



**The implementation of a new parenting practice model
in the Queen Elizabeth Early Parenting Centre
residential service:**

A study of organisational adaptation

Final Report
prepared by

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Executive summary

The literature on early-parenting residential services provides little discussion of current models of practice or the change processes used to integrate different parts of these services under a particular practice model. At the same time, the existing literature on the Family Adaptation Model (FAM)² gives no examples of its implementation in an Australian early-parenting residential service. This project is therefore important because it tracked and documented this model of practice as it was adapted and then implemented in the residential services of the Queen Elizabeth Early Parenting Centre (QEC), as well as the processes and changes occurring through that implementation.

The research used a modified action-research approach over the three stages of the project. Data was gathered from focus groups in stage 1, before implementation began, stage 2, after early implementation, including education and early team changes, and stage 3, one year later and after further implementation, including changes to processes and tools. Other project data included meeting minutes, staff reflections, documentary analysis and documented discussions.

Research data was first analysed and then used to document the theoretical model as it was finally adapted to the needs of the service. While the FAM continues to be the cornerstone of the model, other models have also been incorporated to extend this model's relevance to the early-parenting residential context. The overall model, named the QEC Parenting Practice Model, incorporates *NCAST Keys to Caregiving*³, the *Parent Partnership Model*⁴ and other strengths-based⁵ and solution-focused⁶ approaches to working with parents and children. Each of these approaches has its own empirical basis, adds relevant detail to the FAM and is consistent with the FAM's theoretical basis.

The research also documented the process of implementing the model. In the first stage, planning took place, and a reference group and staff focus groups were set up to provide feedback throughout the process and reflect on current practice. In the second stage, all staff were brought together for team development and education sessions on the model, including its underlying theories and practices. Weekly reflective-practice sessions began and small teams were developed across the two residential programs (the five- and ten-day programs). Third-stage changes included redeveloping the education program for families to include videotaping of parent/child interactions, reflective and instructive feedback for parents on video sequences, new parent educational groups, new handouts and videos, all consistent with the model. Stage 3 also included redesign of organisational processes and tools including intake and assessment, care planning, handover and discharge.

Finally, the data was used to describe the changes over the year of the model's implementation and to summarise the model in practice. At the broadest level, there has been an organisational shift away from a focus on teaching specific strategies for dealing with specific issues such as sleep disturbance, behaviour and feeding. This is most clearly shown in the move away from the concepts of controlled comforting and teaching parents a specific set of rigid strategies to address sleep issues. The shift has been towards a more consistent practice of empowering parents, building on their strengths and improving their skills in listening and responding to their children's cues, and then applying these skills to their particular issues. The approach and the language are gentler, more child-centred and more flexible with respect to family needs.

The approach is a lot gentler ... the focus has gone from the clock ... it's back to the baby



Key learnings from the project

Developing and implementing the QEC Parenting Practice Model has been valuable for integrating the processes, structures, practices and tools of the service, and improving consistency and quality of services received by parents. It has extended current staff skills, incorporated up-to-date theories and evidence, and challenged some outdated language and practice.

Extending the original FAM made the model considerably more useful for QEC by introducing current best-practice tools, processes and resources for implementation, and provided a strong evidence-to-practice base for staff.

An action-research design ensured staff input to overall changes and encouraged involvement in trialing and adapting ways of working.

Sustained change may be a long process. It was important to allow time to invest in an ongoing process of change. With each change, for example, educating staff in new approaches, other necessary changes were uncovered including tools to support staff's new approach and procedures to be updated.

Changing staff practice requires ongoing reinforcement and support over time.



Research aims

1. To track the processes of developing and implementing a new model of practice in the QEC residential service.
2. To involve staff in the planning and implementation of the model.
3. To document changes in the practice model operating in the QEC residential service over one year of the new model's implementation.

Research questions

1. What changes occurred in the practice model during the development and implementation of the QEC Parenting Practice Model?
2. How has the implementation of the QEC Parenting Practice Model affected consistency of language and practice and integration of staff practice with the theory of the model, across the residential service?
3. What are the key elements of the QEC Parenting Practice Model?



Context

The Queen Elizabeth Centre: Early parenting centre residential service

The Queen Elizabeth Centre was founded in 1917 as a hospital and training school with a primary focus on resolving problems in infant and early-childhood morbidity and mortality.⁷ Since then it has gone through major shifts from service models that treated specific medical problems to a social-health model with a focus on the child within the family within the community.⁸ These changes reflect societal change, improved hygiene, public health and sanitation and better understanding of depression, mental illness and intellectual disability.⁹

QEC residential service is funded by the Victorian Department of Human Services to provide both five-day and ten-day residential programs for families with children between the ages of birth and four years living in Victoria. Throughout the residential program, staff work intensively with families to assess their issues, and plan, implement and evaluate a program aimed at resolving their particular issues. The service focus is on working in collaboration with families, understanding their needs and contexts and providing the relevant information, education, skills and resources so families can respond to future challenges.

This change to the way the work of early-parenting services (EPCs) is framed has meant that the role of staff has also shifted. Under the old medical model, staff were “the experts” who had the knowledge to evaluate and apply particular problem-solving strategies or treatments to the issues their clients presented with. In contrast, in a family-centred, strengths-based social-interaction model, the ways the clients perceive their needs informs the way staff apply their knowledge and expertise to the issues being presented. Clients are seen as equal partners in a helping relationship, where the professional skills of staff help the clients formulate ways to access support, information, skill-development opportunities and other solutions that are relevant to their specific needs.¹⁰

These shifts in the ways clients are perceived and health and welfare services are delivered are not isolated to EPCs, nor have they happened all at once. The movement away from a treatment-focused model of service towards one with a more humanistic, strengths-development focus has been taking place across community and health sectors since the 1960s.¹¹

Early parenting residential service research

This project aimed to address a gap in EPC research in which there is little documented about specific models of practice underlying services. Current EPC literature includes evaluations of family outcomes^{12,13}, but not practices within the service, models of interventions used, organisational systems used or the theory and evidence supporting these practices and systems.

Using action research as a methodology has meant that the research developed alongside the organisational changes and included staff and management perspectives at each level of design, analysis and reporting. The qualitative, grounded approach of the research provided a more detailed description of practice and service context than would be possible in an outcome study. It has allowed questions and theories to develop to both inform the ongoing changes and allow detailed exploration of the complexity of “practice change” across the service, over time, from different perspectives.



Research developments

The QEC Parenting Practice Model has been developed to more directly ground organisational practice in current research evidence and theory. The research informing the model includes child development, parenting, attachment, family adaptation and resilience.

Child-development research has shown the critical importance of a child's first three years on later development, particularly brain development.¹⁴ Attachment research has shown that the quality of early interactions between parent and infant is a critical element in this effect on later development.¹⁵ High-quality interactions leading to secure attachment are characterised by mutual warmth, sensitivity and responsiveness. Secure attachment has been shown to foster cognitive and social-skill development and to be linked to later IQ and social and emotional outcomes. Attachment may potentially also provide the model for adult relationships.^{16,17}

The development in knowledge about risk and protective factors for healthy child development has occurred alongside research relating to brain development. Risk factors shown to impinge on children's opportunities for successful development include experience of poverty, low levels of parental education, parental isolation¹⁸ and lack of support networks.

Resilience is a concept describing the capacity of individuals to cope under adverse circumstances and still develop in a healthy way. Secure attachment is a critical component of healthy child development and a strong protective factor. Secure attachment is increasingly believed to be an important factor in supporting resilience in children¹⁹.

Family resilience similarly represents the family's capacity to function well and support healthy outcomes for members through adverse circumstances and periods of change and crisis.²⁰ Research has identified a number of factors associated with resilience in families, including a commitment by members to a meaningful, integrated family unit and the ability to respond or adapt when there is the need to change.²¹

Such research suggests the potential for EPC residential services to contribute to improved health outcomes in the community. Through family-centred practice, and solution-focused and strengths-based approaches, services are more likely to support improved family resilience.²² Through focusing services towards the capacity of parents and caregivers to provide high-quality interaction with children, EPCs potentially improve children's developmental outcomes and resilience.

Policy context

There have been a number of reviews and policy papers from both federal and state governments, which formulate current service principles and directions in early childhood services.²³ These are an important adjunct to the current research, as they provide the broader policy context informing the model and its implementation. Relevant ideas, recommendations and directions coming out of these papers include:

- Ensuring that every level of the service system promotes positive child development and learning that includes social and emotional development, provides the best in family-centred practice and sensitivity to diversity among families.
- Improved integration and co-ordination of services within and across services.
- Engaging with and providing quality services to vulnerable families and those experiencing complex issues.



- Ensuring that programs and services are of the highest quality and based on the best available evidence.
- Improving methods of collating, translating and applying the latest research evidence to current practice.
- Identifying, acknowledging and promoting best practice in services.

The Best Start Project²⁴ across Victoria undertook to document the characteristics of those intervention models associated with the most effective interventions. The models found to be most effective²⁵ included those:

- with a focus on empowerment, family centredness and building on strengths;
- individualised to family needs and sensitive to cultural, ethnic and socioeconomic diversity;
- based on clear, scientifically-validated theoretical frameworks;
- which address the needs of all family members, particularly the child; and
- staffed by trained personnel who are supported to provide high-quality, responsive services.

The QEC Early Parenting Practice Model

The QEC Early Parenting Practice Model is based on and grew out of the Family Adaptation model (FAM) developed by Professor Drummond. It was modified by QEC and adapted to local ways of working and to fit the organisation culture by the action-research process. The QEC Early Parenting Practice Model now provides a theoretical framework and addresses issues of putting theory into practice. Natural Teaching Strategies and Responsive Parenting approaches and the NCAST Keys to Caregiving program have been included within the FAM framework, to provide a rich, flexible and family-centred way of working that aims to build on existing staff knowledge and skills in working with families.

- The FAM is based on the concept of family resilience. It defines resilience as a dynamic concept representing the balance between protective factors (strengths, resources, capacity) available to families and risk factors (poverty, isolation).
- The QEC Parenting Practice Model orients services around a set of coherent, evidence-based theories, principles, concepts and terminology relevant to EPC residential services. These include family adaptation, family centredness, strengths-based and solution-focused approaches and attachment theory.
- The FAM focuses on how services can best respond to the complex needs of families. In operationalising the concept of resilience, the FAM recognises the importance of professionals working in partnership with vulnerable families to assist them to develop resources respond to difficulties and change.
- Attachment theory is central to the parenting practice supported by the QEC model.

