



Final report:

***The use of Communities for Children programs to
improve the Social Determinants of health
outcomes in Western Adelaide***



Authors:

Dr Yvonne Parry
Flinders University
Faculty of Health Sciences
School of Nursing and Midwifery
Email: yvonne.parry@flinders.edu.au
Phone: 8201 3354

Dr Julian Grant
Flinders University
Faculty of Health Sciences
School of Nursing and Midwifery
Email: julian.grant@flinders.edu.au
Phone: 8201 2126

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Communities for Children



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Introduction

The evaluation of the programs provided by the Communities for Children initiative (CfC) is presented here. This report is divided into five sections. The first section presents the background information on the CfC initiative including an outline of the demographic and epidemiological outcomes for children in the area of focus for this evaluation. Additionally, the introduction outlines some of the theoretical basis for the models of care and the therapeutic models of care that are common in all the programs provided. Subsequent sections provide the therapeutic models of care specific to the particular program provided by the organisation or service. The report also provides a conclusion for each program and a final conclusion for the evaluation research project as a whole.

Background

There are known linkages between child maltreatment and levels of economic and social stress that are generally prevalent in areas of relative disadvantage [1-3]. Accordingly, Communities for Children (CfC) was established in 2004 following a decision by the then Australian Government to establish the 'Stronger Families and Communities Strategy' (2004–08). Communities for Children was one of four streams of the Strategy, with the aim of addressing the risk factors for child abuse and neglect before they escalate, and to help

parents of children at risk to provide a safe, happy and healthy life for their children and thus circumvent the deleterious health, education and welfare outcomes for children at risk.

Underpinned by the social determinants of health [3], the CfC strategy's key feature sought to engage parents and care givers in activities that enhanced their children's development and learning. The CfC program providers have developed activities such as home visiting, early learning and literacy programs, early development of social and communication skills, parenting and family support programs, and child nutrition programs [2, 4, 5]. The CfC is a community based strategy aimed at improving an areas' childhood disadvantage factors through programs that target disadvantaged families living in areas of disadvantage.

UnitingCare Wesley Port Adelaide is the Facilitating Partner of CfC and, as such, acts as a broker in engaging the community in the delivery of children's and parent's programs aimed at enhancing community outcomes [6]. The CfC initiative aimed to improve the coordination of services for children 0-12 years and their families in order to minimise the impact of area-based disadvantage [6]. Further, the initiative aimed to build community capacity to provide appropriate, targeted and enhanced services delivery and improve the community context for children [6]. The whole community approach to improving child development incorporated the needs of the community [6]. This report presents the findings from the evaluation of the following programs:

- Western Perinatal Support Program
- Cultural Community Capacity Building Programs
- Save the Children
- Refugee Community Capacity Builder

