The Case for Change
Proposing an Enhanced Service Delivery Framework for the Child and Family Health Service

Discussion Paper
Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contents</td>
<td>2</td>
</tr>
<tr>
<td>Definitions</td>
<td>3</td>
</tr>
<tr>
<td>Section 1: Purpose and scope of this paper</td>
<td>4</td>
</tr>
<tr>
<td>1.1 Consultation process</td>
<td>4</td>
</tr>
<tr>
<td>Section 2: Executive summary</td>
<td>7</td>
</tr>
<tr>
<td>Section 3: Introduction</td>
<td>9</td>
</tr>
<tr>
<td>Section 4: South Australian Child and Family Health Service</td>
<td>11</td>
</tr>
<tr>
<td>4.1 Background</td>
<td>11</td>
</tr>
<tr>
<td>4.2 Service delivery principles</td>
<td>12</td>
</tr>
<tr>
<td>4.3 Current service delivery model</td>
<td>14</td>
</tr>
<tr>
<td>Section 5: Context for continuous improvement and change</td>
<td>17</td>
</tr>
<tr>
<td>5.1 Responding to national and local policy context</td>
<td>17</td>
</tr>
<tr>
<td>5.2 Understanding the demographic context</td>
<td>18</td>
</tr>
<tr>
<td>5.3 Positioning for a digital world</td>
<td>20</td>
</tr>
<tr>
<td>5.4 Translating research into practice and embracing rigorous evaluation</td>
<td>21</td>
</tr>
<tr>
<td>5.5 Summary – what this means for the Child and Family Health Service</td>
<td>32</td>
</tr>
<tr>
<td>Section 6: Proposing an enhanced Service Delivery Framework</td>
<td>35</td>
</tr>
<tr>
<td>6.1 The Universal Contact Visit</td>
<td>35</td>
</tr>
<tr>
<td>6.2 Screening</td>
<td>37</td>
</tr>
<tr>
<td>6.3 Supporting effective parenting</td>
<td>38</td>
</tr>
<tr>
<td>Section 7: Appendices</td>
<td>51</td>
</tr>
<tr>
<td>Appendix 1 – Five by Five Report Fact Sheet</td>
<td>52</td>
</tr>
<tr>
<td>Appendix 2 – Strategic policy framework</td>
<td>54</td>
</tr>
<tr>
<td>Section 8: References</td>
<td>55</td>
</tr>
</tbody>
</table>
Definitions

**Parent:** In this document, ‘parent’ is used to describe a person performing the role of primary caregiver to a child. This parent may or may not be the biological parent; they may be a step-parent, foster parent, grandparent, or other carer.

**Aboriginal:** ‘Indigenous’ and ‘Aboriginal and Torres Strait Islander’ and are terms used interchangeably to refer to Australian Aboriginal people and Torres Strait Islander people. In this document, ‘Aboriginal’ refers to Australia’s first people.
Section 1: Purpose and scope of this paper

This paper is the second in a suite of documents.

The first, Five by Five: A Supporting Systems Framework for Child Health and Development (A. Sawyer, Gialamas, Pearce, Sawyer, & Lynch, 2014) reviews the basics of child health and development, including key milestones, and proposes a platform from which services could locate research activities and service practice. See Appendix 1 Five by Five: A Supporting Systems Framework for Child Health and Development Fact Sheet for a summary of the full paper.

This Discussion Paper outlines the current and emerging research, including those presented in Five by Five: A Supporting Systems Framework for Child Health and Development (A. Sawyer et al., 2014) and the contexts that support a review of the Child and Family Health Service (‘the Service’) current practice to better support parents in their role with infants and young children. This paper makes the case for change: a rationale for enhancing and developing the current service framework, and the implications that this will have for clients.

It proposes a draft enhanced service delivery framework and seeks feedback on it.

1.1 Consultation process

Consultation with both consumers and staff on elements of service delivery including the evidence base has been underway since 2010. This is an iterative process undertaken in line with continuous practice improvement.

For a list of the main related consultations that have occurred to date, see Figure 1 page 6.

In order to ensure that the final version of the framework is as good as it can be, feedback is now sought in relation to the following questions:

Q1: What do you see as the main strengths of the draft framework?

Q2: In your experience, does the draft framework as described meet the needs of all families? If not, which families are not represented and how could they better be supported?

Q3: Are there any issues that this draft framework doesn’t address (bear in mind that operational details will follow)?

Q4: Are there any risks associated with this draft framework?

Q5: Supporting families with a range of parenting barriers is complex and will require a joined-up, multi-agency approach. Are there any opportunities that you are aware of to increase our partnership work?

Q6: Are there any further comments you’d like to make regarding this draft framework?
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<tr>
<th>Date</th>
<th>Area</th>
<th>Involved</th>
<th>Mode</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>Universal Contact Visit</td>
<td>Consumers</td>
<td>All nursing staff</td>
<td>Internal review</td>
</tr>
<tr>
<td>2008 - present</td>
<td>Family Home Visiting program</td>
<td>Consumers</td>
<td>Service staff</td>
<td>External review (Adelaide University)</td>
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<td></td>
<td>Service staff</td>
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<td>(M. G. Sawyer, Barnes, et al., 2013)</td>
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<td>(M. G. Sawyer, Frost, Bowering, &amp; Lynch, 2013)</td>
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<td>2011 - present</td>
<td>‘eMums’ program</td>
<td>Consumers</td>
<td>All nursing staff</td>
<td>National Health &amp; Medical Research Council Random Control Trial</td>
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<tr>
<td>2012 - 2013</td>
<td>The Aboriginal Families Study</td>
<td>Consumers</td>
<td>All nursing staff</td>
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<td>Sept 2013</td>
<td>Sustaining NSW Families</td>
<td>Consumers</td>
<td>All nursing staff</td>
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<td>Family Home Visiting</td>
<td>Consumers</td>
<td>All nursing staff</td>
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<td>Local Area Meetings</td>
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<td>Aug 2014</td>
<td>Development of draft service delivery framework</td>
<td>Consumers</td>
<td>All nursing staff</td>
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<td>Use of the Family Partnership model</td>
<td>Consumers</td>
<td>All nursing staff</td>
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*Figure 1: Related consultations to date*
A seven-week period is provided to review this Discussion Paper and provide feedback by 3 June 2016.

The questions can be found at https://www.surveymonkey.com/s/CaseforChangeDiscussionPaper.

Alternatively feedback can be forwarded to CaFHSfeedback@health.sa.gov.au or posted to:

The Case for Change – feedback
The Child and Family Health Service
295 South Terrace
ADELAIDE SA 5000

The proposed timeline for development of the final framework is as follows:

**February 2015:** Discussion Paper finalised. The paper reflects the information and research available at that time.


**July 2016:** Feedback will be taken into account to develop the final version of a Child and Family Health Service framework.

**From July 2016:** Ongoing consultations will continue to inform the development of the enhanced framework. Following formal consultation, and subsequent amendment, work will begin to add the operational detail. Most staff involvement will happen here. Currently it is envisioned that groups will be established to work on thematic areas, which may include:

- Workforce, HR & IR
- Change management
- Performance
- Quality and safety
- Resourcing
- Communication
- Working up details of the service response to address the five broad levels of barriers to effective parenting as outlined in Five by Five: A Supporting Systems Framework for Child Health and Development (A. Sawyer et al., 2014).
Section 2: Executive summary

There is no disputing that the ‘early years’ are important in a child’s developmental journey. This is true no matter the lens that this is viewed through – whether economic or social.

There has been much reported about the economic benefit of investing in the ‘early years’. The additional argument cited is that of a moral or social obligation to ensure that all children have the opportunity to be a part of safe, nurturing and supportive communities and to be able to access educational opportunities leading to employment.

Both lenses through which children’s development is viewed support these goals but recognise that the ‘playing field is not equal’ and to address the gaps requires a concerted effort. The debate is less defined regarding what to invest in at a population level to make a difference and address the inequities that exist.

South Australia has a long history of recognising and delivering services to meet the needs of children, and has had significant champions across the health, education and welfare sectors that have impacted on outcomes over the last 100 years. In recent years, Every Chance For Every Child: Making The Early Years Count: A Framework For Early Childhood Services In South Australia and Fraser Mustard, Adelaide Thinker in Residence 2006-2007 have argued for the importance of giving every child a strong start in life.

However, recent data from the Australian Early Development Census highlights that many South Australian children are vulnerable in one or more of the five domains. This signals the need to refocus and review the policy context and how services are arranged and delivered to meet needs of all, and in particular the most vulnerable.

There has been much written about children’s development and many reviews undertaken and published. The importance of early brain development for the ongoing health and wellbeing of individuals, and the rate at which brain developments occur in the early years is now widely understood. The research shows that there is an important opportunity in the early years to build a strong foundation for children’s long-term health and wellbeing.

The evidence base around how to do this is evolving, with some areas of practice underpinned by a strong evidence base, whereas in other areas the evidence base needs building. Harvard University challenges the status quo:

“The marching orders are clear – we must embrace a spirit of constructive dissatisfaction with best practices, continually design and test new ideas, learn from things that do not work, and settle for nothing less than breakthrough impacts on important outcomes.” (Shonkoff, 2014)

Most recently the University of Adelaide in partnership with University College London has produced a report entitled Five by Five: A Supporting Systems Framework for Child Health and Development (A. Sawyer et al., 2014). Rather than commissioning another review of the literature, this critical report synthesises the current evidence base, laying out a solid case for the existence of five stages of development across five domains, that is influenced by the five Australian systems.

This Discussion Paper is intended to be read alongside Five by Five: A Supporting Systems Framework for Child Health and Development (A. Sawyer et al., 2014), which is its foundational document. Consequently, extensive details are not provided here but key messages and concepts will be highlighted.
Underlying the Five by Five framework are a number of principles. The goals of healthy development are the same for all children, and effective parenting is the key ingredient for achieving the Five by Five. While all carers want to parent effectively, some may face barriers that can disrupt effective parenting. Where this is the case, services need to recognise and respond to these barriers.

The Child and Family Health Service has adopted this conceptual framework and approach to supporting children’s development and using a program logic methodology, has developed this Discussion Paper.

The paper builds upon the 2009 Child and Family Health Service framework, and through an iterative process has taken into account national and state policy directions, has translated evidence into practice and developed service options that will take advantage of opportunities offered by technology. This will support ‘working smarter’ and remaining contemporary and relevant in the eyes of consumers.

The proposed framework is structured to highlight elements of the current service that will be retained, enhanced and introduced.

