Territory and on expiration or termination of this Agreement, to the extent those Assets are unfixed or moveable, will be delivered by the Organisation to the Territory or to a third party as directed by the Territory:

~~Not applicable. Disagree~~

(a) computers, printers and phones; and

Commented [KM(95]: This a repeat of 3 (b)

(b) any other Assets notified.

Commented [KM(96]: Do not agree. This needs to be specified.

~~(2) Schedule 5 Item 1 (1) (2) & (3) must be reinstated from the 2013-2016 Agreement.~~

(2) The Territory is responsible for the building and external fencing, and is responsible for maintaining security and emergency management facilities.

(3) ~~(2)~~ The Territory will bear the following obligations in respect of the Assets ~~listed in Item 31(1)~~:

(a) ~~(a)~~ Maintenance of the building and external fencing, monitoring of security and emergency management facilities.

(b) ~~(b)~~ The Territory also funds and owns the computers and printers. The Territory also owns the phones however the organisation pays for their use.

(4) ~~(3)~~ The Organisation will bear the following obligations in respect of the Assets ~~listed in Item 31(1)~~:

(a) Provide timely advice to ACT Health facilities management through MAINET and any subsequent management system regarding any concerns relating to the maintenance of the building and external fencing, monitoring of security and emergency management facilities.

(5) ~~(2)~~ The Organisation will maintain an assets register which identifies all Assets and will be supported by receipts or other documentation which evidence the purchase. The register will be maintained throughout the Agreement Period.

~~(3)~~(6) Subject to the Territory's approval, ~~t~~The ~~following~~ Assets identified in the assets register remain the property of the Organisation and the Organisation must at its cost maintain, store, insure and in every respect control, deal with and supervise the use of the Assets in a way that causes no injury, loss or damage to any person (whether a Service User or not) or property during the Agreement Period.

~~See Item 3(5).~~

~~(4)~~(7) ~~(3)~~ The party responsible for an Asset will bear the following obligations in respect of the Assets ~~listed in (1) and (2)~~including:

(a) repair and maintenance,

(b) insurance, including where relevant, comprehensive third party motor vehicle insurance,

(c) deal with and supervise the use of the Assets in a way that causes no injury, loss or damage to any person (whether a Service User or not) or property during the Agreement Period, and

(d) security of the Assets at the Premises.

~~(5)~~(8) ~~(4)~~ The following assets will not be purchased with the Funding Amount but may be leased or hired by expending the Funding Amount:

Motor vehicles, vans, trucks, etc. ~~Agree~~

~~(5) The Organisation will maintain an assets register which identifies all Assets and will be supported by receipts or other documentation which evidence the purchase. The register will be maintained throughout the Agreement Period.~~

~~(6)~~(9) ~~(6)~~ The Organisation will provide the Territory with access to the assets register on the request of the Territory.

Item 4. PREQUALIFICATION

Not applicable.

Item 5. CHILD PROTECTION - REPORTING & TRAINING

(1) The Organisation is required to have a written child protection policy that:

(a) clearly states and appropriately details (having regard to the activities, functions and powers of the Organisation) that the care and protection of children and young people is paramount in the conduct of activities, powers and functions of the Organisation; ~~Agree~~

(b) by reference to the *Children and Young People Act 2008* (ACT) ("Act"), outlines:

(i) that a person who believes or suspects that a child or young person is being abused, neglected or at risk of being abused or neglected may (under section 354 of the Act) report the relevant circumstances ("Voluntary Report"), ~~Agree~~

(ii) the persons, if any, for whom it would be an offence (under section 356 of the Act) not to report reasonable suspicions about a child or young person experiencing or having experienced sexual abuse or non-accidental physical injury ("Mandatory Report"), and ~~Agree~~

(iii) the procedures outlined in the Act for reporting suspected cases of children or young persons suffering sexual abuse or non-accidental physical injury or who are in need of care and protection; ~~Agree~~

(c) outlines training which is available to all employees, contractors or volunteers of the Organisation ("Personnel") for purposes of the Act, including the availability of training through any available Territory training program; and ~~Agree~~

(d) outlines the support which is available to any of the Organisation's Personnel who make either a Voluntary Report or a Mandatory Report. ~~Agree~~

