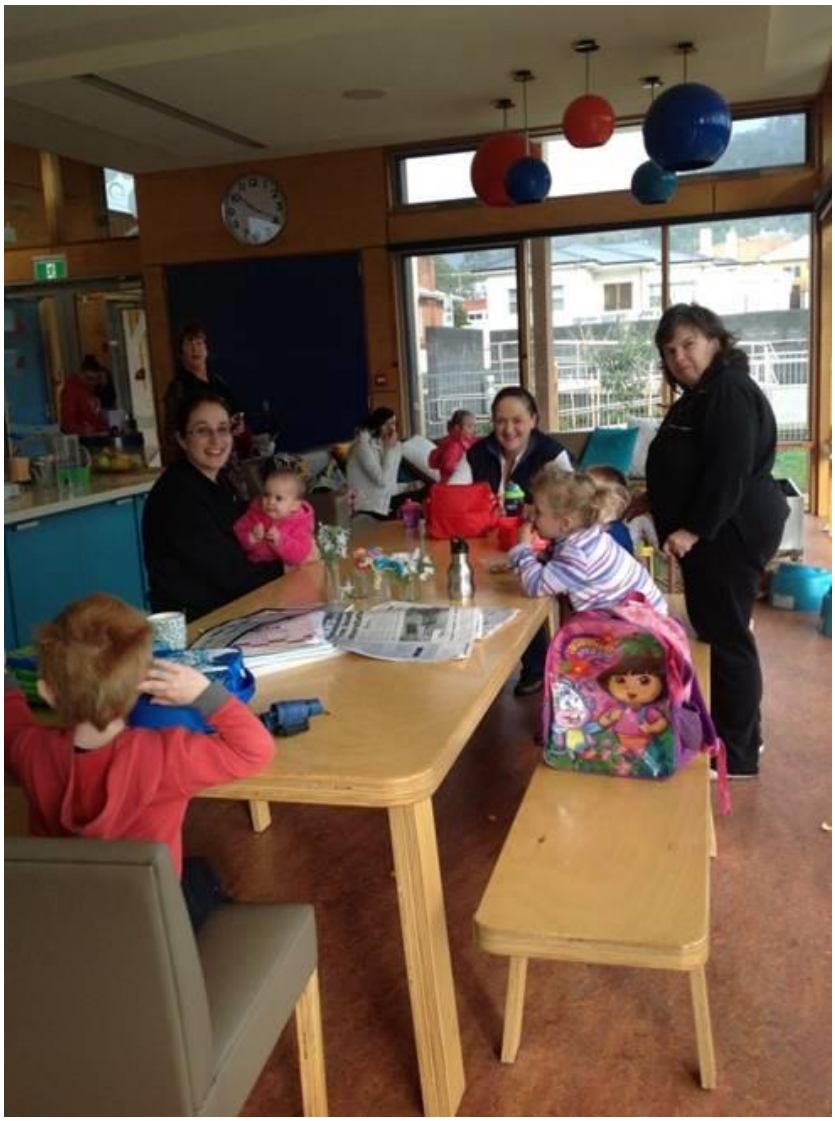
Using the Family Partnership Model to engage communities

Lessons from Tasmanian Child and Family Centres

Centre for Community Child Health



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"Social infrastructure is built not of bricks, mortar and dirt, but rather from the social actions and practices that restore relationships between and among people and the places they hold dear"

Erika S. Svendsen et al (2014)

American Journal of Public Health (p. 582)

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Introduction

One afternoon, in a small Tasmanian town, a group of people gather in the meeting room of a local community organisation. There are people in suits, and people in jeans; there are young children, young adults, parents and other community members.

The purpose of the meeting to discuss a proposed Child and Family Centre in the town – a dedicated space for young children and their families that provides support services, parenting and early childhood programs, and offers families with young children opportunities to make friends and learn from one another.

The meeting space is set up in a standard way; with rows of tightly packed chairs all facing a table at the front of the room. As people enter the room and find a chair, three people are standing around the table at the front of the room, talking with each other, and one person is sitting at the table writing.

By the time the meeting has begun, about 40 people pack the small space. Mothers with prams and toddlers are towards the back of the room, where there is more space to park prams and keep an eye on their children, some of whom are on the ground, playing with toys and drawing.

The people at the front of the room, sitting at the table, introduce themselves as the managers of Government services responsible for the development of Child and Family Centres across Tasmania. They speak with passion and excitement about the prospect of a Child and Family Centre being built in this community. Sometimes there is a question or comment from the audience.

Eventually, discussion turns to the next community meeting which will focus upon the design of the Child and Family Centre. There is some discussion between the meeting convenors at the front table. Some days and times are mentioned. A woman at the back of the room, with a young child sitting on her lap, calls out:

"Those times won't suit me and other parents of young children because that's when we pick them up from school." There is an approving murmur from the audience.

This young mother attended the next meeting with her two children. She eventually became a Co-chair of the local committee that oversaw the implementation and ongoing development of the Child and Family Centre. Subsequent committee meetings were undertaken with chairs in a circle, as opposed to a table at the front of the room led by a group of 'experts'.

The Family Partnership Model (FPM) is an evidence-based approach to working with families that has played a central role in the inception, design, planning and delivery of 12 integrated Child and Family Centres (CFCs) in Tasmania.

In this paper we seek to provide policy-makers, organisations and communities involved in the design, planning and delivery of services for young children and families, with an insight into the benefits and challenges involved in utilising the FPM to engage communities. The FPM is founded upon a respect for and encouragement of the expertise and self-determination of parents. It requires and encourages a different approach to service design and delivery, as the example above indicates. What does the model look like when it is used with entire communities? This is the overarching question we seek to address in this paper.

The paper begins with a description of the Family Partnership Model and Tasmanian Child and Family Centres. We then describe the importance of community engagement in the context of rapid and far-reaching social changes in Australia that have benefited many families, but have left other families behind. We then provide six case studies that provide an insight into the integral role of the FPM in the process of engaging the 12 Tasmanian communities. We conclude with a discussion regarding the key lessons learnt about community engagement as a result of the design, planning and delivery of the Tasmanian CFCs.

This paper does not report upon the evaluation of the CFCs, nor is it intended to be a comprehensive review of the relevant literature. Rather this is a conceptual paper that outlines a number of key lessons regarding community engagement that are especially relevant to communities experiencing significant levels of socio-economic disadvantage.

The Context

The Family Partnership Model

The Family Partnership Model (FPM) was devised in the UK in the 1980s by Hilton Davis and his colleagues at the Centre for Parent and Child Support (Davis et al, 2002; Davis & Rushton, 1991). It is an evidence-based approach to working with families that involves:

- building parents' capacity to utilise their own resources and establish methods for adapting to and managing problems in the long-term;
- engaging parents and developing a relationship with them that is supportive in and of itself; and
- understanding families in a holistic way, "hearing the whole story, seeing the full picture, knowing their main worries, learning their strengths" (Davis et al, 2002, p. ix-x).

As the name suggests, at the heart of the FPM is a partnership between professionals and families characterised by shared expertise and active collaboration in order to achieve shared, meaningful outcomes (Fowler et al, 2012). As such, the FPM – similar to other partnership approaches – contrasts with 'expert' models of working with families that are based upon a deficit view of families which may ignore the strengths, capabilities and context-specific knowledge of parents and assumes that helping people involves providing them with an answer or a solution (Davis & Meltzer, 2007; Rossiter et al, 2011).

The FPM has a distinct structure comprising three core aspects:

1. a staged helping process that involves identifying parents' goals, exploring strategies, evaluating outcomes and joint decision-making on further steps;
2. helper qualities, skills and behaviours which enable collaborative and respectful interactions (e.g. humility, personal integrity); and
3. the theoretical basis for understanding parenting and parent-child relationships (Rossiter et al, 2011).

Participants learn how to use the Model in a five-day training program. Ongoing supervision is an integral aspect of the Model (Keatinge et al, 2008; Wilson & Huntington, 2009).