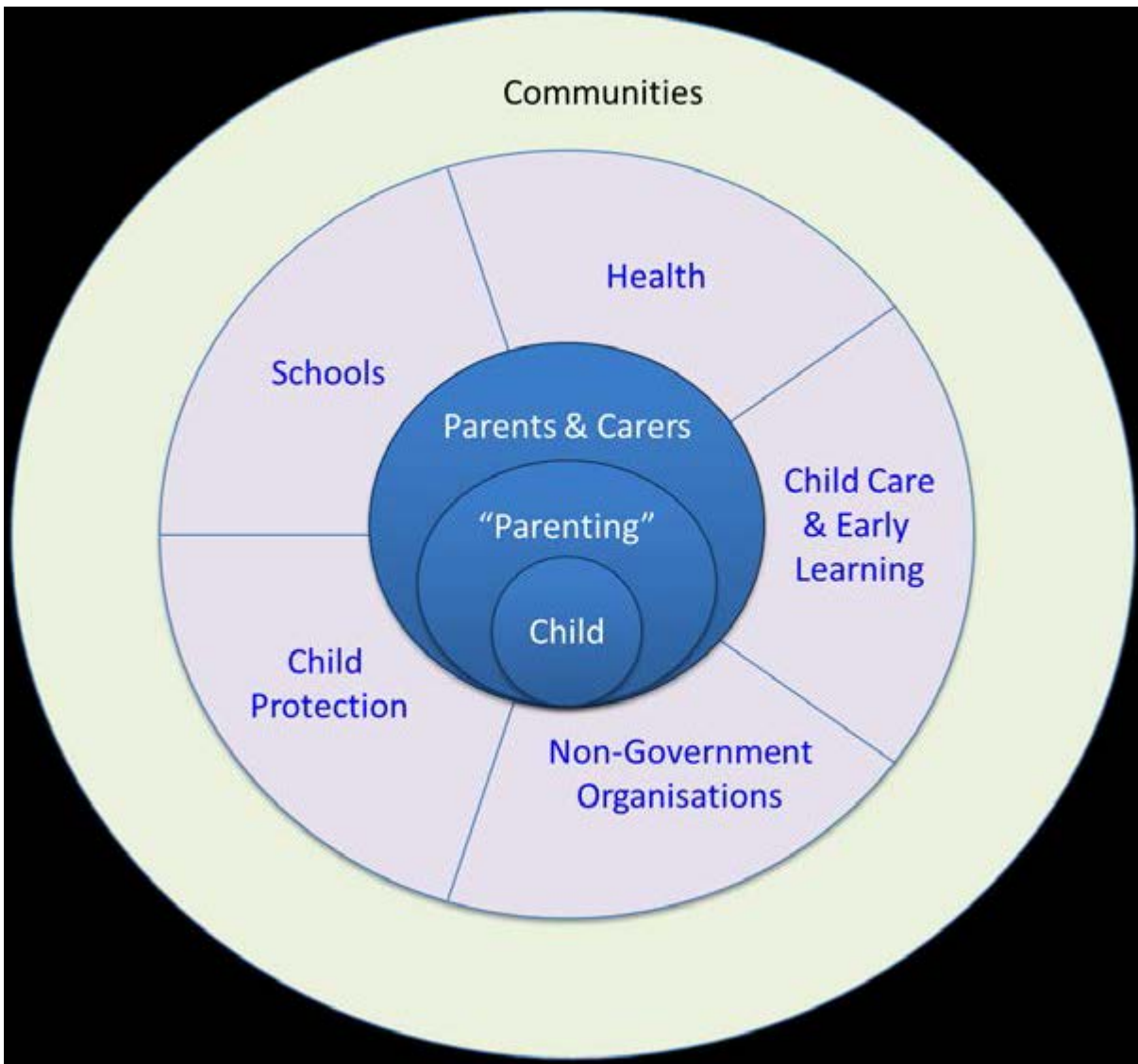
The Western Perinatal Support Program, Save the Children and the Refugee Community Capacity Builder programs are delivered on site at Seaton Central an integrated Child and Family Centre. The centre provides an integrated service delivery approach supporting multiple service providers and a resource for the parents accessing the programs through individual support when the program managers are not available. The majority of programs provided at Seaton Central are based on the targeted relationship framework and interventions.

Theoretical Basis for Program Models

Targeted relationship based programs

Early human development impacts on health, learning, and behaviour throughout life [7]. Programs targeting parents of children at risk aim to decrease the impact of the negative characteristics of some of the Social Determinants of Health (SDH) [8] and address the children's potential level of complex vulnerabilities that accumulate to produce poorer adult health outcomes [8-25]. Of note, the use of parenting programs have been effective in decreasing emotional and behavioural problems in children [26]. This includes children with behavioural conduct disorder, oppositional behaviour, attention-deficit hyperactivity disorder, and anxiety disorders [9, 26]. In addition, there is evidence that investing economically in early childhood programming for children in disadvantaged circumstances has sustained benefits for the community and from a human resources perspective [9, 27-33]. Early Child Development (ECD) research has established that infants and children, who participate in well-conceived ECD programs tend to be more successful learners in primary, secondary and tertiary education, are more competent socially and emotionally, and show higher verbal and intellectual development during early childhood than children not enrolled in high quality programs [7, 9, 19, 30, 33]. Ensuring healthy child development, therefore, is an investment in a country's future workforce and capacity to thrive economically and as a society [33]. Figure 1 below illustrates the interconnections between health, welfare, and the community.

