Centre for Community Child Health

Murdoch Childrens Research Institute

Engaging and partnering with vulnerable families and communities: The keys to effective place-based approaches

Invited presentation at the Goulburn Child FIRST Alliance Conference 2015. The NEXT Generation: The future of our children and young people's safety is in our hands

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Engaging and partnering with vulnerable families and communities: The keys to effective place-based approaches

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Summary

This presentation seeks to understand the most effective ways of engaging vulnerable and marginalised families and communities. The presentation begins with a brief overview of where we are now – the social and service challenges we are facing. This is followed by analyses of what we need to do to address these challenges, and what we know about how services are delivered – what makes services for vulnerable and marginalised families effective The main focus is on this second of these questions, and various sources of evidence are summarised to see if there is any consensus regarding the importance of how services are delivered and what the key features of effective service delivery might be. On the basis of this evidence, a universal human services framework is described. An exemplary community engagement project – the Tasmanian Child and Family Centres – is then outlined, and the presentation concludes with some summary points and reflections.

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Introduction

This presentation seeks to understand the most effective ways of engaging vulnerable and marginalised families and communities. The presentation begins with a brief overview of where we are now – the social and service challenges we are facing. This is followed by analyses of *what* we need to do to address these challenges, and what we know about *how* services are delivered – what makes services for vulnerable and marginalised families effective The main focus is on this second of these questions, and various sources of evidence are summarised to see if there is any consensus regarding the importance of how services are delivered and what the key features of effective service delivery might be. On the basis of this evidence, a universal human services framework is described. An exemplary community engagement project – the Tasmanian Child and Family Centres – is then outlined, and the presentation concludes with some summary points and reflections.

Where we are now

What have we learned about child development and family functioning, and what are the challenges we currently face in promoting positive outcomes for children and families. Here's a few key points to provide some context for the discussion that follows.

- The early years (including prenatal period) are of profound importance and what happens to children during this time can have lifelong consequences (Gluckman & Hanson, 2006; Lieberman, D., 2013; Prescott, 2015). While this message has been understood for some time, new evidence clarifies and strengthens the message (Moore, 2014).

- We need to ensure that young children have the conditions they need to develop well: responsive caregiving and secure attachments, environments that provide them with opportunities to participate and learn, protection from the effects of adverse circumstances (Gerhardt, 2014; National Scientific Council on the Developing Child, 2004; Richter, 2004; Siegel, 2012).

- 'Social climate change' has had a profound impact on children, families, communities and services, with mixed outcomes (Trask, 2010). As a result of the rapid social changes that have occurred over the last 50 years or so, the conditions under which families are raising young children have altered significantly. Many children and families have benefited greatly from these changes, but a significant minority have not: there is evidence of worsening or unacceptably high levels of problems in a minority of children across all aspects of development, health and well-being (Putnam, 2015; Richardson & Prior, 2005; Stanley et al., 2005).

- We need to ensure that families have the conditions they need to raise their children as they (and we) would wish. So far, efforts by governments and services to address the worst of these outcomes have not had any significant success. This is partly because the nature of the problems facing society have changed, with many of the most pressing problems being complex or 'wicked' (Australian Public Service Commission, 2007; Head & Alford, 2008; Moore & Fry, 2011).

What we need to do

In the light of the issues just identified, what action should we be taking to ensure more equitable outcomes for young children and their families?

First, it has become apparent that the kind of problems we are facing cannot be addressed by single services, departments or sectors but required the coordinated efforts of multiple players at multiple levels (Moore & McDonald, 2013). This will require new forms of place-based collaborative organisation involving many stakeholders - families and communities members, faith-based and community services, service clubs, non-government services, businesses and local chambers of commerce, and local, state and federal government services and policies.

We also need to learn to view the needs of children's and families from their perspective, and not think solely of service solutions (ie. from a professional perspective). Families and communities need to be involved as full partners in the design, delivery and evaluation of community and service initiatives - if they are not, then their 'take up' of services will be reduced and their outcomes worsened.

In a policy paper commissioned by the Benevolent Society, my colleague Myfanwy McDonald and I summarised what action was needed in the following terms:

> *In order to reduce the likelihood of poor long-term outcomes for children experiencing significant disadvantage, a multilevel, ecological approach to early intervention is required that involves programs, community and service system level changes as well interventions to address the structural (e.g. government policy) and wider social factors (e.g. societal attitudes and values) that impact either directly or indirectly on children and families (Moore & McDonald, 2013).*

We argued that, to achieve better outcomes for children and families, we need to take action on three levels: ECEC and early intervention service level, community and system level interventions, and societal and structural level interventions. Interventions targeted at one level only are unlikely to be successful at achieving significant and sustainable change amongst children and families experiencing significant disadvantage – we need to intervene at multiple levels simultaneously.