Acknowledging that parenting is the most immediate support for children’s development and that a range of factors are barriers to this, the Child and Family Health Service has utilised the five levels developed by Sawyer et al (2014) to articulate proposed responses for each level. It is critical that families are connected within their communities and local networks, and that strong partnerships underpin this approach.

This tiered, child-centred response addresses the barriers that parents face and provides services to those families who need them most. This will challenge and shape the way services are delivered, shifting the focus to outreach and assertive, sustained and intensive engagement with vulnerable families.

Feedback on this draft framework is now sought to ensure that the final version of the framework is as good as it can be, and that it supports the needs of all families at the same time as addressing inequity. It needs to take the Child and Family Health Service from its current base into the future.
Section 3: Introduction

Following decades of research, the importance of the early years for the ongoing health and wellbeing of young children is now widely understood. There is also greater understanding of what contributes to vulnerabilities, and the strengths and resilience that families can draw on to overcome barriers and support their children. A report entitled Five by Five: A Supporting Systems Framework for Child Health and Development (A. Sawyer et al., 2014) has now laid out a solid case for the existence of five basic developmental domains that are achieved in five stages by all children, and of the differing needs parents face at each stage to support them.

It is recognised that there are multiple agencies which currently have a role and contribute to the health and development of children. These include SA Health, the Department for Education and Child Development and the Department for Communities and Social Inclusion.

It is acknowledged that throughout pregnancy and the first two years of a child’s life, the health care system will be the predominate government service, after which child care and early learning systems begin to be increasingly involved (A. Sawyer et al., 2014). The role of the health care system at this time is therefore central, and it is also complex, as there are a whole range of providers that may be involved – both government and non-government.

Health systems have a great deal of experience in working in partnership to attain good health outcomes for families and the Child and Family Health Service, in partnership with the Department for Education and Child Development, is well placed to continue to play this role.

Supporting a family at the early stage is essential as each developmental stage builds on the successful attainment of the previous stage, and without this, achieving later stages becomes more difficult for the family and requires more input for those agencies supporting them (A. Sawyer et al., 2014). Promoting young children’s learning capacity, health and wellbeing, and intervening early when problems emerge has the potential to improve productivity and to reduce the financial burden of illness, school failure and social problems on the South Australian economy.

In addition, there is ample evidence supporting the economic benefits of investment in the ‘early years’. For example, economic modelling in Canada has shown that untreated developmental problems in young children today will contribute to a potential 20% loss to national gross domestic product (GDP) growth in the next 60 years. (Kershaw, Anderson, Warburton, & Hertzman, 2009)

The international evidence regarding the benefits of participation in quality early childhood education and care services is also significant. Recent Australian data confirms that investment in early childhood education and care could provide returns for individual children as well as the Australian economy in the order of $7.0 to $9.3 billion dollars (PricewaterhouseCoopers, 2014).

Participation in quality early childhood education and care settings has a positive impact on a child’s social and intellectual development. Early childhood education and care services can have a protective factor for vulnerable children due to the social inclusion and opportunities to engage in quality learning experiences. Children’s participation in an education and care setting can also provide parents with opportunities to access early intervention services for any developmental issues, as required (Sylva, Melhuish, Sammons, Siraj-Blatchford & Taggart, 2004).
A population approach is widely employed to achieve improvements in child health and development on the understanding that all families will need access to universal levels of support and services. Targeted approaches focus on fewer children, and are provided to parents identified as experiencing challenges and who may find access to services more challenging, or those parents where it is believed that their child’s journey is likely to be less than optimal.

The Child and Family Health Service is in a unique position, providing a coordinated state-wide population approach to linking with and supporting families of children from birth to five years. In reviewing its service delivery framework, the Child and Family Health Service aims to ensure the models employed are contemporary, evidence-based, child-focused, culturally responsive and effective, thereby providing the best health outcomes for families, acknowledging social determinants of health.
Section 4: South Australian Child and Family Health Service

4.1 Background

South Australia has a long history of providing services and supports to families by both government and non-government providers.

In 1909 Helen Mayo established what is now known as the Child and Family Health Service, and so for more than 100 years a range of services have been provided to support parenting.

In the 1980s more information became available about resilience and the factors that impact on children’s development. The importance of the relationship/attachment between the parent and the child strengthened and influenced practice, and lessons learnt from the Nurse Family Partnership program in the United States influenced the development of a ‘sustained nurse home visiting program’ for the State.

In 2003 the South Australian Government launched Every Chance For Every Child: Making The Early Years Count: A Framework For Early Childhood Services In South Australia, which directed funding to programs aimed at giving every child the best possible start in life. This supported a universal platform for services and resources for all families, and provided resources for a state-wide sustained nurse home visiting program for families with additional needs.

Fraser Mustard in his 2006-2007 Thinkers in Residence report highlighted the importance of investing in the early years:

“The challenge for all societies is to close the gap between what we know about the determinants of early child development and what we do.” (Mustard, 2007)

Since January 2012, as a result of wider Machinery of Government changes, the Department for Education and Child Development has overall leadership responsibility for education, health and child development policies for the early years. The Women’s and Children’s Health Network continues to work in tandem with the Department for Education and Child Development, and continue to provide services to children and families within South Australia.
4.2 Service delivery principles

The following key principles guide the way that the Child and Family Health Service operates:

**Child-centred**

We will:
- communicate openly and honestly, developing partnership-based, respectful relationships with families to help them achieve their goals and aspirations for their child
- build parent confidence and capacity in their parenting role
- provide parents with information to develop their skills to enable them to become better self-managers
- deliver a response that assists parents to ‘keep their child in mind’, to prioritise the child’s needs and to create environments that are safe and nurturing
- intervene in the best interest of the child where they are at risk of harm
- tailor this response, providing services to those children who need them most.

**Culturally responsive**

“Aboriginal people should be recognised as having a special heritage and the health system should, in interacting with Aboriginal people, support values that respect their historical and contemporary cultures.” (SA Health Care Act 2008 Part 1, Section 5 (b), n.d.)

We will:
- provide culturally safe and accessible services for families which value diversity and are responsive to cultural needs
- develop a culturally competent and respectful organisation by working in partnership with Aboriginal communities, recognizing cultural knowledge, expertise and resilience
- demonstrate through practice, our commitment to improve health outcomes for Aboriginal families.

**Contemporary**

We will:
- demonstrate through our practice that the services we provide reflect the best evidence or harness practice wisdom where evidence is not available
- apply the practice of continuous improvement and evaluation of services to promote better outcomes for children.
Coordinated

We will:

- work in partnership with all Service staff to maximise the knowledge and skills of our diverse workforce to best support parents in their roles
- work in partnership with primary, secondary and tertiary health, education, welfare and disability sectors to provide coordinated, multidisciplinary care and integrated service delivery
- ensure a seamless response between agencies and with local community services and supports commensurate with best practice
- maximise opportunities for families to develop and sustain relationships with health, education, welfare and disability service providers.

Consistent

We will:

- deliver high quality services across the State no matter where families live
- support all families to meet their goal of providing a strong start for their children by providing high quality information and support, using a range of delivery options to best align with the evidence, and that is accessible for all families.
4.3 Current service delivery model

The Child and Family Health Service is an integral part of the early childhood development system in South Australia, providing services from more than 120 sites to an overall population of approximately 20,000 births per annum. It supports families with children from birth up to five years of age with a focus on the early years.

The Child and Family Health Service recognises that communities are diverse and people’s individual preferences will vary. For example, some Aboriginal people will choose a mainstream service, while others may prefer to access services through an Aboriginal Health Service or Aboriginal Community Controlled Health Service. Aboriginal families in South Australia have access to the same breadth of the Child and Family Health Service support as non-Aboriginal families.

At the birthing hospital all new parents receive a copy of My Health and Development Record (known as the ‘Blue Book’) that includes information about developmental milestones and activities to support their child’s development. The ‘Blue Book’ has recently been updated to help parents track their child’s health and developmental progress in conjunction with the Service and other providers and to provide guidance about when to seek help.

Soon after their baby comes home, the Child and Family Health Service offers the family a first contact (the Universal Contact Visit) to provide immediate feeding and settling support and advice, as well as screening and assisting in the development of goals to assist meeting the needs of their child. Over 90% of the general population and 80% of parents of Aboriginal children engage with the Child and Family Health Service via a Universal Contact Visit.

For the majority of parents, who have social and family supports and are linked in with a general practitioner, the initial visit and provision of the ‘Blue Book’ will guide their journey and support self-management. If families or providers identify concerns regarding children’s development, a health check and development screen can be undertaken using the parent-led Ages and Stages Questionnaire.

At the primary health care level, there is a range of services available to families who require a little extra help:

- access to web-based information (eg, www.cyh.com and www.raisingchildren.net.au)
- the 24-hour Parent Helpline staffed by the Child and Family Health Service nurses in conjunction with healthdirect Australia
- parenting groups – utilising parent-infant attachment and Family Partnership principles, the groups focus on adjusting to being a new parent
- clinic services (including groups) to support feeding, settling and parenting, including access to Day Service in local regions.

Where additional input is required families can access the appropriate service to meet their varied and variable needs, from both within and external to the Child and Family Health Service.
Families who are identified through the Universal Contact Visit as requiring additional support to assist their child to develop in a safe and nurturing environment may be linked to a variety of programs:

- **Family Home Visiting** is a two-year, nurse-led preventative parenting program delivered over 34 visits to support parents around a range of issues including attachment and development and to link them in to other support services. Families can also access services provided by social workers and psychologists to meet their parenting needs. Families need to enter the program while their baby is aged three months or younger. Currently some 1450 families are in the program at any one time, including around 160 Aboriginal families.

- For those families living in the northern and western metropolitan suburbs who have more complex issues, a referral can be made to the Child and Family Health Service’s Early Child Parent Service. This program can support children up to three years of age. It is led by allied health staff, and focuses on working with the parent and their issues that hinder parenting, the child, and the parent-child relationship. Nurses work within the team. Currently some 180 families are being supported by these services at any one time, including around 20 Aboriginal families.

- For families living within and outside of these regions, there is a range of providers who also engage with and deliver a range of services to families with more complex issues.

- Additional external specialist help may be required by adult mental health services, drug and alcohol services and/or domestic violence services, amongst others.

- For those families with significant psychosocial issues, or for those who require support under state legislation, a referral/notification is made to Families SA. In these instances, the Child and Family Health Service provide a secondary role – advice about feeding, settling, and monitoring of child development.

Families who identify as Aboriginal may elect to receive support to improve the accessibility of services, including outreach, and the provision of services complemented by an Aboriginal Cultural Consultant or delivered by an Aboriginal Family and Community Health Worker.