Attachment theory

Attachment theory was developed by John Bowlby²⁶ in the 1950s and further developed by Mary Ainsworth.²⁷ It continues to be a major theory in child development and the basis of many practices in parenting and early childhood education. There are different perspectives within current attachment theory; points of agreement include:²⁸

- The adult-caregiver/child attachment relationship in the first three years has major consequences for infant functioning and developmental outcomes.



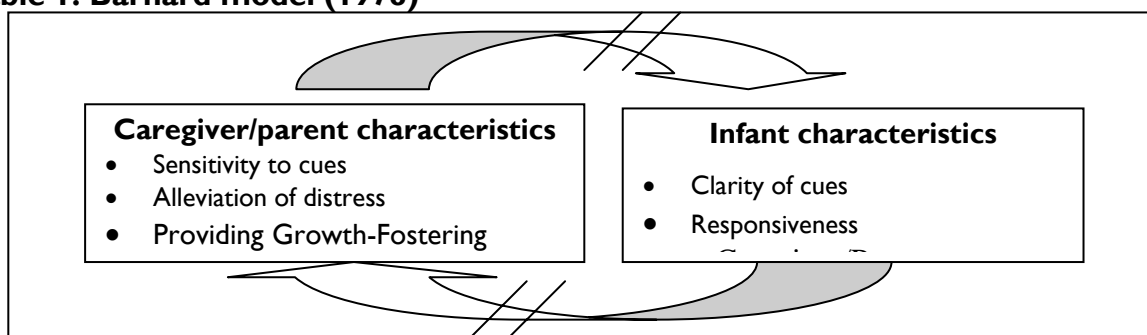
- The level of sensitive and responsive adult caregiving behaviour is the key feature of attachment.
- Infant attachment may provide the internal working model for later close relationships and development of self-image.
- The nature of the attachment relationship is influenced by behaviours of the child and behaviours of the adult caregiver.
- Infant behaviour involves signals such as crying or smiling aimed at bringing the attachment figure closer and at bringing the child closer to the figure.

Child and caregiver interaction: Helping parents bond with their children

Practice components which have been developed from attachment theory include Natural Teaching Strategies and Responsive Parenting approaches. Barnard’s research forms the basis of the NCAST Keys to Caregiving program.²⁹

The Barnard model (below) shows how the parent’s and child’s abilities to adapt and respond to each other are key to their relationship. The infant’s role is to produce clear cues and be responsive to the parent or primary caregiver, who in turn needs to be sensitive to infant cues, alleviate the infant’s distress and provide growth-fostering situations for the infant, who in turn continues to give clear cues. This should move smoothly unless issues arise from the infant, the parent or the environment. (Such interference is represented by a break in the arrows (//)). These might include an infant’s inability to give consistent cues, a parent’s lack of knowledge of infant behaviour, a caregiver’s illness, depression or a crisis in the environment. For example, a mother suffering postnatal depression might find it difficult to notice her infant’s cues during feeding (such as attempting to get eye contact). In her not responding to these, the infant is not reinforced in giving these cues and over time might become less clear or cease.

Table 1: Barnard model (1978)³⁰



Natural Teaching Strategies (NTS) is a component of the FAM and the QEC model. It teaches effective parenting practices based on understandings about child development, attachment theory and early child learning. Strategies include following the child’s lead, turn-taking through imitation, expansion of activities, teaching during naturally-occurring times and a non-aversive approach to managing difficult behaviour.³¹

The NCAST Keys to Caregiving program complements the Natural Teaching Strategies. Based on the Barnard model, Keys to Caregiving educates parents in effective responses to their babies’ and toddlers’



behaviour, sleeping and eating, while maintaining high-quality interactions with their babies. NCAST teaches parents to:

- learn how to observe the behaviours, cues and states of their infants/children;
- apply this knowledge in skills of state modulation and optimising interactions during feeding.

Practice elements which build on family supports

Practice elements flowing from family centredness include an integrated, family-centred assessment and planning process to make this process more wholistic and less medically focused. All steps in this process include an explicit focus on family strengths, knowledge and prior attempts to solve problems. A strengths-based planning tool adapted from the St Lukes Innovative Resources and solution-focused approaches formed the basis for the process of one-to-one planning, implementing and evaluating care plans for resolving parent problems.

Staff practices, structures, processes and tools that focus on attachment, responsive parenting and Natural Teaching Strategies include educating and modeling to parents responsive parenting and natural teaching strategies, an educational group for parents based on natural teaching methods, and educational groups based on NCAST Keys to Caregiving strategies of responding to infant cues, state modulation and quality interactions during feeding.

A co-operative learning and problem-solving approach reinforces the principles of responsiveness when working with parents. This is mirrored in the participative and co-operative approaches in which staff are educated and in which management support staff. This approach needs to be supported through education, clinical supervision, mentoring and reflective practice for staff.

Tools include videos and handouts from these packages, use of filming of parent/child interactions in educating parents, Emotional Scales and PCI Scales, Keys to Caregiving and Community Life Scales from the NCAST.

Organisational structures

The FAM specifies a small-team-based structure consistent with co-operative learning and problem solving. Teams should ideally be structured across the service consistent with a family-centred, partnership approach, rather than based on concepts of families with different levels of problems or motivation, for example, DHS-referred versus self-referred clients.



Table 2: The theoretical model

Theoretical underpinnings regarding child development & parenting		Theoretical underpinnings regarding supporting & developing resilience of families		
Attachment theory	Child-parent interaction	Family Adaptation Theory	Personal Construct Theory	Strengths-based/solution-focused & Partnership approaches
Reflected in ↓		Reflected in ↓		Reflected in ↓
Natural Teaching Methods and Responsive Approaches		Family-centred problem-solving approach		Co-operative learning approach
Staff ways of working with families	<ul style="list-style-type: none"> Terminology: “responsive settling”, “listening to cues” No “controlled comforting” Staff more confident in explaining theory/approaches of model in terms of attachment, responding to cues, not Ferber or controlled comforting Strategies centre on needs of the child More gentle, flexible to child need; spread over time No rigid strategies or times 	<ul style="list-style-type: none"> Strengths terminology used with parents Parent-focused throughout: integrates their understandings, past experiences, strengths into process Closely involve families and primary caregivers 		<ul style="list-style-type: none"> Staff role model communication interactions to parent & children Partnership terminology/approaches Adapting new terminology to parents while also using as education tool
Organisational processes	<ul style="list-style-type: none"> Above theories and approaches to child development underlie triage, assessment, residential work These are reflected in procedure manual etc. 	<ul style="list-style-type: none"> New intake/care planning process focus on family’s understandings, strengths, resources, plans etc. Care plan provides a tool for parents to continue the process, ideas at home Goal setting: parents: goals reset and actions evaluated each day 		<ul style="list-style-type: none"> Intake, care plan, hand-over, discharge reflect: Co-operative learning staff/parents Co-operative learning within & across teams, shifts & levels Reflective practice process: needs to ensure co-operative learning process Mentoring (informal) Handovers for night staff (need a look) Co-operative approach staff/co-ordinators for developing programs
Organisational structures	<ul style="list-style-type: none"> Above concepts and ideas seem to be supported in systems of communications across teams Reflective practice: structure for encouraging reflection across teams on these ideas in practice 	Small teams across both programs: encourage family centredness in staff perceptions. Family’s written care plan is focus for communications across staff/shifts/teams.		Team structure mostly seen to support co-operative learning and communication across staff, across different teams, levels and shifts. (Still some concerns)
Tools	<ul style="list-style-type: none"> Handouts and videos from Keys to Caregiving and FAM Parent education groups based on Keys to Caregiving Play session based on natural Teaching Methods 	<ul style="list-style-type: none"> Referral & triage forms Intake forms and care map Exit surveys 		<ul style="list-style-type: none"> First Relationship handouts Play session includes communication skills for parent/child interactions

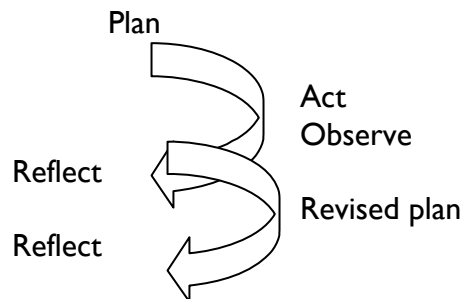


Methodology

Action research was chosen for this project because it allowed a process of learning and describing during implementation, which subsequently provided the basis for further improvements in ongoing organisational change and better understanding of the change process.

Action research

Lewin³² described action research as a process of following a spiral of steps. Each step is composed of planning, action and the evaluation of the result of the action. While action-research (AR) models exhibit a range of designs,³³ this diagram, showing a cycle of action–reflection–evaluation, captures most approaches.³⁴



AR methodology is based on principles of participation and democracy. It is particularly relevant to areas of social change and organisational development where the focus is on systems-level change which is studied at the same time as the change actually occurs. AR is well recognised in organisation-development literature³⁵ as a means of improving the outcomes of organisational change through providing ongoing evaluation and reflection and supporting broader participation across the organisation throughout the different stages of change.

From a research perspective, AR provides an inductive rather than a deductive framework for exploring change from a range of perspectives. The grounded-theory approach seeks to generate hypotheses and theories and explore these in action, without starting with a particular set of assumptions. The questions and research focus develop over time, as actions are implemented, as information is gathered and as further action proceeds. This developmental approach to research means that, while conclusions cannot be drawn about specific outcomes of the program, a detailed analysis of change over time is gained. This provides a context for interpreting outcomes; it also provides the basis for generating hypotheses for later research.

The methodology used in this project follows steps of planning, action, reflection, review and further action. The research is best summarised as three stages, each of which includes actions and research, with each stage of action influencing the next. Table 3 summarises these stages.