Interventions that have drawn upon the philosophies underpinning FPM have been found to have a positive impact upon children, parents and families in a range of circumstances including families of children with intellectual or multiple disabilities living in an area high rates of poverty (Davis & Rushton, 1991); families with multiple and complex problems (Davis & Spurr, 1998); and socially disadvantaged mothers receiving a post-natal home-visiting program (Sawyer et al, 2013a).

Tasmanian Child and Family Centres

Funding for the Tasmanian Child and Family Centre initiative was announced by the state Government in 2009. The initiative was envisaged as an opportunity to change how communities, services and government work together in order to better meet the needs of families and their children.[1]

Tasmanian Child and Family Centres (CFCs) are places where families with young children (0-5 years) can gather informally to spend time together, spend time with other families

[1] Concurrent to the Child and Family Centre announcement by the Tasmanian Government, the Tasmanian Early Years Foundation funded the design and implementation of a Learning and Development Strategy to support the roll out of the CFCs (see Department of Education (Tasmania), 2015, p. 9).

and access a range of services. The purpose of CFCs is to improve the health and well-being, education and care of young children by supporting parents and enhancing accessibility of services in local communities.

The specific goals are to:

- improve the health and educational outcomes for young children (0-5 years);
- provide a range of early years services in the local community;
- build on the existing strengths of families and communities and assist in their educational needs;
- increase participation in early years programs;
- build community capacity; and
- respond to child and family needs in a seamless and holistic manner.

CFCs were established in 10 Tasmanian communities where there were significant concerns relating to the health and well-being of young children and families such as teenage pregnancy, smoking during pregnancy and child protection notifications. A further two CFC's, with a specific Aboriginal focus, were established in Bridgewater and Geeveston through Commonwealth Government funding. The sites and opening dates of the Child and Family Centres are listed Table 1 (below) and the location of the sites in Tasmania are illustrated in Figure 1 (below).

Table 1: Tasmanian CFC sites – locations and opening dates

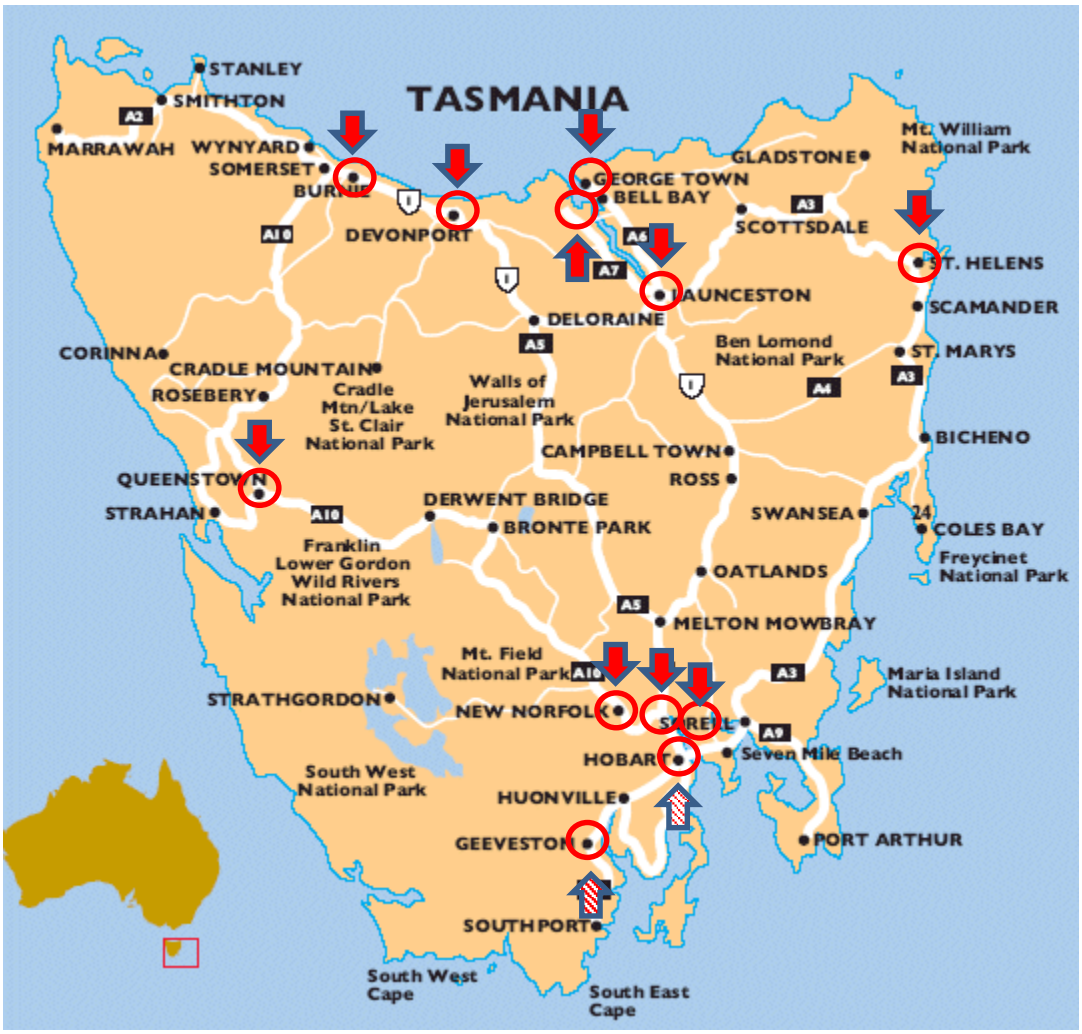
Site	Date of site opening
Beaconsfield[1]	January 2011
Break O' Day (St Helens)	October 2011
Bridgewater (Tagari lia) (Hobart)*	April 2012
Burnie	January 2013
Clarence Plains[2]	December 2011
Chigwell[3]	October 2012
East Devonport	October 2011
George Town	December 2014
Ptunarra (Derwent Valley, New Norfolk)	January 2013
West Coast (Queenstown)	September 2011
Geeveston (Wayraparattee)*	April 2012 (Stage 1) August 2013 (Stage 2)
Ravenswood (Launceston)	January 2012

* Aboriginal focused CFCs (funded through the Commonwealth Government)

CFCs do not operate as traditional places of 'service provision'. Families with young children can come to the Centres at any time; they do not need to make an appointment. Many service providers, such as Child Health and Parenting nurses, are available to meet

and support families within this informal setting (Department of Education (Tasmania), 2015).