(2) The Organisation will monitor adherence by all of its Personnel (as relevant to the provision of the Services) to its child protection policy. ~~Agree~~

(3) Nothing in this Special Condition limits the Organisation's obligations under the Act or any other law applicable to the Organisation. ~~Agree~~

Item 6. CREATING HEALTHY ENVIRONMENTS

(1) The organisation acknowledges that it is a legal requirement for particular public places to be smoke free and will adhere to the *Smoke-Free Public Places Act 2003* (ACT) if conducting the funded activity in a relevant public place. ~~Agree~~

(2) The organisation should consider the provision of healthy food options if the organisation provides catering for a funded activity. ~~Agree~~

(3) The organisation must, if alcohol is available at a funded activity, ensure that non-alcoholic beverages are also available. ~~Agree~~

(4) The organisation must take all reasonable measures to minimise the likelihood of injury to persons occurring at or as a result of a funded activity. ~~Agree~~

(5) The organisation acknowledges the Territory's encouragement of the organisation to engage in environmental health practices (e.g. reduce, reuse and recycle) in relation to the funded activity. ~~Agree~~

(6) The organisation must ensure it has in place a sun protection policy for participants in the funded activity when an event is held outdoors during daylight hours. ~~Agree~~

Item 7. ADMISSION CRITERIA FOR QUEEN ELIZABETH II

Note: The following admission criteria relate to a number of issues and problems which, in many circumstances can be managed by secondary level services. The prime factors which differentiate between secondary and tertiary level support relate to the complexity and severity of the problem, the frequency of the interventions, and the extent to which that support needs to be intensive and continuous. An assessment must be made that an admission to the residential services is the most appropriate for the client/s and that community based care is not adequate or appropriate for the effective management of the difficulties being experienced.

(1) **Complex lactation and other feeding problems** ~~Agree~~

(a) requiring support for mother and baby on a feed-by-feed basis over a 24-hour period or longer to ensure that lactation or a suitable feeding regime is established and/or continued.

(2) **Failure to thrive** ~~Agree~~

(a) following lack of success in ensuring that adequate caloric intake is being achieved and that further and closer observations, interventions and investigations are required.

(3) **Unsettled baby** ~~Agree~~

(a) following lack of success of the interventions of secondary level service providers and where closer observation and investigation, and more intensive therapy and/or trialling of a range of strategies is warranted;

(b) for support for parent/s and family who have become very stressed by this experience; and

(c) when the parent/s require more intensive support and education about parenting skills.

(4) **Mood Disorders** ~~Agree~~

(a) for women experiencing Mood Disorders such that normal coping mechanisms have been assessed as being compromised and more intensive support and counselling is needed in order to regain strength and confidence in parenting abilities;

(b) for women and partners when the problem is severely affecting the family dynamics and functioning and where both partners need support and counselling; and

(c) when the care of the baby is of concern.

Note: Women experiencing a severe psychosis or other acute and serious mental illness should be cared for in an appropriate psychiatric unit. The tertiary service is appropriate for the admission of these clients once the acute episode has been treated and where the client/s requires additional close parenting support and/or to aid in establishing or improving the relationship (~~bonding~~attachment) between baby and mother/parents, and prior to discharge or transfer back to secondary supports. ~~Partially agree~~

Commented [KM(97]: Change to (attachment)

Commented [ACTGS98]: Noted.

(5) **Child at risk** ~~Agree~~

(a) when risk of harm or neglect of baby/child is a concern, and when the provision of intensive parenting support, education and implementation of suitable strategies is assessed as being necessary for the improvement of family functioning and the well-being of the child; and

(b) on request from Child Protection Agencies when further assessment, support and education is needed.

(6) **Special need families** ~~Agree~~

(a) Where multiple babies are born or one or both parents have a physical or intellectual disability and require considerable supervision, information and practical support in establishing and maintaining parenting roles and skills.

(7) **Primary carer support** ~~Agree~~

(a) when a parent/s requires close and intensive support and encouragement in the acquisition of basic parenting skills, and/or a supportive environment in which to develop and gain confidence in parenting.