Table 3: Action-research stages of the project

Stages	Action	Research
Stage 1	<p>Plan</p> <ul style="list-style-type: none"> • Deciding on FAM & AR approach • Ethics approval, research plan • Develop Reference group • Staff information session • Adapt, extend FAM 	<p>Reflect on current practice & context</p> <ul style="list-style-type: none"> • 3 focus groups (night and day staff) • Supplementary data: reference minutes, 1:1 discussions and email questionnaire of management, data from education session and extra focus group on a specific practice example
Stage 2	<p>Education & team development</p> <ul style="list-style-type: none"> • Staff education sessions • Weekly reflective practice • Team development activities • Team structure changes 	<p>Feedback & reflection on early changes</p> <ul style="list-style-type: none"> • 3 staff focus groups • Supplementary data: reference minutes, focus group with management • Feedback from staff & management on interim analysis
Stage 3	<p>Systems development</p> <ul style="list-style-type: none"> • Continued team development • Continue reflective practice • Redevelop systems to one integrated, family-centred assessment and problem-solving process • Redevelop family educational system 	<p>Feedback & reflection on change, process and learnings</p> <ul style="list-style-type: none"> • 4 focus groups (2 day, 2 night) • Analysis of data across 3 stages • Feedback on draft

Stage 1: Plan and reflect

Plan

Following a review of potential models, QEC board and management decided on the FAM as the basis for implementing a formal service model. This led to discussions with Professor Jane Drummond, a developer of the FAM, to help plan its implementation at QEC. Professor Drummond visited QEC several times to provide staff education and help plan. The Research and Education Co-ordinator was employed, with this project as part of her brief, and the Wellness Promotion Unit of Victoria University was engaged to undertake the research component of the planned changes.

Ethics approval processes

Ethics approval was gained through the Victoria University Ethics Committee. While all staff participated in the organisation-change processes as part of their employment, they had a choice about participating in the research. Those who chose to participate in the research completed a written consent-to-participate form. Thirty-two staff agreed to participate.

Reference group

Active staff participation was central to the action-research approach. The reference group provided a formal structure to guide the project and foster this involvement. Its membership was gained through self-nomination and was open to all residential service staff. The eight members came from different backgrounds, shifts and levels in the service. It met monthly and then fortnightly and was chaired by the Education and Research Co-



ordinator. The external researchers attended the majority of the reference group meetings.

Other mechanisms for participation were established throughout regular discussion at team meetings, handovers, education sessions and supervision sessions about the project. Staff were also encouraged to feed back verbally, in writing and through emails.

Staff information session

A full-day information session was run for all residential-service staff in November 2004. This officially launched the project and provided an overview of the FAM and the research, as well as outlining a plan for its implementation at QEC residential service. It was an opportunity for staff to learn about and discuss the project and have further input and feedback at this planning stage.

Adapt and extend FAM

From the beginning, staff and management had highlighted some potential gaps in the FAM in some of the areas specific to QEC residential service. As management continued its review of potential evidence-based models, a number of other programs and models were seen to be relevant to QEC and to complement the FAM. These other models included:

- the NCAST: Keys to Caregiving and NCAST, Promoting First Relationships;
- the Parent Partnership Model;
- the strengths-based approach; and
- the solution-focused approaches.

Towards the end of this first planning stage, there was a meeting of managers and the Research and Education Co-ordinator, which produced an outline of the framework for implementing the FAM as well as the other models in the QEC residential service. This was later entitled the QEC Early Parenting Education Model.

Focus groups

Three focus groups were run with 35 staff who work in the QEC's residential services. As the project developed, a number of staff who hadn't been included in the original process requested to join the research activities. Participants included maternal and child health nurses, ECW team members and team leaders. They included full-time, part-time and casual staff and those on morning, afternoon and night shifts. One group was held for night-duty staff and two groups for day staff. Questions focused on what issues parents bring, what range of practices staff use in response to these issues, the current systems and ways of working together, and staff members' ideas and suggestions for implementing the FAM.

Additional data and specific practice example

Additional data was gathered to broaden the picture of the current practice model. This was not systematically analysed, but provided additional information on the overall practice model. It included a questionnaire emailed to management, reference-group meeting notes, participant-observation notes from researchers attending the original information day, and a review of current forms and handouts used in the residential services.

To gain more detail about specific practice and practice changes over time, it was considered necessary to collect data on a specific area of practice as a case example. "Sleep disturbance and interruption" was chosen, as it was the most common issue families present with and the issue most discussed by staff in the focus groups. Sources of data were:



- *Education.* During an education session, staff were divided into groups and given the questions about their practices in supporting families with concerns about their child's sleep behaviour. A member of each group documented the group's replies. These were transcribed and given to the researchers.
- *Reference group reflection.* One reference-group meeting was set aside as a focus group with the researchers, to further explore the case example around sleep disturbances and interruption. This session was recorded in notes and audio-taped in the same way as other focus groups.

Analysis of first-round data

Focus-group notes were processed for each group. Researchers watched videos and transcribed a large proportion of the video material. Notes were collated in the areas of interest: 1. staff reflections on current practice model; 2. more detailed reflections on model regarding sleep; 3. staff ideas for input into processes for organisational change and education.

Stage 2: Education and team development

The aim for this stage was to gain feedback on the processes, which included education, reflective action, team development and change. At this point it was approximately two months after the education phase but only a few weeks since team changes.

Staff education sessions

Education sessions were held one day per week for five weeks for all staff on:

- introduction to action research;
- Family Adaptation Model (professional education package);
- official training modules from the NCAST Keys to Care givinG Education packages;
- education on the program and resources of the NCAST Promoting First Relationships package;
- therapeutic communication: solution-focused approaches and strengths-based practice;
- team building.

Weekly reflective practice

Weekly reflective-practice sessions were established with invitations to all staff. These involved staff in discussion of everyday practice in the context of the model, sharing ideas and understandings about theory and practice, and encouraging a culture of FAM co-operative learning and problem solving and mentoring among staff.

Team development and team structuring

The aims for small-team development were:

1. To build a small-team structure which was the cornerstone of the FAM co-operative learning approach;
2. To enhance the co-operation across programs and specifically to reduce divisions across the five- and ten-day residential programs.

Team development included opportunities to bring staff together across the service in education sessions and social activities.

Structural changes to teams followed education sessions. Small teams were developed on each day shift with



one team leader (maternal and child health nurse) and a small number of staff. Each team worked with a mixture of five- and ten-day staff. As night shift had only between three and four staff, their team structures were not changed.

Focus groups at stage 2

Three groups were run including one during night shift. Thirty-three staff participated. Most had attended the previous focus groups but four had not attended the first groups. The focus groups were held two months after the education sessions and a few weeks after team changes.

Additional data: Management group, reference-group minutes

In April 2005 a focus group was arranged with senior management to explore, from their perspective, the process and changes at this early stage of implementation.

Analysis of second-round data

Themes were drawn from the focus-group data. Those themes were used to address the research questions. Data regarding assistance with sleep was incorporated into the case study on sleep. At the end of this stage, an interim report was drafted and made available for comment, with presentations to staff to ensure adequate opportunity for their input.

Continuation and fine tuning of previous changes

Weekly reflective-practice sessions continued, though at times their structure and process changed. In terms of team structural changes from stage 2, there were extensive processes of negotiating and adapting throughout stage 3.

Development of a system of family-centred assessment and problem-solving

Processes and procedures from the moment families contacted the service to the evaluation and discharge were integrated into a system called Family-Centred Assessment and Problem Solving. This included the following elements within one consistent approach based on the new model.

Assessment and intake

A new name, “assessment and intake”, replaced “triage”. The forms were redeveloped to be consistent with the focus on the whole family.

Strengths-based care-plan tools

New care-plan tools were developed based on the five-column strengths-based planning tool developed by St Lukes Innovative Resources.³⁶ The tool requires staff to engage parents in discussion and fill in the column headings of: “admission issue”, “family strengths”, “what’s been tried” and “how do we get there and who might help”. This tool also guided handover between staff members working with the same families, as well as guiding the way staff worked with families in resolving their particular issues. Each day the staff would discuss with the parents their goal and what strategies were being used and if these were effective. Strategies to reach goals would remain the same to be adopted or modified.

Education groups

Parent educational groups were also redeveloped using the Keys to Caregiving and Promoting First Relationships resources and handouts. An educational video produced by the Northern Beaches Child and Family Health Service and the NSW Institute of Psychiatry, “Getting to Know You,”³⁷ which shows examples of parent/infant interactions and how these might contain cues which can help parents better understand and



respond to their child, was also included.

Filming parent/child interactions

Another change was the early introduction of filming parent/child interactions and using these to provide instructive and reflective feedback to parents based on the NCAST model. It was very early in the process, since a group of staff needed to be trained in the accredited program. It is now standard practice for some QEC programs. Management particularly raised the major shift this will bring to the focus of work with families. NCAST PCI Scales are a valuable tool for detailed and specific work to assist in focusing interventions and improve parent/child interactions.

Stage 3 research review change: One year later

A final set of focus groups was run in October 2005 after approximately one year of the project's implementation. These had not been planned in the original project, but were set up to capture further changes which had occurred since the second round of groups.

Focus groups

Four groups were run, including two evening groups for afternoon and night staff. The range of participants was similar to previous groups. Questions explored what changes had occurred across the year in staff practice, systems and across the service, how these related to the model, and how the experience had been for staff over that time, as well as what was important for the future.

Additional data

This included documented discussions with management, reference-group minutes, analysis of new forms and participant observation from a reflective practice session.



Findings

Issues brought by parents

The literature on EPCs suggests that, generally, sleep issues are a particular area of demand and specialisation.³⁸ Other issues are feeding, behavioural issues and parent/infant relationships.³⁹ The research also suggests that these presenting issues are compounded by a range of mental, physical and social health concerns, which add to the complexity of response required by the services. Initial focus groups explored the understanding by staff of issues brought to the centre by families. This provided a contextual backdrop for the researchers as to the nature of the work of the centre, as perceived by its staff. However, its main purpose was to allow staff to reflect on their current practice as they embarked on a process of education and organisational change. It was expected that a clear understanding of current work practice would facilitate a thoughtful and effective change and development of practice with the least possible disruption to staff or clients of the centre. Table 4 summarises staff responses from initial focus groups exploring the issues brought by parents to QEC residential services.