Below is a brief summary of the actions that need to be taken at each of the three levels.

Level 1: ECEC and ECI Service Interventions

- *Provide high quality inclusive ECEC services for all children*. All children benefit from high quality services, but disadvantaged children do so the most (and are also most harmed by poor quality services.)
- *Blend early childhood care and education services*. These have traditionally been seen and run as separate forms of service, but should properly be recognised as a single form of service with a common curriculum.
- *Integrated child and family centres* – providing ECEC services, playgroups, facilitated playgroups, parenting programs, MCH and other health services, and evidence-based specialist intervention programs.
- *Create family-friendly early childhood service environments where parents can stay.* The right mix of social support, mother-child programs, and parenting programs contribute much to improving parental abilities to support their children's learning.

Level 2: Community and Service System Interventions

Community and system level interventions can take four forms:

- *Neighbourhood and community-level interventions*. Build rich, supportive and inclusive social networks and community environments for families of young children.
- *Service system interventions*. Build a strong universal service system that provides high quality, inclusive and well integrated child and family services.
- *Place-based approaches*. Collaborative efforts involving community members and services to address agreed issues within a defined geographic location.
- *Whole-of-community or 'collective impact' initiatives*. Comprehensive, collaborative, long-term, multi-level efforts to address simultaneously all the factors that affect child, family and community functioning in a defined a socio-geographic area.

Level 3: Societal and Structural Interventions

There are three general forms of intervention at the 'macro' level:

- *Address the conditions under families are raising young children.* The current system of intervention and support services in developed countries such as Australia is predominantly geared towards responding to presenting problems rather than seeking to address the underlying causes that lead to families having problems in the first place.
- *Develop new ways of working in partnership with communities and services.* Rather than governments and services making all the decisions about what services are needed, what form they should take and where they should be located, these decisions need to be shared with the people who will use the services.
- *Raise public awareness regarding the nature and importance of the early years*. While many policy makers and professionals now appreciate the importance of the early years, the general public has yet to be persuaded that this is an area that we should be investing in.

This brief overview of *what* we need to do to ensure better child and family outcomes needs to be complemented by a review of the evidence regarding *how* services need to be delivered. This is the main topic of this paper.

How we need to do it: Engaging and partnering vulnerable families and communities

In a literature review designed to inform the development of a new model of home visiting, my colleagues and I (McDonald et al., 2012) looked at the evidence regarding the most effective home visiting programs for working with vulnerable families of young children. We found that even the best of programs (such as David Old's Nurse Family Partnership) were not always effective and even when they were they were only modestly effective. The indications were that there were other factors contributing to the success of interventions that were not being captured in the RCT studies.

Accordingly, we conducted a second literature review (Moore et al., 2012), this time looking at the evidence regarding service delivery processes and strategies, and effective methods of engaging with vulnerable families. We concluded that there is general support for the notion that process aspects of service delivery matter for outcomes. What this indicates is that evidence-based practice involves not just the efficacy of the program or intervention, but also the efficacy of the *process* – the *way* in which the program is delivered.

Insights regarding effective ways of engaging vulnerable families and communities comes from a variety of sources other than RCTs, including

- lessons from research with vulnerable families,
- research on psychotherapy efficacy,
- research on effective help-giving practices,
- research on the neurobiology of interpersonal relationships,
- evidence-based practice, and
- family-centred practice and the Family Partnership Model

The evidence from each of these sources is summarized below.

Lessons from vulnerable families

The first body of evidence comes from studies of vulnerable and marginalised families, focusing on those features of service delivery that are associated with more successful engagement with families and greater 'take up' of services (Boag-Munroe & Evangelou, 2012; Cortis et a., 2009). A number of key elements of effective service delivery processes have been repeatedly identified in the research literature (CCCH, 2010; Moore et al., 2012). Regardless of the focus or content of the intervention, effective programs

- are relationship-based,
- involve partnerships between professionals and parents,
- target goals that parents see as important,
- provide parents with choices regarding strategies,
- build parental competencies,
- are non-stigmatising,
- demonstrate cultural awareness and sensitivity, and
- maintain continuity of care.