The Aboriginal Cultural Consultant provides a cultural link between the nurse and the family, and is an integral part of supporting the development of the relationship with the nurse, providing cultural insights, cultural context and a link to community resources and services. Aboriginal Family and Community Health Workers work in partnership with nurses to provide a holistic response that focuses on parenting support and capacity building, reducing stressors and vulnerabilities, advocacy, referrals and links to other services and community resources.

For Aboriginal families who live on the Apangu Pitjantjatjara Yankunytjatjara lands, nurses provide a visiting service in conjunction with other providers including the Department for Education and Child Development, Nganampa Health Service and Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council.

The current Child and Family Health Service framework (2009) is depicted in Figure 2.
Figure 2: Current Child and Family Health Service framework (2009)
Section 5: Context for continuous improvement and change

5.1 Responding to national and local policy context

Key national and state policy directions that impact on decision-making for service delivery are documented in Appendix 2. Alongside the directives that directly influence services such as South Australia’s Every Chance For Every Child and the draft National Child and Youth Strategic Framework for Health that is currently under development, there are other reforms underway that indicate the changing governmental climate in which the Child and Family Health Service operates.

The Transforming Health agenda has recently been launched, with a requirement from Minister Snelling that the health system needs to be “dynamic and flexible to respond to changes in health care and limits to funding growth, without sacrificing the world-class care South Australians deserve.” (Transforming Health: Best Care, First Time, Every Time - Discussion Paper, 2014)

Strengthening the quality of care provided by health agencies is a key priority, with Transforming Health expecting ‘Best care. First time. Every time’ and outlining the ‘six quality principles’ of a quality, world-class health system as:

- Patient centred
- Safe
- Effective
- Accessible
- Efficient
- Equitable.

There are valuable lessons to be learnt that can be applied directly to the Child and Family Health Service as the metropolitan hospitals make recommendations for service improvements and overarching standards are recommended for the whole health system.

These emphasise the right to equitable health care, patient-centred and evidence-based care, client pathways that are diagnostic or procedure-specific, and delivering care in the right place, by the right person and in the right time. Transforming Health requires that “we must think differently, work differently and deliver healthcare differently”.

Equally there are valuable lessons to be learnt from the National Health Reform Act 2011 and the associated implementation of Activity Based Funding and Clinical Service Commissioning. Consistent with the principles identified for the Child and Family Health Service, this focus is on increasing transparency and efficiency in the provision of all services; providing services that are contemporary and time-limited; providing services that link families to a general practitioner, and introducing measurable outcomes for all clients.

All providers will need to ‘work smarter’ to maximise efficiencies and have a ‘one service, many sites’ philosophy to ensure greater consistency and accountability.
5.2 Understanding the demographic context

South Australia’s demographic profile has changed over the past 105 years, predominantly in respect to its multiculturalism. Equally importantly, the level of knowledge about this demography has increased greatly eg, services such as SA-NT DataLink provide the ability to link multiple data sets and provide additional information to support research, policy development, service planning and evaluation.

There is now a greater understanding of factors that impact on children’s development and a greater ability to translate the outcomes from the research sector, and the Child and Family Health Service is better informed and has the opportunity to use demographic information in planning, service delivery and review.

The following data is relevant to the provision of services to infants and young children.

For South Australian families:
- The number of births notified in South Australia in 2011 was 20344, compared with 17704 in 2001.
- The mean age of women giving birth increased from 26.6 years in 1981 to 29.7 years in 2011, and, among first time mothers, from 24.4 years to 27.9 years. The proportion of women aged 35 years was 20.6% in 2011. The number of teenage women giving birth is declining (803 in 2011) accounting for 4.0% of women who gave birth.
- 78% of women who gave birth in 2011 were Australian-born. Of women born overseas who gave birth, the largest proportions came from India (3.6% of women), China (1.7%), Vietnam (1.3%), the Philippines (1.0%), and Sudan, Afghanistan and Cambodia (0.7%). (Scheil, Scott, Catcheside, Sage, & Kennare, 2013)

For South Australian Aboriginal families:
- A recent Australian Bureau of Statistics report shows that Aboriginal children are far more likely to be disadvantaged in terms of health and wellbeing. They are:
  - 2–3 times more likely to die at birth
  - 2–3 times more likely to be of low birth weight or born prematurely
  - 2–3 times more likely to have dental caries
  - 8–9 times more likely to be in the child protection system
- In 2010, 88% of non-Aboriginal women and 54% of Aboriginal women attended for antenatal care within the first 14 weeks of pregnancy. (SA Health, 2012)

The following factors or barriers to parenting may have an impact on a child’s development.

Mental health:
- Results from the 2007 National Survey of Mental Health and Wellbeing estimated that 14.4% of Australians aged 16-85 years had an anxiety disorder (eg, generalised anxiety disorder, panic disorder), 6.2% had an affective disorder (eg, depression or bi-polar disorder) and 5.1% had a substance use disorder in the past 12-months. (Australian Bureau of Statistics, 2008)
- Australian research indicates that antenatal depression is experienced by 9% of women and postnatal depression affects almost 16% of women giving birth in Australia. (beyondblue, 2014)
Trauma:
- In 2006, an Australian Bureau of Statistics survey reported that 17% of women had experienced violence by a partner across the lifespan and a further 17% experienced sexual violence. (Australian Bureau of Statistics, 2006)
- In 2012-2013, there were 2,740 intervention orders (under the Prevention of Abuse Act 2009) lodged with the South Australian Magistrates Court. (Courts Administration Authority, 2013)
- In 2012-13 The Australian Humanitarian Program was increased to 20,000 places. (Department of Immigration and Citizenship, 2013) As well as experiencing the same health problems as the general Australian population, refugees and asylum seekers are at particular risk from trauma-related issues. (Australian Medical Association, 2011)

Drug use:
- The Australian Government’s National Drug Strategy reported on women’s alcohol use during pregnancy and found that “a significant proportion drink at some time during pregnancy and a significant minority of women continue to drink at high levels.” Aboriginal women are less likely to use alcohol while pregnant, however if they do drink it may be at higher levels. (Burns, Black, & Elliot, 2009)
- The proportion of women smoking at the first antenatal visit has declined steadily from 25% in 1998 to 13.1% in 2011. About 4% each year quit smoking before the first antenatal visit. (Scheil et al., 2013)
- Aboriginal women are more than three times more likely to smoke during pregnancy than non-Aboriginal women, greatly increasing the risk of poor birth outcomes. (Passey, Bryant, Hall, & Sanson-Fisher, 2013)

Developmental vulnerability:
- It is estimated that between 5-18% of children will have a disability or significant developmental delay. (Boyle, Decoufle, & Yeargin-Allsopp, 1994)
- In South Australia, it is estimated that one in 10 children are developmentally vulnerable on two or more domains. (Australian Early Development Census, 2012)
- Recent data indicates that Aboriginal children are twice as likely to be ‘developmentally vulnerable’ in at least one domain than non-Aboriginal children. (“The Forrest review: creating parity,” 2014)

Greater awareness of the level of need, and the ability to monitor changes, are drivers in shaping the way services can be delivered to ensure adequate service reach and outcomes for clients.
5.3 Positioning for a digital world

During the past two decades rapid developments in communications and internet technology have begun to transform the provision of healthcare and developmental services for young children and their families.

For parents of young children, the internet now provides a plethora of options to access information about children’s health and development. This information is increasingly accessed through mobile devices such as smart phones and tablets. These technologies also provide the opportunity to share and exchange information with other parents through social media platforms. Most importantly, it facilitates the opportunity to access interactive therapeutic programs designed to address problems such as depression or anxiety.

The ability to obtain, understand and use information relating to child development to make appropriate choices has been termed ‘developmental literacy’ (personal communication, Professor Michael Sawyer, University of Adelaide). To support a self-management approach, the promotion of good ‘developmental literacy’ should be an aim of all agencies working with children and their families.

Evidence of the extent to which the internet is consulted by parents of young children is available from several sources. According to the Australian Communications and Media Authority, 15.8 million household consumers had a mobile phone, 10.9 million had internet access, 10.0 million Australians went online at least once a day, 9.68 million had an internet capable mobile handset (an increase of 43% over the previous year), and 36.3 billion text messages were sent (an increase of 23% over the previous year). (Australian Communications and Media Authority, 2010) The ABS reported that in 2012–13, 96% of those with a Bachelor degree or above and 75% of persons educated to Year 12 or below were internet users. According to the ABS, 95%+ of those aged from 15-34 accessed the internet. (Australian Bureau of Statistics, 2014) However, this gap is closing and there is no doubt that soon accessing the internet, especially for younger people of child-bearing age will be ubiquitous.

A study of 360 parents of young children attending the Emergency Department at the Royal Children's Hospital in Melbourne, (Khoo, Bolt, Babl, Jury, & Goldman, 2008) reported that 81% of carers had access to the internet either at home or work and 43% had sought information from the internet about their children’s health.

This new approach to help-seeking by parents provides services with new methods through which accurate and relevant information can be provided to large numbers of parents. Consequently there are clear trends within the Australian population to place greater emphasis on information provided through web-enabled technology.

Web-based technology has enormous potential to strengthen and reach out to parents in a more comprehensive way, providing additional choice for families in rural and remote areas.

During the last decade, the Child and Family Health Service has sought to make greater use of technology to respond to changing patterns of parental help-seeking and to improve the Service’s capacity to deliver effective universal and targeted services for young children and parents. Further opportunities will become available as the costs associated with technology (such as hand-held tablets) decrease and the competence and expectation levels of both parents and staff increases.

The Child and Family Health Service recognises the need to position itself to remain relevant in a digital world – this is also a key driver in the Transforming Health agenda. Embracing new technologies as they
arise will future-proof the Service, enabling it to ‘work smarter’ and also to evolve and remain contemporary and relevant with consumers.

5.4 Translating research into practice and embracing rigorous evaluation

Strengthening the quality of care provided by health agencies is a key priority of the Transforming Health agenda. One of the pillars to achieve quality of care is the adoption of evidence-based practice. This can occur in many ways with the recent growth in ‘implementation science’ challenging and supporting a more collaborative approach between research, policy makers and service delivery agencies. (Denis & Lomas, 2003; Grimshaw, Eccles, Lavis, Hill, & Squires, 2012)

A dissatisfaction with current early years interventions is expressed by Shonkoff in the Journal of the American Medical Association who critically examined the achievements of some of the main approaches and concludes that the

“fundamental challenge is not just the inability to produce larger impacts but also the absence of a research and development enterprise to encourage the development and testing of innovative strategies. Funding that is restricted solely to services with previously documented effectiveness eliminates the opportunity to try new things…The marching orders are clear – we must embrace a spirit of constructive dissatisfaction with best practices, continually design and test new ideas, learn from things that do not work, and settle for nothing less than breakthrough impacts on important outcomes.” (Shonkoff, 2014)

The Child and Family Health Service has demonstrated its ongoing commitment to adopting evidence-based practice, and where the evidence needs strengthening, developing strong partnership to address this.