Table 4: Issues parents bring

Presenting issues	<ul style="list-style-type: none"> Sleep (parents and children) Parental stress Parent/child relationship Child(ren)’s behaviour management Feeding
Parenting issues	<ul style="list-style-type: none"> Feeling in crisis Parental stress and anxiety Parent stressed by child’s crying Parents’ feeling of failure Parents feeling out of control Fear of collapse Fear of hurting the child Parenting not as expected Parents need sleep Parents returning to paid work New child Parent/child relationship Lack of family/friendship support for parents Need for parenting skills and knowledge
Contextual issues	<ul style="list-style-type: none"> Drug and alcohol issues Domestic violence Mental illness Intellectual disability of parent Postnatal depression Isolation Marital issues Financial issues Housing Childhood sexual abuse of parent Societal expectations of perfect family

Presenting issues

Presenting issues are those for which parents were first referred. These included sleep (parents and babies), parental stress, the parent/child relationship, children’s behaviour management and feeding. These are similar to the presenting issues described in other early-parenting services.

There was considerable discussion about the complex relationship between presenting issues, other issues and contextual issues for families. Firstly, the sleep issues of the child have often reached crisis point before admission to the unit, with problems in co-existing parents and family including stress, exhaustion, and relationship and health issues.

Staff talked at length about how sleep issues can be either a symptom of or, at times, a safe “front” for other issues, particularly those related to parental stress and inability to cope with the demands of infants. Staff believed that parents find it easier to seek help for sleep issues rather than other parental issues. One quote from a staff member illustrates this point well:



Yes, like the child not sleeping at night is a really big issue, but actually when you start delving into everything else that is going on, you find that is a side issue of something else. Perhaps a symptom of what is going on between the mum and the dad or in the family unit. You eventually get it out. But they are coming in with the big problem: the child won't sleep. Then a lot of other problems come with it.

This suggestion by staff is supported by some small studies of families attending EPCs.⁴⁰

Parental stress as a presenting issue may also relate to other issues apart from sleep. It can include serious anxiety about parenting, fear of hurting the child(ren) or feeling out of control. A serious level of parental stress is often triggered by family events such as the arrival of another child or the end of maternity leave and the need to return to the paid workforce. Such changes can bring to a head any earlier, but previously not concerning, sleep issues for a child/infant. For example, when a mother has another child, co-sleeping might no longer be possible and sleep issues become problematic.

Parenting issues

Parenting issues cover the range of parental concerns that had led parents to refer themselves or were referred to the QEC. The majority of issues are related to the stress experienced by parents in caring for their child(ren) and they demonstrate the complex set of feelings and concerns that can lead parents to feel as if they are having a crisis that they do not have the resources to deal with.

Part of parental stress, which allows it to reach the point of crisis for many parents, is the feeling that their referral to QEC might be seen as failure:

Often they'll battle on until either they'll collapse or they're scared they'll do something to their baby ... most have been battling on for a period of time before they make the phone call expecting to get help immediately, but then they have to wait

Staff understood that this meant parents often did not reveal some of their core concerns and issues until later in their stay at the QEC, when they had come to trust their primary worker. This difficulty in approaching parenting issues is compounded by broader social pressures:

(Parents) don't like to have to ring. They feel that they've failed, that it should be natural ... there is a perception out there that it should be easy, like Johnson & Johnson ads where mothers are glowing.

Contextual issues

Contextual issues are a range of more complex concerns which can lie below the surface of presenting issues and parenting issues. Staff reported that contextual issues such as relationship difficulties, postnatal depression and other mental-health problems, and social and economic concerns such as housing, are very common for families seeking help in the unit. They also reported a high number of mothers talking about previous sexual abuse. Issues like these are likely to emerge later in the service period when trust has built up. For many it seems to be an important step, just telling someone about what had happened:

Sometimes people don't want to get formal counselling. We're almost anonymous in some ways. They are only going to see us for a few days and sometimes they'll disclose things to us and that is all they want.



A recent report⁴¹ on research at another EPC supports this point raised by QEC residential unit staff about the high occurrence of complexities among EPC clients. They showed high levels of postnatal depression, serious anxiety and suicidal ideation.

The significance of this to the project is that it suggests that a range of skills and organisational supports are required to deal with the often-complex mix of issues for families entering the unit. While sleep, behavioural and feeding concerns might be the referral basis, these are often interrelated with parental stress (including anxiety and depression) and contextual issues, which need to be recognised and responded to. In addition, even while staff respond to the presenting issue, other issues will impact on what changes can be developed and sustained once the family leaves the unit.

Staff are increasingly required to have a level of proficiency in recognising and responding to serious issues such as postnatal depression and other mental-health issues, drug and alcohol issues and domestic violence. The impact of these issues on the parent/child relationship were a focus for the model's implementation.

Staff practice models prior to implementation of the model

Table 5 presents an overall structure of practice as summarised from staff and management discussions and is of interest as a baseline for change. Four elements were identified: education, role modelling and coaching, support/reassurance and individual goal setting. These elements were interlinked and describe a range of methods and ways of working with families throughout their stay, rather than individual steps.



Table 5: Staff practice models prior to implementation of the model

<p>Parent education</p>	<p>Respond to the presenting issue Teach strategies re presenting issue Info on child development, responding to child cues Flexible strategies, encourage parent flexibility One to one, handouts, charts, videos Groups: sleep patterns, communication, limit setting, stress/self; care and parent/child groups e.g. story telling, music Some clients feel they get conflicting advice (not always the case, sometimes misconstrued) Some inconsistencies between staff in language</p>
<p>Role modelling and coaching</p>	<p>Staff get baby to sleep, then parent does it, staff stands back Discuss process, as parents learn it, break into small steps “Give them positive reinforcement” Echo back what parents are saying to themselves Reinforce in practice</p>
<p>Support and reassurance</p>	<p>Build friendship, trust, safety through respect, listening, professionalism, nurturing, acknowledging their problem, continuity of staff Asking throughout, “How are you?” Clarifying parent expectations Adapt to the parent: reading their ability, their capacity Giving them the choices so they are making the decision as well Draw attention to successes: “You’ve made big changes” Link them to their resources e.g. family background, play groups, family day care, use “the ecogram” Referral to in-house counsellor, CASA etc. Staff can get lost in complex issues e.g. DV, drug/ alcohol, mental health, financial issues, sexual assault</p>
<p>Individual goal setting and achievement</p>	<p>Flexibility: “There are many ways to raise a child” “(Parent) makes ... decision, not us. We ... give ... options” Sometimes staff feel pressured to resolve the issue Set and modify goals and strategies to family needs: based on parents’ goals, what they want to achieve, modify as the week progresses, take account of home situation, current routines, what they can do at home, individualise strategies to child, discuss current routine Respect that they will do it when ready</p>

Education

There is the professional side of it, you teach them what they came in to learn and you supervise that so they go home very confident they can do it themselves.

Education is the main element of the model, particularly educating parents to deal with the presenting issues e.g. sleep disturbance, behaviour, feeding. Education used different modalities and tools (group, one to one, video, charts, handouts) to focus, adapt and teach parents these strategies. Broader parenting education provides a background to the strategies e.g. sleep requirements, developmental stages of children, sleep



associations, tiredness cues, parenting styles, limit setting etc.

Broadly, the steps in education begin from the first phone contact. At intake, parents discuss issues one-to-one with staff to develop goals and explore their history. Then, throughout their stay, they receive one-to-one discussion of the issues, role modelling and group education. Strategies and goals are modified as they learn and try things. One-to-one work on sleep strategies are continued at night. Documentation is done throughout, using a pro-forma care plan and notes. Handover between shifts allows staff to discuss strategies. Continuity is seen as very important. Although parents sometimes feed back to staff their frustration over inconsistency, some staff feel this may be about parents not hearing or misconstruing some advice. Staff feedback suggests that, while practice is mostly similar across staff, language can be inconsistent.

Role modelling and coaching

To get the child to go to sleep you are role modelling. You actually get the baby to sleep. And then the next time they do it and you are standing there with them. And then you back off so that they are confident doing it themselves before they go home.

Modelling behaviour for parents is an important aspect of the education model, especially as it ensures parents' confidence in carrying out new parenting approaches. Focus-group research with parents in EPC residential services have shown this one-to-one modelling in a supportive environment to be of vital importance to parents.⁴²

Support and reassurance

A bit of nurturing, I think.

*Often people just want acknowledgement. Is it okay? Do other people have problems? And oftentimes when they hear other people have problems they relax. They feed off each other, the general acknowledgement of each other. **They don't feel so alone.***

Pivotal to the practice model at QEC was the support and reassurance provided to parents. This includes recognising and listening to concerns, and providing support, reassurance and encouragement. Both staff and management viewed this aspect as very important. Management highlighted the one-to-one discussion of issues with staff as an area that parents give positive feedback about in their exit surveys. Staff further raised the point that the QEC should not compromise on the supportiveness in attempts to formalise a practice model. As one staff member said: *"How can you make nurture into a model?"*

Discussions explored in depth how support and reassurance were provided. Primarily, staff aimed at providing for parents an environment and relationship of respect, professionalism, acknowledgement, empathy, trust and safety. Over time, this supports parents to share their concerns more openly. This sometimes means that major contextual issues, such as previously unreported sexual abuse, will come out on the day before they leave, which creates obvious challenges and the need for reflection for staff. An in-house counsellor is available for referrals. Staff also talked about referring to outside agencies such as the Centre Against Sexual Assault.

Support and reassurance are also essential parts of education and role modelling. This includes drawing attention to, acknowledging and praising parents' achievements in one-to-one and group sessions. It also requires staff to interpret and adapt strategies to parents' abilities and how they are coping. It means



continually checking in and asking how they are.

Some staff spoke about strengths-based, solution-focused approaches to the education of parents as what they had been doing all along. This seemed to refer to the general values of client centredness, flexibility and working with families to set their own goals, e.g.

Solution focused (approaches from education sessions), talk coming from the staff is that we are doing all that anyway

We work with their goals

Sometimes I just listen ... eventually they come up with their own solutions.