(8) **Behavioural problems in children/families** ~~Agree~~

(a) when an infant or child to 3 years is exhibiting disruptive and distressing behaviour and the family requires intensive assessment in

determining, and support in implementing strategies aimed at managing this behaviour; and

(b) for families with infants or young children, where one or more members are displaying abnormal behaviour which is having a detrimental effect on the other family members, and where a planned and intensive program to modify such behaviour and/or improve family dynamics will be beneficial.

Item 8. CONTINUITY OF EMPLOYMENT

(1) For the purpose of this **Item 8**, Incoming Organisation means the Territory-contracted provider of services that (on expiry or early termination of this Agreement) will provide services required to now be provided by the Organisation under this Agreement.

(2) Subject to **Item 8(3)**, the Territory will use its best endeavours to ensure an Incoming Organisation will consider offering employment to such of the Organisation's employees who are suitably experienced in the provision of any of the Services and who wish to be considered for employment with the Incoming Organisation.

(3) The Territory's obligation under **Item 8(2)** will apply for a period of six months from the expiry or earlier termination of this Agreement and to the extent that during that period of time the Incoming Organisation does not have a sufficient number of employees to deliver the Services in accordance with the performance, quality and other requirements of this Agreement.

Commented [ACTGS99]: The Territory has included this special condition, in good faith, to address the concerns Mothercraft has of its employees once this Agreement ends.

Commented [KM(100]: Do not agree. This is aspiratior and provides no foundation for staff to remain employed witl to and following a public tender process. We only seek equity provisions provided to the ACT other non Government public hospital provider in relation to continuity of employment and redundancy.

SCHEDULE 6

TRANSITION OUT

(1) To the extent of any inconsistency with **clause 13**, this **Schedule 6** takes precedence.

(2) In this **Schedule 6** the following definitions apply:

"Transition Out" means the activities undertaken by the Organisation towards the end of this Agreement, which results in the progressive reduction of Services and the progressive handover of responsibilities to a new organisation (**Incoming Organisation**), while ensuring that there is no interruption to the Services. ~~Agree~~

"Transition Out Date" means:

(a) a date 6 months from the end of the Term; or

(b) if this Agreement is earlier terminated and the Organisation is notified that this Item will apply, the date as specified in the notice of termination.

"Transition Out Period" means the period commencing on the Transition Out Date and ending at the end of the Term. ~~Agree~~

(3) The parties acknowledge that the objective of the Transition Out Period is to prepare for and undertake the activities, including Transition Out activities, necessary to enable the orderly transition of the Services to the Incoming Organisation. ~~Agree~~

(~~4~~3) The Organisation acknowledges that:

(a) it is essential that there is no interruption to the provision of the Services as a result of the transition from the Organisation to the Incoming Organisation; and ~~Agree~~

(b) the Organisation will be required to provide the Services in ~~full~~ accordance with the Transition Out plan and this Agreement until the end of the Transition Out Period. ~~Disagree~~

(~~5~~4) The Organisation must develop a Transition Out plan satisfactory to the Territory within 6 months of the start of the Agreement. ~~Agree~~

Commented [KM(101]: Contradicts Clause 6.6 in the Agreement

Commented [ACTGS102]: Please see amendment to clause 6.6 to align with this provision.

Commented [ACTGS103]: Please consider amendment.

Commented [KM(104]: Agree

Commented [KM(105]: This contradicts 6 (2) definition of 'Transition Out' which calls for a progressive reduction of Services by the Organisation and a handover to the Incoming Organisation.

(65) The Territory may at any time, by notice to the Organisation, require a reduction in scope of Services being provided by the Organisation during the Transition Out Period. Disagree

(76) The Territory may request at any time during the Transition Out Period, by notice to the Organisation, for the Organisation to provide require additional services to facilitate the transition of the Services to the Incoming Organisation, which may include training to an Incoming Organisation. Disagree

(87) During the Transition Out Period, the Territory is only liable for: Disagree

(a) payments under the existing payment terms of this Agreement for work conducted during the Transition Out Period; Agree

(b) any reasonable costs incurred by the Organisation that are directly attributable to additional services, required by the Territory, to facilitate the transition of the Services to the Incoming Organisation; Agree and

(c) any reasonable costs incurred by the Organisation that are directly attributable to a reduction in the scope of Services. Clarification required