Figure 1: Location of Child and Family Centres in Tasmania



Key: = State government funded = Commonwealth funded

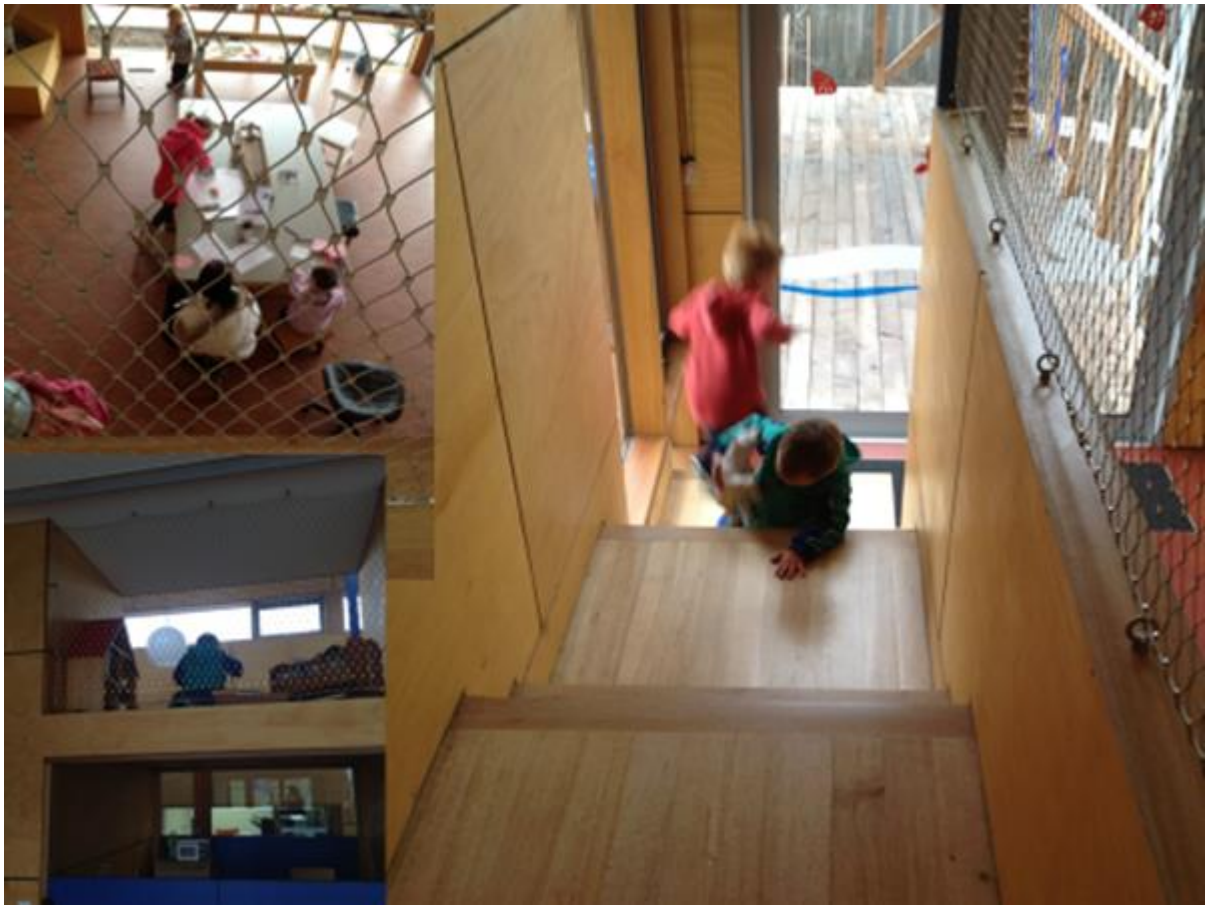
Unlike the majority of service settings, the Centres do not have reception areas, and many of the buildings where the Centres are located were purpose built, through an extensive local engagement process, to ensure they reflect a culture of acceptance and inclusion for parents and children (as illustrated in Figure 2 below). The Centres aim for activities to be driven by the children and families themselves.

Although all 12 CFCs are different in regards to the population they serve and day-to-day operations, a conceptual cornerstone of all CFCs is the FPM. Since 2009, the FPM Foundation Course has been offered for all participating services and their staff in CFC communities. Over time, as community members became actively involved in the

planning and implementation of the CFC's, they too have had an opportunity to undertake the FPM alongside local workers. In order to make this an ongoing sustainable strategy, many workers, and where possible – community members, have received facilitator-level training in the FPM, enabling them to deliver the course.

In regards to organisational structure, each CFC employs a Community Inclusion Worker (CIW) and a Centre Leader.[2] In addition to the CFC staff, each Centre is guided by a Local Enabling Group (LEG) that comprises parents and service providers from the local community (for more information on organisational structure, see Appendix 1). In some communities the LEG then evolved to assume a local governance function.

Figure 2: Building designed with children and families in mind



[2] The primary focus of CIWs is to support the day-to-day operation of the Centres, including outreach to the local community and encouraging community engagement.

Community engagement: A critical aspect of improving outcomes in disadvantaged communities

What is community engagement?

For the purposes of this paper, community engagement is defined as a process of getting communities actively involved in a meaningful way. In this case, we are focusing on the process of getting communities actively involved in a meaningful way in services that support families of young children, with the ultimate goal of improving outcomes for children. In other words, engagement is a means to an end: the ultimate end being improved child outcomes.

It is important to note also that community engagement will not, in and of itself, improve children's outcomes. However, in marginalised communities (i.e. communities with significant levels of socio-economic disadvantage) community engagement is likely to enhance the potential for improved child outcomes.

Why is it important for services to engage communities?

Australia has undergone a number of changes in recent decades that have had a significant impact upon family life (Moore, 2008; Moore et al, 2014). In general, these changes – such as mobility and changing workplace demands – have led to families becoming less involved with and connected to extended family (e.g. cousins, aunts, uncles, grandparents) and their local community (e.g. neighbours, community groups) (Moore et al, 2014). As a result of these changes, the informal support networks that families in previous decades relied upon have weakened (Baum et al, 2005, p. 02.10).

Along with these changes in family and community life, broader economic and societal trends have led to increased inequity in Australia: the divide between rich and poor is growing wider and more entrenched (Leigh, 2013). The aforementioned weakening of informal support networks compounds the challenges for those families who have been 'left behind' in the midst of Australia's increasing economic prosperity because when compared to their more affluent counterparts, these families have less resources to fall back upon.

For families who are experiencing socio-economic disadvantage – referred to in this report as 'marginalized families' – the formal support that is offered by health and human services is critically important.[3] Socio-economic disadvantage has a negative impact upon children, parents, families and family functioning (Duncan & Magnuson, 2013; Hirsch, 2008; Lamb, 2012; Pavalko & Caputo, 2013). Services during a child's early years – such as infant and maternal health and early childhood education and care – have the

[3] Marginalized families are defined in this report as families experiencing socio-economic disadvantage.

capacity to offset some of those negative effects (Moore & McDonald, 2013). However, marginalized families are typically the least likely to access those services (see Fram, 2003; Ghate and Hazel, 2002; Watson et al. 2005).

In those circumstances where marginalized families are not accessing formal support services – especially during the early years – there is a risk that problems for the child and problems within the family that impact upon the child (e.g. parental conflict, unemployment, parent mental illness) will not be identified, or rectified, potentially leading to a host of additional problems for the child that subsequently become entrenched and intractable (Moore & McDonald, 2013). The absence of informal support networks – from extended family, neighbours and local communities – means that families who are disengaged from the formal service support system can experience profound levels of social isolation.

Community engagement in disadvantaged communities

Families experiencing socio-economic disadvantage reside in every Australian neighbourhood. However, there is undoubtedly a geographical element to disadvantage in Australia; socio-economic disadvantage is more heavily concentrated in some Australian neighbourhoods than in others (Baum et al, 2005; Swan et al, 2005; Vinson, 2007). These disadvantaged communities typically have poorer rates of utilisation of child and family services such as early childhood education and care, and maternal and child health services (Baxter & Hand, 2013; Kelaher et al, 2009).

There are numerous reasons why marginalised families have poorer rates of service utilisation than other families, but we know that families with young children face a range of barriers when attempting to access early childhood services including:

- *service level (structural) barriers* such as lack of publicity about services, limited availability, inaccessible locations, lack of public transport, poor coordination between services;
- *family level barriers* such as limited income, lack of private transport, low literacy levels, physical or mental health issues, day-to-day stress; and
- *relational or interpersonal barriers* which include, in the case of service providers, insensitive or judgemental attitudes or behaviours, inability to put parents at ease and, in the case of parents, lack of trust in services, misperceptions of what parents offer, and lack of social skills and confidence to negotiate with professionals (Carbone et al, 2004; CCCH, 2010).

These barriers can lead to disengagement from the service system whereby families:

- stop attending services, and/or
- only attend services in a time of crisis, and/or

- only attend services under duress (e.g. parenting programs mandated by child protection).

Any family can disengage from the service system, however families who have *not* experienced significant, prolonged disadvantage are less likely to face one of the aforementioned barriers and, even if they do, they typically have the resources to manage it without disengaging from the service system entirely.[4] As a result, they reap the benefits that the service system provides – such as preventative care, expert advice and support.

However, families who are experiencing significant socio-economic disadvantage are more likely to experience one of these barriers and, when they do, it may simply confirm their belief – and possibly the belief of their friends, family and neighbours – that the service system is not intended for them. In communities with a high proportion of socio-economically disadvantaged families, there is a risk that the whole community becomes despondent and distrustful of service providers, subsequently leading to *community-wide* disengagement from the service system.