Individual goal setting and achievement

What are they doing at home, what do they want to do here ... May set goals they may not be able to follow. We need to support and allow them to do what is realistic for them, what is within their capabilities and their emotional state at that time ... (it) may not be the perfect solution at the end of the day, but at least it was something they could achieve.

Individual goal setting and achievement sum up a range of processes and approaches which ensure that parental needs and goals are central to staff's work. Again, these are essential elements and flow through different steps and parts of the program. Goals and issues begin to be explored from triage. Goals are further explored and documented in the intake process. In the care plan, the goal is at the top of the notes. Staff also noted that this goal might adapt and change over the stay.

Goals might be for the parent or for the child. They may be behavioural e.g. child sleeping through the night or parents able to spend time settling their child before picking them up or may relate to parents' feelings about the situation e.g. being less anxious/stressed.

Staff discussions showed they placed strong importance on parents resolving their own issues, rather than staff solving them. This was seen to be more empowering and meant parents would follow through with strategies. An issue arising in management and reference-group data, but not from staff focus groups, was that staff did feel some pressure to resolve concerns or issues themselves. It seems that, while there is a culture which values solution-focused approaches (supporting families in developing solutions), this does not necessarily translate into practice for all staff. This poses an important challenge for the developing practice model. On the one hand, it needs to expand on the current values of empowerment and building on people's strengths and, on the other hand, it needs to provide practical tools and supports and explicit documentation of the model to support staff in their practice.

Another point raised in the first-round focus groups was the need to look at the assessment process, and to some extent to formalise aspects of the new model in assessment. The FAM, for example, theorises the importance of exploring families' backgrounds, resources and cultural beliefs more fully. One person asked: "How much do we explore values and beliefs, minimally?" The answer from staff in this group (and in other groups) was that this information arises informally when the team leaders go through intake forms such as health details and when documenting the ecogram. They are not formally required for the form, however, and might not be passed on to other staff.



The desired model: The QEC Early Parenting Practice Model

The QEC Parenting Practice Model is detailed on pages 10–14 of this report. The theoretical model provides the connections between theory and practice which were the basis for the QEC residential service redevelopment. It shows how staff approaches and the processes, structures and tools of the organisation would all be integrated in the desired model to flow from specific, consistent theories and evidence-based approaches.

At the broadest level the model is an extension of the Family Adaptation Model. The theoretical elements underpinning the QEC Early Parenting Practice Model are attachment theory, theories relating to parent/child interaction, family adaptation theory and personal construct theory. The FAM incorporates strengths-based, solution-focused and partnership approaches which flow from these theories: Natural Teaching Strategies, Family-Centred Assessment and Planning, Co-operative Learning and Problem Solving.⁴³ To develop the QEC Early Parenting practice Model, the FAM was further extended to include specific staff practice, organisational processes, structures and tools. For example, tools from the NCAST Keys to Caregiving include filming of parent/child interactions and use of this in educating parents, and a strengths-based planning tool was adapted from St Lukes Innovative Resources.

Organisational processes, structures and tools flowing from Natural Teaching Strategies and Responsive Parenting approaches

The model suggests specific ways for QEC residential services to operationalise these approaches into service delivery, by ensuring that staff approaches, organisational processes, structures and tools all flow from the explicit approaches.

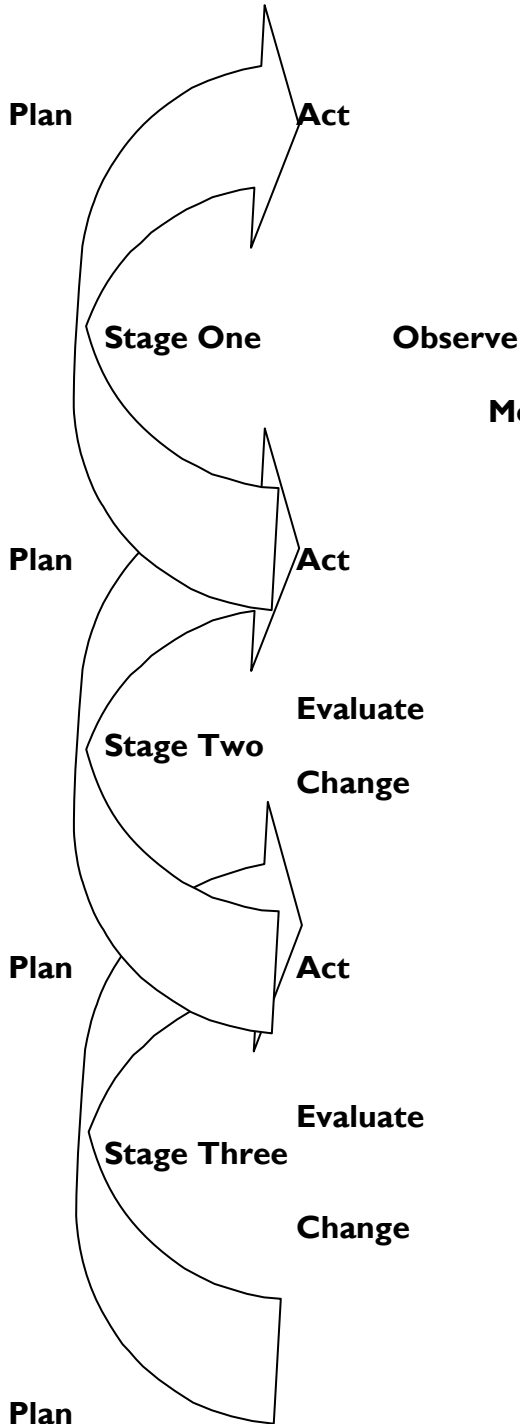
Discussion and reflection

Within the action-research design, changes resulting from implementing the QEC Parenting Practice Model were undertaken within the cycles of reflection (research and planning), action and reflection (research and review).

Table 6 outlines the three stages of action and some reflections on each stage, of the project, with a brief summary of the ideas related to the relevant change. A more detailed discussion of the processes and reflections follows.



Table 6: Action and reflection



Stage 1 Observations: models of practice
 Staff positive to new model: but “is it different?”
 Some parent/staff notice inconsistency
 Not one clear or consistent model or theory base
 Some focus still on problems and strategies not parenting

Model changed from FAM to QEC Parenting Practice Model

Stage 2 Actions	Reflections on stage 2 actions
Education: NCAST, Keys to Caregiving Reflective practice Team development Team structure change	Model extends on current work Value/challenge: learning new model Value: staff all together Value: reflective practice but need for skilled facilitation

Change to practice (stage 2)
 More aware of practice and how model is different
 Staff practice: gentler, more flexible: less rigid
 Some confusion: re: “old ways”

Stage 3 Actions	Reflections on actions
Continue/adapt team change System developed: Family Centred Assessment & Problem Solving Family Educational System	Importance of cooperative /learning/problem solving between staff/management “One step forward, two steps back” Value of family educational & process tools

More consistent staff practice: more child & family centred
 Consistent language reinforcing the parenting approach
 Systems supports and reinforces staff practice, which in turn supports the parenting approach
 Parents more likely to notice consistency & to learn the parenting principles at the core of the model



The implementation process and learnings from this process

Stage 1: Plan and reflect

A major learning from this stage for management was the value of action research as a model for organisational change. This process provided the impetus for management to examine each part of the service. The research functioned like a pair of eyes watching the process and encouraging management to ask what else was planned and why. The action-research methodology also ensured that staff participation was central to the change process. This has been vital to the project's success and also helped with challenges along the way. Reference-group staff, for example, were able to feed back staff concerns, and at times passed information to staff to which helped to alleviate their concerns. Staff on the reference group also fed back the value of involvement.

At the planning stage, implementation of the model had first been viewed as providing staff education about the practices of the model. Instead, the project reviewed and redeveloped nearly every process, tool and structure in the residential service. This has also spilled into the other QEC services. "Nothing hard is ever easy" was one reflection from management, referring to how much the extent of the changes which unfolded, had been beyond their comprehension at the planning stage.

Management had also questioned whether the FAM model provided enough detail to bring about real change in day-to-day practice. This concern provoked important discussion and, with further research, led to the incorporation of consistent models and tools such as NCAST Keys to Caregiving.

Staff also reflected on worries they had had earlier about what "change" might mean to them. While their concerns did not come to fruition, this shows how staff might be feeling in the early stages of planning change. Processes to ensure staff are fully involved are particularly important in quelling and responding to these concerns.

Stage 2: Education sessions, team development and team restructuring

Reflection and feedback on stage 2 processes

There was ongoing discussion about whether the model extended current practice, whether it only provided different terminology for practice that was already being used, or whether it created extensive changes to practice. Views varied across staff and changed during the process of implementation. At this early stage, education was broadly focused on the overall principles and theories underlying the model. Without specifics, staff felt they were being re-educated on principles that were already familiar to them. As the specifics were filled in during the process, this perception seemed to change. Staff realised that the model did bring specific change, even though this built on values and approaches that already existed, for example, attachment theory and strengths-based approaches.

All staff were very positive about the new concepts and practices they were learning, particularly cues and strengths-based, solution-focused and partnership approaches. They looked forward to obtaining tools more specific to practice. Later, staff reflected that the new terms and approaches were challenging because they had been using some of their old practices for many years. Some also described feeling confusion at this time of change "Do we no longer use controlled comforting, or open-door/closed-door approaches?"

It was very important to staff that they came together and include both day and night shifts. It was important that both night and day staff received the same level of education opportunities. At the third stage, night staff



felt they had missed out on later education, such as care planning. Night staff were also hoping that parental education groups could be taped so that they could see what parents were being taught.

Stage 3: Redevelopment of systems and tools; adapting previous changes

The third stage brought the bulk of the organisational changes. Weekly reflective-practice sessions continued, although at times their structure and process changed when the Research and Education Co-ordinator was not able to attend. Sometimes the Family Counsellor or Clinical Services Manager were able to help facilitate the sessions, and at other times they were run by other staff.

At the third stage there was concern that these reflective-practice sessions were not always effective for staff learning. They seemed to work best when staff were broken into smaller groups for discussion, but without enough skilled facilitators this could not always be done. One area of improvement for the future is to build these skills across the staff, ensuring facilitators will always be available for leading small-group co-operative learning and problem solving-based groups. Perhaps, as in the implementation of family-centred care-planning, staff might need specific tools, as well as education, to guide them in co-operative learning and problem solving processes.