Central to this is the need for all partners to work together to clearly identify the ‘issue’, to develop the methodology and to undertake the research in such a manner as to provide the greatest opportunity to translate the findings into practice whilst maintaining program fidelity.

5.4.1 Five by Five: A Supporting Systems Framework for Child Health and Development

The most important of all of the contexts in which the service currently operates is that provided by the framework proposed in Five by Five: A Supporting Systems Framework for Child Health and Development. (A. Sawyer et al., 2014)

The BetterStart Child Health and Development Research Group is a group of inter-disciplinary researchers from epidemiology, public health, nutrition, paediatrics, biostatistics, and psychology who are trying to better understand how to ensure children have the best start in life that will enhance their health and development over the life course. In September 2014, they published a document entitled Five by Five: A Supporting Systems Framework for Child Health and Development (A. Sawyer et al., 2014) that:

- presents an overview of the main concepts underpinning early childhood health and development
- summarises the goals of healthy child development in a concept termed Five by Five by the group
- describes the five basic developmental domains that are achieved in five stages
• describes a child-centred system that supports the Five by Five, ranging from parenting to the main service support systems
• describes different barriers to effective parenting that may be experienced by parents
• provides a general introduction to the types of service responses that might better support achieving Five by Five for all children.

The report highlights that the most important characteristic of effective parenting is being responsive to children’s needs. This is characterised by warm and nurturing interactions that are accepting and mindful of the child – and this seen as a key ingredient to healthy child development.

Parents can however face a range of barriers to effective parenting, and as barriers increase, additional supports may be required. Sawyer et al. (2014 p19) have estimated the distribution of the South Australian population according to increasing barriers to effective parenting – see Figure 3.

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**Figure 3: The distribution of the population according to increasing barriers to parenting**

**What does this mean for the Child and Family Health Service?**

Five by Five: A Supporting Systems Framework for Child Health and Development is a critical foundational document for the Child and Family Health Service. It focuses on a whole-of-population approach, describes development across ages and domains, and highlights the critical role of ‘effective parenting’.
The development of the concept of five levels of effective parenting provides a consolidated evidence-based frame that underpins this draft framework. The report:

- provides a structured framework from which to discuss children’s development with all the providers who work in the ‘early years’, providing a common understanding and a common language
- challenges providers including the Child and Family Health Service to review and ensure that the services provided are evidence-based and minimise the impact of any barriers to parenting identified
- recognises that there are many opportunities to ‘provide more to those who need it most’ – and this is consistent with best practice: “providing a proportionate or progressive universal service response – universal services for everyone with a greater response to those facing greater parenting barriers.” (A. Sawyer et al., 2014)

The report acknowledges that a more nuanced understanding of parental needs requires a service approach that can better distinguish between and meet these needs.

### 5.4.2 Aboriginal context

The high level of disadvantage experienced by Aboriginal people is well documented and there is increasing recognition of the effects of intergenerational trauma, cultural disconnection and family disruption. However through this historical social and economic disadvantage Aboriginal people have demonstrated high levels of resilience and as a community Aboriginal people highly value children’s wellbeing. (Lohoar, Butera, & Kennedy, 2014)

The Aboriginal Families Study (2013) investigated the views and experiences of mothers having an Aboriginal baby in South Australia between July 2011 and 2013. This significant piece of work which is already influencing Service planning and delivery, found that:

- Aboriginal women are more likely to experience social health issues in pregnancy: 60% of women living in Adelaide reported three or more social health issues in pregnancy compared with 47% living in regional areas. One in four women (24%) reported five to eight of these issues.
- In comparison, 18% of non-Aboriginal women participating in a population-based survey of women giving birth in South Australia and Victoria in 2008 reported three or more social health issues in pregnancy.
- One in four women (26%) were experiencing high to very high levels of psychological distress, and one in three (35%) a moderate level of psychological distress (Aboriginal Families Study: Policy Brief # 2 Social Health Issues in Pregnancy, 2013)

Evidence indicates a range of factors that contribute to improved outcomes for Aboriginal families:

- utilising cultural expertise and knowledge and developing the workforce to ensure the choice for Aboriginal people to work in partnership with an Aboriginal worker (Bowes & Grace, 2014)
- Aboriginal culture values reciprocal relationships, an integral component of engaging with Aboriginal people is taking time to build meaningful relationships (Ware, 2013)
- provide services that contribute to community feelings of safety, delivered by a culturally competent workforce who receive ongoing cultural competency training (Bowes & Grace, 2014)
• providing flexible and culturally appropriate services / interventions informed by an ‘evidence-base’ for Aboriginal communities, which are adaptable and able to meet the needs of diverse communities (Bowes & Grace, 2014).

**What does this mean for the Child and Family Health Service?**

Access to high quality health care can make a significant difference to Aboriginal people’s quality of life and in closing the gap in Aboriginal disadvantage. In line with SA Health’s Aboriginal Health Care Plan 2010 – 2016 the Child and Family Health Service commits to the development of culturally responsive services that promote Aboriginal community health and wellbeing.

Key pieces of foundational work that should underpin the provision of enhanced services for Aboriginal families include:

- supporting the Child and Family Health Service staff around cultural competency
- ensuring that services provided are safe and accessible for Aboriginal families – including the provision of outreach services where required
- developing a Service that maintains, supports and grows its Aboriginal workforce, including strengthening the roles of positions working specifically with Aboriginal families, for example the Aboriginal Cultural Consultants.

As part of ongoing service improvements, work is currently underway to ensure services are made accessible and appropriate for Aboriginal families and to ensure that they are based on contemporary evidence. As antenatal engagement is important, the Child and Family Health Service will continue to grow its partnership with the Aboriginal Maternal Infant Care program to improve transitions for Aboriginal families.

**5.4.3 The Data Linkage project**

The BetterStart Child Health and Development Research Group along with partners the Department for Education and Child Development and the Child and Family Health Service were recently awarded a National Health and Medical Research Council grant. The grant supported a research project that examined how administrative data collected around the time of birth on the whole South Australian child population predicts developmental vulnerability at entry to school.

They found that “six risk factors available in the perinatal data...predict vulnerability on two or more Australian Early Development Census domains at age 5.” These six risk factors were:

- area-level socioeconomic disadvantage
- mother’s marital status
- mother’s occupation status
- father’s occupation status
- the number of previous pregnancies resulting in births ≥ 20 weeks
- mother’s smoking during pregnancy.

They went on to state that providing greater support to children and families with three or more of the six risk factors seems realistic.

However important maternal psychosocial characteristics such as lack of social support and isolation had not been included but may improve predictive validity. (Better Start Child Health and Development Research Group, 2014).
What does this mean for the Child and Family Health Service?

A challenge for the Child and Family Health Service is to identify as early as possible the factors that may impact on a child’s development in order to begin to address them. The ability to predict later child vulnerability, as provided by the Data Linkage project, allows the Service to do just this.

It is proposed that the screening process will continue to be based on sound clinical judgement and be supported by careful case review, but will be improved through the inclusion of information about potential barriers and risk factors. This process is preventative in focus and is based on world-leading best practice. It will help increase the likelihood of matching families with the response that best meets their current circumstances and their child’s future developmental needs.

5.4.4 Infant health, wellbeing and development

The first 12 months of a child’s life is a period of rapid social, emotional, physical and cognitive growth and development. At birth, a baby’s brain is approximately a quarter of the size of an adult brain but during the first three years it will triple in size. Synaptic growth peaks in the areas of the brain associated first with vision and hearing, then with receptive language and then in regions associated with higher cognitive functions. (A. Sawyer et al., 2014) – see Figure 4.

The daily experiences of the child with their primary caregiver are essential for healthy brain development. During this period, the child’s brain is flexible and prepared to learn, and a child’s repeated experiences determine which connections are strengthened and grow and which connections will be weakened and ultimately eliminated.

![Synapse Formation in the Developing Brain](image)

*Figure 4: Human brain development from conception into adulthood (Sourced from: Five by Five: A Supporting Systems Framework for Child Health and Development (A. Sawyer et al., 2014))*

The child’s fundamental task is to learn how to get their needs met and thus, if parents respond in a predictable and caring manner and provide for their needs, they feel safe and can concentrate on exploring their world. If the child’s needs are only sporadically met, they will focus their energies on meeting their own needs and will have increasing difficulty exploring their world and gaining experiences needed for healthy brain development.
Babies are born with an instinct to engage socially and emotionally, especially with their primary caregivers. From birth, they naturally reach out to create connections, and they develop best when caring and sensitive adults respond in a warm, responsive and consistent manner demonstrated by the emotional availability of the parent.

This secure attachment with their parent leads them to develop a sense of trust, security and stability and lays the strong foundation for optimal brain development, emotional wellbeing, social competence, positive physical health and emerging cognitive and language abilities. Conversely, a neglectful or abusive environment often results in the child having difficulty in learning how to regulate their emotions, develop social skills and thus impacts on their ability to learn. This can lead to an increased risk of emotional and behavioural problems, relationship difficulties, limited learning opportunities and aggressive behaviours in later life.

This growing body of research builds upon the work established regarding the importance of the attachment relationship between baby and parent and the profound impact this can have upon the baby’s current and future development. Attachment theory has provided an understanding of the effect of neglectful parental care on infants and the need to provide best practice support from an infant’s point of view.

**What does this mean for the Child and Family Health Service?**

The importance of early brain development for the ongoing health and wellbeing of individuals, and the rate at which brain developments occurs in the early years indicate that there is a narrow window of opportunity to build a strong foundation for children’s long term health and wellbeing. After this time it becomes increasingly difficult for children to ‘catch up’.

This means that the Child and Family Health Service will:

- be informed by the infant mental health body of knowledge and have this guide its child-centred practice
- promote positive health and wellbeing, that is informed by the mental health needs of the child
- engage with parents quickly and assertively to focus on identifying and responding to the underlying causes to facilitate safe and nurturing environments for children early in their development
- engage antenatally as part of a ‘Level 4’ response
- provide an integrated, therapeutic approach informed by both attachment and trauma theory where it is required to meet the needs of the child

As the Child and Family Health Service is not a mental health agency, it will ensure that there is a clear understanding of its scope of practice and those of others – where specialist services are required for the parent or the child, high quality, supported referrals will be made.