Therefore, community engagement in the service system is important for five key reasons:

- *Weakening informal ties within our society mean that some families do not have the buffers that can protect them from the challenges associated with raising children* – services can help to fill that gap. They can also help families establish informal supports (e.g. friends, neighbours), and strengthen the capacity of communities to support families.
- *Traditional approaches to service delivery (i.e. that don't involve the broader community) are unlikely to improve child outcomes if there is widespread community-wide distrust of the service system* – families simply won't use the services, or will only use them when problems have reached crisis point.
- Because traditional approaches to service delivery typically aren't working in these communities, *service providers need to learn from communities about what approaches will work* – the best way of doing this is actively involving communities in the process of designing and delivering services.
- *Mobilising the resources of a community through community engagement can help to change community-wide perceptions of services*, thereby leading to families becoming more likely to utilise services.

[4] These resources might include, for example, the resources to travel to a different area to access another service; and the confidence to make official complaints about a service.

- Disengagement from the service system is not always associated with socioeconomic disadvantage, however there is a well-established association between the two – *a community that is disengaged from the service system is likely to have high rates of socioeconomic disadvantage* and, thus, a greater need for the support that health and human services can offer.

The logic of community engagement – as a means of improving child outcomes – is outlined in Figure 3 (below).

Community engagement and the Family Partnership Model

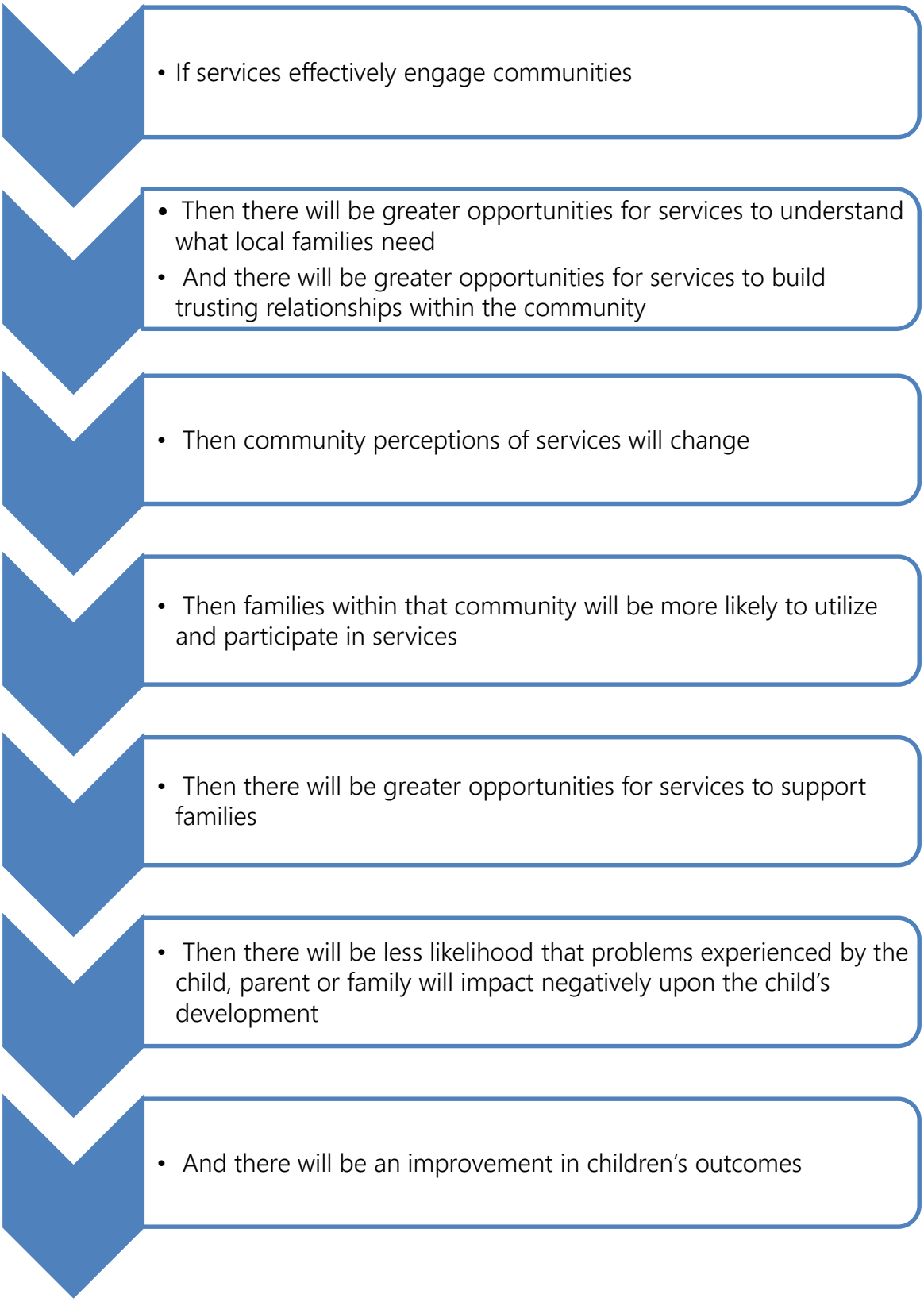
Genuine engagement of previously disengaged families in services is complex and time consuming. Services need to be dynamic and flexible in their approach to working with families and aware of the complexities of the lives and situations of the people they are trying to engage and the reasons for their disengagement (Boag-Munroe & Evangelou, 2012; Evangelou et al, 2013). There is "no single simple solution" to engagement, but the keys to engaging disengaged and vulnerable groups are "consistency, sustainability, creativity, and holistic approaches" (Boag-Munroe & Evangelou, 2012, p.235).

In regards to engagement, the strengths of the FPM lies in the central place that partnership plays in the Model. 'Expert' approaches have been shown to be a poor means of engaging vulnerable families (Arney in Rossiter et al, 2011). The FPM is not a replacement for professional expertise but a, "vehicle by which [expertise] might be delivered more effectively, while maximising… parents' contribution to the specific problem area, and facilitating their general well-being" (Davis et al, 2002, p. x). By focusing on a parent-professional partnership, the basic assumption of the model is that,

> "the quality of the relationship established between the parent and the professional… [will] determine the adequacy of the communication between them, the respect accorded to the professional, the satisfaction the parent derive[s], and hence the desire and ability [of the parent] to follow professional advice and/or to feel confident to pursue their own plans" (Davis et al, 2002, p. 91).

Although much has been written about utilising the FPM with individual families (see Davis & Rushton, 1991; Davis & Spurr, 1998; Sawyer et al, 2013), less has been written about how the FPM might be used with communities. That is, when there is community-wide poor rates of service engagement, how might the FPM be used as a means of engaging communities?

Figure 3: The relationship between community engagement and improved child outcomes



Case studies

In the following discussion six case studies are provided. These case studies are based upon the experiences and knowledge of two of the authors (Prichard and O'Bryne) heavily involved in the design, planning and delivery of all 12 CFCs.[5] The aim of these case studies, and the brief analyses that accompany them (which draw upon relevant literature), is to describe the key role that the FPM has played in the process of engaging 12 Tasmanian communities in the design, planning and delivery of CFCs.

The case studies are organised according to six of the desired 'helper qualities' illustrated within the FPM:

- *respect*: 'unconditional positive regard' which most importantly is characterised by a strong belief in families' ability to adapt and change;
- *genuineness*: honesty and sincerity, being flexible and prepared for change;
- *humility*: recognition of differences between ourselves and others – as well as an acknowledgement of one's own, and others, strengths and weaknesses;
- *empathy*: attempting to understand the world from another person's viewpoint;
- *quiet enthusiasm*: enthusiasm that comes from taking pride in one's work and striving to do it well but in way is appropriate to the needs of families (i.e. quiet enthusiasm); and
- *personal integrity*: the strength to support the family, to tolerate the anxiety that problems may create and to have an independent viewpoint (Davis et al, 2002).

All of the case studies highlight at least one of the aforementioned helper qualities, and demonstrate the interconnected relationships between them.

Respect

Case Study 1: Greg (state government public servant)

Greg is a data specialist working in state government. It was Greg's role to present community-level data (i.e. quantitative data pertaining to, for example, birth rates, household income, and hospitalisation rates of children) to CFC Local Enabling Groups so that community members and service providers could begin to build a collective understanding of the current situation for children and families in their community.

