Early Childhood Development (ECD) services in the Southern Adelaide Health Service region

Angela Lawless
Catherine Hurley
Katherine Biedrzycki

July 2007

Table of contents

Executive Summary 1
Introduction 3
Methods 3
Project Advisory Group 3
Scoping of services 3
Focus groups: early childhood workers 4
In-depth interviews 4
Telephone interviews with Consumers 4
Scan of the relevant literature 5
Document analysis 5
Ethics 5
Summary of services and service models at SAHS sites 6
Noarlunga Health Village 6
Inner Southern Community Health Service 6
Southern Primary Health Woodcroft 6
Southern Primary Health - Seaford 6
GP Plus Health Care Centre Aldinga 7
Flinders Medical Centre 7
Findings 15
Staffing 15
Intake 16
Services provided 17
Range of services 17
Settings 19
Presenting problems 19
Consumer satisfaction 20
Outcomes 22
Impact on family 24
Equity 24
Waiting lists 27
Referrals and collaboration 28
Consumer perspectives 29
Models of practice 30
Discussion 33
Frameworks for discussion 33
What does the evidence tell us? 33
Early childhood research 33
Early childhood practice 36
Attachment based therapy 38
Good practice in early childhood services 42
Disciplinary roles and ECD teams 43
How does current practice relate to accepted understandings of good practice in primary health care? 46
How does current practice relate to strategies outlined in the Ottawa Charter? 51
What is the distribution and balance of services from the individual to population level? 52
Recommendations 55
References 60

Executive Summary

This report documents the findings of a review conducted by the South Australian Community Health Research Unit (SACHRU) at the request of the Southern Adelaide Health Service (SAHS) into the provision of Early Childhood Development services in southern Adelaide. This review was undertaken between June and December 2006 and overseen by a Project Management group consisting of representatives from the SAHS, the primary health services managers, practitioners, an acute service manager and the researchers.

The review examined the early childhood services provided by primary health services across the region, the models used, intake procedures and referral pathways. The findings were to be used for future service planning, implementation and resourcing.

The review undertook a number of activities including:

- Scoping of current services including client numbers, waiting list numbers, intake and assessment procedures, services provided and models used.
- Focus groups (n=3) with practitioners from each primary health care site
- Interviews with managers, heads of discipline and workers in the acute sector with an involvement in early childhood services (n=12)
- Development, analysis and reporting of a telephone survey for parents/carers of children currently receiving services from primary health or on the waiting list for services, stratified by area (n=51). These interviews were conducted by a project officer from SAHS who was not involved in service delivery.
- Scan of the relevant literature on early childhood development models of practice and evidence
- Analysis of current policy documents relating to early childhood development

Findings covered a wide range of issues that are outlined at the end of each section of the report. Some key recommendations include:

1. Current models of practice should be described within a program logic framework to ensure :
    a. Practice is based on intervention evidence for positive outcomes for children and families.
    b. Where it is not possible to draw on an existing evidence base (e.g. linking attachment based therapy to specific developmental outcomes such as speech and language), practice must be based on explicitly stated values and theories and provide a clear rationale linking practice to desired outcomes.

2. . A regional commitment and either investment in staff development to undertake such tasks or funding for an external body to do so is required.

3. Regional planning should ensure a comprehensive range of services from individual to population, from universal to targeted. SAHS ECD services must be considered in the context of ECD services more generally including those provided by other agencies and sectors.

4. SAHS ECD should work in collaboration with other agencies/sectors to ensure a ‘seamless service’ from birth until school entry.

5. There needs to be resolution of what is core business for ECD teams appropriate staffing levels and team composition across the region. The role of community based ECD teams would be clarified by the development of clear guidelines regarding the operation of such of teams in the SAHS.

6. There needs to be resolution of disciplinary roles within ECD teams. For example whether or not attachment based therapy is “core business” for Speech Pathologists and Occupational Therapists is contested.

7. Community and consumer involvement in planning, implementation and evaluation of services should take a central role in the development of services.

8. The relationship between FMC and ECD primary health services should be addressed to provide integrated child and family centred services across the region.

9. Clear channels of communication between treatment focussed areas of service and population focussed areas of services must be established and maintained.

10. Staff development opportunities need to be considered at a regional level and future training and development should be linked to regional and organisational strategic goals and values through planning and development processes.

11. Equity figures as a key concern for many ECD workers and managers and needs to systematically inform the development and delivery of ECD services. SAHS needs to consider access barriers to services at a number of different levels. This implies an understanding of community needs across the region and will have an impact on distribution, service focus, entry criteria and models of service delivery.

Introduction

In 2006 the South Australian Community Health Research Unit (SACHRU) was commissioned to conduct a project examining Early Childhood Development (ECD) services in the Southern Adelaide Health Service region with a focus on services provided by Southern Primary Health: Noarlunga, Seaford/Aldinga, Woodcroft (all of which were managed by the Noarlunga Health service prior to regionalisation) and the Inner Southern service (previously under the auspices of Flinders Medical Centre). Recent moves to regionalise services had highlighted the variation in ECD programs, eligibility, staffing, intake and service models across the four sites.
The project aimed to:

> *Review early childhood development services across SAHS with emphasis on the community based service models and referral pathways through to acute services with the aim of recommending locations and allocation of existing resources across the SAHS region to address need, demand and obtain optimal outcomes.*

Project tasks included:

- Scoping current ECD services (policies, structures and resources) across the region, detailing existing models of service, disciplinary roles, team structures, referrals and waiting lists.
- Explore current understandings of best and promising practice for ECD services with reference to the peer reviewed literature
- Consult with and engage key stakeholders – ECD workers, Primary Health managers and consumers
- Relate findings to relevant regional priorities and directions
- Explore current and alternate models detailing strengths and weaknesses
- Make recommendations about models of practice

Methods

Project Advisory Group

A Project Advisory Group (PAG) comprising representatives from SAHS, one manager or head of discipline from each site, and a FMC representative provided guidance to the project. The PAG informed the scope of the focus groups and interviews and provided feedback to SACHRU regarding the project process. The PAG also endorsed the frameworks used in evaluating and discussing project results.

Scoping of services

Each of the four service sites provided information on current waiting lists, models of service, priority setting and discipline-specific waiting times. These areas were also explored in interviews and focus groups with ECD staff and managers and in the consumer telephone interviews (see below). The description of services was distributed to ECD teams for comment and corrections and inaccuracies corrected.

Focus groups: early childhood workers

Focus groups were conducted with the ECD teams (speech pathologists, occupational therapists, psychologists, social workers, nurses and therapy assistants) at Woodcroft/Seaford, Noarlunga and Inner Southern. Each group was facilitated by a member of the SACHRU team and recorded by one or two other members by hand. Groups explored priority setting, service models, referral patterns, collaboration with other services and future directions for ECD services in the region. Notes from the groups were distributed to participants for comments on accuracy or corrections. Two responses making minor corrections were received.

In-depth interviews

A total of 12 interviews were held with Primary Health site managers (n=4), heads of discipline(HODs) for Speech Pathology, Occupational therapy and Psychology (n=3), and representatives of FMC including Paediatricians (n=2), Occupational therapists (n=3 in a group interview), Speech Pathologist (n=1, interviewed by phone) and the Manager of Allied Health Services. All interviews were conducted by SACHRU staff and recorded by hand by the interviewer. Questions asked were similar to those for the ECD focus groups. Given the small number of respondents quotes to be used were sent to respondents and a few were omitted as too identifying at their request. All primary health respondents are identified as "managers" in the quotes- this title includes both site managers and HODs.

Telephone interviews with Consumers

A project officer employed by SAHS conducted a total of 51 telephone interviews with current and waitlisted consumers of ECD services in the region. The interview schedule was constructed by SACHRU and endorsed by the PAG. Numbers for each service were chosen according to the size of the area that it serviced. Participants were selected randomly from a list provided by the services although some potential participants were excluded from the list based on recommendations from ECD staff that they would find a phone call about the project disturbing. It is not known how this may have skewed the data. Numbers were stratified according to the population of each region.

The numbers involved in the interviews are as follows:

	ISCHS	WOODCROFT	NOARLUNGA	SEAFORD	TOTAL
Number of current consumers interviewed	12	3	10	5	30
Number of waitlisted consumers interviewed	6	5	7	3	21
Total interviewed	18	8	17	8	51

Once the data was collected, it was forwarded to SACHRU for analysis using the qualitative research program QSR NVIVO 7.

Scan of the relevant literature

Searches of relevant databases and internet sources were undertaken to provide a sense of the evidence that is available, particularly with reference to the current models of practice. It was beyond the scope of this project to undertake a comprehensive review of the evidence for various therapy models, nevertheless the scan of the literature provides a starting point for discussion regarding evidence.

Document analysis

SACHRU staff also collected documents related to ECD services such as current SAHS strategic directions, the Population Health and Primary Care business plan, job descriptions, previous evaluation reports etc.

Ethics

This project received ethics approval from the Flinders University Social and Behavioural Ethics committee.

Summary of services and service models at SAHS sites

Noarlunga Health Village

Early childhood services at NHV are demand driven, with children mostly being referred by parents, and CYWHS with referrals also from GPs, and FMC. Children undergo a joint discipline assessment and are subsequently triaged into one of three service streams which are based on the level of developmental delay and presence of social/family issues. The model of intervention offered is based on the needs of the family and the resources available.

Rating 1 = severe difficulties in ECD + other social/family factors →into next available group and individual support in meantime with appropriate referrals

Rating 2 = severe difficulties in ECD with no other issues OR moderate difficulties in ECD plus other social/family issues→ wait as second priority for placement in a group and maybe get booked in for individual appointment

Rating 3 = Mild difficulties → → reviewed termly and home program provided. Referral to other services if required and information provided re private services eg, speech pathology, OT

Workers operate in a transdisciplinary model of service delivery which include interventions based on developmental models, and attachment theory

Inner Southern Community Health Service

The main intake method for early childhood services at ISCHS is the Early Developmental Screening Service (EDSS). This is a drop in screening service which provides single discipline assessments, run one day per month at Marion shopping centre in conjunction with FMC staff and CYH. Families are able to access Speech Pathology, OT and Physiotherapy. 95% of the 23 children screened on average each month are found to have some developmental delay, and are placed in appropriate services thereafter. ISCHS is soon to develop an adapted version of the NHV triage system. The model of practice is a developmental management model, although staff are implementing broader case management to provide a more holistic service.

Southern Primary Health Woodcroft

Most referrals to Woodcroft occur after parents or professionals identify developmental delay and approach the service. Children are given either an individual or joint assessment and prioritised into one of three categories as per NHV. Attendance at groups versus one on one therapy is based on the needs of the child and family, the appropriateness and the ability of the child/parent to attend, and whether there are attachment issues present within their relationship.

Southern Primary Health - Seaford

Most intake to Seaford occurs after parents or professionals identify developmental delay and approach the service. Children are given a joint assessment and triaged into one of three categories as per NVH. Staff work within an attachment theory model. Following the opening of the new GP Plus Health Care Centre at Aldinga, early childhood staff from Seaford have divided existing services and programs between these two sites.

GP Plus Health Care Centre Aldinga

The GP Plus Health Care Centre Aldinga opened in November 2006. GP Plus Aldinga is serviced by staff from many agencies including SAHS, all agreeing to work in an integrated service model. ECD services are provided by Southern Primary Health – Seaford, Children Youth and Women's Health Service and City of Onkaparinga.. Most intake to Southern Primary Health ECD services occurs after parents or professionals identify developmental delay and approach the service. Children are given a joint assessment and triaged into one of three categories as per NVH. Staff work within an attachment theory model. As the philosophy of GP Plus centres is based around a strong inter-agency partnership model, it is likely that collaboration and co-working with other relevant early childhood service agencies will increase in the future.

Flinders Medical Centre

Intake to FMC early childhood services is mainly through the Community Assessment Team (CAT) which operates 2 days per week, seeing two clients per day. Services are also offered through the Neonate Follow-up Program and the General Paediatric Clinic. FMC also runs a pilot home visiting service out of Woodcroft CHS. Clinical services are delivered in mostly one to one sessions, with some group work. Services are delivered in a holistic multi-disciplinary model, and are tailored for each child.