The Child and Family Health Service recognises that many agencies currently engage and work with families with complex needs, and will strengthen its partnership with these agencies to promote a state-wide approach.
5.4.5 The eMums program

In 2012, the Research and Evaluation Unit in the Women’s and Children’s Health Network was awarded funding by the National Health and Medical Research Council to develop and evaluate an internet-based support program for new mothers in partnership with the Child and Family Health Service.

The program is believed to be a first internationally and is providing proof of concept of the feasibility of providing internet-based support for new mothers.

The eMums program was facilitated by nurses who were allocated time to support ‘virtual groups’ of mothers through their baby’s first six months of life and provided them with information about children’s development and solutions to common problems experienced by new parents. It also provided them with the opportunity to participate in nurse-mentored online participant groups where they could obtain information about child raising, and benefit from support provided by other mothers.

The content of this program addressed three broad issues:

- steps that parents can take to resolve common parenting problems experienced by families with young children (eg, feeding and settling)
- approaches that parents can take to look after their own health and wellbeing, including problems with mood/depression
- activities that parents and families can use to promote the health of their infant (improving parent-infant attachment, stimulating language development, etc.).

There were several areas on the site that the parents could navigate:

- chat room/home group – a similar environment to social media sites that provided the communication forum to seek or provide support to group members
- milestones and reminders – provided an interactive display of child development milestones and health reminders that could be printed out
- resources – contained responses to frequently asked questions that mirror discussion material.

A group of Child and Family Health Service nurses were closely involved throughout the development of the program and over the trial period. They:

- provided feedback on on-line resources and raised technical issues for the software developers to improve the program for both the nurses and parents
- recognised the potential to improve health outcomes for both parents and children by providing anticipatory guidance as well responding to specific questions
- saw potential benefits to parents particularly in the areas of increasing knowledge about child development, increasing and sustaining breastfeeding, and increasing confidence in parenting skills
- observed the program to have potential benefits to children by improving child development, nutrition, sleeping and settling
- provided feedback on factors which helped improve and maintain mothers’ engagement with the program. One area identified for future development is to provide access to the program through mobile phone/iPad applications.

The evaluation of eMums is still underway with final participant interviews due to be completed in September 2015. Early findings have shown that mothers engage well with the program and value the combination of peer and professional support offered by means of its group-based format.
There has also been positive feedback from mothers through their comments, including the value of information being available to them at any time of the day/night, the value of the nurse posts, and the milestones and reminders section. There have also been comments that reflect the value of contact with other mothers in similar situations to their own.

**What does this mean for the Child and Family Health Service?**

The findings to date from the eMums trial, along with increasing prevalence of use of electronic media to access information, support the development of internet-based learning opportunities. It is proposed that the Child and Family Health Service will therefore:

- investigate options to translate this concept from the research environment and embed it into practice
- utilise the current (0-6 month) web-based modules and develop additional modules to cover the period 7-12 months for use by all parents, and introduce this as the key platform for Level 1 pending funding
- continue to develop the modules to meet the needs of families identified in Level 2, strengthening the support for those with low to moderate levels of depression, using the virtual networking with other parents, and the virtual access to the nurse
- support staff to work effectively and confidently in this new medium.

**5.4.6 Sustained nurse visiting programs**

Home visiting programs have been offered for more than 60 years internationally, with the aim to ‘create safe and nurturing environments for infants’. They can be delivered by professionals (mostly by registered nurses) or paraprofessionals; programs commence antenatally or soon after birth and often continue until the child is two years old.

During the last decade, services delivered in homes by trained nurses have increasingly been used to enhance parent-child relationships and the quality of children’s home environments (Azzi-Lessing, 2011; Chaffin & Friedrich, 2004; Gomby, 2005; Sweet & Appelbaum, 2004). There is also evidence that nurse-led programs in Australia have beneficial outcomes for vulnerable families (Kemp et al., 2011).

It was in this context that the South Australian Family Home Visiting program was established in 2004 as part of the Department of Health’s Every Chance For Every Child initiative. The program aimed to improve the quality of mother-infant relationships, provide anticipatory guidance about infant health, safety and development, and better connect families to local community supports (Hood, 2007).

It was based on the Family Partnership model (Davis & Day, 2010; Hood, 2007), with the content of the program broadly similar to that of the post-natal components of the Family Nurse Partnership and the Nurse-Family Partnership programs in England and USA respectively (Barnes et al., 2008; Barnes, Ball, Meadows, Belsky, & FNP Implementation Research Team, 2009; Olds, Sadler, & Kitzman, 2007).

In 2012, the University of Adelaide received funding to evaluate the effectiveness of the South Australian Family Home Visiting program. Effectiveness of Nurse Home-Visiting For Disadvantaged Families: Results of a Natural Experiment (M. G. Sawyer, Frost, et al., 2013) was completed and published in the British Medical Journal in July 2013. Key findings were:
• the provision of a sustained, nurse-led Family Home Visiting program is an important component within a range of services to support the developmental needs of children, consistent with international, national and state directions regarding the importance of the early years
• the program’s level of effectiveness in engaging with families is similar to, or better than, that achieved in the United Kingdom
• the program makes a difference for parents in terms of their confidence in their parenting abilities and a more positive relationship with their child, thereby providing a good foundation for their children’s future growth, development and learning
• both the parents and nursing staff report that there is a positive difference in parents’ ability to settle their baby and reduce sleeping problems, as well as a benefit to the child’s social and emotional development
• staff effectively utilised population-level screening to identify mothers experiencing higher levels of social disadvantage with the aim of ensuring that these mothers received the Family Home Visiting program
• staff have the ability to deliver a manual-based, nurse Family Home Visiting program to new parents across South Australia with a level of fidelity that is comparable to, or better than, that achieved in other countries.

However, consistent with findings from similar programs, the evaluation also found that:

• over time there was no difference between the participants and the control group in changes to levels of maternal mental health problems, nor in changes to levels of health-risk behaviours (eg, cigarette and alcohol use)
• the effect sizes were modest, although it noted that achieving these across a population of socially disadvantaged mothers, who were unlikely to have otherwise received professional help, is an important achievement.

The report also identified a significant reduction of family participation after 12 months, which raised a question in relation to the optimal length of the program, and whether a reduction in duration should be considered. In December 2013, this theme was reflected in an internal staff survey of the Family Home Visiting program with almost 40% of respondents indicating that a shorter timeframe was required.

Trials of sustained nurse visiting programs in this area are occurring within Victoria and Tasmania, and in New South Wales. The Australian Research Alliance for Children and Youth, the Centre for Community Child Health and the Centre for Health Equity Training Research and Evaluation are conducting a multi-state (Victoria and Tasmania) sustained nurse home visiting randomised controlled trial designed to promote family wellbeing and child development.

The Australian Research Alliance for Children and Youth advise that:

“The trial is based on the Maternal Early Childhood Sustained Home-visiting (MECSH) program and incorporates additional modules based on the best evidence that are focused on helping parents care for, and respond to, their children, and create a supportive home learning environment.”
right@home aims to find out how the universal maternal and child health nursing service might be improved to better meet the needs of all families. One way to do this is to offer more nurse visits in people’s homes for families who might benefit from this type of approach.

We want to know if offering these extra visits, that would be available until babies turn 2 years old, make it easier for parents to learn about things like feeding, parenting and managing their baby’s sleep. (Australian Research Alliance for Children and Youth (ARACY))

New South Wales Kids and Families has developed Sustaining NSW Families, an evidence-based, nurse-led home-visiting program that supports vulnerable families in pregnancy and for the first two years of a child’s life.

The Sax Institute, a not-for-profit organisation, found that the program:

“builds on credible international, national and local evidence that supporting families in pregnancy and for the first two years of life is an effective strategy for vulnerable families, such as the Nurse Family Partnership (Olds, 2006; Olds et al., 2004), and the Miller Early Childhood Sustained home visiting (MECSH) program (Kemp et al., 2011)… Further evidence to inform the evolution of the model will come from the evaluation of the program underway as part of the Keep Them Safe evaluations.” (SAX Institute.)

The program:

- is delivered in disadvantaged urban communities (according to the Australian Bureau of Statistics Socio-Economic Indexes for Areas or SEIFA) to families who have moderate vulnerabilities and associated psychosocial distress, and are identified via the universal psychosocial assessment process at booking in (antenatally) or at the universal health home visit
- commences antenatally, or no later than four weeks after the birth of the baby, and continues until the child is two years of age with an average of 26 visits in total
- is a comprehensive intervention with a focus on supporting families to identify and achieve their goals and aspirations for their child and themselves as parents, and optimise child health development and wellbeing with a focus on social and emotional health. Nurses utilise findings of a number of evidenced-based measures to tailor the program to maximise outcomes
- includes a structured program of child development parent education that has its foundation in attachment theory underpinned through working in a partnership model (strengthened by use of motivational interviewing techniques) and health promotion for the family and child to ensure a healthy and safe environment
- provides individual and team clinical supervision which occurs regularly (at least monthly)
- systematically monitors fidelity to the program with regular review of both qualitative and quantitative measures monthly
- uses a nurse as the primary provider of the service
- introduces a social worker to all families as part of the team so that the issues that may prevent the parent focussing on the needs of the baby are dealt with allowing the parent to ‘keep the baby in mind’
- has a second tier of allied and psychosocial staff that provide support to the nurse through their participation in regular case reviews, professional development and provide resources and advice to support optimal outcomes.
What does this mean for the Child and Family Health Service?

While the Family Home Visiting program supports some families to achieve good outcomes and has a place in the suite of services on offer by the Child and Family Health Service, both internal and external evaluations identify opportunities that exist to improve the current program. Consistent with the recommendation of the South Australian evaluation, it is proposed that the Service will:

- maintain the state-wide infrastructure and population-based platform which currently exists as a sound way of screening and linking families to the appropriate level of support
- refine the entry criteria so that there is a greater chance that families linked to the program will gain benefit
- amend the structure and content of the program to maximise the health outcomes for children of these parents
- introduce outcome measures to support ongoing discussions with parents about their child's development and to provide ongoing feedback to staff to support program fidelity.
5.5 Summary – what this means for the Child and Family Health Service

The Child and Family Health Service has never been so well informed about South Australian families as it is today. There is a clear picture of family demographics, the range of issues faced by parents, the inequities in the distribution of barriers to parenting and of the services that exist to support them.