~~*the public hospital employees at the Queen Elizabeth II Family Centre and, as far as possible, redeploy those public hospital employees into other public services; recognise service for long service leave purposes and honour other accrued leave entitlements; and*~~

~~(c) *assuming responsibility for the public hospital employee entitlements and any redundancy payments for the public hospital employees.*~~

(98) During the Transition Out Period, the Organisation must:

(a) fully co-operate with the Territory and Incoming Organisation to do all things as may be reasonably necessary to ensure the smooth transition of the Services to the Incoming Organisation without interruption; Agree

(b) use its best endeavours to resolve any issues arising out of the transition from the Organisation to the Incoming Organisation; Agree

(c) comply with all reasonable directions from the Territory; Agree

Commented [ACTGS106]: The amendment should now clarify this provision.

Commented [KM(107]: This contradicts (3) (b)

Commented [ACTGS108]: Please consider amendment.

Commented [KM(109]: Agree

Commented [KM(110]: The Territory may negotiate additional services

Commented [KM(111]: This clause fails to reflect the or g employment by the Territory or Incoming Organisation or st redundancies funded by the Territory.

Commented [ACTGS112]: Please refer to new special condi... to address concerns regarding continuity of employment.

Commented [ACTGS113]: This provision outlines that the Territory will only pay for Services that have been provided in accordance with this Agreement. A reduction in scope during the transition phase will result in a reduction of costs payable by the Territory. This should be set out in the transition plan.

Commented [KM(114]: To me this says that 'reasonable' costs will be covered by the Territory. In that light the costs of terminating staff will be covered by the Territory. It is clear that we have a different interpretation of 'reasonable'. The view of the Territory is simplistic, in the first instance scaling down services is not cost neutral or cost saving in the first instance and reduction in costs only follows after expenses are covered.

Commented [KM(115]: This needs to be specific and mutually agreed.

Commented [KM(116]: Schedule 6 (7) (c) is not specific enough to cover contingencies in (d) & (e). This clause only provides for a small degree of equity with the ACT's other no. government public hospital provider.

Commented [ACTGS117]: Please consider the new special condition.

Commented [KM(118]: Considered and unacceptable. If we are to provide a quality service through the retention of an appropriately skilled and qualified workforce until 2022 then we need to be able to either assure staff they will have continuing employment or a redundancy will be offered. The proposed special condition is aspiration only and provides no financial assurance.

(d) upon request from the Territory or otherwise at the end of the Transition Out Period:

(i) provide to the Territory all documents which contain or relate to any Territory Information; ~~Agree~~

(ii) deliver all existing data for Services provided up to the end of the Transition Out Period; and ~~Agree~~

(iii) return to the Territory (or such other person as directed by the Territory) all Contract Material and Territory Material, data and other property or information provided by the Territory to the Organisation under this Agreement; ~~Agree~~

(e) engage in briefings as required by the Territory and the Incoming Organisation with a view to ensuring that the Territory or Incoming Organisation have sufficient information to provide the Services. ~~Agree~~

ATTACHMENT A

FINANCIAL REPORT
Schedule 4 Item 1
for the year ending [*INSERT DATE*]

Service	ACT Health Service Funding Agreement funding amount	Expenditure $	$ Variation +/- 10%*
Total	per annum (ex GST)		
NET SURPLUS / DEFICIT			

*The Organisation must provide the Territory with an explanation of variations of 10% (surplus/deficit) of expenditure by program.

Certificate:

I certify that the above program funding was used for the approved purpose(s).

Signature of Delegate: _____ **Position:** _____

Print Name of Delegate: _____ **Date:** _____

ATTACHMENT B

PERFORMANCE REPORT

for the year ending [*INSERT DATE*]

Section 1: Report against Output and Performance Expectations

Schedule 2	Service Funding Agreement Specification	Actual Delivery	Variance As a % (+ or -)	Reason for Variance	Action to be Taken
Item 4 Outputs					
Item 5 Performance Expectations	The Organisation must implement strategies to ensure access by Aboriginal and Torres Strait Islanders and people from culturally and linguistically diverse backgrounds.				
	A Working With Vulnerable People check is obtained for all employees and volunteers who are likely to work directly with older people and/or children.				