These process variables appear to be of particular importance for the most vulnerable families, who are less likely to make use of professional services that do not possess such qualities. Reviews of the evidence (Centre for Community Child Health, 2010; Moore et al., 2012) suggest that what vulnerable and marginalised families need are services that

- help them feel valued and understood, and that are non-judgmental and honest,
- have respect for their inherent human dignity, and are responsive to their needs, rather than prescriptive,
- allow them to feel in control and help them feel capable, competent and empowered,
- are practical and help them meet their self-defined needs,
- are timely, providing help when they feel they need it, not weeks, months or even years later, and
- provide continuity of care – parents value the sense of security that comes from having a long-term relationship with the same service provider.

More detailed accounts of working with vulnerable families and children can be found in Arney and Scott (2010), Ensher and Clark (2011), Landy and Menna (2006), and Roggman et al. (2008).

Efficacy in psychotherapy

The second source of evidence comes from studies of the efficacy of various forms of psychotherapy. This research has shown that all forms of psychotherapy are effective with some people, and that no single model can be shown to be more effective than others (Duncan et al., 2010). The evidence indicates that psychotherapies work not because of the unique contributions of any particular model of intervention but because of a set of common factors or mechanisms of change that cuts across all effective therapies – known as the *common factors approach* (Sprenkle et al., 2009). The two principle features of successful psychotherapy, regardless of the model used, are

- the *therapeutic alliance* (the joint working relationship between the therapist and the client), and
- the *personal qualities* of the therapists themselves

This is illustrated by a study of the psychiatrist effects in the psychopharmacological treatment of depression (McKay et al., 2006). This RCT found that the drug being trialed was significantly more beneficial than a placebo. However, *who* the patient saw rather than *what* they prescribed had an even bigger effect: 7% to 9% of the variability in outcomes was due to the psychiatrist and only 3.4% to the drug. Some psychiatrists were consistently more effective than others, regardless of whether they were prescribing the drug or the placebo: the top third performing psychiatrists in the study achieved better outcomes using the placebo than the bottom third did using the drug.

In the light of these findings, McKay et al. concluded that we should consider that psychiatrist 'not only as a provider of treatment, but also as a means of treatment.'

Effective help-giving

Another way in which the processes of service delivery have been analysed is in terms of the key features of effective helping (Braun et al., 2007; Dunst & Trivette, 2007, 2009). On the basis of their research over 20 years, Dunst and Trivette (2009) identify twelve principles of effective help-giving. Help-giving is more likely to be effective when:

- It is both positive and proactive and conveys a sincere sense of help giver warmth, caring, and encouragement.
- It is offered in response to an indicated need for assistance.
- It engages the help receiver in choice and decisions about the options best suited for obtaining desired supports and resources.
- It is normative and typical of the help receivers' culture and values and is similar to how others would obtain assistance to meet similar needs.
- It is congruent with how the help receiver views the appropriateness of the supports and resources for meeting needs.
- The response-costs for seeking and accepting help do not outweigh the benefits.
- It includes opportunities for reciprocating and the ability to limit indebtedness.
- It bolsters the self-esteem of the help receiver by making resource and support procurement immediately successful.
- It promotes, to the extent possible, the use of informal supports and resources for meeting needs.
- It is provided in the context of help giver-help receiver collaboration.
- It promotes the acquisition of effective behaviour that decreases the need for the same type of help for the same kind of supports and resources.
- It actively involves the help receiver in obtaining desired resource supports in ways bolstering his or her self-efficacy beliefs.

Translating these principles into practice, effective help-giving involves three components, each with two elements (Dunst et al., 2007):

- *Technical quality* includes the knowledge, skills, and competence one possesses as a professional
- *Relational practices* include behaviours typically associated with effective help-giving (active listening, compassion, empathy, etc.) and positive practitioner attributions about help-receiver capabilities.
- *Participatory practices* include behaviours that involve help-receiver choice and decision-making, and which help them gain the skills and resources to achieve their desired outcomes.