The potentially dire consequences of not addressing these barriers and not supporting parents to parent effectively to the best of their capacity are widely understood. Thanks to ongoing research and evaluation there is also wealth of knowledge around what is effective, contemporary practice. Having access to this knowledge, and being an organisation that has always striven to ‘do the right thing’ for parents, the obvious choice when we ‘know more’ is to use this information to ‘do better’.

In developing this draft enhanced service delivery framework we recognise that all parents ‘want the best for their child’, but that there are a range of challenges that impact on how families can provide a safe and nurturing environment for their children.

To address these challenges, it is proposed that the draft Framework retain the following elements:

- the state-wide population approach to the provision of services
- post-birth engagement with the majority – and engaging antenatally where issues are identified in pregnancy by providers already engaged with families
- the Universal Contact Visit as the key entry point to the Child and Family Health Service, with a streamlined pathway for those women engaged antenatally.

It will enhance the following elements:

- use of contemporary, evidence-based practice. The current evidence around effective parenting – parenting that is responsive to the children’s needs and characterised by warm and nurturing interactions that are accepting and mindful of the child – is that this is a key ingredient to healthy child development. Parents can however face a range of barriers to effective parenting, and as barriers increase, additional supports may be required. This concept is clearly outlined in Five by Five: A Supporting Systems Framework for Child Health and Development (A. Sawyer et al., 2014) and it is around this key document that this draft framework is constructed

- the screening process. Improvements will enable parents to be screened to assess their parenting barriers and allow skilled clinicians to link them to the services that best suit their individual needs, and to do this accurately and in a timely manner. It will support a more coordinated use of the available information to link families to the services in the least complicated way
• **service accessibility.** This will be maintained in relation to where services are provided (home, clinic or community) and expanded through offering web-based applications. The determination of location will be linked not to the type of service provided but to the needs of the family and how this choice will support their learning and change journey

• **the Family Partnership model.** This will continue to underpin the Child and Family Health Service approach and all Service staff will receive training or retaining. The updated training will support some of the more challenging aspects of working in partnership. In order to successfully embed the Family Partnership model into practice continuous organisational attention and clear strategies for supporting staff are required

• **child-centred.** Services will reflect a change of practice from child-focused to child-centred. Through assertive, timely engagement, the service will work with families so that they prioritise the needs of their child and keep them in mind regardless of wider circumstances eg, reducing or ceasing using drugs and alcohol during pregnancy

• **increase equity.** All parents desire to ‘do the best for their child’ and all children have the right to a strong start, however life is unequal. People experience differing levels of social disadvantage and have differing abilities to overcome the barriers to parenting that they face. The Child and Family Health Service will address inequity to support the varying needs of all parents. The principle underpinning this approach is not one of universal and targeted services but a continuum of services to meet differing barriers to parenting, each with an objective that is appropriate to address that parent’s individual challenges. This approach, known as ‘progressive or proportionate universalism’, is both consistent with the Child and Family Health Service principles and is the most equitable way to share limited resources (staff time) given the level of demand that exists. An important aspect to equity is that parents facing the same issues receive the same services regardless of the site at which they present ie, that services vary only in respect to parents’ needs, not by site or by clinician

• **increase accountability.** The Child and Family Health Service will develop a comprehensive performance and evaluation plan that will include measures to determine the extent to which the proposed changes have met their intended aims, and a suite of key performance indicators that allow transparent and comparable measurement of outcomes against service specific objectives. The Service will hold itself accountable for clinical outcomes by promoting regular review and monitoring, and through the introduction of key outcome measures for clients. These will be used for direct feedback with families as well as support ongoing practice evaluation, ongoing improvement and future service planning.
It will **introduce** the following:

- adoption of **technology to ‘work smarter’**. Health-seeking behaviour is changing. Use of web-based applications as a preferred means to gain access to information, and also to communicate and be linked socially, is widespread and ever evolving. Findings to date from the eMums trial support the development of web-based learning opportunities for families. The draft framework incorporates the adoption of new technologies to enable staff to ‘work smarter’, to future-proof the Service and to remain contemporary and relevant in the eyes of consumers.

- presenting as one **cohesive, integrated service**, avoiding the use of ‘internal’ terminology (such as program and team names) with families. Each family should be aware only that they have received the most appropriate Child and Family Health Service response for them. This supports a ‘one service, many sites’ philosophy, minimises the risk of stigma and ensures that internal systems, services and programs do not need to be ‘navigated’ by families. This will impact on marketing and promotion. This will also impact on intake and referrals processes for the Service to ensure they are streamlined and are managed efficiently ‘behind the scenes’ regardless of the quality of the information provided in the referral, to gain the best outcomes for children.
Section 6: Proposing an enhanced Service Delivery Framework

The following sections of this paper will outline how the Child and Family Health Service, which is in a unique position, providing a coordinated state-wide population approach to linking with and supporting families of children from birth to five years, proposes to enhance services currently provided, building on research and evaluation to ‘do better’ for South Australian families.

6.1 The Universal Contact Visit

The Universal Contact Visit remains crucial in the service response as it will be the first experience of the Child and Family Health Service for the majority of families. It acts as a continuum of care between the birthing hospital and the community and it is the point at which important clinical assessments, including screening, are made. The transfer of good information is essential at this point to minimise risk, support efficiency and good practice – minimising the need for parents to repeat information.

Nurses will continue to provide the Universal Contact Visit, using screening measures to support their clinical assessment.

During this visit, a nurse will respond to any parenting concerns (usually related to feeding and settling) and will conduct the 1-4 week health check and make an assessment of the family, the family’s relationships, the parent-infant relationship, and the mother’s mental health. Anticipatory guidance and information are provided.

The role of the Universal Contact Visit and the subsequent services available are summarised in Figure 5 page 37.
Level 5: A statutory response is required from Families SA as the safety and wellbeing of the child cannot be mediated.

- Supported access to community supports and networks including child care and preschool.

Level 4: Multi-disciplinary allied health led program

- Self-directed access to credible evidence-based information including via ‘CaFHS online’
- Partnership with Learning Together.

Level 3: Sustained nurse visiting program

- Self-directed access to credible evidence-based information including via ‘CaFHS online’
- Partnership with Learning Together.

Level 2: Interactive areas of ‘CaFHS online’ including virtual networking and nurse moderation

- Self-directed access to credible evidence-based information including via ‘CaFHS online’

Level 1: Self-directed access to credible, evidence-based information, including via ‘CaFHS online’

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**Figure 5:** Primary pathways - draft Child and Family Health Service Delivery Framework
6.2 Screening

Accurate screening is a prerequisite to providing the service that most closely meets the five levels of parental need, as identified in Five by Five: A Supporting Systems Framework for Child Health and Development. (A. Sawyer et al., 2014) It is therefore important that screening processes are well resourced through the provision of an improved and more sensitive screening tool and a skilled and effective workforce.

Building on the Data Linkage project, and on developments introduced as part of the National Perinatal Initiative, work has been commissioned by the Child and Family Health Service and is currently being facilitated by the Women’s and Children’s Research and Evaluation Unit to develop an improved version of the current psychosocial screening form used by nurses at the Universal Contact Visit to identify the type of service most relevant to the parent’s need.

The new screening measure will incorporate findings from the literature regarding predictive risk factors, and feedback from staff and families and includes additional questions. These questions are designed to:

- determine the extent to which issues identified by the parent are currently causing distress
- determine the extent to which the parent is able to prioritise the needs of their newborn.

The questions will support families’ confidence and trust in sharing their dreams and hopes for their child, and also any areas that are challenging their ability to ‘keep their baby in mind’. This structured conversation provides important additional information to enable nurses to better match a parent’s needs to the service response most suited to support them as outlined in the Five by Five: a Supporting Systems Framework for Child Health and Development. (A. Sawyer et al., 2014)

What does this mean for the Child and Family Health Service?

Screening is a critical component to maximise the opportunity to link families with services that best match their need in the least possible steps. It is proposed that the Child and Family Health Service will:

- improve the screening tool to increase the likelihood of a better client/service response match
- provide training to ensure the tool is administered as it is intended
- provide Family Partnership training for all staff to increase skills in building families’ confidence and trust in sharing their dreams and hopes for their child, and also any areas that are challenging their ability to ‘keep their baby in mind’.

Alongside an enhanced screening tool, strong, transparent, consistently-applied systems to support good practice and ensure equity of service provision are required, as is high quality professional development, including supervision, of all the Child and Family Health Service staff.

Having all staff trained and supported to utilise the Family Partnership Model ensures that from the outset, at the Universal Contact Visit and at the screening stage, all staff will understand the importance of developing a shared understanding of a family’s strengths, goals and barriers, and have the skills to respectfully challenge, support and negotiate where required to bring about change.
6.3 Supporting effective parenting

It is recognised that the “main and most immediate support for children’s development is parenting.” (A. Sawyer et al., 2014)

The following sections of this report describe the proposed service response to address the barriers to parenting across the five levels (as identified by Sawyer et al., 2014).

The Child and Family Health Service believes that all parents want the best for their child and have hopes and dreams for them; however they also face barriers that at times compromise effective parenting. The “extent to which barriers compromise effective parenting will differ depending on individual variation in parents’ ability to continue to be mindful of their child’s needs in the face of the barriers. That is, the level of parenting support required is not only determined by the type of barriers faced but also the impact of these barriers on individual parents’ ability to parent effectively.” (A. Sawyer et al., 2014)

In reviewing the service responses that combine to form the draft enhanced framework, the Service proposes a tiered response to address the barriers that parents face and to provide services to those families who need them most.

Figure 6 and sections that follow summarise the cumulative barriers to effective parenting and propose how the Child and Family Health Service will respond to address them.
**Figure 6 Tiered service approach objectives**

**Assumptions:** All parents want the best for their child. All parents have hopes and dreams for their child.

**Service Objective:**
- Children are supported in a safe and nurturing environment through the timely intervention of statutory services
- With therapeutic intervention, parents are able to support their child in a safe and nurturing environment
- Parents with sustained assistance are able to support their child in a safe and nurturing environment
- Parents with some assistance are able to support their child in a safe and nurturing environment
- Parents to support their child in a safe and nurturing environment
- Parents with some assistance are able to support their child in a safe and nurturing environment
- Parents want the best for their child.
6.3.1 Level 1

Typically parents at this level have social support and are ‘able’ to experience and respond to the day-to-day challenges of caring for a new infant. They have access to resources to enable them to ‘self-manage’ – that is they seek information when required, and when provided with access to ‘good’ information, they can apply this to their own circumstances and provide a safe and nurturing environment for their children.

As well as being able to access and apply information, families are most likely to seek out help in a timely manner when they have a concern. These parents are able to parent effectively and able to access universal services when required. See diagram below.