[5] The case studies in this report that refer to parents and families were collected as part of Paul Prichard's doctoral thesis. Ethics approval to collect and report upon these families' stories was provided by the University of Western Sydney. Permission to use the case study referring to a government employee was sought and provided directly by that individual. All of the case studies have been de-identified through the use of pseudonyms and amending key identifying characteristics.

At the first few workshops that Greg attended, he became aware of the importance of tailoring the presentation of data in a way that did not draw too much attention to the multiple problems within the community (e.g. high rates of self-reported smoking, substance use during pregnancy and substantiated child protection notifications). Otherwise, LEG representatives (i.e. parents and local service providers who lived and worked in those communities) could easily begin to feel demoralised about working for and within their community.

CFC representatives were able to work with Greg and collaboratively develop an approach that ensured language, technology and deficit focused data did not create barriers to engaging local stakeholders. This included discussion about presentation format, engaging community members and service providers in a discussion about the strengths of the community and, where possible, identifying available formal data that reinforces these strengths (e.g. where data for a particular community rates favourably alongside state and national averages).

In subsequent LEG workshops, Greg began his data presentation by indicating his interest in the participants and their community. This was followed by a conversation among the participants about the positive aspects of their community. Greg made a concerted effort to reflect on and explore the nuanced effect of various approaches towards the community, including dressing less formally so he wouldn't intimidate parents, and trialling different types of introductions and questions during his presentation to determine the extent to which they led to increased engagement of community members. Data that indicated problems within the community were introduced later in the presentation as 'areas for improvement'.

Respect is defined, for the purposes of the FPM, as "'unconditional positive regard which most importantly is characterised by a "strong belief in families' ability to adapt and change." In this example, a strong belief in a *community's* ability to adapt and change rested upon a strengths-based approach to the data. Starting these presentations with the data that indicated the multiple problems within these communities would clearly not have been a good starting point for meaningful involvement, thereby impacting negatively upon the process of engagement. Importantly, unconditional positive regard does not mean overlooking or ignoring the 'bad news' but taking care to acknowledge the strengths within a community *as well*.

When describing the importance of respect within the FPM, Davis et al (2002) state that, "respect here does not simply derive from humanitarian values, but from the belief that it has a number of important functions" (p. 59). In this case, if data presentations had continued to emphasise the bad news, the families and service providers involved in the LEGs would have most likely been discouraged from participation, as the data represented simply another 'slap down' – further indication of the problems within their community. As a result, it would have been difficult for them to share their expertise

about their community, what is sometimes referred to as 'local wisdom'. The local wisdom of families and service providers was critical not only to the process of empowering communities, but also to ensure that CFCs met the specific needs of local families and communities.

The possibility for meaningful participation is limited by a failure to respect communities. As Davis et al (2002) note in regards to individual parents:

> "The assumption that parents are somehow bad, incapable or helpless not only makes it impossible to engage in meaningful partnerships, it can make the situation worse. It is likely to alienate the parents, increase antagonism, reinforce their deviant status, reduce their self-esteem and therefore inhibit their ability to help themselves" (p. 60).

Similarly, the assumption that communities are 'bad' also makes it difficult to develop meaningful partnerships with communities. These assumption can be reflected in a number of ways including, as in this example, the seemingly neutral act of presenting data.

Genuineness

Case Study 2: Service providers

Service providers involved with the design of CFCs, and the delivery of services within the neighbourhoods where CFCs are located, come from a wide range of sectors including health (e.g. Child and Family Health nurses[6]), education (e.g. early childhood education and care professionals) and welfare (e.g. non-government family support services). In the initial stages of the set-up of the CFCs, many were involved in Family Partnership Training. Importantly, participation was not mandatory and, wherever possible, any potential barriers to participation were addressed.

Family Partnership Training played a central role in shifting service providers' attitudes about their practice. Many service providers initially claimed that they were already working in partnership and collaboration with parents, but as a result of what they were learning realised – as is often the case within FPM – that some aspects of their practice might in fact alienate parents.

[6] Child and Family Health Nurses in Tasmania provide child health and development checks to infants and young children. They also offer parents information on a range of topics relevant to parenting including: nutrition, settling and sleep, and injury prevention (Department of Health and Human Services Tasmania, 2014).

During the training, which typically involved mixed groups of parents and services providers, parents developed the confidence to speak up about their experiences and began to feel that service providers were listening to them and valuing their input.

In some cases, service providers were despondent about these discussions. They felt they had been doing the wrong thing. It was important for the training facilitators to remind them that, based upon what parents were saying, it was clear that some improvements could be made.

Within the FPM, genuineness is defined as "honesty and sincerity, being flexible and prepared for change." For service providers, flexibility and preparedness for change might involve a willingness to recognise how one's own practice could be improved. However, in order for service providers to learn from parents, parents need to feel as if they are in a space where they can be honest – where their views and opinions are respected and valued. This can be empowering for parents, but difficult for service providers, as it may highlight aspects of their practice that alienate parents.

Democratic forms of partnership, which enable people to work together to achieve a shared outcome, can be difficult to initiate and maintain. As Case Study 2 (above) demonstrates, it can be challenging for some professionals to shift their practice from a more directive to a more collaborative approach (Fowler et al, 2012a, Fowler et al, 2012b). As Fowler et al (2012b) note, a collaborative approach, which involves a redistribution of power can be challenging because it is "counterintuitive" to traditional models of professional practice (p. 8).

The unsettling nature of working in partnership perhaps relates at least partly to the fact that developing democratic forms of partnership is a necessarily ambiguous and uncertain process (Roose et al, 2014). Democratic partnership is a "point of departure" which means that professionals are:

> "constructing partnership with families [and] driven by a desire for engagement with an ongoing, ambiguous, uncertain, open and undetermined experiment… in a diversity of situations" (Roose et al, 2014, p. 454).

The fact that democratic partnership is a form of 'experiment' which, as such, is ambiguous and uncertain highlights the importance of genuineness. Without flexibility and preparedness for change, the ongoing process of democratic partnership is unlikely to succeed. And, as a result, the process of community engagement is likely to suffer.

Humility

Case Study 3: Anna (parent) and Renata (service provider)

Anna, now 37 years old and a single parent of five dependent children, did not progress beyond Year 10 in high school, due to an unplanned pregnancy. Anna describes herself as a person who has had some hard knocks and understands just how quickly a persons' luck can change. Over time, Anna's involvement in her local CFC had increased and she has now progressed through two levels of training and supervision to become a paid parent facilitator of the Empowering Parent Empowering Communities (EPEC) programme (Centre for Parent and Child Support, UK).

As a part of the local CFC team, Anna enrolled to undertake the Family Partnership Model foundation course alongside other community members and early-years practitioners. Although daunted about the concept of learning alongside professional workers, she was ready for a new challenge.

During the training course Anna reacted strongly when a local professional, Renata, told the group that during the first appointment with mothers she has to ask if they "feel safe in their relationship with their partner". Anna retorted, "I've had five children, and that is exactly why I've never trusted professional workers – cos you're prepared to throw all the relationship stuff out the window by asking mums stuff like that when you first meet them. Would you ever get an honest answer to a question like that from a stranger? I doubt it!"

Given the nature of the course, exploring and working towards a shared understanding between participants, both Renata and Anna were later able to acknowledge their differing world views and how these can lead to misunderstanding and tension in relationships.

This was a powerful personal realisation for both Anna and Renata. Renata came to understand that service policies and processes do not always support the development of trusting partnerships with distrusting parents. Anna was able to discover and understand the pressure that some service providers are under to adhere to policies and procedures that exist for good enough reasons but can still hinder the process of relationship development.

Within the FPM humility is defined as, "recognition of differences between ourselves and others – as well as an acknowledgement of one's own, and others', strengths and weaknesses." The fact that parents and service providers undertook Family Partnership Training together – a training course that encourages and facilitates open communication and reflection – enabled conversations that had previously been 'off limits.' The outcome of the conversations were important, but so too was the process as Block (2009) notes:

> "Holding [conversations] in a context of possibility [and] generosity, in relationship with others – is as much the transformation as any place those conversations might lead you" (p. 106).