In terms of team-structural changes from stage 2, there were extensive processes of negotiating and adapting throughout stage 3. By the end of the stage-3 focus groups, there began to be some acceptance of the new structure. At the start of the project, there had been difficulties organising rosters and setting up a consistent, team-based system across the service. This had created some confusion. There were also concerns that some team leaders had increased workloads. The process therefore involved many discussions with staff about their concerns, and renegotiations of the teams.

Development of a system of family-centred assessment and problem solving

At this stage there were changes to the whole system of contact and working with families, so as to ensure consistency with the model. This meant changing the processes and procedures staff followed, documenting these in the procedures manual, and redeveloping the tools including assessment forms in place for each stage.

A new name, “assessment and intake,” replaced “triage” (the medical terminology). New forms were developed to include questions consistent with the focus on the whole family, rather than on medically-defined issues.

Care plans were a major area of change. The new form was based on the five-column strengths-based planning tool developed by St Lukes Innovative Resources.⁴⁴ This tool required staff to engage parents in discussion and write under the column headings of “Admission issue,” “Family strengths,” “What’s been tried” and “How do we get there and who might help.” Handover would also be guided by the care-planning tool, as would one-to-one work with families. Each day the staff would sit with the parents to fill in the tool with a new daily goal.

While there had been attempts to change the handover process to a smaller one, with the handing-over staff and parents together, this did not eventuate. Some unsuccessful attempts were made to move to a smaller group handover. Management believed that, with the changes already implemented, this was a change that needed to be taken in small steps.

Parental education groups were also revamped, using the Keys to Caregiving and Promoting First Relationships resources and handouts, including an educational video called “Getting to Know You” which shows examples of parent/infant interactions and how cues can help parents better understand and respond to



their child.

Another change was the introduction of filming parent/child interactions and using these to provide instructive and reflective feedback to parents, based on the NCAST model. This took place very early in the process, since a group of staff needed to be trained in the accredited program. Management particularly noted the major shift this would bring to the focus of working with families. It is a very valuable tool for detailed work to improve parent/child interactions.

Reflections on the third stage

While many staff found the process of team changes difficult and frustrating, there was a general acceptance of team changes by the third-stage focus groups. The processes of education discussion and negotiation had been central to reaching this level of acceptance.

A collaborative process takes time. “One step forward, two steps back” was the way one manager described the process of organisational change. This reflects the nature of organisational changes generally. Real change means shifting the culture of the organisation, which has its own history and familiar functions for people. Change is therefore a long term process requiring smaller changes at a number of levels.⁴⁵ Over the course of the project, management started to phase in changes a bit more slowly, so as to consolidate one area of change before trialing another. Again, co-operating with staff was an important part of the process, where a change might be developed by management, then trialed by staff and then, after discussion about how it was working, some adaptation might occur. Staff spoke positively, for example, about how the new educational groups were adapted based on staff feedback. They felt it made the groups work better and they were more confident running them.

The value of the tools was another important learning from this stage. There was a major shift in practice, noticeable to staff and management, between the second and third stages, mostly based on the changes to organisational processes and tools. Staff gave strong feedback that the care map had formalised the strengths-based approach and brought about a major shift in the way they worked with families. Staff also found the video “Getting to Know You” a very powerful tool which helped many parents improve their interactions with their child. They felt, however, that there was a need for similar tools relevant to older children. Management also discussed the importance of tools and, particularly, the filming of parent/child interactions as part of the education focus.

A major learning from the process has been the importance of the action-research approach with regard to the complexity and comprehensiveness of change implemented in the service. The action-research methodology meant that, after each step of change was implemented, staff and management could then reflect and share feedback on further changes. This flexibility of design and ongoing staff involvement led to a detailed examination of how QEC systems operate. This encouraged the development of more detailed and systematic processes over time. What began as a plan focused mostly on staff education became a major revamp of all systems, tools and processes across the service. This has led to a long term process more likely to bring enduring and effective cultural change at all levels.

Discussion: The QEC model in practice — after one year

The final set of focus groups conducted a year after beginning the process of developing and implementing a revised theoretical model of practice for staff predictably showed the greatest change. The most striking change was in the way they talked about their practice and the words they used to describe the work they did



with families. Staff had ceased using sleep-specific terminology and were using more child-cue terminology. They were also more fluent in explaining the theoretical basis of strengths-based, solution-focused and partnership approaches.

In working with families in a Co-operative Learning and Problem Solving approach, staff felt there was a shift towards a greater partnership and co-operative approach with families. For example, many staff talked about the shift from a teaching (didactic) role to a partnering role where parents and caregivers had more say.

Because child-centred approaches take longer than outcome-focused approaches, it was important that any previous emphasis on resolving the presenting problems quickly should also shift. In the framework of the first focus groups, staff felt their performance was linked to resolving issues within the period of the stay.

Organisational changes were vital to implementing the model. While staff education provided an overview and theoretical understanding to staff, organisational change provided a structure to guide staff practice and helped define how the model related to specific, everyday practices. The tools, including videos and handouts, provided specifics for implementing the model and staff found it very useful to work with a consistent set of tools.

Co-operation between staff and management in implementing change processes was raised by both management and staff in discussing the overall learnings from the project. There were mixed views on how much co-operation and participation had been included in the process, with some staff feeling it could have been more participatory.

How staff work with families

The third-stage data illustrated a number of elements of the staff approaches with families, which were more consistent with the model than they had been previously.

Language shift

First was the language used by staff. Their use of language suggested not only how individual staff members now viewed and described their practice, but also revealed aspects of the broader culture and cultural change. While not all staff (or even the majority) seemed confident at the third stage in describing an overall model of practice, they definitely had more confidence at this stage in talking about how different parts of their practice link together and using the terminology of the new model in describing this:

I think it is about giving the child the opportunity ... like looking at the cues and listening and using those skills so you can make a change for whatever they want. ... and using the skills that they (the family) hadn't thought of before so that you can make these positive changes happen. So it is about everyone having an opportunity. The parents having the opportunity to learn things or discover something new that they might not have thought of before ... And giving the child the opportunity to do it.

(staff member in third-stage focus group)

This was different from the first-round data, where there were no descriptions of an overall approach capturing the different aspects of work across different issues. Then the staff described their overall approach as about educating parents in a range of different strategies for different presenting issues:



There is the professional side of it (as well as the support with complex issues), you teach them what they came in to learn and you supervise that so they go home very confident, they can do it themselves.

(staff in first-stage focus group)

Families often come in for sleep and settling, then they have different issues, they can move and begin working on those issues

(staff in first-stage focus group)

One of the most noticeable shifts at the language level was that the sleep-specific terms of “controlled crying” and “controlled comforting” had been replaced by the terms “responsive settling” and “listening to cues.” This observation by staff was supported by the comparison of data from different stages. Earlier, the sleep terms were very prominent across different staff groups. At the second stage, some staff seemed to be confused about whether the term “controlled comforting” should be used or not. At that stage, staff observed less use of the sleep terms in the notes. By the third stage, each group observed that staff no longer used these terms. The terms they now used reinforced a positive process of parenting where parents learn about, notice and respond sensitively to their individual child.

This language change has been very important in changing the orientation of the service and parents’ perceptions of the process. Staff discussed, for example, how parents often assume that the QEC staff will teach their child to sleep. In the past, this perception might have been reinforced by the terminology used, for example, referring to Ferber’s model⁴⁶ and controlled-comforting strategies. Current terminology challenges that assumption and encourages parents to realise that resolving sleep issues is based on the same skills and principles as all areas of quality parenting, that is, knowing their child and listening and responding to their specific cues:

That has been quite dramatic in the clients to actually realise ... “responsive settling” and they’re so keyed into controlled crying. “Oh, that’s what we’re doing” and by the end of the actual week they’re realising “What I’ve learned is to actually listen to my child.

(staff in focus group at stage 3)

While consistency in terminology was generally reported, some confusion crept in about the specific use of words. Some staff also talked about the difficulty of replacing terms they had been using for years, saying this takes time and an ongoing process of education.

When looking at the language expected from the desired model, it is important to note that at this third stage, the specific phrase “attachment theory” was hardly used by staff. Attachment theory and its related parent/child-interactions theories are the main theories underlying what parents were being taught in the new model, so it was an important concept for staff to be confident with. While more work might need to be done to develop staff confidence in discussing these theories and how they relate to practice, there has been some shift. At the third stage, staff were more likely to use terms associated with attachment theory, such as being responsive to the child’s needs and basing parenting approaches on the emotional and developmental needs of children:

(I explained the approach to a parent by saying) we don’t all work like clockwork, and some children are going to need much more support to learn the skill and every family is different and it is more important to be responding to that. She really agreed with that and it was all crystal clear to her.



(previously we'd thought) "we're not going to pick you up or we're not going to feed you (until) ten minutes ... because the book says that"... so (now) we say (to parents and caregivers) "the current literature says we really need to be tuning in to the baby ... we've had to re-educate ourselves, we've had to start to think in another way, and we do think in another way and it's just wonderful to get to know your baby in that special way"

(staff focus group, stage 3)

Staff in the first-stage groups did mention attachment theory, but the conceptual links between this and their practice were not clear, and it was not seen as an important part of what underlies practice. The above quotes reflect more general clarity that attachment-based ideas of child centredness and responding to children (rather than the clock) lead to a different understanding of how to work.

Another shift in language was that, at stage 3, staff were more specific in explaining the practice and the theoretical basis of strengths-based, solution-focused and partnership approaches.

I suppose it's the recognition that families are doing really well before they came in here and just validating that.

(staff focus group, stage 3)

P1: ... And I think for us to be working towards whatever the family wants. Whatever their goal is. We work with that.

P2: And using their strengths to achieve that goal that they want.

(staff focus group, stage 3)

These values were present in earlier groups, as discussed in the section on prior staff practice, but now language referred more specifically to how they explored family strengths and involved families in identifying different resources and how all of this fits into their general process of working with families. It was now more formalised and more consistent.