All three elements need to be present for help-giving to be truly effective. The first two elements cannot be faked:

> Research indicates that help receivers are especially able to 'see through' help-givers who act as if they care but don't, and help-givers that give the impression that help receivers have meaningful choices and decisions when they do not. (Dunst & Trivette, 1996)

Another key feature of effective help-giving are *beliefs:* both parental and professional beliefs play an important mediating role in achieving positive outcomes in helping relationships (Dunst et al., 2007, 2008). Services are more effective when parents believe in the intervention plan, and also believe in their personal ability to implement the intervention as planned. The efficacy of services is also dependent upon the professionals believing in the efficacy of the intervention, and in the parent's ability to implement the plan.

Neurobiology of interpersonal relationships

Another body of research on the neurological functioning and development (Davidson & Begley, 2012; Doidge, 2007; LeDoux, 2003; McGilchrist, 2009; Panksepp, 1998; Siegel, 2012), and the neurobiology of interpersonal relationships (Cozolino, 2010, 2014; Schore, 2012a, 2012b). This research has shown that our brains constantly communicate with other people's brains via subconscious high-speed pathways. These enable us to register others' feelings and states of mind, and enables them to register our own feelings and states of mind, which is why we cannot fake being interested, caring or empathetic.

We are intensely social creatures, and our brains are shaped by relationships, for good or otherwise (Lieberman, M., 2013). This is particularly true for children, but relationships continue to play an important role in shaping our health and well-being throughout our lives.

A particularly important feature of our neurobiology is that relationships affect other relationships, a phenomenon known in the mental health field as *parallel process*.
Parallel processes operate at all levels of the chain of relationships and services, so that our capacity to relate to others is supported or undermined by the quality of our own support relationships. This flow-on effect can be seen in the relationships between early childhood professionals and parents of young children: we model for parents how to relate to their young children by the way we relate to them

Relationships form a cascade of parallel processes, so that the quality of relationships at one level shapes the quality of relationships at other levels (Moore, 2006).

Evidence-based practice

A recent authoritative review of effective treatments for children and adolescents (Fonagy et al., 2015) recognised that

> … the mere availability of evidence-based therapy is unlikely to deliver good outcomes for children and young people and their families, and that there are many more issues that clinicians need to consider …

Two of the most important are the involvement of families and children in decision making concerning their therapy, and routine observations of the impact of treatment on the patient's well-being. These two factors alone contribute as much to the outcome as the choice of treatment method.

Fonagy and colleagues note that these findings pose a challenge to the current way that evidence-based practice is interpreted. They propose that evidence-based practice (EBP) involves 'a commitment to identify and evaluate as comprehensively as possible the extant information, which has been systematically and rigorously collected, concerning the effectiveness of assessment and intervention practices' (Fonagy et al., 2014). However, evidence-based practice is often interpreted narrowly to mean the collecting and selecting from lists of 'proven' interventions. Properly understood, EBP is much broader than this and involves four elements or sources of evidence:

- Reviewing research evidence for effective interventions
- Identifying patient preferences
- Systematically observing progress in the course of treatment
- Adapting treatment interventions in response to ongoing patient-reported outcome measures

EBP is best understood as a decision-making process that integrates all four of these sources of evidence on an ongoing basis. A model for doing this outlined later.

How services are delivered

Overall, the evidence is clear: *how* services are delivered is as important as *what* is delivered.

> The manner in which support is provided, offered, or procured influences whether the support has positive, neutral, or negative consequences (Dunst & Trivette, 2009)
>
> Outcomes are not simply the result of advice (e.g. take drug X or play with your child) but are determined also by the ways in which advice is given (Davis & Day, 2010)

These two quotations come from the champions of two well-developed models that describe how services can be delivered effectively. *family-centred practice* (Dunst et al. 1988, 2008; Dunst & Trivette, 2009) and the *Family Partnership Model* (Davis & Day, 2010). These models come from the US and the UK respectively, and, despite being developed in different contexts and drawing upon different intellectual traditions, the core principles and practices identified by these two models are remarkably similar.

The rationale for the approach they recommend can be summed up as follows:

- *If* service providers and families work collaboratively to identify family goals and priorities, *then* services are more likely to address families' most salient needs.

  If professionals determine what the goals of intervention should be, *then* the issues that are most important for families and have most impact on their lives are likely to be overlooked.

- *If* service providers and families work as partners to determine what action should be taken, *then* there is a greater probability that the desired outcomes will be achieved.

If decisions about goals and actions are made by professionals, *then* they are less likely to be realisable in the circumstances in which the family lives.

- *If* service providers listen to families and establish good working relationships with them, *then* parents are more likely to listen to what the professionals have to say and to make better use of professional services.