Summary of SAHS ECS sites

	Noarlunga	Inner Southern	Woodcroft	Seaford	GP Plus - Aldinga	FMC
Staff	1.7 x SP 1.6 x OT1.6 x Psych 0.2 x Social Worker 6 hours Therapy assistant per week 0.5 PHC Nurse Consultant nutritionist	2 x SP 1 x OT 1 x psych 0.6 therapy assistant per week 1 x crèche coordinator	2 x SP 0.4 x OT (+ 0.3 temp) 1 x Child Psych 6 hrs therapy assistant per week 1 x midwife	0.5 x OT 0.5 x SP 3hrs therapy assistant per week Nutritionist input requested as needed. Support to be provided in Term 1 by community foodies for 'snack time' in group programs.	0.4 x OT 0.3 x Sp (+0.3 temp) 3 hrs therapy assistant per week Nutritionist input requested as needed. Project officer	5-6 FTEs across programs: *CAT team* (physio, OT, psych, paed, SP, CAMHS, DECS), *Paediatric clinic* (nurses, dieticians, psych, specialists and CAMHS (behaviour clinic)), *Neonate program* (SP, OT, psych, physio, paed).
Referrals and intake method	Children often referred by parents or health care professionals ,in particular CYWHS for speech delay. A holistic joint	Early Development Screening Service (EDSS) screens children identified by CYH, kindys, parents (40%), GPs, paediatricians, and FMC. EDSS operates at Marion	Children are usually referred by parents or health care professionals concerns regarding a child's development A joint or individual assessment is provided and	Children are usually referred by parents or CYWHS and GPs for speech delay. A joint assessment is provided and children are triaged as per NHV	Children are usually referred by parents or CYWHS and GPs for speech delay. A joint assessment is provided and children are triaged as per NHV	EDSS is the main intake process for outpatients (usually multi-need severe children). GPs and others

	assessment is provided and children are triaged and allocated to services (see description above	one day a month with FMC and CYH staff. Children receive individual discipline screens and are then placed in programs. Most children are identified with speech delay or multiple issues. Supported playgroups (x3) with CYH are to capture children who do not access EDSS. Soon to develop an adapted version of NHV triage system.	children are prioritised as per the NHV system. Working towards more links with CYH home visiting program	system.	system.	refer to General Paed clinic. The CAT team picks up children linked in by kindys, childcare, DECS, CYH, Families SA, parents or GPs (previously also located at NHV). There is also the pilot home visiting service: (runs from Woodcroft).

	Noarlunga	Inner Southern	Woodcroft	Seaford	GP Plus - Aldinga	FMC
Services	*-The main service models are developmental management, attachment based group work and some 1:1 therapy. Workers see mostly complex cases and hardly any priority 3 cases. Significant collaborative work with other agencies such as Pathways for Families, Learning Together, CAMHS and CYWHS. Further community development opportunities are being explored.* -Baby group (babies under 6 months with extreme delay) -Developmental groups graded on age and skills of children (1 hr play	*The main service model is developmental management group and 1:1 work. There is a lesser focus on family services. There is minimal community development work and some collaborative initiatives (EDSS).* The services are clustered: -Developmental services -Developmental and family services -Supported playgroups -Complex family services	*- The main service model is attachment based and developmental group work and 1:1 services. There is limited capacity for collaborative or community development focus due to limited resources.* -2 developmental groups (1 hour play and 1 hour parent session) -Building Blocks group for 18 months to 3 year olds focusing on parent/child relationships and development. -Speech group -Books from Birth (community	*The main service model is attachment based and developmental group work and 1:1 services. There is little collaborative or community development focus.* -Fun for Toddlers (1 hr play, 1 hr parent session) -Talk and Do for 0-3 year olds (1 hr play)	*The main service model is attachment based and developmental group work and 1:1 services.* *Collaborative and community development initiatives are increasing.* - Fun for Toddlers (1hr play, 1hr parent session) - Toddler Playgroup - Baby Playgroup - Parent Group – "The First Four Years" run in collaboration with Centacare	*The main service model is 1:1 developmental management with some group work. There is limited community development focus and some collaborative initiatives (EDSS and pilot home visiting).* Services are -Assessment -Mostly 1 to1 and some group work -Advocacy to get kids into other services -Therapy (group or individual) for a small number of kids

	and 1 hr parent support session) -Walk and Talk program to encourage exercise and language -1 to 1 work (140 kids on the database and not all can fit into groups) - usually fortnightly sessions and joint reviews -Input into the antenatal program -ATSI playgroup (some CD focus i.e. collaborative and multi-agency) -staff speak at kindergartens or peer workers are trained at playgroups -Book Bank -Home visiting	That is: -multidisciplinary groups and development programs -1 to 1 and group work are provided during school terms. -Fortnightly appointments for individual sessions and groups are either weekly or fortnightly.	initiative) -Raising Secure Children group (informed by attachment theory and principles and using video review) -Some home visiting occurs.		- Links and partnerships currently being investigated with view to establish an ATSI playgroup in the near future.	-Case coordination Cat team sees 0-8 year olds focusing on: -Disadvantaged -Family dysfunction -Kids who are at-risk -Those with major developmental issues e.g. autism NB. Access to paediatric gym means physio clients tend to stay at FMC not CH

	upon request from the family					
	Noarlunga	**Inner Southern**	**Woodcroft**	**Seaford**	**GP Plus - Aldinga**	**FMC**
Referrals out	There are strong referrals, including to some adult services. Sometimes refer to CAMHS. Access to OTs in other agencies is problematic. Links with Pathways, Families SA, IDSC, Autism SA, FMC. .	Work with DECS, FMC including the CAT team, WCH, Families SA, IDSC (Busy Babies Program), NOVITA, CPU, CAMHS, CYH, kindergartens. Referrals to/from adult services e.g. Helen Mayo house, and 'Connecting Parents'.	Strong referral to Disability SA, Autism Assoc., FMC, DECS (Kindergartens, First Start, Early Learning Program), Hearing Assessment (CYH), Adult Counselling, Centacare, Families SA,	Sometimes refer to adult teams e.g. around DV and other wider family issues Refer to FMC, DECS (First Start and Early Learning Programme), Disability SA, CYWHS	Sometimes refer to adult teams e.g. around DV and other wider family issues Refer to FMC, DECS(First Start and Early Learning Programme), Disability SA, CYWHS	Referrals are to Disability SA, IDSC etc. Link in with CYH universal visiting with referrals and picking up issues. Staff are provided to EDSS. Link in with Helen Mayo House.
Models/framework	NHV works in a trans-disciplinary model using developmental and attachment theory models. "Never work with children	The model of practice is a developmental management model. Staff do broader case management to implement a more	works in a trans-disciplinary model using developmental and attachment theory models. "Never work with children alone"..	works in a trans-disciplinary model using developmental and attachment theory models. "Never work with children	works in a trans-disciplinary model using developmental and attachment theory models. "Never work with children	Holistic, collaborative multi-D model (and in some ways trans and inter-D models). Look at child and family

	alone". Staff use a 'toolkit' of different practices..	holistic approach. Staff use a 'toolkit' of different practices	Staff use a 'toolkit' of different practices	alone". Staff use a 'toolkit' of different practices	alone". Staff use a 'toolkit' of different practices	together. Services are tailored in an 'eclectic mix' to suit each child. The community pilot project is a nurse-led case management model
	Noarlunga	**Inner Southern**	**Woodcroft**	**Seaford**	**GP Plus - Aldinga**	**FMC**
Outcomes	Defined outcomes are usually skills based (goals are set and informally assessed for each client) but few discharges 'due to the nature of the clients'. Discharged to DECS at age 4.	For speech, discharge is based on formal assessment or to DECS at age 4. Most kids still need some services at time of transfer to DECS.	Not discussed due to Time constraints	Not discussed due to Time constraints	Not discussed	Discharge timeframe is dependent on the service. CAT is a one day screening service with immediate referral but some kids may be clients for up to 10 years Allied health services are dependent on

						eligibility. A time of service will be offered e.g. one term of treatment.

Findings

The table below sets out the average ages of children whose parent participated in the consumer survey.

	ISCHS	WOODCROFT	NOARLUNGA	SEAFORD	TOTAL
Average age of **children (all)** at interview (mths)	39.5	39.8	38	37.1	38.6
Average age of **waitlisted children** at interview (mths)	39.2	40.6	32.6	32	36.1
Average age of **current consumers** at interview (mths)	39.8	39	43.4	42.2	41.1

Staffing

In discussing staff numbers and team composition, the lack of resources, particularly staff numbers, was a theme raised in almost all interviews and focus groups. The type of services provided, and by whom, was also discussed in the context of finite resources.

Management of the workforce within teams and across the region was an area of interest for many workers and managers. Commonly, managers saw that reorganisation and more effective use and support for staff was an important aspect of the way forward for the region. Increasing demands on staff and services was often linked to the need for more efficient and planned approaches to workforce development and utilisation. Some workers were concerned however that their roles would be diminished by such reorganisation.

> *"Now that we are one region we have potentially huge numbers of children compared to the staffing… I'm learning that it's hard to get beyond the 1 to 1 work especially when under-resourced." (Manager, Inner south area)*

> *"Staffing was not ever based on a planned approach- (across the region) we have 19 FTEs, including SP, OT, Psych and crèche care workers. These are the core staff. We have some PHC nursing for pregnancy and post-natal services but would like more. There is no dedicated SW time and no paediatric PT. Southern Vales has no Psych. We also have therapy assistants. We would love to have access to a community Paediatrician too." (Manager, Inner south area))*

> *"I hope that our Family centre starts within 2 years and that AHWs (ATSI health workers) get acceptance as professionals with an ECD career path for them because at the moment there's nothing." (Manager, Outer south area)*

A number of respondents raised the question of what exactly was the core role of specific disciplines in relation to early childhood services:

"Is this (attachment work) SP and OT core business? Is this the best tool to achieve desired outcomes? Need to demonstrate the evidence." (Manager, Outer south area)

"(There needs to be) reconsideration of what is core business and of how PHC fits with therapeutic work." (Manager, Outer south area)

Concern was also expressed regarding the appropriateness of senior disciplinary staff undertaking some roles e.g. working with supported playgroups, with the suggestion that generic or community development workers usefully involved in such work.

There were a number of respondents who noted the importance of continuing education and the ability to try new approaches.

"It's good to have some autonomy to try new things. There is a good commitment to staff training here and historically, a good level of support for staff." (Focus group, Woodcroft/Seaford)

One worker identified undertaking further study in mental health to assist with their role:

"That study's been supported and we have external supervision of workers, it's (attachment) a new area of work so there was recognition that support was needed." (Focus group Noarlunga)

Intake

The intake processes at different sites were described and discussed in terms of access, generalisability, efficiency etc. In particular, the Early Developmental Screening Service (EDSS) was a point of praise and concern alike for workers and managers. Some felt that it was a cost effective and useful model, especially when complemented by other intake processes. Others felt that it was a model which could not be duplicated across the region due to the nature of the consumers in some areas.

> *"EDSS is a terrific model and well patronised. It could work in other sites apart from Marion. NHV doesn't like the model." (Worker, FMC).*
>
> *The fact that we get most through EDSS (therefore via CYH) mean we miss those who are not accessing CYH… but some people receive assistance to come to EDSS which improves the reach of the service… we are seeing hard cases so we're not just receiving the worried well." (Focus group, Inner Southern)*

"I think it is too medical a model but it has its place in that centre (Marion shopping centre) with CY&WH there and a large number of people converging there. I don't think the same model would work at Colonnades or Aldinga at all."(Manager, Outer south area)

Across the region, it was noted that there is a potential risk that services are responding only to people 'who walk through the door' and that the full extent of the need across the region is not known. Many noted that although the intention is to service those most in need (via the priority rating system), the nature of the intake system (often self referral, requiring parental empowerment) is a paradoxical barrier to access for such consumers.

"…not necessarily the most needy, only those who come through the door." (Manager, Outer south area)

"We target the more disadvantaged children and families, however we have to respond to the people who walk in the door." (Manager, Outer south area)

"(there is) difficulty accessing families most in need." (Manager, Outer south area)

"We see highly complex cases/families now and hardly any priority 3 cases." (Focus group, Noarlunga)

Some expressed concerns regarding intake to services once the child turns 4 years of age.

"There has been impact on clients regarding age limits/boundaries and there has been some client feedback and complaints about this." (Manager, Inner south area)

"If children turn 4 while on the waiting list, we are now telling parents that it's likely they won't be seen so they miss out. We discuss their other options, such as Private Therapy or the DECS." (Manager, Inner south area)

"We are trying to use evidence e.g. Fraser Mustard, to drive our priorities. Therefore we focus up to 3 years old." (Focus group, Noarlunga)

Services provided

Range of services

Both managers and workers identified that 1 to 1 and group work were the most common methods used to deliver ECD services with a small amount of time going to work such as "creating supportive environments" ie playgroups and community development. There was general acknowledgment that community development work is limited due to time and resource constraints with "talks at kindys" and the "book bank" the main two examples given of community development work. The issue of how to manage the high levels of demand and still be able to tackle macro issues was one that a number of workers and managers commented upon:

"At the moment, it's (dealing with demand) like mopping up a flood with a box of tissues- (Manager, Inner south area)

"We used to say at Noarlunga that we had the 30/30/30 rule- 30% for individual, groupwork and community development time. The challenge now is to look within that and ask is 30% 1 to 1 work appropriate?"… I don't think all team members have the 30/30/30 split of their work and we are now looking at teams rather than disciplines- this is a new focus, how do we respond to an issue as a team? (Manager, Outer south area)

A newer emphasis within their service model was now being placed on family support, promoting attachment between children and parents and using this as a foundation for other work in early childhood. This work is now incorporated into most parent/child groups and staff were enthusiastic about its impact. There was also mention of more intensive groups run by various disciplines that employed videoing of parent/child interactions. Many outer south workers suggested that the attachment work had been the "missing link" in previous work with families they had perceived as being unresponsive to more traditional methods. Some felt that by doing attachment work, they were tackling the antecedents of developmental problems and enabling parents to help their children.