To calculate the Variation as a %, use the following formula: Actual delivery / Agreed outputs = %

Section 2: Information on Policy and Planning Implications (See Schedule 2, Item 2)
Optional report which may be submitted to the Territory at least once each 12 months of the Agreement Period on:

(i) new or unmet needs
(ii) service gaps
(iii) innovations in service delivery
(iv) suggestions for policy change
(v) system issues

Signature of Delegate: _____ Position: _____

Print Name of Delegate: _____ Date: _____

Emerson, Marc (Health)

From: [redacted] (Health)
Sent: Thursday, 2 August 2018 6:27 PM
To: DGACTHealth
Cc: [redacted]com
Subject: RE: Correspondence to Canberra Mothercraft Society.pdf [DLM=For-Official-Use-Only]
Attachments: QEII Service Delivery Model 2017 - 2022.pdf; Attachment B Estimated Transition Out Budget.pdf; CMS Response to DG letter of 31 July.pdf; Attachment C QEII Finance service and staffing data.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Mr De'Ath,
Please find attached the information requested on 25 July and a response to your letter of 31 July.
Regards

[redacted]

[redacted]

Queen Elizabeth II Family Centre
PO Box 126
(129 Carruthers Street)
Curtin ACT 2605
Australia

Ph: [redacted]
Fax: + 61 2 62052344
e mail: [redacted]@act.gov.au

CANBERRA MOTHERCRAFT SOCIETY INC

Towards Healthy Families
Ija Mulanggari, Goodtha Mulanggari
Thriving Mothers, Thriving babies *[Ngunnawal meaning]*

Attachment A

Service Delivery Model

January 2017 - 2020

Canberra Mothercraft Society Inc.

129 Carruthers Street

Curtin ACT. 2605

+61 2 6205 2333

www.cmsinc.org.com

Contents

Contents (continued)

1.0 Executive Summary

Service Delivery Model
2014 - 2017

The purpose of this document is to provide a clear overview of the service delivery model of Primary Health Care for the Canberra Mothercraft Society (CMS) and its services provided from the Queen Elizabeth II Family Centre, one of Canberra's three public hospitals (QE II). It was developed over a four month period by the Board and the service management team and revised on two occasions. The document gives an overview of the context to the work of the Society and why QEII exists. It reflects where we are now and aspects of where we would like to be in the future.

The document outlines the Primary Health Care Model, which is underpinned by the principles and practices of health promotion, and the platform for the delivery of care - C Frame. This document also outlines the scope of care and linkages and partnerships. Managing, leading and organising services to meet the demands and needs of families of young children as well as future workforce requirements will continue to be an ongoing challenge into the future.

CMS as an organisation has been evolving and changing for over eighty years, and has always striven to be relevant to the context of community at that time. During the late 20th Century and now into the new millennium, the history, context and evidence provides a strong direction for CMS's work in primary health care and early parenting. It is now well known that the effects of early life last a lifetime and that there is substantial evidence that factors operating in early life, including pregnancy and early childhood, sets the foundation for a child's future social, physical, emotional and mental well being throughout life.

The Service Delivery Model and the Strategic Plan both inform each other. This foundational document will continue to be adapted as we evolve and as substantial new evidence comes to light. The strategic direction has a focus of 5 years at which time it is reviewed and changed. QEII is one of the ACT's leading non-government primary health care service providers, and is known and respected throughout Canberra and the surrounding region for its knowledge and evidence-based approach to primary health care, and for its support to families with babies and young children, particularly in the 0-3 years. QEII works from a holistic perspective and routinely involves all primary carers, including mother, fathers and other primary carers both within and outside of the family of origin. CMS also successfully undertakes community development activities in several locations and continues to promote resources and supports be available to families in the ACT community.

CMS has always been about promoting and protecting the interests and rights of children and recognises that in our society the family remains the primary means for meeting the needs of young children. Working in partnership with families, QEII ensures that the rights for the child are central to any decisions taken and seeks to maximise positive health outcomes for families while strengthening and promoting the healthy physical, social and emotional development of the child. We know that it is important to view children in the context of broader ecologies – families, schools, neighbourhoods, churches

and communities. As a primary health care service it is our responsibility to strengthen and improve the capacity of parents and other primary carers to meet the needs of their children as they grow and develop.