  If families feel that the professionals do not really understand their views or their circumstances, *then* they are less likely to trust and listen to what the professionals have to offer.

- *If* service providers support family decision-making, *then* families are more likely to develop the confidence, competence, and ability to make decisions about their child and family over their lifetime.

  This is important because support services for families drop away significantly as the child gets older, and families need to become more self-reliant.

- *If* service providers and parents share and respect each other's knowledge and expertise, *then* better solutions for the child and family are likely to be found.

  If parent knowledge of the child and family is ignored, *then* the intervention strategies are less likely to be effective.

- *If* child and family needs are met solely or primarily through professional sources of help, *then* families are more likely to become dependent upon professional services.

  If service providers help families identify and mobilise family and community sources of help, *then* their dependence on scarce professional resources is reduced.

Community-centred practice

At the community level, engagement and partnering involve the relationship between a service system and groupings of community members. The same principles and practices that have shown to be effective in engaging and empowering families at an individual level are also effective at community levels (Block, 2008; Gamble & Weil, 2010; Hughes et al., 2007; McKnight & Block, 2010). Community centred-practice is family-centred practice 'writ large' and applied at a group level.

For example, a recent review of what works in effective Indigenous community-managed programs and organisations (Morley, 2015) identified the following factors as are common to successful community-managed programs and organisations:

- the community has ownership of and control over decision-making;
- culture is central to the program, including an understanding of local context, history and community leaders;
- local Indigenous staff work on the program or in the organisation;
- good corporate governance exists;
- Indigenous staff are working on programs and existing capacity is harnessed;
- trusting relationships with partners are established;
- flexibility in implementation timelines.

Evidence from community practice literature supports the key principles identified above as being central to community-centred practice. Thus, we can take the rationale for family-centred practice just outlined and apply it to community-centred practice. For example,

- *If* service providers and communities work collaboratively to identify community goals and priorities, *then* services are more likely to address communities' most salient needs.

  If professionals determine what the goals of intervention should be, *then* the issues that are most important for communities and have most impact on their lives are likely to be overlooked.

For service systems to engage community groups effectively, the members of those groups need to be engaged with one another. Forming supportive personal networks is important for parents as a goal in its own right (Blau & Fingerman, 2009; Christakis & Fowler, 2009; Leigh, 2010; Pinker, 2015) – it promotes better parenting and parental mental health – but it is allows shared group concerns to emerge. What we need to know are the emergent views of groups of parents and community members rather than the combined views of individuals. To help parents to become engaged with other parents, we need to provide them with multiple opportunities to meet.

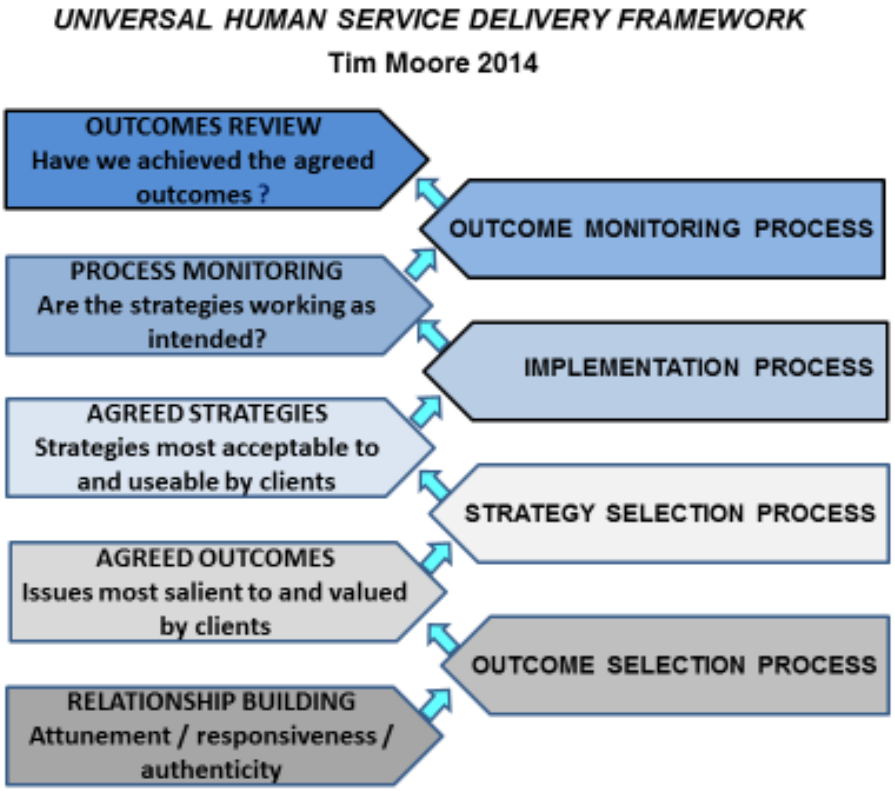
A universal framework for human services