" the shift was informed by what parents wanted, that is parent support. But we still didn't have the solution to fix the big problems which is how we arrived at using attachment models and interventions." (Focus group, Noarlunga).

"the results we have seen as therapists have led to us using it- in some cases the kids end up not needing therapy once the relationships were sorted out." (Focus group, Woodcroft/Seaford)

The focus on treatment rather than system level issues was also commented on. Some managers identified that policy level decisions were now made at quite some distance from service providers and that this made it difficult for them to influence system wide issues. A lack of time and resources has also meant that workers are not able to address broader determinants of health.

"Since the Generational Health Review, the system has become more bureaucratic and management more remote. The board of NHS used to know about services and vice versa. There has been a loss of the sense of collegiality and common purpose." (Manager, Outer south area).

"What's missing is that I think it is very difficult for people to stand back and look at need from a whole population perspective. We have no stats that I am aware of to tell us what the needs are or even how many children under 4 have developmental delay in this area. The services provided are based on history rather than what needs are being met and what are not." (Manager, Inner south area)

Among the outer south ECD workers, there was a concern that the move to regionalisation might mean an increased role for FMC in determining the role and direction of ECD services. Staff were concerned that their autonomy of their agencies and themselves as practitioners may become limited and this may be a barrier to collaboration between the two levels of care.

"FMC may drive the way we have to report or operate being the powerful entity in the region- what does it mean for us?"(Focus group, Noarlunga)

"There has been some feeling around 'FMC now runs Noarlunga' and feeling they can influence NHV…I think there needs to be more communication."(Focus group Woodcroft/ Seaford)

Settings

Centre-based groups and individual sessions were identified as the main setting for ECD services. Issues such as occupational health and safety and risk management had led to fewer home visits being undertaken. Apart from the supported playgroups community settings did not appear to be utilised to any great extent.

Presenting problems

The major issue identified by consumers in their interviews (both waitlisted and current consumers) was for services to address their child's speech problems. These problems ranged from children who did not speak at all to those whose speech was limited or affected by dyspraxia or stuttering. This finding reflects the services information that speech problems are the most common reason for referral. A few children had general developmental concerns that had been present since birth or were diagnosed as autism or developmental delay. Concerns about fine and gross motor abilities were also mentioned by a number of parents and one mentioned issues related to behaviour. Problems with socialization with other children were often an adjunct to speech problems in that others could not understand them or the affected child preferred to play alone. Many parents identified that they were keen to address these problems as soon as possible to avoid their child getting too far behind their peers:

At just past 2 she was not using any words. Another little girl her age would visit and she would use a couple of words together (Consumer5, Seaford)

Speech therapy treatment was also the most commonly identified need with those on the waiting list particularly seeking regular treatment for difficulties their child had:

> *Ongoing speech therapy from Noarlunga. The current group is more of a play group although it does teach some speech and she is on the waiting list for 1 to 1. (Consumer 15, Noarlunga)*

> *He is using more words but still not understanding. For example when he comes home from Child Care you can't ask him "what did you do in child care today?" because he will answer "Child care today." The service needs to be more frequent. Monthly support does not help and leaves it up to the parents to do everything. Staff do give you ideas but when you are at home it is hard to take the time out to do things whereas if you have an appointment you set aside the time (Consumer 6, Woodcroft)*

> *He needs regular 1 to 1 therapy every week. The family has only seen the Woodcroft workers 3 times in 6 months (Consumer 6, Woodcroft)*

Whilst workers in the outer south identified parent child relationships and attachment as a key need for the population served it did not figure amongst consumer concerns. Among the fifty one parents interviewed, only one specifically identified relationships with her child as a major concern. This consumer had attended the Reflections group, held at the Pathways centre and found it beneficial.

Many parents indicated that they saw behavioural problems that were the result of the child's primary issue, most often frustration related to speech delay .Of the 51 parents interviewed, no parents stated that their child was referred for behavioural problems alone. Eleven were referred for multiple problems, and of those, three parents stated that their child was referred in part due to behavioural problems, and four indicated Autism-like disorders or global delay.

Consumer satisfaction

Feedback from current and waitlisted consumers indicated that most were happy with the services they had received. Consumers were also asked to identify the impact, if any of the early childhood services received on their child. Many respondents were able to identify positive outcomes for the child including improved speech, lowered frustration and better social skills in some cases.

> *"…better than expected. Fantastic what the therapist did with her and how she got through to her. She has just snapped out of not talking in the last 3 weeks. She is now putting 2 words together when she speaks and can understand three. They will move on to 4 words next. It was fantastic to see how the therapist worked with the child, how she tested and communicated" (Consumer 4, Woodcroft)*

"Better than expected – would recommend it to anyone… everyone is lovely, friendly and helpful." (Consumer 3, Noarlunga)

"At first she thought "How the hell will this help him!" After about a week she was very impressed. He went for 2 terms and it worked well." (Consumer 9, Noarlunga)

"It is a terrific service offered. They give you a special insight, advice, opportunities to practice with your child, help through your Circle of Support. They also help with other issues e.g. toilet training. Feels she is very fortunate." (Consumer 5, Seaford)

"One of the best things they did - so easy. Very impressed especially because it is all free and all the staff are so enthusiastic." (Consumer 1, Inner Southern)

"Great! Fantastic! They say "let's do it this way" and the kids learn it straight away." (Consumer 12, Inner Southern)

A few consumers related specific concerns about issues such as continuing access to services once the child turned four years of age or lack of feedback:

Only that sometimes the room in which the group is held is too small for the numbers of children there. Because they are physically active children it may also be good to have an outdoor space sometimes that simulates real life play more – bearing in mind the activity has to be controlled.
At present there is a fair amount of parent intervention to keep the children from hurting each other (Consumer 7, Inner Southern)

It would be good to have had more feedback from staff. They were required to evaluate how they thought their child was progressing and it would have been good if the staff did the same. It would also have given the parents a better idea of what to use as measurements.
She would also have liked some written information and some exercises she could do with her son at home. (Consumer 9, Noarlunga)

…she expected more small group work at least, or some 1 on 1 time where parents received more direction and could try helping techniques out. An example would be doing some sign language. She is now seeing a private speech therapist who teaches a technique where the parent says the word but also signs it so the child can lessen their frustration sometimes and use that.
They didn't really address what was useful for her as an individual because of the group focus (Consumer 7, Noarlunga)

"Only a few letters left to work on now so not that much improvement noted from the public service – more from the private service." (Consumer 1, Woodcroft)

School readiness was a concern for a sub-group of parents whose children had passed the age limit for ECD services:

> *Yes, they suggested he join the Ready For School group and he has done this. He does a lot of cutting and drawing there and he was not really into this before – it was a big struggle (Consumer 8, Woodcroft)*

> *In her case she and her husband are doing all they can to help their child and his service has been cut on the basis of his age not his need for continued work on his fine motor skills. She wants him to be able to do things like write his name and draw a Circle when he starts school the same as the other kids can. (Consumer 4, Inner Southern)*

There was also an example of service responsiveness to a consumer request:

> *Staff responded positively to a request for the group to be an hour earlier because a number of mothers had older children to drop off at school and changed the time (Consumer 2, Noarlunga)*

Outcomes

ECD Managers and workers talked about the need to show effectiveness in what they were doing for children and families but identified a number of problems that made this difficult:

- Lack of time and resources to carry out formal evaluation of activities and outcomes

"Some work comes not from best practice but from what resources we have." (Manager, Inner south area)

"I think there needs to be formal evaluation of what we are doing and I would like to see support and money for this."(Manager, Outer south area)

- Lack of access to research evidence to inform practice

"The problem is that we have no access to evaluated programs that will tell us whether home programs are better or not than group programs or individual therapy."(Manager, Inner south area)

- Pressure to demonstrate effectiveness usually using methods that did not capture the complexity of the work being undertaken

"There is not enough time for reflection on work practises or building community links. We are moving to a stats driven model which is not able to capture the complexity of the work we do or the community development work." (Manager, Outer south area)

I think we will be challenged to come up with costings in the way that hospitals are- if someone presents with developmental problems, how much will intervention cost and what will be the outcomes?"(Manager, Inner south area)

- Workers identified that most processes and outcomes were measured informally

"Individual outcomes are noted in case notes of gains made. Anecdotally, people tell us they are thinking about their child differently." (Focus group, Noarlunga)

"There is a drive to be evidence based and therefore accountable but the lack of resources means we can't do this. Also there is a lack of research so most of us do what we know, what we have always done." (Worker, FMC)

"For speech, discharge is based on formal assessment or by default at the age of 4 to DECS. Most kids still need some services at the time of transfer to DECS." (Focus group, Inner Southern)

- Perceptions that the consumer group may be unresponsive to or reluctant to participate in formal evaluation activities.

We don't do much formal assessment because of age range and the sorts of families we get."(Focus group, Noarlunga)

Other consumers identified that their child had not changed much as a result of ECD services for a variety of reasons including that the child was too young, did not respond to the service offered or that the service was not timely enough. In a few cases, parents sought other services including private ones to address the perceived needs of their children:

Mother feels she is finding him easier to understand but it is still hard for his father and his older brother to understand him. It would have been better if he could have gone more frequently earlier on (Consumer 5, Noarlunga)

It has been good but the child has not made a lot of progress. The mother feels this is not because of poor service but due to the child's ability to learn/not learn at this age. He "talks for Australia" but is still difficult to understand (Consumer 2, Seaford)

Impact on family

Consumers also identified a range of impacts on themselves and their families from receiving ECD services. These included more understanding of the child's problems, ways to help them and lower frustration in dealing with them:

> *"They know they are doing all they can to help her. They are very happy. Without the service they would still probably be struggling." (Consumer 5, Seaford)*

> *"Yes. Before he would ignore you if you asked him to do a simple task which was very frustrating for the parents. Now he understands and can do things." (Consumer 6, Inner Southern)*

In many cases, parents had been encouraged to adapt their interactions with the child to facilitate their development:

> *"He is easier to understand now. Staff have done a lot of work on tantrums so mother understands that he is not naughty, he just does not understand what he should be doing, and takes a second look, showing him in person what he needs to do."(Consumer 2, Noarlunga)*

> *"Yes, it is not so frustrating. They have things they can do with him like puzzles, asking him if he wants a ball or a clown, asking him which drink he wants to he is encouraged to make decisions."(Consumer 8, Inner Southern)*

Equity

Managers and workers were aware that there were a number of issues that affected how accessible and equitable their ECD services were. It was clear from their feedback that in many cases accessibility depended on the availability of resources such as staff time, room availability, crèche services that catered for the children and other supports.

Workers and managers were aware of the need to target those who were in greatest need for services. Aboriginal people were identified as being one such group but it was identified that there are limited numbers of ATSI children in mainstream ECD programs. Children of ATSI background tend to be seen in Aboriginal specific programs such as playgroups or as part of a family visit to an Aboriginal health team.

> *"Need to focus on equity- not high ATSI involvement but strong efforts- no early childhood worker on the ATSI team" (Manager, Outer south area)*

> *"We don't have an ATSI caseload but we have involvement with the ATSI playgroup, by request when appropriate. Those that are referred don't work well in our model of service, even when we tried home visits. But when we're at the ATSI playgroup we get up to 3 families crossing over to the general playgroup and this is sustained." (Focus group, Inner Southern)*

Many of the staff perceived that they were servicing the most difficult and needy families but there was also a lack of information on the level of need in the region, along with the reliance on a demand- driven model for ECD services means it is not possible to be sure that this is the case.

> *"We see more families with multiple needs and we hang on to them" (Focus group, Noarlunga)*
>
> *"We target the more disadvantaged children and families, however we have to respond to the people who walk through the door."(Manager, Outer south area)*
>
> *"Demand management- the only way to cope with the demand is to limit entry to the system eg by not replicating DECS services- not necessarily the most needy, only those who come through the door" (Manager, Outer south area)*

Staff identified that they were struggling to meet current demand without knowing if that demand was in fact coming from those with the greatest needs:

> *"Families wait 3-6 months for speech therapy services which is not good. (Children previously seen by) Hospital services have been redirected to community health so we're doing more with less and we're quite stretched."(Focus group, Inner Southern)*

Workers and managers were able to identify a number of gaps in current ECD services that were impacting on their ability to provide quality and accessible programs to consumers. These identified gaps included things such as the lack of a community-based physiotherapist, no psychology services at the Seaford site and, as mentioned above, the recent limitation of services to only children under 4 years of age. Most of these limitations were imposed by resource constraints.