By sharing their experiences, parents such as Anna felt empowered because they felt they had something to teach service providers. They became engaged, that is, they felt *they had a stake* in the CFCs, an important role, and a *responsibility* to share their experiences and their knowledge. However, any successful partnership is a two-way process. Humility on the part of service providers is important (as Case Study 2 also demonstrates) however humility on the part of parents is just as critical. The process of engaging communities is not about simply about 'changing' service providers, it is about changing the *dynamics* between parents and service providers.

Roose and colleagues (2014) describe democratic partnership as a "learning process [whereby] parents… and social workers become 'partners in crime'". This case study demonstrates how through humility – that is, the recognition of one's own, and others, strengths and weaknesses – both Anna and Renata came to see the problem not as each other, but of broader structural factors that restrict the capacity for partnerships between professionals and parents. They are, no doubt, now both in a better place to work together to address those broader structural factors and work, as Roose and colleagues (2014) describe it as 'partners in crime.'

Empathy

Case study 4: Sally (parent)

Gemma is a twenty one year old mother of a two year old boy, Callam, who was born at twenty five weeks gestation. As a result, Callam has received ongoing intensive medical interventions and continues to encounter serious developmental issues.

During 2014, Gemma participated in Family Partnership Model training which provided a space for her to explore the notion of partnership and consider the meaning of concepts such as sharing of power' and 'acknowledging complementary expertise'. In reflecting on the discovery, and wondering what it meant, Gemma had an experience she described as "a light bulb going on".

"I remember when Callam was in hospital all those months, just after he was born. I was scared and worried, and I didn't know what was going to happen – but it didn't feel too good. Every morning the top doctor came in, would look at Callam, then me, and say something like 'Gemma, how is he going?' At the time I felt (but didn't say it), 'how the hell would I know! You're the bloody doctor. You tell me how he's going'. I didn't say it. I was too scared. He was the doctor and I was just the mum from [community name]."

Gemma went on to describe her new realisation that the doctor was not testing her or trying to make her look stupid. In fact he was attempting to back-pedal from an expert stance and demonstrate a partnership approach with her and Callam.

"He was valuing my knowledge as Callam's mum. He was trying to say, there's stuff you know about Callam that I don't know 'cos you're his mum, and you sit here all day, every day, looking at him and touching him. How can we work together to make sure we get the best for him."

Gemma was able to draw a parallel between her experience with the doctor and her own role in co-facilitating the BAP course. She was able to recognise that it may be easier for her to model partnership with her peers, living in her own community, because of the different perception the participants will have about her as 'just one of us' rather than someone who is more powerful.

Empathy is defined within the FPM as "attempting to understand the world from another person's viewpoint." In an expert model, there may be little opportunity for empathy – it is the expert's knowledge that is respected and sought, not the viewpoint of the parent. Enculturated into an expert model, Gemma misunderstood the doctor's intention when he asked her about her son. She interpreted his questions as a 'test' or a way of demeaning her, rather than a way of sharing power. To some parents, this attempt to share power would be valued and appreciated, yet to Gemma it was frustrating. If the purpose of sharing power is to build trust, this doctor's attempt – however well intentioned – clearly failed. Gemma may in fact have been more trusting of a doctor who related to her as an 'expert', as opposed to a doctor who utilised a partnership-based approach.

From what she learnt through the FPM course, Gemma was able to reflect upon her experience in the hospital with Callam. Gemma was able to empathise with the doctor – and see the world from his viewpoint, as someone who wanted to build upon her knowledge and expertise as a parent. What Gemma learnt through the FPM course has not only impacted upon her as an individual, but also has the potential to impact upon her community. As a co-facilitator of the BAP course, Gemma will be able to model empathy as she works with other parents.

Quiet enthusiasm

Case study 5: Working Together Agreements

Working Together Agreements (WTAs) play a critical role in the overall philosophy, and everyday operation, of CFCs. The WTA is a document produced jointly by parents and service providers which outlines how parents and staff will work with each other (including parent-parent and staff-staff relationships and well as parent-staff relationships) (an example of a WTA is provided in Appendix 2).

WTAs have been critical to the process of engaging parents and building relationships between parents, service providers and CFC staff. They are not intended to replace service provider policies and guidelines or bureaucratic requirements, but serve a number of purposes including:

- when new parents or workers come to a CFC the WTA is used to outline expectations and orient new people 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.

Each WTA was developed with the broadest possible input from the local community, via the Local Enabling Groups. As such, although they appear to be relatively simple, each WTA took a minimum of 3 months to develop.

WTAs are not static documents – they continue to evolve as parents, staff and the community develops and changes. The WTA serves as a 'structure' for relationships within the Centre.

For the purposes of the FPM, quiet enthusiasm is defined as "taking pride in one's work and striving to do it well, in way that is appropriate to the needs of families." The most obvious examples of quiet enthusiasm are reflected in the actions and behaviours of service providers. However quiet enthusiasm is just as evident in the processes utilised within the CFCs, including the development of WTAs.

In the process of developing the WTA what we can see is families and professionals striving to do *partnerships* well by producing a document that serves as a 'touchstone', that is, a foundation for all interactions that occur within the CFC. The fact that WTAs are not static documents, but evolve over time, highlights the difference between *consultation* and *engagement* – two terms that are often used interchangeably. Consultation involves obtaining advice or information from families and is typically confined to a particular point in time. Most often than not it is the opinions of the most articulate and confident community members that are heard and acted upon in 'consultative' processes. Maximum practicable engagement of communities, as reflected in the process of developing WTAs, is one of the characteristics of successful interventions within disadvantaged communities (Vinson et al, 2009).

Although the WTA is important in and of itself, the process of developing the WTA is equally as important. Some stakeholders involved in the development of WTAs asked why another community's WTA could not be adapted for their own community, thereby circumventing the time-consuming process of developing the WTA with the broader community. Yet it was the process of developing the WTA that served as a form of engagement. By participating in the process of developing the WTA, community members felt they were participating meaningfully in the development of the CFC itself.

Hartz-Karp (2007) describes a process of community engagement that resolved a long-standing conflict between an Australian state government department and residents opposed to the construction of a highway exit in their community. A 'jury' comprising local residents was established to make a decision about the highway exit and,

> "As it happened, the jurors' unanimous decision was the same as that originally proposed by the department … The department responded immediately… with evident exasperation that, if the public had listened to them in the first place, they would not have needed to go through this process." (Hartz-Karp, 2007, p.12)

In the incident described by Hartz-Karp (2007), it was only because residents felt that they had been listened to, genuinely able to influence the government's decision, and come up with a solution that was acceptable to their community that a resolution was achieved (Hartz-Karp, 2007). In other words, where communities feel that their views have been disregarded and overlooked, it is the process of decision-making that is just as – perhaps even more – important than the final 'product.' In regards to the quality of 'quiet enthusiasm', the realisation of a WTA, in spite of the time-consuming nature of the process, is an example of 'striving to do well.'

Personal integrity

Case study 6: Deadlines

CFC buildings were built from scratch in 11 of the 12 CFC communities, the twelfth was a major refurbishment of an existing building. In accordance with the philosophies underpinning the CFCs (outlined in the Family Partnership Model), Local Enabling Groups made decisions about these buildings, in partnership with local communities, architects and state government.

Many of the architects involved in the process of designing these CFC buildings were accustomed to a process of community consultation, however some of the state government representatives who were responsible for ensuring that building deadlines were met were frustrated about that the time-consuming nature of the community-based decision-making process.

In some cases, Local Enabling Groups were pressured to make decisions more rapidly, however the Local Enabling Groups pushed back, stating that they needed to take decisions back to their community first, in order to ensure the community was involved in the decision-making process.

Within the FPM, personal integrity is defined as "the strength to support the family, to tolerate the anxiety that problems may create and to have an independent viewpoint." Although the rhetoric of community partnerships sounds appealing, community partnerships – like any partnership – can be challenging.