The evidence reviewed in this paper indicates that how services are delivered is as important as what is delivered. This challenges the dominant practice of giving priority to what is delivered, and viewing efficacy in terms of a narrow interpretation of evidence-based practice. What is needed is a decision-making or service-delivery framework to guide work with families and communities, and that incorporates the key features of effective help-giving into a decision-making process that includes evidence-based strategies and outcomes-based monitoring.

Based on the analysis in this paper, such a framework should include the following elements:

- First, we need to align program content and methodology with client values, addressing what the client sees as most important for them.
- Second, we need to be attuned and responsive to the views and circumstances of the clients, and engage them as partners.
- Third, we need to use a purposeful process of joint decision-making in identifying goals to work on and choosing strategies to use.
- Fourth, we need to be able to offer parents the choice of a range of evidence-based strategies and program modules to address the goals that have been agreed.
- Finally, we need monitor all three types of fidelity on an ongoing basis and make immediate corrections when it is apparent that they are not being met.

Here is a service delivery framework that meets these criteria.



Step 1	*Begin to build a partnership relationship with the family*. The key qualities of effective relationships are engagement, attunement and responsiveness, and the key skill is reflective listening. The process of building a sound relationship is ongoing, not something that is done once, but is built over time through a process of repeated reconnections and feedback (as shown in the side arrows on the diagram).
Step 2	*Explore what outcomes are important to the family.* This involves an exploration of family values and circumstances, and what achievable change would make the most difference to their lives. Finding out what matters most to the family is critical, but it is also important that, over time, the professionals share what they see as important outcomes. The final decision, however, always rests with the family.
Step 3	*Agree what outcome will be the focus of work with the family*. Identify how they will know when the outcome has been achieved, and how this will be measured. The outcomes chosen by families initially may not be what the professionals would have chosen, but it is important to respect their first choices as a basis for building a sound partnership. With continued mutual sharing of information, the choices that the family makes should become progressively better informed.

Step 4	*Explore what strategies are available for addressing the outcomes chosen.* This involves exploring with the family what strategies they already know about or use, as well as sharing with them information about what evidence-based strategies are available. The emphasis here should be on identifying and building upon existing family strengths and resources, as well as on building new competencies, promoting the family's capacity to meet the needs of family members.
Step 5	*Agree on what strategy or strategies will be used.* The strategies should be acceptable to the family and able to be implemented in their family circumstances. The result should be an action plan that describes the outcomes and strategies chosen, how the implementation will be monitored, and what roles the parents, professionals and any others will play.
Step 6	*Monitor the process of intervention implementation*. During the actual implementation phase, the role of the professional is to support the family as they implement the strategy, and to help them make any necessary adjustments. The issues to be addressed are whether the strategies chosen are able to be implemented as intended, and whether they are being implemented with program fidelity. Any problems identified should be addressed promptly and the plan modified as required. It is important not to persist with strategies that are not working or are causing undue stress.
Step 7	*Review the process of implementation.* In addition to the ongoing support and monitoring of the implementation, time should be made for a review of action plan. The key questions are whether the strategy has been able to be implemented and everyone has been able to contribute as planned. If not, then Steps 4 and 5 should be revisited This is also a time for reviewing the parent-professional partnership. The professionals should be seeking feedback as to whether the parents feel their views are being heard and respected, and whether they are being helped to develop new competencies.
Step 8	*Monitor the intervention outcomes*. In addition to monitoring the processes involved in implementation, it is also important to monitor the actual outcomes. The role of the professional is to help the family uses measures identified earlier (Step 3) to check whether the strategies are producing the changes that they wanted. Family capacities and circumstances vary so much that it is impossible to be sure that any particular strategy, even one that has been proven effective elsewhere, will work for a particular family. Any indication that a strategy is not effective or is even causing harm in some way should be signal for an immediate review.
Step 9	*Review the outcomes.* At an agreed point, a review of the whole intervention plan should be undertaken by the professional and parents. The main questions to be addressed are whether the desired outcomes were achieved, and, if not, then why not. There are many reasons why This is also a time for a general reflection on what has been learned – by the family (what new skills have they developed?) as well as by the professional (what new strategies did they discover?).