> *"It would be good to have a physio to work on gross motor skills" (Focus group, Noarlunga)*
>
> ***"****Southern vales team is under-resourced, need more resources for Aldinga."(Manager, Outer south area)*
>
> *"There is impact from not taking children over 4, DECS will only take the very severe which means there are great gaps in services for OT/PT, with tight restrictions- these are not available through DECS. But lots of parents can't afford private therapy. No-one fights for these services because both DECS and Health say it's not their issue." (Worker, FMC).*

Most consumers did not identify issues physically accessing the service with most being able to use a car to drive to their service. A couple identified difficulties around reaching the service related to transport.

It is OK although she does not have a car at the moment – her husband uses it
It is a half hour walk with both girls but she manages (Consumer 8, Seaford)

It is a 45 minute walk. She doesn't have a car. She quite enjoys the walk and has been given a double pram which makes it a lot easier. She uses the walking time to practise language (Consumer 9, Inner Southern)

Parking is a bugger. As well as being difficult to find there is a need for off street parking. Children like her son do not understand road rules and have to be carefully watched when they have parked across the road near the bus depot. (Consumer 2, Noarlunga)

Many consumers appreciated other things that made the service more accessible such as the ability to bring other children when visiting the centre, the creche provided for parent groups and home visits in some cases.

"A Counsellor has visited the mother at home because of the difficulties they are having with their sons' speech and because she is temporarily off work after a car accident." (Consumer 8, Noarlunga)

In some cases services that enhanced accessibility were not available at all sites:

It is hard taking the 2nd child sometimes as she is in the "in your face" stage and sometimes mother has to take her for a walk around. Her own Mum is fostering a special needs daughter so babysits when she can but it is not always possible. A crèche would be great. (Consumer 6, Seaford)

The greatest equity issue related to the ability of older children to receive and retain services. Many parents were aware of the age limits newly imposed on ECD services and felt this was inequitable for older children or those who would reach the age limit before or shortly after services had been commenced. In many cases, parents identified that their children's need was significant and perceived that service access was restricted by lack of resources or age limits.

It is frustrating to wait for the service. Noarlunga also puts an age limit of 3 before they work with children. Mother could see at an early age speech was going to be a problem for the twins and only got in for an assessment because she pushed and worked at it. She is concerned that other parents might not do this and their children suffer.
She can appreciate where it is coming from but more resources are needed (Consumer 11, Noarlunga)

The 3 year old has speech problems and was assessed and that went really well but the only follow up is that she will be seen again in January. Mother can understand her but others, for example those in her playgroup, can't. She is

getting better but it is very slow. She is too old (she will be 4 in May 2007) (Consumer 12, Noarlunga)

The system change for OT that cut his service access before he was eligible for another government service is very unfair to him. It means he will flounder for 12 months and will not be in a normal class. If he had an intensive year now he could draw circle around it all when he started school (Consumer 4, Inner Southern)

Some consumers also had issues around the suitability of group programs for their children and the need for one to one or home based therapy

At the beginning of term 4 he was given a place in the Spot Group. He found the noise of the other children too much to tolerate and hated going. He stopped after 2 sessions. Yesterday 2 therapists made a home visit and talked over options.
They will try to find a smaller group for him or to schedule regular 1 to 1 (Consumer 6, Woodcroft)

Waiting lists

Consumer experiences of waiting lists varied considerably and were affected by a number of factors including the location and nature of the service they were seeking and the assessed severity (by the service) of their child's problems. When questioned in the interviews, all respondents were aware that waiting lists existed but the length of time waited varied considerably from no wait at all in a few cases, to weeks and in some cases, months.

The table below sets out the average time children are waitlisted before receiving a service and the average length of time spent receiving services.

	ISCHS	WOODCROFT	NOARLUNGA	SEAFORD	TOTAL
Avg wait for **current consumers** (wks)	5.6	24	10	3.6	10.8
Avg wait for **waitlisted consumers** (wks)	16	23.6	7.4	8.7	13.9
Avg **length of service** (excl waitlisted) (wks)	54.6	23	38	32	36.9

One consumer reported still waiting for an assessment 10 months after the initial request but most had waited two to four months to receive ongoing services. Some consumers understood and accepted the need to wait while others expressed frustration and concern that their child's needs were not being attended to. Some were aware that consumers were prioritized and others were not.

They got in straight away as the service had a vacancy and their child was identified as having severe language problems and developmental delay (Consumer 2, Noarlunga)

They have been on the waiting list since April (3 year old child) and have not had even an assessment yet. They have an appointment for February 2007 by which time the wait will have been 10 months. They said the waiting list was long but the mother did not know it would be that long… they clearly need more resources and more staff (Consumer 15, Inner Southern)

3 months - she thought it would automatically start after assessment and she is not really happy about this for the 3 year old especially (Consumer 12, Noarlunga)

In many cases, private services were suggested to consumers on the waiting lists, particularly for those seeking speech or occupational therapy. Some consumers were able to take up this option but others identified that they either could not afford it (private therapy generally costs between $80 and $100 per hour) or were reluctant to access it for other reasons.

Private OT when the Community Health Service was terminated due to a system change that required focus on younger children and early intervention. Could not afford it as already paying for private speech pathology (Consumer 4, Inner Southern)

Another issue in waiting lists was that if the child was receiving one service and then was found to need another, they usually had to join a waiting list for that service eg a few parents reported their child was receiving speech therapy and was on the waiting list for psychology.

Referrals and collaboration

Workers and managers were able to identify a long list of other agencies, services and individuals with whom they had contact in the course of carrying out ECD work. These included other health workers both from within their agency and outside. Other health services included hospitals, Child and Youth Health, and mental health services. Intersectoral involvement included disability services eg Autism SA, Disability SA, Families SA, child protection services, local and non-government welfare services and education services especially kindergartens, childcare centres and schools.

"We get referrals to EDS from CYH nurses (from developmental checks) and kindys. About 40% are self-referrals and the rest are from GPs, Paediatricians and FMC. We send brochures to CYH, DECS and childcare centres." (Focus group, Inner Southern)

Referral to another service was sometimes inhibited by long waiting lists for that service. There were also other barriers identified including the fact that the primary health services were treated as external referrals for FMC ECD services and consumers referred there had to go on to a paediatric waiting list. This meant that for services such as physiotherapy which primary health is unable to provide, there is a long wait.

> *"I think the link with FMC is not as strong due to funding constraints which meant they changed their criteria for acceptance and now will only accept referrals for children needing OT services via the CAT team or Paediatric clinic." (Manager, Outer south area)*

> *"We used to be able to refer people there (FMC) but now we can't as people have to go through paediatrics and that's a huge waiting list- I think too they are cross that we no longer see 4 year olds and that there was not enough consultation on both sides about that." (Focus group, Woodcroft/Seaford).*

Consumer perspectives

One of the questions asked in phone interviews with consumers was whether they had been referred to other agencies by the primary health service. This varied according to whether there appeared to be additional needs that could be met by other services. Many consumers also identified that they had been referred to the ECD team by another service, most often CYH, EDSS in the case of Inner Southern and GPs or Paediatricians. In some cases, consumers triaged as being low priority were referred to private practitioners such as speech pathologists.

> *Yes. Private Speech Therapy was suggested and they took this up for 10 weeks. Individual Therapy led to a big improvement. At the end of 10 weeks he could understand concepts like on, under, in, out (Consumer 6, Inner Southern)*

On the other hand, one consumer was advised not to pursue private therapy while waiting for ECD services and another was concerned that her child was not appropriately diagnosed or referred:

> *"CYH suggested private speech therapy but when the mother contacted Noarlunga they advised her to wait as Therapists utilised different approaches and it is sometimes confusing for the child" (Consumer 6, Noarlunga)*

> *"He has now been to a paediatrician and been diagnosed with Autism. As Autism SA had a 6 months waiting list, the paediatrician referred him to this particular speech therapist… he still has severe speech and language difficulties but Noarlunga did not 'see it'." (Consumer 7, Noarlunga)*

The most common referral reported was to kindergarten for early admission or pre-entry, often to enable the child to access speech pathology offered through DECS. A few children had also been referred to speech and language programs offered at some kindergartens. Referral for hearing tests and to disability support organisations were also mentioned in a couple of cases.

> *Referred for a hearing test at that time and, more recently, for early entry to Kindy. They are also applying for enrolment in the Kindy Speech and Language program. (Consumer 2, Noarlunga)*

In some cases, parents followed up extras services themselves:

> *The mother independently accessed another program in which staff bring toys and books to the house and play with the children. It is located in the same building as the Playgroup. They bring flash cards for words and bubbles to strengthen the muscles in the mouth. This worker tried to liaise with Noarlunga to get some advice as to what else she could be doing but nothing different was suggested (Consumer 12, Noarlunga)*

A number of other consumers interviewed mentioned being involved with this program known as "Early Start".

Models of practice

> *Different models are used and there is no consistent approach around services and interventions- there are strong camps in terms of how services are delivered and there needs to be clarification and clear processes around change which some people find hard to do- how do we move forward? Also needs to be clarity around resources, models and who is doing what work.* (Worker, FMC)

No cohesive vision for a model of ECD services currently exists and all parties acknowledge this. Differing models of practice have evolved in response to a number of factors: dissatisfaction with existing models; contact with new models through professional development activities; championing of models by professionals; responses to local factors; attempts to better meet the apparent needs of children and families; positive outcomes from particular ways of working to name some.

> *We're trying a triaging process as of next year",*
> *"we need to make it appropriate to our service…"*
> *"…because we have a different system, it needs to be tailored. The models of service do determine priorities to some extent." (Focus group, Inner Southern).*

> *Sometimes the models that have evolved across sites in the region are simply due to someone doing a certain type of training /professional development. That's the extent of the robustness." (Worker, FMC)*

"There is good evidence (for the Kent Hoffman COS model). At least that's what they told us at the training. I'm not sure how it got into the service though." (Focus Group, Woodcroft/ Seaford)

"We kept being exposed to the model (COS) and so it occurred gradually."
"It makes sense and feels good to work in this model." (Focus Group, Woodcroft/Seaford)

"It's too behavioural (PPP). We looked at that model closely, but a behavioural model already wasn't working for us." (Focus group Woodcroft/Seaford)

"The shift was also informed by what parents wanted. That is, parent support. But we still didn't have the solution to fix the big problems, which is how we arrived at using attachment models and interventions."
"It was starting to feel unethical to keep giving parents strategies that we knew they couldn't do. " (Focus group, Noarlunga)

"Attachment work has been driven by SP and OT. Individuals saw that model as advantageous and advocated for it." (Manager, Outer south area)

The Outer South have integrated attachment based models of therapy including use of the Circle of Security (COS) model developed by Cooper, Hoffman, Marvin and Powell into their work with families and expressed strong support for this model[1]. ECD workers reported high levels of commitment to this way of working, felt that it allowed them to address the antecedents of developmental problems, was effective and believed the intervention to be evidence-based (see discussion re evidence p38).

"There's a concern we won't be able to continue with this model of COS and 'attachment', as we've spent such a long time developing it, and put a lot of resources into it." (Focus Group, Noarlunga)

The Inner South and FMC workers felt that aspects of their model of practice were effective and should be retained.

"We see kids who need a multi-d/paed input and for those families we are a one-stop shop. We also have some specialised areas eg cleft palate, failure to thrive, feeding issues etc." (Worker, FMC)

"The work that is done is well grounded in current practice and evidence and the staff are dedicated and committed. We have a three month waiting list for services which I think is pretty good." (Manager, Inner Southern)

"We get good outcomes for families." (Focus group, Inner Southern)

[1] See the model developers website http://www.circleofsecurity.org/ for more information

Inner south workers have had less exposure to the Circle of Security model but are willing to integrate this model as part of their practice given reflection and evaluation of its efficacy. There were also plans to introduce attachment based models of therapy including use of the Circle of Security model developed by Cooper, Hoffman, Marvin and Powell to the inner south as part of the Vulnerable Infants Program. Other regional partners also supported a mix of services.

> *"Circle of Security is part of the vulnerable infant program so there will be collaborative training for a COS trial here." (Focus group, Inner Southern)*

> *"...we are hoping to validate the models needed and see where they fit on the continuum- I'm sure there is a place for all as each have their different strengths." (Manager, Inner Southern)*

> *"We value a development model and a relationship based model." (Focus group, Inner Southern)*

> *"Both an EDSS model and an attachment model of service delivery have utility depending on the role of the service. It's really a philosophical difference but it could work on a practical level (to have parallel type services)." (Worker, FMC)*

Some respondents expressed concerns regarding the dominance of the attachment model and the costs involved.