As the Tasmanian CFC experience demonstrates, these partnerships are likely to involve a range of different stakeholders such as local and state government, service providers, parents, and 'technical' experts (e.g. architects). Each of these stakeholders will differ in regards to their role, their responsibilities, their personal and professional experiences, values and attitudes. The other qualities described thus far – such as genuineness, humility and empathy – will assist in strengthening the partnership, but problems are likely to emerge.

Disadvantaged communities are typically characterised by a sense of disempowerment. Building community capacity, one of the oft-cited goals of community-level or place-based initiatives, involves sharing power with communities. Sharing power with communities is not just an appealing principle, but an integral aspect of improving outcomes for children and families in disadvantaged communities.

The Tasmanian state government made a bold decision to invest in Child and Family Centres. Their boldness is reflected in their willingness to approach the planning and delivery of these Centres with an open mind, resisting the temptation to do 'business as usual.' But in the process of empowering communities, those communities pushed back against the deadlines that the state government themselves were working towards. Although it was most likely a frustrating aspect of the partnership for some individuals involved, the fact that Local Enabling Groups were *able* to push back is paradoxically an indication of the value of the state government's investment. The LEGs who pushed back demonstrated the strength to support their communities, and to tolerate the anxiety that came from putting their communities' needs first. This strength is the starting point for a more engaged community – a community that is willing and able to participate meaningfully in the decision-making processes that will impact upon them, their children, and their fellow community members.

What have we learnt about engaging communities?

In this paper we have sought to provide an insight into how the Family Partnership Model was used to engage disadvantaged Tasmanian communities in the process of establishing 12 community-based Child and Family Centres. Based upon our analysis of

the case studies provided in this report, and reflecting upon these in light of the underlying principles of the FPM, we have identified 13 key lessons for policy-makers, organisations and communities interested in community engagement, especially in communities experiencing significant levels of disadvantage.

1. *Community engagement should be an integral part of any community-wide initiative that seeks to improve outcomes for families with young children*. In marginalised communities, community engagement is especially important. Meaningful involvement is not the equivalent of 'consultation', and it is unlikely to occur if it is viewed as an addendum to the initiative itself. Meaningful involvement entails communities participating in important decisions. For this reason, it should begin as early as possible in the life of the initiative, not after all the important decisions have been made.

2. *Every community has strengths – start with the good news*. There are often several deficit-focused reasons why particular communities are earmarked for capacity-building initiatives. Attempting to build the capacity of a community by focusing only on the weaknesses will never work. Just like individuals, communities need to feel affirmed and valued if they are to engage in processes that attempt to support change. Even the most disadvantaged community has strengths that can and must be celebrated.

3. *Don't assume that nothing is happening in marginalised communities*. No community is a blank slate, just waiting for an initiative to 'save' them. There will already be work going on – whether it's led by grassroots community groups, service providers, schools, or non-profit organisations. Before implementing a community-wide initiative it's important to gauge what's already happening in the community and start by building on existing strengths. If that is not done, the momentum of initiatives within the community can be lost. Community members will feel demoralised and there is further potential for disempowerment (i.e. 'our concerns and ideas don't matter').

4. *The history of the community matters*. Many marginalised communities have a history of failed social initiatives. As a result, those communities may have become understandably cynical about proposals for new social initiatives. A community that is cynical about a new social initiative is unlikely to engage with it and, as a result, unlikely to benefit from it. In the same way that the FPM encourages a holistic understanding of the family, a holistic understanding of the community is required, including an understanding of the history of the community. Community members will be one of the expert groups that can provide information on the history of the community. In most cases, this information will not have been captured or recognised before. By uncovering the history of their community, those involved in the initiative can reflect upon what has and hasn't worked in the past.

5. *To engage marginalised communities, you need to do engagement differently*. Traditional modes of engagement represent a failure to genuinely connect and share a common understanding with the community. What is needed are highly respectful ways of interacting with individuals in communities rather than just new programs or initiatives. That means you need people who have the skills and qualities to interact with and animate others, rather than people who are focussed on implementing the latest services or programs. The key skills required are those that support the development of mutually respectful partnerships across the entire community and services. Remember also that the most powerful influence on people within a community are other community members.

6. *Symbols of power matter*. The way a room is set up (e.g. tables for 'important people') and the way people dress may appear to be trivial issues, but in some communities these things are extremely significant. Communities that feel a collective sense of disempowerment may be especially sensitive to these 'symbols of power'. It is impossible to develop an equal partnership when one party feels disempowered. A willingness to dress casually, and to talk with community members in a setting and format that is comfortable for them, represents an attempt to understand the context and local culture and adapt ones behaviour to the situation. This willingness to meet others 'where they're at' is one of the first steps for a fruitful partnership.

7. *Easier said than done*. The notion of working in partnership with parents and communities sounds simple – and some people view is as *simplistic* – but, in very subtle ways, partnership is a complex process because it challenges the norms of power and power structures that operate in our society. Community members, service providers and government are all embedded in those structures. Even when empowerment will ultimately benefit someone, they may be resistant to it because they too are embedded in those power structures. Hence, parents may be suspicious of service providers who behave in a genuine and sincere manner – interpreting their behaviour as 'smarmy.' Parents may be unfamiliar with the experience of being treated with respect and, thereby, distrustful of people who treat them that way.

8. *Relationships are important at every level*. Clearly, parent-professional relationships are critical to improving outcomes for children. However, bringing about changes that facilitate those relationships – such as, changing the culture of the service system to enable shared power between professionals and parents – are also critically important. In that sense, the relationships that services, advocacy groups, and organisations have with senior bureaucrats and high-profile champions (e.g. ambassadors for organisations and social initiatives) are also important as they can help to bring about service and structural change.

9. *When working to develop a community initiative, all the principles that are used in a FPM approach are important*. Those principles need to be used not only by service providers when working with families, but also when management works with service providers, when community members work with one another, when parents are working together, and so on. Everyone, regardless of whether their role in the initiative, will feel more inspired to support change if they feel respected and valued.

10. *Language can alienate people*. People can feel alienated if the language others use does not reflect their views, perspectives and experience. Practitioners and policy makers need to be attuned to the subtle but potentially damaging effect of exclusive or deficit-focused language, and be willing to modify the terms and descriptions they use. A genuine partnership with community members will allow for negotiation about language, in order that terms and descriptions make sense to everyone (see Appendix 2 for an example of a Working Together Agreement that uses terms and descriptions that make sense to everyone).

11. *Communities exist within broader socio-political structures*. A community-level initiative, such as Tasmanian Child and Family Centres, can change the way in which individual service providers and parents interact with one another. It is also possible for these initiatives to change the culture of service provision within a community. But the community exists within a broader socio-political structure comprising service systems, economic factors and institutions. When developing the capacity of a community, there are always external factors that can challenge that process – such as restrictive policies, threats to funding, and changes in government. For that reason, organisations and advocacy groups who implement a change process in communities must have the strength to defend the process, until the community has the capacity to defend itself.

12. *Flexibility and preparedness for change is required by everyone involved in the process of engagement and empowerment*. Government is likely to be a key partner in any attempt to engage communities in a social initiative. Just as parents, professionals and services need to be flexible and prepared for change, so too does government, however there may be systemic factors which make this difficult (e.g. already established deadlines for completion of tasks, inflexible policies around existing programs). An investment by governments in community empowerment – where that initiative is successful – is unlikely to produce a neutral result, and may in fact lead to empowered communities challenging government (e.g. how decisions are made, what processes are followed, what resources are available to their community). Hence, even when governments are flexible and prepared for change, there may be conflict. A level of independence from government in the initiative is important, therefore, as there is less

likelihood that community empowerment (e.g. pushing back against deadlines) will be undermined by a conflict of interests.

13. *Engagement is an ongoing process*. There is a danger of becoming complacent about engagement, but the process of engagement needs to keep expanding – reaching further and further out to the most vulnerable people in the community. This takes time. The process of engagement cannot be forced. Nor can we treat it as if it is just another task to tick off from a timeline of events.

Conclusions

The journey of the Tasmanian Child and Family Centre initiative is a good example of an attempt to facilitate genuine partnerships between community members and service providers. With all stakeholders being clear about the steps in the process, both workers and community members have, in most cases, been able to respectfully work alongside each other in new ways. The FPM has supported this process by providing the foundation for shared decision-making and compromise, as well as the development of common understandings.