The focus of CMS programs is to offer families support and assistance through its health service based at QEII and through its community development programs. We cannot do this on our own and it is a collaborative effort with sponsors, partners, universities, government and non government services. We take a transformational approach to service development and enhancement which is underpinned by our vision and values and has to be through strong partnerships and delivered locally to families.

We know there are no quick fixes that actually work In order to improve the quality of life of children and families; therefore we purposefully take a primary health care preventive and long-term approach that is developmental in nature and one that operates in coordination with other forces in a child's life. We are also purposefully mindful that effective programs need to be linked with other systems of support and intervention to ensure they can produce and sustain their impacts over time. They also are based upon research and service development and quality professional staff having effective management support structures in place and ongoing staff development opportunities.

The principles of social inclusion provide a way of looking today and into the future at the well-being of children and families and has potential to frame a national dialogue around the creation of a just, healthy and inclusive society. This commitment affirms the need for targeted programs for vulnerable groups, programs that aim to reduce the distance between the everyday lives and the life outcomes for vulnerable and other children. Targeted programs, whether they are mainstream or discrete, acknowledge that children and families, who are vulnerable for whatever reason, will need additional support and resources if their childhoods are to be healthy and to be rich in relationships and interactions that support their social and emotional health, general wellbeing and development. Universal programs provide the framework of commitment to all children within which to sit the targeted programs necessary to achieve the social inclusion of all children[1].

2.0 Context

2.1 History and global context

CMS operates within a territory-wide context in the ACT and is recognized as a leading resource for families with babies and young children. CMS also provides services to families from the surrounding regions of NSW. CMS' history reflects the changing nature of service delivery to the families and communities it serves, as well as organizational adaptation, continual improvement and renewal.

QEII recognizes that the family remains the primary means for meeting the needs of young children. Family and family circumstances have evolved over the last two or three decades which means that the demands on families are higher and society is less homogenous. Changing family contexts and raised expectations of self and others, the variability of parenting wisdom being supported by extended families, the increase of all primary carers in the workforce and the rising costs of living without growth in wages, all contribute to make it increasingly challenging to be a parent.

Many parents have high expectations of how they should be managing, and often have a fear of 'getting it wrong'. This perceived locus of control creates high anxiety levels which are often reflected in their abilities to parent by being physically, socially and emotionally available to their children. As evidence reveals, this anxiety can have a direct impact on the wellbeing of the child and the attachment of the parent and child.

2.2 Specific factors influencing service provision

2.2.1 Demand for services

The demand for services and the factors which affect this demand has been escalating over time. Factors affecting demand for services include:

- the rise in birth rate;
- housing affordability and lack of acceptable alternative accommodation options;
- increasing prevalence of mental health issues and complexity of client issues;
- poverty and financial crises/hardship with increased reliance upon credit;
- consumers increased knowledge and expectations;
- substance misuse;
- gambling issues;

- an increase in culturally diverse families;
- children caring for adults with a disability or affected by substance abuse;
- generational effects of the "stolen generation";
- increase in homelessness;
- increasing reports of domestic violence;
- the difficulty of Government community health services to respond to unmet demands; and
- changing Federal and State Government legislation; and
- changing governmental contractual and fiscal initiatives.

The dynamic operating environment continues to affect QEII and other non-government services. Should funding allocation and availability of appropriately qualified staff not match demand for services this may result in reduced service quality, accessibility and availability. The situation in regard to guaranteed funding into the medium and long term future and the recruitment and retention of staff, is a challenge for CMS when balancing resourcing and the provision quality services at QEII.

2.2.2 Workforce recruitment and retention

There are a number of workforce challenges confronting QEII now and into the future. These are predominantly about the shortage of midwives and nurses as well as other health professionals immersed in primary health care. With the transition to interdisciplinary team work, a range of health professionals are required for a medium/longer term strategy [2]. Societal issues present major challenges for services in maintaining a work environment that supports the needs of professionals in today's world. Issues affecting the availability of an appropriately qualified workforce include:

- the workforce is strongly influenced by lifestyle choices and demands increasing access to part time shifts to enable them to balance family, study, and the social elements of their lives. This presents significant challenges for managers who are required to staff 24 hour per day services;
- the majority of QEII workforce are women and often manage family responsibilities;
- the average age of the current health workforce is increasing;
- the rising percentage of part time and casual employees impacts upon the need to create capacity in the organisation for succession planning, support for staff and cost efficiencies; and

- the not-for-profit sector is struggling to maintain remuneration packages that compare with Government and the broader market; and
- guaranteed Government funding for the medium and long term.