> *"(There is a) concern re pathologising people who otherwise wouldn't have been- it takes up a lot of time and it's costly, pay an external supervisor $20000 per year, this needs to be justified." (Manager, Outer south area)*

> *"I'm concerned that individual services have become less likely and that there is a lack of balance with a massive push toward family supports at the expense of therapy. There needs to be a balance." (Worker, FMC)*

> *"All of the HODs came from Noarlunga and therefore have a push for COS/attachment models. We feel a bit swamped by numbers within the region in this respect." (Focus group, Inner Southern)*

> *"Historically we have used a developmental management approach and it is increasingly the case that staff are using attachment theory. There is some concern here that this model will overshadow the other work.*
> *(Manager, Inner south area)*

Discussion

Frameworks for discussion

In their 2006 Business plan, SAHS Population and Primary Health branch identified that Southern Primary health services outlined a number of criteria for planning decisions made in service delivery areas, two of which: early development and vulnerable infants, are the province of ECD services. These criteria include the following:

- Balanced response across the continuum (Ottawa charter strategies, well population through to those with established illness and individualized service through to community development).
- Need
- Effectiveness,
- Equity of Access
- Cost efficiency
- Sustainability
- Builds resilience
- Builds partnerships towards integration.
- Multidisciplinary teamwork

Additionally, planning assumptions are outlined in the SAHS PPH business plan:

- Sound evidence base: based on needs analysis and demonstrated program effectiveness, to ensure most effective interventions
- Primary health care approach explicit: decisions are made as close as possible to the community, consumer and community participation and collaborations need to be built into planning
- Evaluation is built in as part of planning.

In addition to the feedback on current services we have posed five questions that relate to the SAHS PPH business plan and the frameworks agreed by the PAG in order to organise the project data and discussion in a manner that can inform policy and practice:

1. What does the evidence tell us?
2. What are current understandings of good practice in early childhood services?
3. How does current practice relate to accepted understandings of good practice in primary health care?
4. How does current practice relate to strategies outlined in the Ottawa Charter?
5. What is the distribution and balance of services from the individual to population level?

What does the evidence tell us?

Early childhood research

A focus on the early years of life in policy and practice has emerged from evidence from a range of disciplines as diverse as neurobiology, social science, psychology and epidemiology. Research has demonstrated adverse long-term outcomes for children when the quality, safety and nurturing of their early years environment is compromised.

The effects are apparent in a range of domains such as health, education and social outcomes. They are expressed in outcomes such as infant mortality rates, school achievement, mental health, obesity and chronic diseases (Hertzman 2000b). This evidence has caught the attention of policy-makers in a number of countries, including Australia.

The links between early childhood and later outcomes had been made well before the burgeoning recent interest. In the 1840s, Engels noted the links between early life deprivation and adult health and a research history extends back to the 18th century (Krieger 2001). Hertzman (2002) puts the current "rediscovery" of early childhood down to the role of science in the current debate:

> …issues of early child development have begun to be expressed in a credible vocabulary for modern society – the vocabulary of science."

Blair, Stewart-Brown et al (2003) suggest that our current understanding of the links between child and adult health have emerged primarily from three schools of thought with differing research paradigms:

- biological programming; "a biological stimulus (such as an infection or the lack of a key nutrient) at a critical period of development causes a lasting positive or negative effect on health" (p. 155). Research is still emerging in this area and some evidence e.g. The "Barker hypothesis", has been called into question in other studies. Indeed the whole notion of "critical periods" has been the subject of some critique (See for example Bailey 2002).

- socio-economic circumstance; "…exposures to inadequate socio-economic circumstances accumulate over time for three reasons. First, because one such experience predisposes the individual to experience another; second, because each experience has a damaging impact on the individual's resilience to other negative experiences; and third, because social resources and opportunities are constrained by various forms of social stratification and by social resources and opportunities (social patterning)" (p. 164). This paradigm is consistent with current understandings of the social determinants of health, a key platform of the new public health and comprehensive primary health care.

- early care and nurture. "the relationship between babies and their main carer (usually the mother) has a decisive and long-lasting impact on mental health, relationships, and the ability to learn. The 'prime time' for social and emotional development is in the first three years of life. " (p169). Attachment to a primary caregiver provides the basis for physical and emotional development. When the responses of caregivers consistently fail to meet the needs of the child (e.g. in families where neglect or abuse occurs) children may fail to develop a secure attachment relationship. Children who do not experience positive early care and nurturing are at increased risk of a wide range of mental and physical health problems in adulthood (Blair et al). Children with compromised attachment relationships have been found to

The three paradigms, if taken alone, are likely to lead to differing policy and practice responses. How the early childhood research is understood and operationalised in models of practice will have an impact on who provides services, who receives services, the types of services offered, outcomes achieved, allocation of resources etc. Blair and colleagues argue however, that the three schools are not mutually exclusive and in fact it may be through combining the knowledge bases of all three that powerful policy and practice responses will emerge.

From a primary health care perspective a comprehensive service response would be likely to incorporate aspects of all: e.g. programs such as those to ensure adequate and appropriate nutrition in pregnancy and for infants, and childhood immunisation; programs addressing the social determinants of health or influencing factors which mediate the effect of social and economic disadvantage; and programs that support positive parenting and relationships emphasizing the early care and nurture perspective.

The research evidence regarding the important role of the early years supports arguments that prevention and early intervention initiatives at this time are likely to have better outcomes for children and be more cost efficient. Whilst there are strong arguments for investment in the early years it is also clear that children will continue to need investment throughout their development. Appropriate interventions at all stages of the life course have the potential to achieve a shift to a more advantaged life trajectory:

> *…each phase of life appears capable of adding its own protection or disadvantage (Blane 1999)".*

Ongoing investments are likely to be required in order to capitalise on the effects of early years interventions. Brooks-Gunn (2003) suggests it is naïve if not "magical thinking" to expect children will not continue to require help beyond the early years of life. Prevention and early intervention strategies will lessen, but are not likely to remove the need for treatment services.

The notion of cost-savings to be made by investing in early years interventions has proved particularly attractive to policy-makers and is often quoted by early childhood advocates. RAND Corporation work suggests returns can be up to seventeen dollars for every dollar spent on well-designed early intervention programs. The 'seven dollars saved for every dollar spent' finding from the evaluation of the Perry preschool project is widely promoted however, Wise et al (2005) however warn that the generalisability of the Perry finding is not established and few interventions have collected the data necessary to make cost-savings estimates. The characteristics of the programs demonstrating cost-savings (population-based, early childhood education programs, home-visiting programs, family support programs) need to be considered when generalising to other settings or programs.

It is unclear what cost-savings may accrue from other models, and whether evidence from prevention and early intervention programs can be applied to treatment programs for already identified problems.

Clyde Hertzman, an influential early years advocate, (2002, p 3-4) suggests the evidence regarding the importance of the early years of life in determining long term health outcomes leads to five "strategic conclusions for policy makers." In summary these are: (1) an environmental approach rather than simply service provision is required; (2) intersectoral action is required; (3) strategies must be multi-level – family, neighbourhood, community, economy - with strong local leadership; (4) strategies should be universal, and (5) longitudinal data and outcomes must be monitored. He further suggests that a successful early child development strategy must be community-driven. There is considerable resonance between Hertzman's conclusions and the principles of the Ottawa charter which underpin health promotion and primary health care practice.

Early childhood practice

The Centre for Community Child Health (CCCH) based at the Royal Children's Hospital Melbourne (www.rch.org.au/ccch) noted that there is some uncertainty as to how the research regarding the early years translates into their practices and services more broadly. To address this issue CCCH has recently developed eleven "Practice Resources"[2] for professionals working with children and families and for managers making decisions about services for children. They are designed to assist professionals to bridge the gap between research and practice and understand the issues and researched options and strategies available.

The Practice Resources were developed from "the published research, expert advice, and information about innovative and promising practices. An expert committee oversaw the development of the content, and an expert in the field reviewed the content of each resource (Centre for Community Child Health 2006)"

Project data reveals problems with speech and language development account for the majority of presenting problems to SAHS early childhood services. This is in keeping with results from a survey of Victorian community health child health teams (Victorian

[2] Practice Resources cover the following topics:

- Behaviour
- Breastfeeding
- Child and adolescent smoking
- Eating behaviour
- Injury
- Language
- Literacy
- Overweight and obesity
- Passive smoking effects on children
- Settling and sleep
- Smoking during pregnancy

Government Department of Human Services 2006). For this reason the Language Problems: Practice Resource is discussed here briefly as an example.

The 'Language Problems Practice Resource' notes there are currently no universal guidelines on interventions for pre-school children with speech and language delay. On the basis of intervention studies the resource provides the following recommendations:

Intervention focus	Recommended intervention	Effectiveness*
For expressive language delay involving vocabulary	Parent-administered programs (indirect treatment), that is programs in which a parent or carer is trained to use modelling and respond to a child's focus of attention in the child's natural environment are found to be at least as effective as programs using direct treatment by a clinician (for example a speech pathologist) delivering either structured individual or group therapy.	✳✳✳
For expressive language delay involving syntax	Parent-administered programs (indirect treatment), that is programs where a parent or carer is trained to use modelling and respond to a child's focus of attention in the child's natural environment, are found to be at least as effective as programs using direct treatment by a clinician (for example a speech pathologist) delivering either structured individual or group therapy.	✳✳
Receptive language delay	Parent-administered programs (indirect treatment), that is programs where a parent or carer is trained to use modelling and respond to a child's focus of attention within a child's natural environment, appear to be at least as effective as direct treatment for children with receptive language difficulties. However, *this finding is based on very limited number of studies.*	✳

Guide to recommendation of effectiveness category

Level of evidence	Effectiveness	Key
Strong to good evidence	Beneficial	✳✳✳
	Not beneficial	×××
Fair level of evidence	May be beneficial	✳✳
	May not be beneficial	××
Requires more studies	May be beneficial (promising)	✳
	May not be beneficial (not likely)	×
	Unknown benefits	?

Source: CCCH (2006) Language Problems: Practice Resource (p32-33)

The number of intervention studies used in production of the resource is small. Our own literature searches confirmed that whilst there is a strong literature on speech and language development, problems and therapy in early childhood, evidence regarding the effectiveness of specific interventions appears confined to a small number of studies. CCCH, having also ensured experience from the field supplemented research evidence and informed the development of the resources, would appear to have provided a useful resource regarding the evidence for language interventions.

Some of the characteristics of practice described in the "what works?" section of the resource can be found in the models operating at all sites.

Attachment based therapy

It is in the early years of life, particularly the first year of life, that attachment to a caregiver is formed. When the responses of caregivers consistently fail to meet the needs of the child, children may fail to develop a secure attachment relationship. Children who do not experience positive early care and nurturing are at increased risk of a wide range of mental and physical health problems. Attachment-based therapies seek to promote parental sensitivity and secure parent-child attachment and prevent psychopathology which may emerge as a result of disorganised attachment.

A key feature of interventions at Noarlunga, Woodcroft and Seaford is the integration of attachment based therapy in individual and group work. In particular the 'Circle of Security' (COS) model – an attachment based intervention – underpinned the early childhood work at these sites. The practitioners clearly saw significant benefits for children and their families from the use of this model and referred to a sound evidence base for this model of practice.

We were unable to source evidence on the effectiveness of the COS model. The COS approach is based on a history of research regarding attachment theory but our scan of the literature has not revealed an evaluation of efficacy of the COS intervention. The Circle of Security project program website lists three publications: one peer reviewed journal article (Marvin, Cooper et al. 2002) and two chapters appearing in *Enhancing Early Attachments* (Berlin, Ziv et al. 2005). No further publications were found on databases (e.g. Ovid) searches. The journal article provides a rationale for the program, a description of the protocol and presents a case study of a 28 month old girl. The conclusion notes that further data-collection and analysis is underway to assess outcomes for the 75 dyads that completed the protocol, whether community-based therapists are successfully able to carry out the protocol and whether it is "fiscally efficient". In *Enhancing Early Attachments* Chapter 2 discusses a pilot research project exploring precursors to individual differences in infant attachment and implications for further research; Chapter 6 describes the COS approach, principles and procedures. As both the article and book chapters make mention of further research it is possible that such research is forthcoming.

It is important here, to draw a distinction between an evidence base that provides a rationale for an intervention (this is why we believe this intervention will produce these results) and evidence regarding the effectiveness of an intervention (these are the results of this intervention). The evidence for the COS appears to be that of providing a premise and rationale for the model rather than evidence regarding the effectiveness of the COS intervention itself.

The scan of the literature undertaken for this project suggests two meta-analyses on attachment based interventions have been undertaken, one in 1995 (van IJzendoorn, Juffer et al.) and the more recently in 2003 (Bakermans-Kranenburg, van IJzendoorn et al.). The research evidence suggests that brief, highly targeted interventions are likely to be effective. Benoit (2005)summarises the characteristics of the most effective attachment-based interventions (ie comparing different types of attachment based therapy) to improve parent sensitivity and promote secure infant-caregiver attachment:

1) a clear and exclusive focus on behavioural training for parent sensitivity rather than a focus on sensitivity plus support, or a focus on sensitivity plus support plus internal representations (e.g. individual therapy);
2) the use of video feedback;
3) fewer than five sessions (fewer than five sessions were as effective as five
4) to 16 sessions, and 16 sessions or more were least effective);
5) a later start, i.e. after the infant is six months or older (rather than during pregnancy or before age six months); and
6) were conducted by non-professionals.
7) In addition, the intervention site (home versus office) and the presence of multiple risk factors did not affect efficacy, but interventions conducted with clinically referred patients/clients and those that included fathers were more effective than interventions without such characteristics. (p?)