For any initiative that achieves some level of success, there is a danger of becoming complacent. The complex task of developing relationships between parties who may have been previously disengaged or even suspicious of each other remains tenuous. It is critically important for all involved, including community members, services providers, bureaucratic and political stakeholders, to commit to an ongoing cycle of reflection and review that supports joint discovery, learning and change.

Finally, building genuine partnerships is hard work – especially in the context of a history of misunderstanding and distrust, which is often the case in marginalised communities. All parties involved – including parents, service providers, and government representatives – need support during that process. Our experience in Tasmania suggests that all of those parties will, at some point, have conflicting needs, views and perspectives. And all, at some point in time, need to be challenged in order that they can move forward. External stakeholders who are independent of the funding body and government are likely to be beneficial in this respect. They can help to ensure that the views of all stakeholders are considered, and that the critical ongoing cycle of reflection continues.

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Appendix 1: Organisational structure

There were six key inter-related elements within the organisational structure of the Tasmanian Child and Family Centres that enabled the successful engagement of communities:

- Centre Leaders
- Community Inclusion Workers;
- Community workshops;
- Local Enabling Groups (LEGs);
- Learning and Development Strategy; and
- Working Together Agreements.

Each of these is described briefly below.

Centre Leaders

Centre Leaders (CL's) are employed by the Tasmanian Government to lead the development and implementation of CFC's. Their roles include ongoing engagement with community and services towards a model of collaborative service delivery. Their task is to model respectful relationship development through strategic planning, management of local CFC administration and coordination of local early childhood focused services in a way that promotes improved outcomes for children.

Community Inclusion Workers

Community Inclusion Workers (CIWs) were employed before most of the CFCs were built (one CIW is employed in each community). Initially, their role was reach out to the local community and encourage community engagement. They did so by going to community forums and meetings and letting people in the community know what was happening with the CFCs. CIWs are still involved in engagement, however their primary focus is to support the day-to-day operation of the Centres.

CIWs either come from the local community or have a good knowledge of the local community. Their local networks and knowledge is important, especially in regards to engagement as research evidence demonstrates that in disadvantaged communities parents may be more likely to engage with services if they are promoted by people from a community they trust and identify with, as opposed to unfamiliar service providers (Cortis, Katz, & Patulny, 2009, p. 23-24).

Community workshops

In addition to employing CIWs, a number of community workshops were undertaken. These workshops involved service providers and parents working together (rather than separate workshops for each group).

Facilitation of these workshops was provided by trained FPM facilitators and according to the FPM facilitation framework. Because they were trained in the FPM model, the facilitators were able to ensure there was a focus upon factors such as: relationship development, facilitating outcomes that reflect shared understanding and agreement and negotiating on a mutually agreed way of working together. Using the same framework for every workshop ensured a continuity of approach across all workshops, and a common, recognisable culture which facilitated broad participation by both community members and professionals.

Initially, parents and service providers were asked what they were expecting from the CFCs and what they wanted CFCs to achieve. Many parents were unaccustomed to being asked their opinion and lacked the confidence to speak up. However, the facilitator's focus on factors such as relationship development, shared understandings and mutually agreed ways of working together helped remove barriers such as a lack of confidence.

The key underlying principle for the facilitator in this process was to encourage all participants to view each other as having a unique and valuable contribution to make. Whilst the service providers had a body of skills and knowledge relating to specific professional disciplines, community members also had a body of knowledge and experience about the history and lived experience of their local community. This 'local wisdom' was viewed as being equally important to the qualifications and experiences of service providers.

The process of engaging parents meaningfully in the process of planning the CFCs took time. Eventually however most parents became more confident and some took on leadership positions. The community workshops had a 'snowball' effect – parents who attended the workshops encouraged other parents from the local community to participate. Once again, word of mouth was an important factor in driving community engagement.

Local Enabling Groups

Each CFC is guided by a Local Enabling Group (LEG) that comprises parents and service providers from the local community. Ideally, 50% of the LEG should be parents from the local community. Initially, state government representatives chaired the Local Enabling Groups. During the Community Workshops, however, a suggestion was made for the Enabling Groups to be co-chaired by a community member; with the government representative and the community member working in partnership. Gradually, the state government co-chairs handed responsibility for chairing the Local Enabling Groups over to their community co-chairs and, at the time this report was being written, all the CFC Local Governance Groups were being chaired by community members.

Learning and Development Strategy

Since July 2009 the Centre for Community Child Health (MCRI) has been contracted by the Tasmanian Early Years Foundation (TEYF) to design and implement a Learning and Development Strategy to support the roll out of the Tasmanian Child and Family Centres.

The overarching objective of the Tasmanian Child & Family Centres Learning and Development Strategy is to provide a planned professional development program for staff and community members who are involved in the establishment and operation of CFCs to support the operation of integrated child and family services.

The strategy has involved a number of different components designed to support staff and community members, in CFC communities, to work together towards collaborative service models in achieving the stated outcomes of the project. These include:

- Facilitated CFC community workshops on a variety of topics developed around the evidence based "Platforms Service Redevelopment Framework" (CCCH 2009)
- State-wide CFC forums for all stakeholders to support knowledge exchange, relationship development, and shared understanding
- Training for service providers and key community members
- Coordinating the roll out of the "Empowering Parents Empowering Communities" (UK) program, also funded by the TEYF
- Support CFC staff induction programs
- One to one support and reflective practice where required

Working Together Agreements

Working Together Agreements (WTAs) have been critical to the process of engaging parents and building relationships between parents, service providers and CFC staff (see Appendix 2). WTAs are not intended to replace service provider policies and guidelines or bureaucratic requirements, rather they are an agreement between parents and staff will work with each other (including parent-parent and staff-staff relationships and well as parent-staff relationships).

WTAs serve a number of purposes including:

- when new parents staff come to a CFC the WTA is used to outline expectations and orient new people 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.

Each WTA was developed by the entire community, via the Local Governance Groups. WTAs are not static documents – they continue to evolve as parents, staff and the community develops and changes. The WTA services as a 'structure' for relationships within the Centre.

Appendix 2: An example of a Working Together Agreement*

**This Working Together Agreement is used with the permission of the Ravenswood Child and Family Centre.*

Ravenswood Child and Family Centre

'Committed to a safe, supportive community for all children and families'

Working Together Agreement

In order for all of us involved in the Ravenswood Child and Family Centre to work together in a helpful way we have created a Working Together Agreement. This document was created in consultation with families, local community and service providers.

We agreed on the following:

How do we want the language to be?

- *Clear – no big words*
- *Fewer words as possible*
- *What we want (not what we don't want)*
- *We agree to do* **this ……**

Why do we need a Working Together Agreement?

- *Everyone on the same page – a shared or common understanding*
- *What our purposes/needs/behaviours*
- *To all feel safe and respected*
- *All in the know/expectations*
- *Shared info*
- *Protection of privacy*
- *Children are the centre of our lives, are important to us, the reason we are here.*

How will it be used?

- *Attach it to our new information forms*
- *Discuss agreements with new families and service providers*
- *Visible copy on display in the centre*
- *Re-visit it as a group regularly or if there is an issue*
- *On our facebook page*
- *Give it to head of services – the school, St Giles, Link services etc*
- *On table at each meeting*

Ravenswood Child and Family Centre

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The Agreement

1. We agree to be honest and respectful of one another. This means … we agree to listen to one another.

2. We agree to accept that everyone has different ways of doing and seeing things. This means we include everyone.

3. We agree to be flexible. This means we make allowances if we can.

4. We agree to keep personal information private.

5. We agree to do what we say we are going to do.

6. We agree to be welcoming to everyone especially people coming to the CFC for the first time.

7. We understand that things don't always go to plan when we disagree. When this happens we agree to deal with it in a safe and respectful way.

8. We agree to always set a good example for our children.

I agree to participate and work in the Ravenswood Child and Family Centre as described above.

Name: _____ Signed: _____

From: _____