<table>
<thead>
<tr>
<th>Manages day-to-day parenting challenges</th>
<th>Has good reflective functioning: is able to ‘keep the child in mind’</th>
<th>Meets their child’s needs</th>
<th>Engages with services and with community support</th>
</tr>
</thead>
</table>

**Level 1 service response**

To meet the needs of families, it is proposed that parents will have enhanced access to evidence-based, credible web-based information managed through the Child and Family Health Service through the development of an ‘application’ (app).

This information will be:

- convenient – available 24/7
- contemporary – appealing and attractive to engage and retain families’ interest in a competitive environment
- stage specific – will focus initially just on the first 12 months and has the potential to evolve over the entire early years period
- level-specific – will incorporate ‘Quick Fact Sheets’ and frequently asked questions sections
- user-specific – there will be modules for fathers, grandparents etc.

For the purposes of this document, this as yet undeveloped web-based resource is referred to as ‘CaFHSonline’.

It is proposed that information on ‘CaFHSonline’ will mirror that provided by the Child and Family Health Service in face-to-face and telephone interactions with parents and in its printed material.
Information will be organised into modules focusing on the child, and on the parent. The infant modules will address issues such as feeding, settling, sleep, development and health and will be organised around the developmental journey from birth to 12 months.

The parent modules focus on such issues as adjusting to parenthood, health maintenance, and the impact of parenting demands on mood and feelings, and the importance of social supports.

Links to other credible sources of information will be included where useful. It is proposed that ‘CaFHSonline’ will be accessible from a recognised government website and will be widely promoted, especially at the Universal Contact Visit and through the ‘Blue Book’. The concept, structure and content of ‘CaFHSonline’ is based on feedback gained from the eMums program research.

From the eMums feedback received to date, it is apparent that parents value the ability to access information at the time they need it or at the time that they are able to access it. It is anticipated that ‘CaFHSonline’ will assist families living in rural and remote areas of the State and will have the capacity to enable culturally and linguistically diverse communities to access information via translator ‘apps’ on smart phones and other similar technology.

Parents can also continue to:

- access information in multiple ways
- access the existing range of services from the Child and Family Health Service to address any concerns they have as well as seeking support through their general practitioner
- link in with their local community and social networks.

**Addressing barriers**

To provide a response that is appropriate to address ‘Level 1’ barriers to parenting, it is proposed that the following approaches will be utilised:

- strengths-based – services acknowledge parents’ strengths and skills, including ability to access and use ‘good’ health and development information, and an understanding of when to seek support
- partnership-based – developing a shared understanding of a family’s strengths, goals and barriers
- adult learning principles – services help parents learn by providing information that is relevant, meets their needs and helps them achieve their goals. Information will support anticipatory guidance through ‘just in time’ appropriate information
- self-management – assists parents to find the right information, make decisions and take action in relation to their child’s health and development needs. Parents will be able to track their child’s development on an ongoing basis rather than at one-off points, and there will be reminders relating to the key stages questionnaire
- health literacy – that is “an individual’s ability to search for, successfully access, comprehend, and appraise desired health information from electronic sources and to then use such information to attempt to address a particular health problem” (Norman & Skinner, 2006) in order to improve health outcomes
- parent choice - parents can choose to access information via the web if this is their preference, as well as how they apply the information in their daily lives.
Partnerships

Parents will be actively encouraged to maintain and/or develop their networks. Families can access multiple services and supports including playgroups, library reading groups, local government, religious and community services. All families will be encouraged to link with their general practitioner.

Prevalence of ‘Level 1’ barriers to parenting

It is estimated that approximately 70% of new parents ie, approximately 14,000 per year on average in South Australia will have parenting barriers defined as Level 1. (A. Sawyer et al., 2014)
6.3.2 Level 2

Parents at this level will have been identified as having some barriers that may impede their effectiveness to care for their new infant. As with parents in Level 1, these parents face the day-to-day challenges of parenting. Tasks and activities, responding to and enjoying their baby, may be more difficult in the presence of mild to moderate depression and where there is limited social support. See diagram below.

Level 2 service response

To meet the needs of families, it is proposed that a service will be developed specifically to meet the needs of parents with ‘Level 2’ barriers who, it is suggested, will be able to access information in a new way – via an interactive area of ‘CaFHSonline’ that will not be available as part of the Level 1 service. This is based on the findings from the eMums program. This interactive area is designed to function as a ‘virtual’ parenting group with designated nurses facilitating the interactions with parents and acting as moderators.

Parents identified as having Level 2 barriers will be assertively engaged, encouraged and supported to access the interactive area of ‘CaFHSonline’, and remain involved through their baby’s first six months of life.

If the nurse has concerns in relation to a baby or parent, they will explore this with the parent and follow up in a face to face setting. Following completion of the modules, parents can continue to access the ‘CaFHSonline’ and follow the self-paced web based modules for parents of infants aged 7-12 months.

Parents can continue to:

- access information in multiple ways
- access the existing range of services from the Child and Family Health Service to address any concerns they have as well as seeking support through their general practitioner
- link in with their local community and social networks.
**Addressing barriers**

To provide a response that is appropriate to address ‘Level 2’ parenting barriers, it is proposed that the following approaches will be utilised:

- **assertive engagement** – staff will actively contact parents and support and encourage them to engage and remain engaged with services
- **peer education and support** – the concept of peer education is that people experiencing similar situations are often well placed to encourage healthy behaviours in others. By linking parents with others in similar situations, it is hoped that positive behaviours will be adopted
- **social connectedness that acknowledges the role other service providers** – parents are assisted to link with other service providers including their general practitioner
- **strengths-based** – services acknowledge parents’ strengths, skills and resilience
- **partnership-based** – developing a shared understanding of a family’s strengths, goals and barriers, and respectfully challenging, supporting and negotiating where required to bring about change
- **adult learning principles** – services help parents learn by providing information that is relevant, meets their needs and helps them achieve their goals. Information will support anticipatory guidance through ‘just in time’ appropriate information
- **time-limited engagement** – services will support parents for a limited duration at the time that they most require support with a planned transition to self-management. Staff assist parents to find the right information, make decisions and take action in relation to their child’s health and development needs
- **parents will be able to track their child’s development on an ongoing basis rather than at one-off points, and there will be reminders relating to the Key Stages questionnaire for reference**
- **improves accessibility** – through the provision of ‘good’ health and development information via a new web-based medium and via the ‘virtual’ nurse moderators.

**Partnerships**

Parents will be actively encouraged to maintain and / or develop their networks. Families can access multiple services and supports including playgroups, library reading groups, local government, religious and community services. All families will be encouraged to link with their general practitioner.

The general practitioner may link families through a mental health care plan to appropriate providers.

**Prevalence of ‘Level 2’ barriers to parenting**

It is estimated that approximately 12% of new parents ie, approximately 2,480 per year on average in South Australia will have parenting barriers defined as Level 2. (A. Sawyer et al., 2014)
6.3.3 Level 3
Parents at this level have been identified as having barriers that can impede their effectiveness to care for their new infant. As with parents in Level 2, parents identified within this level will report low to moderate levels of depression and limited social supports, as well as reporting smoking during pregnancy (as smoking cessation is a strong indicator of a mother’s willingness to prioritise the needs of her baby over her own), limited education and socio economic disadvantage.

These latter factors are currently the best-known predictors for identifying children who may experience problems in their development. Families will be engaged in a further discussion to hear the dreams and aspirations they have for their child and to discuss their willingness and readiness to embark on a change journey. See diagram below.

Level 3 service response
To meet the needs of families, it is proposed that the key intervention will be access to a sustained, nurse-led visiting program. Families can continue to access ‘CaFHOnline’ as described in the Level 1 service response.

Interventions at this level will apply a combination of approaches including:

- a wider range of clinical assessment tools and techniques
- guided interactions with parents to assist parents to prioritise the needs of the child
- strengthened goal-setting
- clearly articulated parent outcomes with ongoing reviews and outcome measures to track progress
- a shorter program duration with supported engagement with the Learning Together program for the parent on completion.

Based on the available evidence, it is anticipated that these improvements to the sustained, nurse-led visiting program will better support parents, resulting in improved health outcomes for children.
Parents can continue to:

- access information in multiple ways
- access the existing range of services from the Child and Family Health Service to address any concerns they have as well as seeking support through their general practitioner
- link in with their local community and social networks.

**Addressing barriers**

To provide a response that is appropriate to address ‘Level 3’ needs, it is proposed that the following approaches will be utilised:

- assertive engagement – staff will engage proactively, so that early engagement occurs, and at every opportunity to promote positive outcomes
- predominantly nurse-led but will utilise a multidisciplinary approach where required
- social connectedness that acknowledges the role other service providers – parents are assisted to link with other service providers including their general practitioner
- strengths-based – services acknowledge parents’ strengths, skills and resilience
- partnership-based – developing a shared understanding of a family’s strengths, goals and barriers, and respectfully challenging, supporting and negotiating where required to bring about change
- adult learning principles – services help parents learn by providing information that is relevant, meets their needs and helps them achieve their goals. Information will support anticipatory guidance through ‘just in time’ appropriate information
- works towards the goal of self-management – staff assist parents to understand the importance of their child’s health and development needs, to make good decisions, take appropriate actions in relation to this, and to build their own resilience. It is anticipated that ongoing support on completion of the program will be provided through participation in Learning Together, and beyond this by ensuring that families have developed social connections and supportive relationships / networks
- sustained engagement – services will support parents for an extended duration to increase the likelihood of making long-lasting change, with a planned transition to self-management including the completion of Learning Together
- improves accessibility – services will continue to be provided predominantly in parent’s homes, but may also be provided at clinics or community venues if this is required.

**Partnerships**

Parents will be actively encouraged to maintain and / or develop their networks. Families can access multiple services and supports including playgroups, library reading groups, local government, religious and community services. All families will be encouraged to link with their general practitioner who may link them through a mental health care plan to appropriate providers.

It is proposed that strong partnership be developed with Learning Together so that families can transition from the sustained nurse-led program in their child’s second year. This will continue to support their development as well as the parent’s learning journey. Families may be linked to supported playgroups and to the childcare sector if required. Links will be made where appropriate to governmental and non-governmental sectors in relation to housing, employment and related social support needs.
Prevalence of ‘Level 3’ barriers to parenting

It is estimated that approximately 10% of new parents ie, approximately 2,000 per year on average in South Australia will have parenting barriers defined as Level 3. (A. Sawyer et al., 2014) (Sawyer et al., 2014, p19)

6.3.4 Level 4

Parents at this level will experience a range of challenges much broader than that experienced by parents in the preceding levels, often over a more enduring period, potentially through several generations of the family, and impacting on their capacity to be available for their child.