Despite these findings a number of questions regarding the effectiveness of attachment-based therapy remain a matter of debate (see for example, Encyclopaedia on Early Childhood Development: Attachment http://www.excellence-earlychildhood.ca/theme.asp?id=30&lang=EN#). Bakermans-Kranenburg, van IJzendoorn et al. (2003) state that the evidence demonstrates the most effective interventions are those that use a moderate amount of interventions and have a clear behavioural focus whether or not the families involved have multiple problems. However evidence is also cited by Hennighausen and Lyons-Ruth (2005) that suggests longer-term, home-based interventions are required for "more clinically impaired populations[3]" exhibiting disorganized attachment. Zeanah And Shah (2005) suggest the implications for practice may be:

> *…from a health promotion perspective (promoting secure attachments), shorter and more focused interventions may be preferable, but from a risk-reduction perspective (reducing disorganized attachment), longer and more intensive interventions may be necessary (p 4).*

[3] In terms of attachment

The scan of literature undertaken for this project did not reveal evidence for specific developmental outcomes as a result of attachment-based intervention. Attachment theory argues that secure attachment relationships "set the stage" for language development (Grossman and Grossman 2005) and other developmental behavioural milestones (Centre for Community Child Health 2006). This could provide a rationale for attachment based therapy as a preventive response to developmental delay in areas such as language as well as its integration into other developmental interventions. We did not find evidence on the use of, or effectiveness of attachment-based therapy as an intervention for speech and language or other physical development problems per se.

The CCCH "Behaviour problems: Practice Resource" notes the important role of attachment in preventing behaviour problems:

> *Parents, particularly mothers, who are emotionally available, sensitive, perceptive and effective at meeting the needs of their child are likely to have securely attached infants who are more likely to meet important behavioural milestones as they get older (p25).*

Attachment theory is not without critics and in particular there are many feminist critiques (see for example Gourash and other contributors Vol. 9 Issue 1, *Feminism and Psychology*). Gourash (1999) argues it is possible to examine attachment through broader perspectives than an emphasis on infants and maternal behaviour. She concludes

> …the study of attachment requires a greater emphasis on multiple, systemic and dynamic aspects of attachment theory and the recognition of culture and social structure as important to interpersonal functioning across the life span (p49)

Implications for SAHS?

- Different models of practice have emerged in part due to groups proceeding from differing theoretical schools of thought. The theory and assumptions underpinning attachment based therapy differ from the theories and assumptions underpinning developmental/behavioural therapy. As the assumptions and theories differ so do the activities that stem from them.
- The schools of thought are not necessarily mutually exclusive and a comprehensive primary health care service response would be likely to incorporate aspects of all.
- Practice should be based on evidence for positive outcomes for children and families. As the evidence base appears limited it will not always be possible to draw on research evidence. Where it is not possible to draw on an existing evidence base, practice must be based on explicitly stated values and theories and provide a clear rationale linking practice to desired outcomes (a program logic approach would be useful here). Evaluation of interventions will be required to determine their effectiveness and contribute to the development of a relevant evidence base.

- Although small there is an evidence base that can provide guidance in choosing and developing interventions for specific developmental problems. There is also some evidence regarding the type of attachment based interventions that have proved most effective in promoting attachment. This evidence does not tell us whether the interventions were effective in promoting positive outcomes in other domains e.g. speech and language, motor skills.
- Accessing and applying evidence to policy and practice is complex. Clarity regarding levels of evidence and application of evidence from one context to another is required. ECD practitioners do not always have the time, resources or skills to undertake this task in a busy practice environment.

Good practice in early childhood services

The role of early childhood services across a health portfolio is to provide effective and efficient services that improve outcomes for the whole population, as well as addressing those most in need (Centre for Community Child Health and Institute 2006).

Current understandings of early childhood services suggest they are best provided within an *integrated and tiered service system* (figure 1) that is focused on universal and primary services (Centre for Community Child Health and Institute 2006) cites Fonagy 2001, Homel 2005, Prilleltensky et al 2001, Richardson & Prior 2005b), with integrated secondary and tertiary services.

"To be more effective and efficient, the service system for young children needs to shift its focus from predominantly treatment and targeted services to more universal prevention approaches" (Centre for Community Child Health and Institute 2006)

Equity of service access and engaging and retaining contact with vulnerable and marginalised families is also key aspect of early childhood services regardless of a universal service focus (Centre for Community Child Health and Institute 2006) cites Carbone et al 2004, Hertzman 2002b, Offord 2001).

A key recommended service feature is that there should be a *coherent continuum of services* ((Centre for Community Child Health and Australia 2003) quotes Halpern 2000). That is:

- "Comprehensive services: based on the principle that vulnerable families have multiple needs and that services, individually or in conjunction, should be able to address them;
- Continuous or seamless services from birth to 5 years: based on the principle that there should be no gaps in service from birth to when children enter school, and services to particular families should evolve in relation to their changing support needs;
- Continuum of local services: based on the principle that, at any time, there should be a variety of types of service available to young families."

Core business for early childhood services is also to appropriately coordinate and collaborate with sectors such as education, welfare and other health services at policy and service delivery levels (Centre for Community Child Health and Australia 2003) cites Scott 2001).

These characteristics are clearly in keeping with a primary health care approach to service delivery and aspects of these models have been apparent in primary health care services in SA for some years. Primary health care services (previously known as Community health services) have traditionally provided a range of early childhood services. A review of metropolitan community health services in 2001 noted the following core activities under the heading Early Childhood Development:

- 1:1 services
- Counselling
- Immunisation
- Information and education for parents
- Health promotion
- Interagency coordination
- Early intervention therapy
- Advocacy

Teams made up variously of Speech Pathologists, Occupational therapists, Psychologists, community health nurses and other professions have delivered services to children, often in multi-disciplinary teams which bring together a range of disciplinary skills and knowledge. The expansion of roles across disciplinary boundaries has been evident in a number of teams and is sometimes referred to as interdisciplinary or transdisciplinary practice.

The Victorian DHS Primary Health Branch has recently released *Guidelines for the child health teams in Community Health Services.* This work is occurring in the context of larger scale children's policy development in the Victorian Office for Children including the development of an Outcomes framework and an associated data monitoring system. The guidelines provide aims and objectives, details priorities, target populations and child health team characteristics. The guidelines are relatively broad allowing scope for local responsiveness (indeed they call for community needs identification and participation in local planning processes) but also detail the parameters in which local services are to operate.

Disciplinary roles and ECD teams

Multi-disciplinary teamwork has long been a hallmark of primary health care practice. The recent focus on the early years of life and the move to inter- or transdisciplinary practice with sometimes “blurred boundaries” has raised issues around the roles of early childhood professionals. As already noted there is some uncertainty as to how recent research regarding the early years translates into practice. SAHS ECD workers have been proactive in exploring models of practice in an area without clear guidelines.

Neither OT nor SP Australia has publicly available position statements on the role of each profession in the delivery of early childhood services specifically. More broadly however, OT Australia states that “occupational therapists who work with children look at the relationship between the child, their occupational roles (this includes the tasks they need to perform in self-care, play and at school) and an array of external or environmental factors.“(OT Australia 2006) American authors support this with a position regarding the role of OT in facilitating both the capacity of both child and parent: “occupational therapy in early intervention promotes independent function and adaptive interaction with the environment through the use of age-appropriate, purposeful activity” and “facilitates the occupational performance of parents in coping effectively with the challenges of care giving and family life” (Morroni and Kickman 1986).

Hanft and Rhodes (citing Case-Smith and Hanft & Anzalone) outline the role of occupational therapists specifically in community based early intervention settings, highlighting the importance of a family based approach:
"The key to providing effective occupational therapy services to very young children is to collaborate with family members to select meaningful occupations that will support the physical, cognitive and psychosocial dimensions of a young child's play, self-care, and interaction as a family member and playmate. Therapists address the performance skills and habits that both a child and his or her caregivers need in order to function in every day life"(Hanft and Rhodes 2004).

Whether or not attachment-based therapy is "core business" for specific ECD professionals such as Speech Pathologists and OTs is contested. ECD workers in the Outer South would certainly argue it is and they have significant practice experience to draw on. They also acknowledged that their undergraduate training does not include attachment based therapy – however almost all ECD workers felt their professional training did not equip them well for ECD practice in community-based settings. The Competency-Based Occupational Standards for entry-level Speech Pathologists refer to a "Speech Pathology knowledge base" but it is unclear what the parameters are. In undertaking the scan of the literature a search of *Advances in Speech-Language Pathology*, the main academic publication of the Australian Speech Pathology Association using the key word "attachment" did not reveal any 'hits' – this may be indicative that attachment therapy is not yet considered a mainstream Speech Pathology activity. The same search of the *Australian Occupational Therapy Journal* brought up 32 hits but many had no relevance to attachment therapy for children. This is not to say that attachment therapy is not undertaken by SPs and OTs or is without merit, but it does appear that it is a relatively new area of practice without an extensive disciplinary literature or evidence base.

Cost-efficiency
Without evaluation of the various models and their outcomes it is not possible to determine cost efficiency. The issue of cost in terms of the use of the attachment based model including the COS model, the cost of the current staff mix, models for assessment and treatment and of "intensive therapy" was raised by some participants. In terms of the COS model, it was questioned whether the money required for training and external supervision (the latter being variously quoted by interviewees as $7,500 and $20,000 pa) could be justified without evaluation results showing the efficacy of the model for consumers and if it represented the "best-buy" for the resources expended. Proponents of this model argued for its effectiveness and implied cost efficiency.

Implications for SAHS?
- Good practice in early childhood implies provision of a comprehensive range of integrated services (from individual to population and from universal to targeted)
- SAHS ECD services must be considered in the context of ECD services more generally including those provided by other agencies and sectors

- Good practice principles in ECD services are congruent with primary health care principles
- The notion of a 'seamless service' from birth until school entry is not served by the current age limits on some services.
- Disciplinary roles are the subject of debate. It is unclear what constitutes 'core business' for individual disciplines. Again the type of program logic reasoning which is applied when a strong evidence base is not available would be useful here. Disciplinary and generic ECD roles should be based on evidence for positive outcomes for children and families. As the evidence appears limited, roles should be shaped by explicitly stated values and theories and provide a clear rationale linking practice to desired outcomes. Roles also need to relate to organisational and regional goals. Again evaluation will be required to determine their effectiveness and contribute to the development of a relevant evidence base.
- The role of community based ECD teams would be clarified by the development of clear guidelines regarding the operation of such of teams in the SAHS. The Victorian *Guidelines for the child health teams in Community Health Services* may provide a basis for this (See Attachment 1).

How does current practice relate to accepted understandings of good practice in primary health care?

Primary health care practice is underpinned by key principles such as: consumer and community involvement; collaboration; comprehensive range of services; equity etc

Current ECD practice is discussed in relation to current understandings of good primary health care practice.

Consumer/Community Involvement

The involvement of consumers and/or the community in the planning, delivery and evaluation of primary health care services is seen as a critical part of providing responsive and appropriate services. It also values the expertise of the consumer as service user rather than relying on service providers' knowledge alone. An important dimension in service delivery is the capacity for consumers to give feedback on the services.

Data from the focus groups with ECD workers indicated that this feedback was largely informal and usually collected at the conclusion of a group program. One focus group identified that their introduction of a "parent time" in their group programs was in response to parents identifying that they wanted support from other parents. There was a view expressed that informal feedback was preferred because many consumers would not participate in formal mechanisms. It is also clear from the feedback on allocations of service that the expressed need of a consumer is considered during the intake and assessment process.

It is unclear from the data gathered for this project what other mechanisms for consumer or community participation exist at the various sites and how these may inform the development of ECD services. Given the importance of community participation as a fundamental principle of primary health care it is important that SAHS considers this in future planning and implementation of ECD services.

Collaboration

Collaboration between primary health services and other services is a key component of primary health care (WHO 1978). Collaboration is often seen as a mechanism to produce solutions to often difficult or complex problems (Gray 1989). Collaboration offers the chance for the problem to be viewed by a number of people from various perspectives and innovative solutions offered beyond what an individual person or organization could achieve (Gray 1989; Lasker, Weiss et al. 2001). Collaboration has other benefits including that of increasing knowledge of the partners' activities and in some cases, providing economic efficiencies and avoiding the duplication of effort.

Partners can contribute their own resources, both in-kind and financial, to allow a program a greater depth or reach than might be possible with only one service involved.

Konrad in Pirkis, Herrman et al (2001) identifies a typology of collaboration which shows a hierarchy as follows:

1) Information sharing and communication
2) Co-operation and co-ordination
3) Collaboration using shared activities working to a common goal
4) Consolidation of agencies under a single umbrella organisation with separate entities underneath
5) Integration- one single authority addressing all needs

Whilst workers and managers identifies many agencies that had contact with through ECD work, most of the activities identified by primary health ECD workers and managers as collaborative fall into the first two levels of the Konrad typology shown above: information sharing (including referrals) and co-operation and co-ordination. The form of collaboration most commonly referred to was the giving or receiving of information or referrals.