2.3 History, passion and evidence

QEII has a proud record of assisting a minimum of 1,800 clients per annum through the provision of information, parenting skills development, support and primary health care for children and their families, as well as community development programs. Families seek assistance from QEII with issues such as adjustment to parenting and mood disorders, sleep and settling difficulties, health of children, growth and development of children, nutrition (including breastfeeding, weaning and introduction of solids), behavioural issues, high risk families and unsettled babies. In addition, QEII is utilized as a resource and a way for families to forge links with their communities.

What happens to children in the early years has consequences right through the course of their lives. There are many opportunities to intervene and make a difference to the lives of children. The evidence shows the most effective time to intervene is early childhood, including the antenatal period. Supported by the evidence, CMS and its staff have a sense of mission and belief in the work they do with families and children, and the importance of the early years as a foundation for a full and productive life.

In 1993 the *ACT Maternity Services Review* [3] in one of its recommendations called for a review of postnatal health services. The subsequential *Review of ACT Postnatal Health Services for Families With Infants 1995* [4] in its review made 110 recommendations and the following specific recommendations were to have a significant impact on CMS and the way its services were run into the future:

- the existing postnatal health service be defined in terms of primary, secondary and tertiary levels of service;
- the underlying philosophy of postnatal health care be firmly based on the principles of Primary Health Care;
- clear guidelines be developed by each service to ensure there is no duplication;
- guidelines be developed that outline client target groups, catchment areas and referral criteria to ensure clients are using the most appropriate service level at any given time, therefore maximising resources;
- a tertiary level residential child and family health service be established to meet the needs of families with children up to three years of age;

- 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.

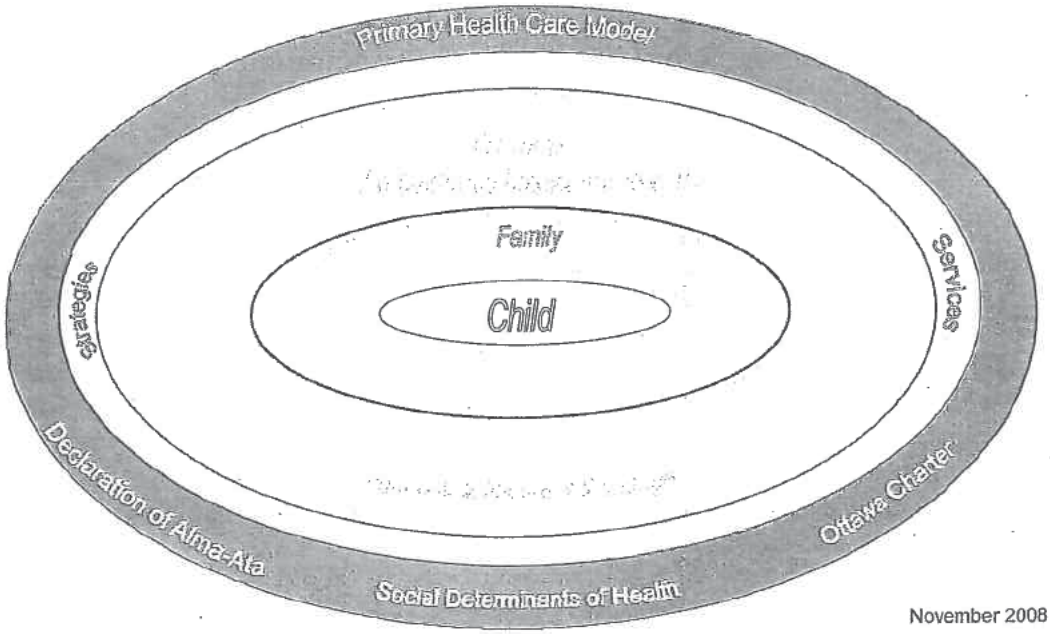
3.0 Service Delivery Model

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



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