Many will struggle to make the transition to parenthood as meeting the demands of an infant while already stressed from managing competing pressures can seem insurmountable. Some parents’ own poor experience of parenting means that they may not have a parenting model to replicate for their children. They may be chronically stressed by multiple issues including substance use and mental health issues and current or previous trauma and this can impact on their ability to relate to the infant.

Parents experiencing high levels of barriers are unlikely to have the resources to ‘keep their child in mind’ and comprehensive supports will be required. (A. Sawyer et al., 2014) See diagram below.

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Level 4 service response

To meet the needs of families, it is proposed that the key intervention will be access to a sustained, allied health-led therapeutic program, as well as continuing to access ‘CaFHSonline’ as described in the Level 1 service response. However, this will need to be tested with families and strategies put into place regarding access and or appropriateness of the way information is structured and can be applied.

Therapeutic interventions will focus on providing the psychosocial support required to support parents to ‘keep the baby in mind’. A significant enhancement is the introduction of a multidisciplinary, therapeutic approach with all clients in recognition of the complexity of parents’ issues, as identified at the screening stage. Services will engage antenatally where issues are identified in pregnancy by providers already engaged with families.
Interventions at this level will apply a combination of approaches including:

- a strong therapeutic intervention based on a mentalising and ‘theory of change’ framework
- a parent–infant psychotherapeutic approach
- addressing the child’s, parent’s and family’s needs, including the concrete as well as psychosocial needs
- provision of parent education and skills training based on behavioural and social learning principles.

Other enhancements associated with the Level 4 service response are mainly associated with improving and standardising systems and processes. Some of the anticipated system improvements are:

- improved assessment processes using comprehensive, validated tools
- consistently applied evidence-based interventions – which will result in clearer, realistic expectations with parents
- ongoing reviews with families and staff which will increase accountability around service outcomes to support equity, involvement of parents in playing an active role in monitoring their child’s progress, and program fidelity
- sustained engagement, with planned transition to ongoing community supports, including access to pre-school.

Parents can continue to:

- access information in multiple ways
- access the existing range of services from the Child and Family Health Service to address any concerns they have as well as seeking support through their general practitioner
- link in with their local community and social networks.

**Addressing barriers**

To provide a response that is appropriate to ‘Level 4’ parenting barriers, it is proposed that the following approaches

- early, assertive engagement – in the antenatal period
- sustained, intensive engagement – services will support parents for an extended duration in acknowledgement of the complexity of their issues and to increase the likelihood of making long-lasting change
- an allied-health led, multidisciplinary, team approach
- a coordinated, multi-agency approach
- strengths-based – services acknowledge parents’ strengths, skills and resilience, as well as honestly and openly challenging behaviours to support positive change
- partnership-based – developing a shared understanding of a family’s strengths, goals and barriers. Service staff will be “facilitative, influential and purposeful in helping parents to identify and address the difficulties that they face” (Day, Ellis & Harris, 2014)
- adult learning principles – services help parents learn by providing information that is relevant, meets their needs and helps them achieve their goals. Information will support anticipatory guidance through ‘just in time’ appropriate information
• works towards the goal of self-management – staff assist parents to understand the importance of their child’s health and development needs, and assist them to make good decisions and take appropriate actions in relation to this, and to build their own resilience. It is anticipated that ongoing support is required beyond the program to increase the focus on social connectedness and supportive relationships and networks
• improves accessibility – services will continue to be provided predominantly in parent’s homes, but may also be provided at clinics or community venue if this is required.

**Partnerships**

Parents will be actively encouraged to maintain and / or develop their networks. All families will be encouraged to link with their general practitioner.

Based on their needs, families may be linked to drug and alcohol support services, mental health services – for the adult and the child, and trauma services. Families may also be linked to supported playgroups and to the childcare sector if required. Links will be made where appropriate to governmental and non-governmental sectors in relation to housing, employment and related social support needs.

The service will strengthen its relationship with the non-government sector who already provide a range of services and supports for families.

**Prevalence of ‘Level 4’ barriers to parenting**

It is estimated that approximately 6% of new parents ie, approximately 1,120 per year on average in South Australia will have parenting barriers defined as Level 4. (A. Sawyer et al., 2014)
6.3.5 Level 5

Parents at this level have been identified as having major barriers that place the child at risk for harm and cumulative neglect. They key difference between levels 4 and 5 is the assessed ability of the parent to prioritise and meet the needs of their child, as well as willingly engage with providers. As the safety of the child cannot be satisfactorily mediated, a notification will be made to the child protection service. See diagram below.

![Level 5 Service Response Diagram]

**Level 5 service response**

An infant’s total dependence on others to meet their needs means that they are highly vulnerable to abuse and neglect. Due to this vulnerability, infants require an immediate response to child protection concerns.

For those families where a child protection response is required, the Child and Family Health Service will respond to Families SA requests to ensure that feeding and settling issues are managed, and that the infant or young child has ongoing monitoring regarding their development. Where significant health or development issues are present, specialist services/clinicians, (i.e. a paediatrician) will lead the response.

**Partnerships**

The Child and Family Health Service will partner with Families SA to identify families where the risk to the child is seen as unmanageable by a voluntary service and a statutory response is required. The service recognises the need to work closely with Families SA to support families once the risk has been appropriately assessed and the service can then provide the family with an intensive support to address their specific needs and support the safety and wellbeing of the infant. The Service will communicate information it has gained in reaching that decision.

**Prevalence of ‘Level 5’ Barriers to Parenting**

It is estimated that approximately 2% of new parents ie, approximately 400 per year on average in South Australia will have parenting barriers defined as Level 5. (A. Sawyer et al., 2014)
Section 7: Appendices
Appendix 1 – Five by Five Report Fact Sheet

BetterStart
Child Health and Development Research Group

FACT SHEET

Five by Five
A Supporting Systems Framework for Child Health and Development

The first five years of life are a crucial period for child health and development. The goal is for every child to have a strong start in life. These goals are summarised in the concept that we call ‘Five by Five’ – 5 basic developmental domains that are achieved in 5 stages:

<table>
<thead>
<tr>
<th>5 dimensions of healthy development:</th>
<th>5 stages of healthy development:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Physical</td>
<td>1. Pregnancy</td>
</tr>
<tr>
<td>2. Language</td>
<td>2. Post-natal</td>
</tr>
<tr>
<td>3. Attachment</td>
<td>3. Infancy</td>
</tr>
<tr>
<td>4. Social emotional</td>
<td>4. Toddlerhood</td>
</tr>
<tr>
<td>5. Cognitve</td>
<td>5. Early childhood</td>
</tr>
</tbody>
</table>

Underlying the Five by Five framework are a number of principles. The goals of healthy development are the same for all children, and effective parenting is the key ingredient for achieving the Five by Five. While all carers want to parent effectively, some may face barriers that can disrupt effective parenting. Where this is the case services need to recognise and respond to these barriers.

Supporting the Five by Five

As shown in Figure 1, the child is the central focus, and effective parenting (parenting that is responsive to the child’s needs, and characterised by warm and nurturing interactions that are accepting and mindful of the child), is the major driver of achieving Five by Five. We have to be concerned about how well parents and carers are able to provide effective parenting.

We assume all carers want to parent effectively but there are large social inequalities in the resources required for effective parenting, and some parents will experience circumstances that may create barriers to effective parenting. Circumstances might relate to physical health of the parent or child (for example chronic illness or physical disability), psychosocial wellbeing (for example post-natal depression or lack of social support) and socioeconomic disadvantage (for example, low income, poor housing, or limited access to services).

Figure 1: A child-centred approach for social system support of the Five by Five.
Supporting systems (schools, health, child protection, child care and early learning and non-government organisations) must respond to those barriers and work together to ensure the *Five by Five* for every child, in every family and every caring situation. It is not just about recognising barriers, it is also about supporting how parents and carers respond to those barriers.

**Parenting Support at the Population Level**

While nobody yet knows the true levels of barriers faced by different segments of the population, Figure 2 provides our best estimates of the South Australian population according to increasing barriers to effective parenting.

The centre of the figure illustrates the five levels of parenting need in the population. The proportion of children represented at each level decreases in size as parenting circumstances become more complex and the barriers to effective parenting increase. As barriers increase a greater service response is required, but regardless of the level, the focus is on the child’s right to be safe, nurtured and have the opportunity to achieve the *Five by Five*.

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**Proportionate Universal Support Systems**

In South Australia a proportionate universal approach is used to support the *Five by Five*, where support is provided for everyone, but with greater support going to those with greater need. Inherent to a proportionate universal system is deciding who would most benefit from a more intensive support response. There are a number of ways to do this including targeting geographic areas and communities, identifying families based on characteristics known to be associated with child health and development outcomes, and the clinical judgement of health professionals about whether families require more intensive services.

**A Learning Support System Informed by Research**

There is growing political and community interest in supporting early childhood development in Australia. However, it is imperative to build practical evidence, specific to the Australian context, regarding how childhood programmes and services can best support effective parenting and achievement of the *Five by Five*. This requires academic research that is fundamentally oriented to answering questions of practical significance to the systems that support the *Five by Five*.
### Appendix 2 – Strategic policy framework

<table>
<thead>
<tr>
<th>Policy/Strategy/Plan</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>United Nations Declaration on the Rights of Indigenous Peoples</td>
<td>2007</td>
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<tr>
<td>Investing in the Early Years: A National Early Childhood Development Strategy</td>
<td>2009</td>
</tr>
<tr>
<td>Protecting Children is Everyone’s Business: National Framework for Protecting Australia’s Children</td>
<td>2009-2020</td>
</tr>
<tr>
<td>The National Plan to Reduce Violence Against Women and their Children</td>
<td>2010-2022</td>
</tr>
<tr>
<td>National Framework for Universal Child and Family Health Services</td>
<td>2011</td>
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<tr>
<td>Framework for the National Perinatal Depression Initiative</td>
<td>2008/09 to 2012/13</td>
</tr>
<tr>
<td>South Australian Department for Education and Child Development Strategic Plan</td>
<td>2014-2017</td>
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<tr>
<td>Australian Children’s Education &amp; Care Quality Authority – National Quality Framework 2011</td>
<td>2011</td>
</tr>
<tr>
<td>National Child and Youth Health Strategic Framework (Consultation Draft, October 2014)</td>
<td>2014</td>
</tr>
</tbody>
</table>
Section 8: References


SA Health Care Act 2008 Part 1, Section 5 (b).