A few activities also fall under the level of shared activities working to a common goal. These include the Early Development Screening Service run jointly by FMC, Inner Southern Primary Health and Child and Youth Health; supported playgroups; and the Books for Babies initiative.

> *"There are three supported playgroups, CYH and our staff attend. We facilitate and model good relationship responses and answer questions."(Focus group Inner Southern)*

Collaboration between primary health and hospital services was also a concern with a number of respondents citing resources and philosophical differences as barriers to collaboration with the outer south primary health care services in particular:

"I think the link with FMC is not as strong due to funding constraints which meant they changed their criteria for acceptance and now will only take people for services via the CAT team or Paediatric clinic." (Manager, Outer south area)

Both managers and workers in ECD identified that things had become more siloed in recent years due to these factors. The workers and managers also reported low levels of integration between ECD services and work undertaken by adult services in primary health. The exception to this appeared to be in the area of ATSI health where the approach appeared to be that families who presented were supported to deal with a wide range of issues by the specialist Aboriginal health team with reference to other therapists such as Speech and Occupational therapy as required. Aboriginal specific playgroups were also available in the inner and outer south.

Integration of the Micro and Macro or the full spectrum of services

According to Legge et al (1996)primary health care services should address both the immediate "micro" health needs of its population while also looking at the broader "macro" issues including the determinants of health. In the case of ECD services, the individual needs as identified by consumers may or may not concur with those identified by the service providers. Also, the workers and managers are well placed to identify some of the system issues and changes that are needed to improve the health and well-being of young children. A comprehensive primary health care service uses information gained through service provision to tackle the wider issues that affect the health of the population.

There was general acknowledgment that community development work is limited due to time and resource constraints with "talks at kindys" and the "book bank" the main two examples given of community development work. The issue of how to manage the high levels of demand and still be able to tackle macro issues was one that a number of workers and managers commented upon:

"We would like to do more community development, prevention and promotion." (Focus group, Noarlunga)

The focus on micro treatment type issues that was evident from the feedback given by both workers and consumers meant that there was not much attention given to macro or system level issues. Some managers identified that policy level decisions were now made at quite some distance from service providers and that this made it difficult for them to influence system wide issues.(see p19) A lack of time and resources has also meant that workers are not able to address broader determinants of health.

"Resources are targeted to the most vulnerable but where does the whole population approach that looks at supporting children's development in the whole community sit?" (Manager, Outer south area)

Organisational Learning

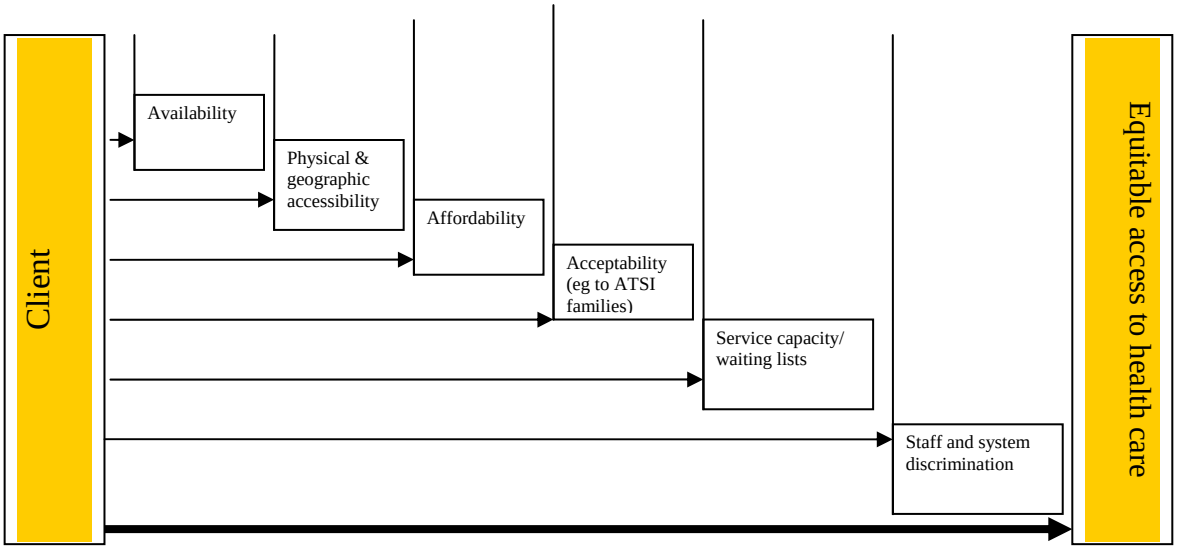
Organisational learning refers to the organizational capacity for learning which contributes to better practice and improved outcomes. Reflective practice, structures, linking research to practice and an investment in training are key features of a learning organization (Legge, Wilson et al. 1996). Improving individual capabilities, a characteristic of learning organisations, emphasises the need for individuals to constantly improve their own proficiencies. Individual learning is however, seen within the context of the team and the organisation more broadly. As Davies and Nutley (2000)note, this discourages professional siloing as it promotes teams rather than individual virtuosity. Training and development should be linked to strategic goals and values through planning and development processes.

The most commonly mentioned organizational learning issue was training and professional development regarding the COS model of attachment therapy. Whilst there was appreciation of organisational support for continuing education there were also concerns expressed that the outer south staff are more resourced for learning than inner south. All staff expressed the view that they lack time for reflection and evaluation of practice.

Equity in health service provision

Equity in health service provision is a key primary health care principle and can be described as follows:
"The principle of equity includes several important elements: ensuring that health care services serving disadvantaged populations are not of poorer quality or less accessible, that the allocation and application of resources are in relation to need and ensuring that positive efforts are made to achieve greater uptake and use of effective services by making extra efforts to reach those whose health is worse." (Acheson 1998).

Access barriers



Equity figured as a concern in both focus groups and interviews but has not always systematically informed the development of services. Whilst we are unable to assess equity of access to ECD services across the southern region a number of issues were raised which relate to the access barriers depicted in the diagram above.

- Availability: identified gaps e.g. the lack of specific disciplines in ECD teams; age limits on services
- Physical and geographic accessibility: transport issues were identified by some consumers; appears to be lack of needs data and analysis to guide distribution of services; historically services have not necessarily been developed on the basis of need.

- Affordability: whilst primary health care services are free of charge private therapy which is suggested as an option to some parents may have an affordability barrier ($80- $100 per session with limits on number of sessions covered by private insurance)
- Acceptability: noted that ATSI families are probably underrepresented in mainstream services and Aboriginal specific programs need further resources and development.
- Service capacity/waiting lists: Limited resources, staff numbers, team composition all impact on the ability to provide equitable and comprehensive services
- Staff and system discrimination: Age limit for services results in gaps and/ or reductions in service for children over four as there is not a seamless transition between primary health care ECD services and other agencies; waiting lists are especially problematic given the relatively short window of opportunity to access services; priority system acts to target those most in need on basis of presenting problem and risk factors but those deemed lower priority may not receive level of service required

Implications for SAHS?

- Good primary health care practice incorporates mechanisms which facilitate community involvement in services from planning through to evaluation.
- There appears to be strong grass roots collaboration around management of individual children and families. Opportunities for higher level collaboration with other agencies towards agreed common goals could be explored.
- Closer collaboration between the various SAHS primary health sites and FMC, and between teams within services would provide a more integrated service for children and their families.
- All ECD teams appear to have a strong focus on treatment services. This may be entirely appropriate provided that at a service level the broader determinants of health are being addressed.
- In order for treatment services to inform community development and policy work, and vice versa, clear channels of communication must be developed.
- Good data collection systems are required in order for treatment services to inform service development as a whole
- Staff development opportunities need to be considered at a regional level and future training and development should be linked to regional and organisational strategic goals and values through planning and development processes. At a practical level this will determine whether future staff development focuses on Circle of Security training or other ECD knowledge and skills areas.
- A number of equity issues were identified by staff and consumers, the most often mentioned being the age limit on services where other service providers were not available.
- Although equity figures as a key concern for many ECD workers and managers, it does not appear to have systematically informed the development

and delivery of ECD services.
- Services which on the face of it appear to be universally accessible to community members often have a number of barriers to equitable uptake of those services. In order to provide as equitable service as possible SAHS needs to consider access barriers to services at a number of different levels:

How does current practice relate to strategies outlined in the Ottawa Charter?

Many managers and staff members identified that the Ottawa Charter was important in guiding how early childhood services (and primary health in general) were planned and delivered.

"We operate under primary health care principles, apply the Ottawa Charter although I'm learning that it's hard to get beyond the 1 to 1 work especially when under-resourced."(Manager, Inner south area)

"As a primary health setting, we look at social justice and the impact of that. I think the Ottawa Charter should be our bible and we should work across the spectrum including influencing policy and advocacy."(Manager, Inner south area).

The Ottawa Charter strategies are as follows:

Ottawa Charter strategies

- Develop personal skills
- Create supportive environments
- Strengthen community action
- Reorient health services
- Build healthy public policy

Although any single practitioner may work within a single strategy, ECD services as a whole should encompass the five Ottawa Charter strategies. It is likely that some staff members are involved in community development work or work at the policy level that was not captured in the interviews and focus groups.

The description of ECD work as predominantly 1 to 1 and group work suggests that most work can be described as "Developing personal skills". The "Creation of supportive environments" was evident in work such as the supported playgroups and the "book bank".

Implications for SAHS

- ECD activities have a strong focus on the 'Development of personal skills'.
- A balance between the strategies is a key component of comprehensive primary health care.
- The Ottawa Charter can be used as a planning framework to ensure all strategies are covered and balanced across the region.

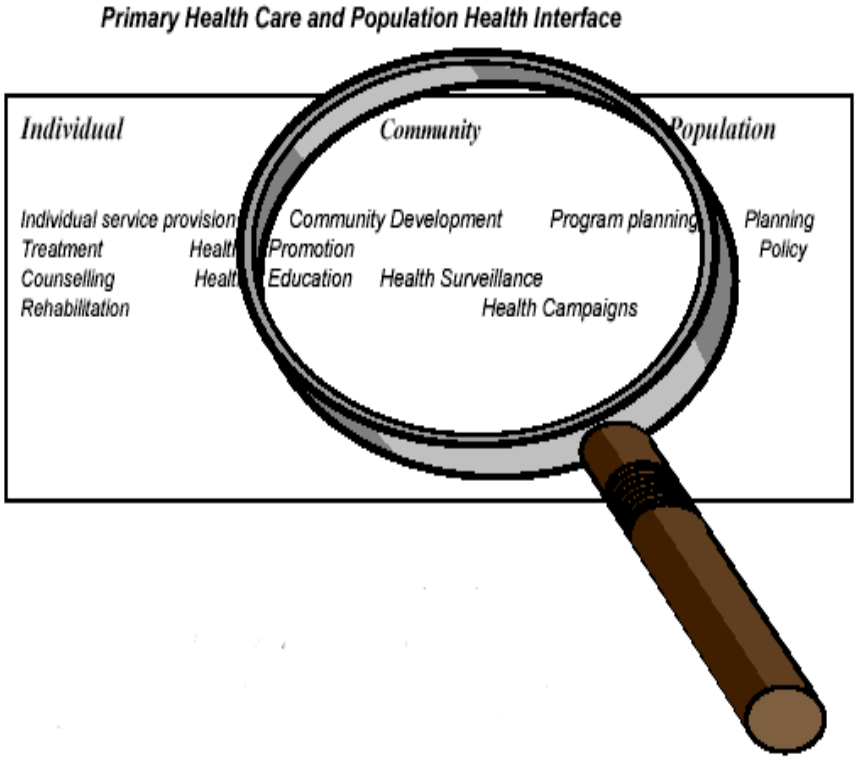
What is the distribution and balance of services from the individual to population level?

Primary health care *activities or functions* can be conceptualized on a continuum which includes direct service delivery for individuals with health problems; early intervention and prevention; health promotion; advocacy; planning, monitoring, regulatory, legislative and institutional action to maintain and improve population health outcomes (Baum, Putland et al. 2002). Some individuals will work at only one point along the continuum and some will undertake a number of activities across the continuum. A comprehensive primary health care service will have a range of activities across the continuum. Striking a balance between activities and functions that focus on the health of populations and those that focus on individuals is often a dilemma for primary health care workers and services.

The main interface between population health and primary health care is represented as the area under the magnifying glass in the figure below. Individual treatment is omitted, although important it is not of itself a population health approach:

> A holistic plan of care for an individual (taking into account the person's physical, social, psychological, economic and spiritual needs) does not constitute a population health approach. On the other hand, planning a service system that would have the capacity to deliver the holistic care plan to a population (or population subgroup) is a population health approach (Health Canada 1998).