In terms of practice, at the third stage staff generally thought that practices across the service had changed to reflect the difference in language. It was not necessarily all new but, rather, the focus was more explicitly on child centredness, the emotional and developmental needs of the child, family centredness, and the empowerment of and partnership with caregivers in decision making. Again staff mostly talked about a greater consistency across the service in using these approaches as the basis of their work.

The approach is a lot gentler.

I think we're thinking more about the baby and the baby's feelings...

And it's not just the under-six-month-olds that needs parental presence. It's also the over-six-months and sometimes you can use parental presence with a two year old.

... the focus has gone from the clock. It's back to the baby.

... when I started it was more about the time, whereas now, it's actually about listening to the cues and helping mum to feel more competent ... about what her baby's actually telling her.



We respect families' uniqueness and individuality in that some parents are fine to let their babies have a good cry ... and others don't cope ...

Let them have more say into how they're going to get their child to sleep and what their routine will be. I think before we were too dogmatic.

I suppose it's the recognition that families are doing really well before they came in here and just validating that ...

And I think it's really good now, that dads are really encouraged to come.
(all from stage 3 staff focus groups)

This gentler, more child-focused, family-centred partnership-based approach from the staff point of view seems also to be reflected in changes in how staff described actual practice. Data suggests that, while they continued to use the previous step-by-step approaches (to encouraging independent sleep, for example), the detail of each step was more likely to be decided by the caregivers and more specifically around the cues and responses of the child. This shifted the emphasis for staff, from resolving the issue quickly to a longer-term approach taken in smaller steps.

Again, in comparison with the desired model, staff might be expected to refer to specific strategies such as state-modulation techniques for resolving sleep and feeding issues, or filming interactions and showing these to parents with feedback to improve their interaction with their children. However, this was not something described in detail and not by many staff, although it was referred to in terms of what was taught in groups and one quote talks about a mother's response to the use of time in feeding routines:

... the infant states in the sleeping groups — that's where the language has changed.

(the approach gives us) the chance to let (the mum) have a bit more focus on the feed ... and the mother often says "gee that's really worked, that feed was really good" because they've keyed into that aspect — time — and that then becomes a pattern, a sleep-wake pattern ...

This seems to suggest where the practice-change process was up to. Discussions with management suggested that the process for introducing practice changes took longer than expected. An area which has received a lot of attention (and shown a lot of change) is the groups and the development of family-centred assessment and planning. Other specific tools such as filming and the use of these videos in education seem to be an important aspect of the next phase for change. These would be expected to become part of the staff lexicon as the specific tools of filming and using assessment scales are put into practice.

The new model seems, from stage 3 data, to have brought about other changes in the general service culture. The fact that the child-centred approaches seem to take longer is one aspect of the new strategies which has the potential to lead to unexpected outcomes, such as staff feeling they are not performing as well. In the past culture, staff felt their performance was linked to resolving the issues within the period of the stay. So, in shifting to Natural Teaching Strategies and Responsive Parenting approaches, it was vital that this emphasis on resolving the presenting problem quickly should also shift. The Family-Centred Assessment and Planning and Co-operative Learning and Problem Solving approaches provided the basis for this shift in culture, to one where staff performance is linked to their development of skills in the caregivers. This means that caregivers



are expected to continue the work at home, and so longer-term strategies are not only possible but preferred.

While staff discussed the general shift in approach, to gentler, child-centred strategies, they also emphasised the importance of adapting this to family need and families' decisions, and taking into account differences between day and night. For example, at night parents might need to change from strategies which take longer and require more parental presence to settle children. This is because, at night, caregivers are more tired and children's settling needs are different. At night they need to be continually resettled, whereas during the day parents can get them up if they don't resettle within two hours. On the other hand, families may plan a strategy during the day which they can't cope with at night, when they are tired and more emotional. They might then move to even gentler steps, with more parental presence or incorporating fewer changes than planned.

Again, this reinforces the importance of integrating different parts of the model at the same time. While certain strategies might be encouraged by the model (such as parental presence), so is the importance of working with family needs and decisions. When all aspects are taken into account, the model allows the flexibility for night staff to adapt when necessary without creating confusion for the parents. This is mostly what has happened in practice, with many night staff saying that conflicts over changes in strategy are generally accepted by other staff if they are explained as parent-led. Some, however, thought this depended on the staff and some conflicts still occurred.

Staff also discussed different ways of adapting the language of cues, strengths etc. to language parents understand and relate to. They reflected on how, on the one hand, this might risk the consistency so important to the model and cause confusion among staff while, on the other hand, some adaptation was necessary in order for parents to understand.

One focus-group discussion raised important ideas about how staff could use terms consistently while still taking individual families into account. In response to the question as to whether the word "strengths" is the best one to use when so many families needed it to be explained, one staff saw this term as an educational tool which reinforced the ideas underlying the strengths-based approach:

But, just by saying to them at the start of that question, what are your family strengths and then breaking it down. You might have actually transferred to them. "There are strengths in my family". So that seems a really good word to use. It's just that they don't understand the question straight away. But then you break it down. It does help them to think, Oh, I do have a few family strengths.

This quote and the broader discussion about staff adapting and interpreting the language of the model are very important when looking at the implementation of any evidence-based model. A vital aspect of the change process has been to incorporate staff knowledge and practice into the process, rather than imposing a set of practices on how staff should work. This has at times been frustrating to staff, who have sometimes asked for more detail about what they "should do." However, this co-operative process needed to operate first, to allow staff to use their own expertise and practice skills, adapted when necessary. Also, in discussing how the theory might be adapted or changed in practice, staff were engaging in their own action research, which was important to the process. It allowed discussions like the one above about strengths where staff built on their previous understandings and each other's experience. Again, this took longer, but seems to have been a positive part of the whole change process.



Shift in approach

In terms of working with families in a Co-operative Learning and Problem Solving approach, staff felt there was a shift towards a greater partnership and co-operative approach with families. As with the strengths-based, solution-focused and family-centred approaches, implementing the model seemed to formalise a value that staff had worked with before, making it explicit. For example, many staff talked about the shift from a teaching (didactic) role to a partnering role where parents and caregivers had more say. This was introduced to the organisational culture through new care-planning tools and a process which will be discussed in more detail below.

Again this perceived shift in approach was supported by a comparison of data from the first and third stages of the focus groups. Staff in the first stage said that they already used a strengths-based, family-centred approach, and the data agreed that this was valued in their practice. But there was no specific description of how it was put into practice. At the third stage, not only were staff more able to describe how this was put into practice, but they felt that families were benefiting from the change.

While consistency and integration have generally been seen to be developing within the approaches of the model, it is important to note that some staff still observed inconsistency and even some confusion in the practices:

We've been told that such and such method has ceased, we no longer use that any more, and the next night I'm told, "No, we are using it" and then, when you get into a discussion you'll have four or five staff members, all with a different idea of what we're doing ...

This is important to take into account for future education and implementation. It suggests that some specifics are important, even while not wanting to impose too many specifics. Areas including "What is the current organisational approach to specific practices such as controlled comforting, closed-door/open-door techniques etc?" might help ease some confusion.

Organisational processes, structures and tools

Organisational changes were vital to implementing the model. While staff education provided an overview and theoretical understanding to staff, organisational change provided a structure to guide staff practice. It helped them define how the model related to specific, everyday practices, and formalised and legitimised these practices within staff understanding of what was now expected from management.

Organisational processes are the first level of organisational change. These include assessment and intake, care planning, handover and discharge processes, all documented in the relevant procedure manuals and with tools to guide staff in following these processes. In general, focus-group data and documentary analysis suggest that these reflect the approaches of the model better than previous processes. In this connection, staff particularly spoke about the care-plan processes and the handover processes.

Most staff felt that the new care-planning process (based on the new care-planning tool) supported a more strengths-based, Family-Centred Assessment and Planning approach. It shifted the focus away from needing to solve the presenting issue quickly, towards improving families' problem-solving skills and towards more parent-led strategies. Some negative views were raised by staff (e.g. whether there was now enough focus on how the mother was going, and whether handover discussions had enough information as provided by the care plans) but these were not shared generally. Some examples of quotes from staff on the care plan are:



(The new care plan) ... really hones in on the family strengths and draws out lots of positives. We did that before, but writing it down and having it there on the piece of paper really helps us focus in on that from the start.

(The new care plan's) been really good for (parents) because they've really visualised the day ahead and then actually planned the day ahead, whereas I think sometimes in the past we've tended to prompt them more, ... asked them what their goal is ... They seem to be making more of the decisions than what ... staff are.

I think it seems to be more concrete, what the parent is aiming to achieve that day, because they're actually verbalising to you how they're actually going to go about it.

I think it's probably very supportive of the families when they go home too (taking the care plan home with them).

(Within the care plans) we don't focus a lot any more on the mum, like, how they're feeling at the beginning of the week as opposed to the end of the week.

I have actually found the care plans have changed the structure of our handovers. And I'm finding personally that the ... transferred information isn't happening as well as it used to, but at least with the new care plans, some staff are really good at filling in what's happened day to day so if I'm not getting the information during handover at least I can refer to that and see what's happened.

There were mixed reactions to the new group-handover processes, with many saying it was better and some feeling it was not working as well, particularly referring to the morning handover. For some night staff who didn't feel it was working, the impact could go beyond the actual handover and interfere with their feeling part of the team with day-shift workers. The handovers between shifts are where the main conversations occur between day- and night-shift workers so, if this was not working well, night staff in particular were likely to feel left out. On the other hand, if morning handover was left unchanged (because it worked), there was concern that the night shift would not feel included in the larger systems of change. Handover seemed therefore to be continuing in the process of adjusting.

Some quotes illustrating different reflections on handover include:

I think the group handovers work the best. Because if you answer somebody else's buzzer, you're kind of off there floating and you say what has so and so been doing with you, and they have to tell you. But if you do a group handover, then you've kind of got a bit of a feel for everyone and it just makes it that little bit easier to handle the buzzer.

The way handover's done at the moment, it's actually quite overwhelming, because you're trying to take in so much information sometimes, about all the different clients, all the different children that they've got, and then you find out, after the fact, which children you've got and which families you've got. So you're trying to really process that through your brain. I guess it's good to have a generalised view, but if you're working with those particular families you really need to know the, the really important things for those families well, and you miss that. I miss that.