The process described in this framework begins with engagement and tuning in to family values and priorities, rather than with professionals deciding beforehand what the family needs are and what strategies are most appropriate for meeting those needs. Evidence-based programs and strategies have an important role to play, but always in the context of family values and priorities: information about such programs is not introduced until a partnership has been established and the professional has understood the family values and circumstances.

The process allows for constant adjustments based upon feedback: it is not assumed that the strategies will always work in the ways intended, and indeed assumes that there will need to be modifications. This is a strength rather than a weakness, as the process of constant adjustments makes it more likely that the interventions will be manageable for the family and ultimately effective.

This service framework is generic, in that it can be used by an individual practitioner or team working with a client or family, an agency working with groups of clients or families, a network of services working with a community, or even a government department working with service networks. The CCCH Platforms Service Redevelopment Framework (Centre for Community Child Health, 2010) is an example of the model applied at a service system level.

Whatever the context, the use of this framework should maximise clients' 'take-up' of the service, that is, their willingness to access professional services, their ability to make use of the support provided, and whether this leads to actual changes in behavior.

An exemplary community engagement project

A place-based community engagement project that best exemplifies the principles and practices described in this paper is the process used to establish the Tasmanian Child and Family Centres[1]. These aim of these Centres is to improve the health and well-being, education and care of Tasmania's very young children by supporting parents and enhancing accessibility of services in the local community. They have been established in 12 disadvantaged communities across Tasmania through an extensive process of community engagement and empowerment.

The process of community engagement has been guided by a Learning and Development Strategy, funded by the Tasmanian Early Years Foundation and delivered by the Centre for Community Child Health (McDonald et al., 2015). The Learning and Development Strategy emphasises genuine engagement with the local community in the visioning, planning, design, implementation and functioning of the CFCs.

The key features of the Tasmanian CFCs are:

- Use of the *Family Partnership Model* (Davis & Day, 2010) as a basis for all planning and operational processes
- Development of a *Learning and Development Strategy*, funded by the Tasmanian Early Years Foundation and delivered by the Centre for Community Child Health
- Establishment of *Local Enabling Gr*oups to guide the planning of the building and the service
- Development of *Working Together Agreements* – these are agreements between parents and staff about how they will work with each other (including parent-parent and staff-staff relationships and well as parent-staff relationships)
- Establishment of *Local Governance Groups* once the CFCs were operational
- Use of the *Empowering Parents Empowering Communities* (EPEC) parent training program

[1] http://www.education.tas.gov.au/parents_carers/early_years/Programs-and-Initiatives/Pages/Child-and-Family-Centres.aspx

One of the most important features of these centres has been the development of *Working Together Agreements (WTAs).* These serve a number of purposes including:

- for new parents and staff, WTAs are is used to outline expectations and orient them to the culture of the CFC
- as a 'touchstone' that parents, service providers and CFC staff can go back to when things don't go well, either in individual relationships or in the Centre as a whole;
- during workshops, seminars and gatherings associated with CFC, WTAs can be used to guide expectations regarding how participants will contribute and participate;
- to remind parents, staff (and external visitors) that the culture of CFCs is being developed jointly by staff and parents; and
- to engage and inform parents and community members who are not yet aware of the CFCs or what they do

Another key feature has been the deployment of the *Empowering Parents, Empowering Communities (EPEC)*[2] parenting program. Developed by the Centre for Parent and Child Support in London (which also developed the Family Partnership Model), EPEC is a community-based program, training local parents to run parenting groups in schools and children's centres. By involving families at every level in the design, implementation and delivery of the programme it ensures that EPEC addresses the real and current concerns of families and delivers them in a friendly, accessible manner. Less stigma is attached to attendance at a programme delivered by members of the local community. Local parents - from diverse backgrounds and all active in their communities – are encouraged to train as facilitators of *Being a Parent* groups.

Factors that have contributed to the success of the Tasmanian CFCs include:

- Amount of time allowed – 18 months for initial community engagement
- The supporting role of the Tasmanian Early Years Foundation
- Contribution of the facilitators – role and personal characteristics
- Engagement and empowerment of local parents in all aspects of the planning and running of the CFCs
- Consistency of the principles and practices underpinning all aspects of the development and operation of the CFCs

But, the initiative is vulnerable ….