High-level policy and planning is also omitted as most community based primary health care practitioners have either only indirect input to this level or are not involved



Source: (Baum, Putland et al. 2002)

On such a continuum SAHS ECD services appear to be clustered toward the individual end of the spectrum. Individual activities can and should inform upstream activities and vice versa. Individual issues are linked with an analysis of the contributing social, economic and political factors. At a practical level this means practitioners need to link demand-driven service provision with the bigger picture *and* link it to action e.g. advocacy, informing other service activities. This requires mechanisms for information sharing between the various points on the continuum, particularly between clinical and community development workers and planning forums. Just as 'downstream' activities should inform and shape 'upstream' activities so should the opposite occur. Looking at health through the "population lens" will raise issues questions about who receives services, the types of services offered, outcomes achieved, allocation of resources etc. A service that is actively engaged with its community, is linked into a range of networks, works cooperatively and collaboratively with other agencies and sectors, will encourage different people to walk through its doors than a less connected service. This will have an impact on demand-driven services. Population health activities such as screening or health promotion campaigns will uncover need which will require a service response.

Adopting a population perspective will lead to the adoption of different strategies and programs than an individual perspective. Changes in population health will not be achieved through individual (or group) service provision. For a primary health care service this provides an enormous challenge in balancing resources between population health approaches and treatment services.

Nosser (Nosser Sept 1998) suggests that an integrated model of healthcare will assist in defining the relationships between the intended purpose of interventions (health promotion versus a response to a health problem) and their target groups (population care versus individual care) and that this will in turn identify regional population health outcomes versus clinical health outcomes. Importantly, Nosser argues that investment in clinical health outcomes does not by default create population health outcomes. This model nests within an *integrated and tiered* early childhood service system as described above, and is useful at a regional level in defining the role of particular services in contributing to population health and/or clinical goals.

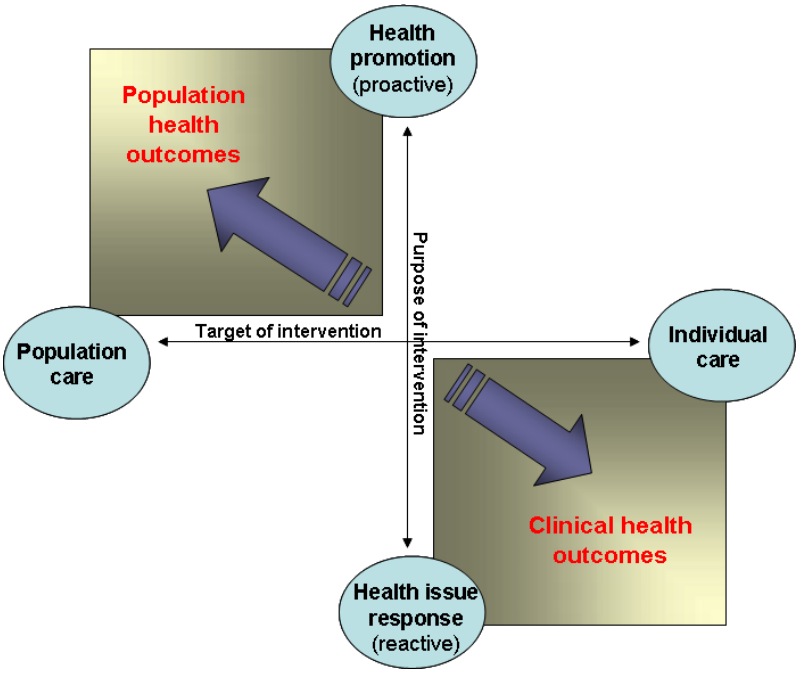


Figure 2: Integrated model of health care with differentiation of health outcomes. Adapted from Nosser,1998 (Nosser Sept 1998).

Lessons from Geoffrey Rose's work also point to issues that arise through targeting resources only to those deemed to be 'high risk'.

- The large number of people at "small risk" generate many more cases than the small number deemed to be at "high risk".
- Whilst we can predict average risk at the population level, our ability to predict which individuals will have adverse health outcomes is poor.

Implications for SAHS?

- SAHS ECD services appear to be clustered at the individual end of the continuum.
- Operating primarily as a demand-driven treatment system will shape ECD services in a particular way. This may not be necessarily be in keeping with broader community needs.
- Mechanisms are required to ensure treatment services inform upstream activities and vice versa.
- Provision of ECD treatment services will have little or no impact on ECD outcomes at a population level. The region and services must develop a balance between interventions aimed at improving population health and those treating individuals with already identified problems.

Recommendations

1. Current models of practice should be described within a program logic framework to ensure :
    a. Practice is based on intervention evidence for positive outcomes for children and families.
    b. Where it is not possible to draw on an existing evidence base (e.g. linking attachment based therapy to specific developmental outcomes such as speech and language), practice must be based on explicitly stated values and theories and provide a clear rationale linking practice to desired outcomes.

    Such an exercise should also ensure common understanding of values, assumptions, practices and impacts of each model.

2. Accessing and applying evidence to policy and practice is complex. A regional commitment and either investment in staff development to undertake such tasks or funding for an external body to do so is required.

3. Regional planning should ensure a comprehensive range of services from individual to population, from universal to targeted. SAHS ECD services must be considered in the context of ECD services more generally including those provided by other agencies and sectors.
4. SAHS ECD should work in collaboration with other agencies/sectors to ensure a 'seamless service' from birth until school entry.

5. There needs to be resolution of what is core business for ECD teams appropriate staffing levels and team composition across the region. The role of community based ECD teams would be clarified by the development of clear guidelines regarding the operation of such of teams in the SAHS. The Victorian *Guidelines for the child health teams in Community Health Services* may provide a basis for this.

6. There needs to be resolution of disciplinary roles within ECD teams. For example whether or not attachment based therapy is "core business" for Speech Pathologists and Occupational Therapists is contested.

7. Community and consumer involvement in planning, implementation and evaluation of services should take a central role in the development of services. Consumer feedback from this project provides a valuable starting point.

8. The relationship between FMC and ECD phc services should be addressed to provide integrated child and family centred services across the region.

9. Clear channels of communication between treatment focussed areas of service and population focussed areas of services must be established and maintained.

10. Staff development opportunities need to be considered at a regional level and future training and development should be linked to regional and organisational strategic goals and values through planning and development processes. At a practical level this will determine whether future staff development focuses on Circle of Security training or other ECD knowledge and skills areas.

11. Equity figures as a key concern for many ECD workers and managers and needs to systematically inform the development and delivery of ECD services. SAHS needs to consider access barriers to services at a number of different levels. This implies an understanding of community needs across the region and will have an impact on distribution, service focus, entry criteria and models of service delivery.

References

Acheson, D (1998) Independent Inquiries into Health Inequities Report

Bailey, D. (2002). "Are critical periods critical for early childhood education? The role of timing in early childhood pedagogy." Early Childhood Reseacrh Quarterly 17: 281- 294.

Bakermans-Kranenburg, M. J., M. H. van IJzendoorn, et al. (2003). "Less is More: Meta-Analyses of sensitivity and attachment interventions in early childhood." Psychological Bulletin 129(2): 195-215.

Barnard, K. (1999). High Risk Families: The Emotionally Unavailable Parent and the Child. The Fragile Early Years: Assessing the Mental Health of Infants and Toddlers. Minneapolis, Minnesota.

Baum, F., C. Putland, et al. (2002). The Primary Health Care Workforce and Population Health Activties: Scope and Potential. Thinking Populations: Population Health and the Primary Health Care Workforce. Adelaide, Public Health Education and Research Program.

Benoit, D. (2005). "Efficacy of attachment-based interventions." Encyclopedia on Early Childhood Development [online] Retrieved Dec, 2005, from http://www.excellenceearlychildhood.ca/documents/Benoit-AttachmentANGxp.pdf.

Berlin, L., Y. Ziv, et al., Eds. (2005). Enhancing Early Attachments, Guilford Press.

Blair, M., S. Stewart-Brown, et al. (2003). Child Public Health. Oxford, Oxford University Press.

Blane, D. (1999). The life course, the social gradient, and health,. Social Determinants of Health. M. Marmot and R. Wilkinson: 64-80.

Brooks-Gunn, J. (2003). "Do you believe in magic? What we can expect from Early Childhood Intervention Programs." Social Policy Report XVII(1): 3-16.

Centre for Community Child Health. (2006). "Behaviour Problems: Practice Resource." 2005.

Centre for Community Child Health. (2006). "Practice Resources CCCH." from http://www.rch.org.au/ccch/research/index.cfm?doc_id=8709.

Centre for Community Child Health, R. C. s. H. M. and G. B. Australia (2003). The Early years project: refocusing community based services for young children and their families: A literature review. R. Rogers and T. Moore. Melbourne, Centre for Community Child Health: 32.

Centre for Community Child Health, R. C. s. H. M. and M. C. R. Institute (2006). Policy Brief: Services for young children and families: an integrated approach. Melbourne. 4: 1-4.

Davies, H. and S. Nutley (2000). "Developing learning organisations in the new NHS." British Medical Journal 320(7240): 998-1001.

English, D. (1994). Risk Assessment: What Do We Know? Findings from Three Research Studies on Children Reported to Child Protective Services. Children in the Shadows: The Fate of Children in Neglecting Families. Proceedings of the Conference Minneapolis, Minnesota.

Erickson, M. F. and B. Egeland (1994). Throwing a Spotlight on the Developmental Outcomes for Children: Findings of a Seventeen-Year Follow-up Study. Children in the Shadows: The Fate of Children in Neglecting Families. Minneapolis, Minnesota.

Gourash, N. (1999). "Securing Attachment Theory's Potential." Feminism And Psychology 9(1): 43-52.

Gray, B. (1989). Collaborating: finding common ground for mulit-party problems. San Francisco, Jossey Bass.

Grossman, K. and K. E. Grossman. (2005). "The impact of attachment to mother and father at an early age on children's psychosocial development through young adulthood." Encyclopaedia on Early Childhood Development (online) Retrieved Nov, 2005.

Hanft, B. and D. Rhodes (2004). "Occupational therapy in community-based early intervention settings." OT Practice 9(1 Suppl): CE-1-CE-8.

Health Canada (1998). Taking Action on Population Health. Ottawa, Ontario, Health Canada.

Hennighausen, K. and K. Lyons-Ruth. (2005). "Disorganisation of attachment strategies in infancy and childhood." Encyclopaedia on Early Childhood Development Retrieved Sept, 2006.

Hertzman, C. (2000b). "The case for an early child development strategy." Isuma: Canadian Journal of Policy Research 1(2): 11-18.

Hertzman, C. (2002). "An early child development strategy for Australia: Lessons from Canada." The Commission for Children and Young People's Issues Paper(1).

Hertzman, C. (2002). An Early Child Development Strategy for Australia? Lessons from Canada, Commission for Children and Young People, Queensland Government.

Krieger, N. (2001). "Historical roots of social epidemiology: socioeconomic gradients in health and contextual analysis." International Journal of Epidemiology 30: 899-903.

Lasker, R., E. Weiss, et al. (2001). "Partnership Synergy: a practical framework for studying and strengthening the collaborative advantage." The Millbank Quarterly 79: 179-205.

Legge, D., G. Wilson, et al. (1996). "Best Practice in primary health care." Australian Journal of Primary Health - Interchange 2 (1): 22-26.

Marvin, R., G. Cooper, et al. (2002). "The Circle of Security project: Attachment-based intervention with caregiver- pre-school dyads." Attachment and Human Development 4(1): 107-124.

Morroni, K. and L. Kickman (1986). "Roles and functions of occupational therapy in early childhood intervention." American Journal of Occupational Therapy 40(12): 835-8.

Nosser, V. (Sept 1998). Integrated model of chilren's health: better definition of health outcomes for children and training requirements for professionals. Training in Child Public Health, Social and Community Paediatrics in Europe, Bordeaux, France, Association for Paediatric Education in Europe.

OT Australia. (2006). "OT Australia Website." from http://www.ausot.com.au/inner.asp?pageid=4#WhatIsOT.

Pirkis, J., H. Herrman, et al. (2001). "Evaluating complex, collaborative programmes: the Partnership Project as a case study." Australian and New Zealand Journal of Psychiatry 35: 639-646.

van IJzendoorn, M. H., F. Juffer, et al. (1995). "Breaking the inter-generational cycle of insecure attachment: A review of the effects of attachment based interventions on maternal sensitivity and infant security." Journal of Child Psychology and Psychiatry 36(2): 225-248.

Victorian Government Department of Human Services (2006). Child health teams in community health. Melbourne, Victoria.

WHO (1978). "Declaration of Alma-Ata." International Conference on Primary Health Care, Alma-Ata, USSR.

Wise, S., L. da Silva, et al. (2005). The efficacy of early childhood interventions. AIFS research Report No. 14. Melbourne, Australian Institute of Family Studies.

Zeanah, C. H. J. and P. Shah. (2005). "Attachment and its impact on child development: Comments on IJzendoorn, Grossman and Grossman, and Henninghausen and Lyons-Ruth." Encyclopedia on Early Childhood Development [online] Retrieved Sept, 2006, from http://www.excellenceearlychildhood.ca/documents/Zeanah-ShahANGxp.pdf.