In terms of organisational processes and the Co-operative Learning and Problem Solving approach, of particular significance in this project have been the change processes and the co-operation between staff and management in implementing these changes. Management and co-ordinators raised this topic in discussing the overall learnings from the project, but it also came out in staff discussions about specific changes. There were concerns for some staff that this could have been done better, that they wanted to have had more participation in deciding on the changes (particularly the team changes). Some quotes relevant to this follow:

We've learnt more about the value of action research in terms of getting ownership by staff and if we really wanted to change the culture of the organisation, we couldn't do it just by didactic teaching. I think that has been one of the greatest learnings.(management focus group at stage 2)

Initially I found (the new group format) difficult to implement. It seemed to come across as too clinical for the clients to really understand. Which I fed back to (the education coordinator) ... So I adjusted it and the new information with the delivery of how I used to do it and that has worked a lot better.
(staff focus group at stage 3)

In theory, the reflective practice structure would enhance the Natural Teaching Strategies and Responsive Parenting as well as the Family-Centred Assessment and Planning approaches, by encouraging staff to reflect on and discuss these as they relate to everyday practice. They should also help in developing Co-operative Learning and Problem Solving among staff, by supporting group-based, non-didactic education in staff work schedules. While the second-round groups found these aspects very positive, the third round felt they were not living up to their aims and could instead make staff feel as if they were being tested.

Co-operative Learning and Problem Solving principles are more obvious in practice at this stage. Staff informally mentored and encouraged each other around the new terminology and practice. Some staff suggested that these principles of Co-operative Learning and Problem Solving were present before. Some of the ideas raised in the second round of groups which had improved on these were coming together in the education sessions and the team-building and social activities which had been run.

Educational tools were an important aspect of the model and its implementation for QEC management and staff. The tools provided specific ways of implementing the model, which made management particularly more confident of real change and development:

I've been really pleased to see the way it's evolved and how we've been able to pull in the NCAST stuff and the other stuff that has made it much more rigorous and is ... that it's going to make some difference, some changes in the way we work with families and I think it will allow families to have better outcomes in the end of the day than where we started with just the FAM model.
(manager at stage 2)

At this third stage, the tools did provide specifics for implementing the model. The NCAST Keys to Caregiving and Promoting First Relationships Programs provided handouts and videos consistent with the Natural Teaching Strategies and Responsive Parenting approach. Staff found these very useful.

There were generally positive responses from staff about how the groups worked, particularly once staff had trialed and adapted some of the language. Some of the language seemed too clinical or too disconnected from



the issues parents were wanting to solve. It also seemed to some staff to be less relevant for older, toddler-aged children. This also seemed to apply to the videos. Some reflections on the tools:

I've ... found the parents have been really interested and quite excited when we do the communication cue cards [in the communications group] ... and I think, still, it's important to put some old knowledge with the new knowledge. You can't just simply throw the baby out with the bathwater. I think the new system should hang on to some of the old knowledge and in the infant states group it's been more communication focused — what's the baby saying? And how to respond. More on the emotional side of stuff.

Actually the video "Getting to Know You." If a mother with a baby under three months watches that, they are absolutely mesmerised by it. And then they're actually picking up on those cues with their own babies. Particularly the human service clients ... it's actually amazing ... but it's no good for a mother with a six-month-old. They burst into tears. Because "I've missed all of that."

NCAST also provided the tools for filming child/caregiver interactions and using these for assessment, education and planning. Education had been given to a small group of staff at QEC, but at this stage it hadn't been used with parents yet. The FAM provided videos and materials for educating staff and parents regarding Natural Teaching Strategies and the St Lukes strengths-based approach, providing a five-column chart adapted for use as a care-plan tool. In addition to this the QEC was able to redesign parent-education groups, and tools for intake and assessment, handover and discharge using the materials provided by the different models.

It will be important that the use of filming parent/child dyads within the staff process be made clear: that their use is for parents to increase their own understanding and, where appropriate, improve their responses, rather than being a test. This would be assumed if all elements of the model are taken into account when using video (i.e. family centredness, strengths-based, co-operative learning and problem solving aspects), but it is still important to emphasise. QEC staff have complex roles in their work with families, and sometimes this does include assessing and developing parenting skills and reporting on parents referred by the Child Protection Unit of the Department of Human Services. With implementation of filming and assessment tools, there might be confusion or misunderstanding about how these apply across the range of complex situations staff deal with each day. It is important, therefore, for management to be very clear about their use across specific possible situations and to ensure plenty of opportunity for discussion, practice and monitoring on how they are used and how families are experiencing this. Questions of how to work within the strengths-based and partnership-based approaches need to be discussed explicitly, including questions of how these approaches might impact on power relationships between staff and clients, and how to maximise family empowerment and choices in the process.



Conclusion

Organisational integration, consistency of practice and evidence-based practice

By the third round of focus groups, staff more consistently understood and referred to a set of ideas and concepts which make up the revised model. These then guided them in using gentler, more child-centred strategies and strategies incorporating family-centred assessment and planning.

*I think there is a much more unified process by the staff, which is adhering to the theories.
(staff focus group at stage 3)*

(We are) trying not to give so many mixed messages, I think to work with the person who is following and the person who worked before you. Trying to run the same routine, you know and not change it and I think that's huge (staff focus group at stage 3)

*I think if you got feedback from the families. I think a while ago. They would say there was inconsistency between what one staff member would say compared to another staff member. Now, what we would see in the feedback, is how pleased they are with the degree of consistency. And even the same words are used.
(staff focus group at stage 3)*

A particularly well-implemented, consistent element of the model in practice at this stage was the process of assessment and planning, within a Family-Centred Assessment and Planning Approach, with processes and tools which staff now accepted and used confidently. Families encountered a coherent process, terminology and focus for learning which was consistent with the Family-Centred Assessment and Planning approach, beginning with the first phone call through to discharge. The skills reinforced throughout this process were planning and responding to issues in a positive, strength-based, solution-focused way, drawing on resources and making decisions about how best to respond to future issues and concerns in parenting.

While values consistent with this approach had previously existed, such as empowerment, working with strengths and focusing on solutions, a change has been implemented by developing a consistent process, structure, tools and staff approach within one evidence-based model. There has been more explicit and organisational recognition of the values and, very clearly, these have more consistently and specifically been attached to ways of working with families. This has made a noticeable difference from most staff members' points of view.

Gaps in this assessment and planning process include handover, which at this stage has started to be influenced by the use of the new care-planning tool but does not yet have the structure favored within the model; small and family-inclusive. Another gap is that the use of filming parent/child dyads and instructive and reflective feedback are yet to be implemented fully. This should provide a powerful educational tool and also link the education more strongly to current interactions between parents and children in the family, which is also important from a family-centred perspective.

Responsive Parenting and Natural Teaching Strategies approaches have also provided a structure for greater consistency across the service. One-to-one work is now more integrated with group work, and the different areas of education including videos, handouts and the instruction given during one-to-one role modelling are also more consistent across staff. The main cultural shifts have been away from the language related to



controlled comforting and a work focus on responding to particular issues for example solving sleep issues to a focus defined more of improving parenting interactions and families' abilities to respond to issues now and in the future.

There is more consistency across staff, although this process is not complete and needs to be ongoing reinforcement through education and ongoing discussion with staff. Some areas for confusion and inconsistencies include: the terms used, for example, those relating to engagement cues and different states; whether old terms and strategies continue to be used or are replaced by new terms and strategies, especially controlled comforting and open-door/closed-door techniques; and whether particular videos relating to controlled comforting should continue to be used.

An area which needs some emphasis in future is how the underlying theories of attachment and parent-child interactions link to the current practice. While staff seem to understand the links, they don't yet use the term "attachment" very much in discussing the theories underlying their approach. This may reflect what stage the changes are at. Becoming skilled in the use of filming parents and children, and providing instructive and reflective feedback to improve attachment and parent/child interactions, are likely to make the link between attachment theory and ways of responding to individual families and their concerns more concrete for staff.

Key learnings from the project

Developing and implementing the QEC Early Parenting Practice Model has been valuable for integrating the processes, structures, practices and tools of the service, improving consistency and quality of services received by parents. It has extended current staff skills, incorporated up-to-date theories and evidence, and challenged some outdated language and practice.

Extending the original FAM made the model considerably more useful for QEC by introducing current best-practice tools, processes and resources for implementation, and provided a strong evidence-into-practice base for staff.

An action-research design ensured staff input to overall changes and encouraged involvement in trialing and adapting ways of working.

Sustained change is a long process. It was important to allow for this and to invest in an ongoing process of change. With each change, for example, educating staff in new approaches, other necessary changes were uncovered including tools to support staff's new approach, procedures to be updated.

Changing staff practice requires ongoing reinforcement and support over time.

Areas for future education might include:

- Reinforcing the terminology of the model, the underlying theories, and specific procedures such as state modulation;
- Clarifying any lingering confusion over the discontinued use of controlled comforting/open door-closed door techniques and old materials such as videos;
- Information and more educational tools about procedures for older children under the new model, and in areas apart from sleep;
- More information to night staff about changes occurring during the day, including filming daytime groups for night staff to watch.



Future changes might include:

- Reviewing handover processes with the aim of making them more family-inclusive and family-centred.
- Processes for reflective-practice sessions were still being fine tuned at the time of completing this project. Improvements might include: changing the structure and process of the sessions to better reflect co-operative and strength-based learning; reinforcing staff skills; documenting these learning approaches; and ensuring skilled facilitators are available to lead sessions when needed.
- An action-research approach was seen as valuable for future organisational change. Future organisational development could incorporate reference groups, feedback from staff and parents, and input from staff on changes and adaptations.



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⁴² Hanna & Rolls (2001) *ibid*.

⁴³ Responsive Approaches to Parenting was added as an approach consistent with Natural Teaching Strategies but adding detail around caregiver/infant interactions particularly reflected in the NCAST program.

⁴⁴ A planning tool developed by St Lukes Innovative Resources, *ibid*.

⁴⁵ French et al. (2000) *ibid*.

⁴⁶ Ferber, R., Dr (1985) *Solve your child's sleep problems: The complete practical guide for parents*. New York, NY: Simon & Schuster.