- The Tasmanian Early Years Foundation has been defunded
- The Learning and Development Strategy has now finished
- Any changes in key CFC staff will place the philosophy and practice at risk unless there is strong ongoing support from the Department of Education

Further reading

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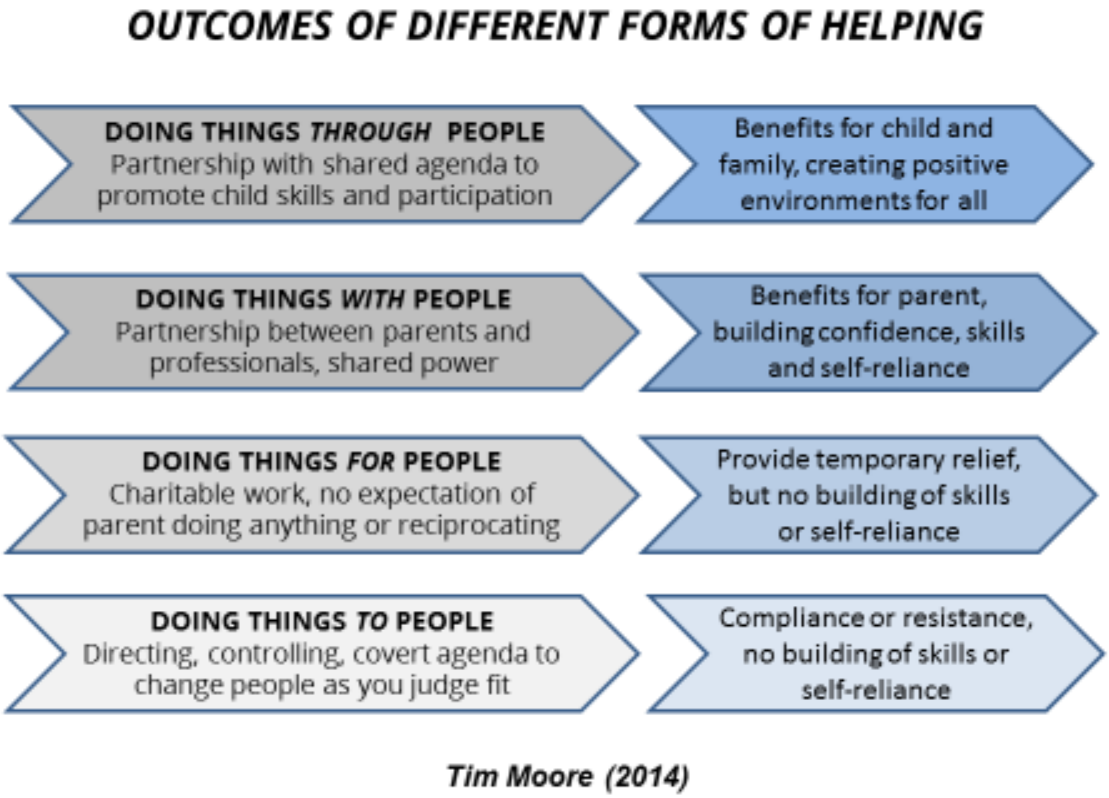
Summary and conclusions

- Engaging and partnering families and communities are quintessentially relational processes whose success depends upon the nature and quality of the relationships established between all those involved
- The skills needed to establish collaborative partnership relationships are well understood and eminently trainable
- The operation of parallel processes implies that direct service providers will be more likely to engage and partner with families and communities more effectively if their managers and others use similar practices
- Evidence-based practice is properly regarded as a decision-making process drawing upon several sources, rather than a selection from a list of evidence-based treatments
- The process of engagement and partnering is a necessary but not sufficient condition for change – it needs to be complemented by strategies that build the skills of parents and caregivers that enable them to provide their children with environments and experiences that promote their development
- Thus, engagement and partnering are the medium through which interventions to change behaviour are driven
- However, we cannot treat engaging and partnering merely as stages to be gone through in order to achieve the changes that we would like to see – they must be done authentically for full 'take up' to occur
- The universal human service framework seeks to incorporate the key features of effective help-giving into a decision-making process that includes evidence-based strategies and outcomes-based monitoring

Finally, here is a summary of the effects of different forms of helping.



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