Figure 1 A child centred approach for social support [34].



Supporting children and parents through community based programs is soundly theoretically based as figure 1 is based on the bio-ecological theory of development [34]. The Communities for Children program offered through UnitingCare Wesley Port Adelaide, provides Early Childhood Care and Development and Parenting programs, to target the most vulnerable and disadvantaged members in society, with the goal of reducing risk factors and improving family functioning and wellbeing. An evaluation of whether the programs efficacy is necessary in order to ensure funds have been well spent and to secure continued funding and expansion of such programs.

Social determinants of health (SDH)

The health of children is determined within the context of the environments in which they are born, grow, live, play, and learn [8, 35-37]. A range of determinants have been identified that shape the health of children and families. These education, housing, employment, health access, income, gender and social processes, such as social support and social exclusion and are coined the Social Determinants of Health [8, 35-37]. As such the SDH are the aspects of people lives in which they are born, grow, live, work, and age [3]. This definition incorporates a variety of factors that impact on children and influence their adult health status. The SDH represent a broad array of characteristics that are not biological or genetic but result from the social, physical, and community environments[3].

The social determinants of health (SDH) are recognised as measures of individual and structural characteristics that can be addressed to assist families and communities to move away from vulnerability [3, 8, 38-41]. The concepts that define the SDH enable research into the structural and intermediary influences on health outcomes. Significantly, these concepts provide a means of understanding differences in health outcomes for different population groups [8, 38-42].

Additionally, the Social Determinants of Health (SDH) provides a framework for exploring health inequities against services that provide supported, wrap around, models of care and intervention, which deliver individual support across a broad range of determinants of health through links with community health, education and welfare services. The development of models of care that address health inequities have been shown to deliver a significant improvements (25%) in children's development, behaviour, education, and health outcomes using community based relationship partnerships in the delivery of targeted parenting programs [25]. As the programs provided by CfC promote the community based delivery ethos then using the SDH measurements could also highlight the impact of these programs on the community.

Communities for Children Programs and the Western Adelaide Region

Our clients

The Communities for Children Facilitating Partner programs are funded by the Australian Government Department of Social Services aimed at delivering strong outcomes for Australian families with a focus on early intervention and prevention to provide programs for children aged 0-12 years and their families [2, 43]. [43]. Research shows that children living in poverty are exposed to higher levels of stress and this interferes with their ability to learn and meet developmental milestones [44, 45]. Furthermore, the differences in cognitive ability are evident at aged four [44, 45]. The North West Adelaide Region has been recognised as an area where children experience high rates of developmental vulnerability [46]. There are five measures that outline domains of vulnerability for Australian children in the Australian Early Development Census (AEDC). The five domains are: physical health and wellbeing; social competency; emotional maturity; language and cognitive skills (school based), and, communication skills and general knowledge [46]. In Australia 6.8% of all children aged 0-12 years are assessed as being developmentally vulnerable in one or more domains [46]. In the Western Region of Adelaide 29.1% of children are assessed as developmentally vulnerable in one or more domains and a further 13.9% assessed as developmentally vulnerable on two or more domains [46]. Of significance, is the decrease in the percentage of children assessed as vulnerable during the time the Communities for Children (CfC) programs have been implemented. In 2006, for example, 42.9% of children in the Western Region were assessed as developmentally vulnerable on one or more domains. This has decreased significantly to 29.1% in 2012, a change of -13.8% [46]. Furthermore, the percentage of children assessed as developmentally vulnerable on two or more domains in 2006 was 23.7%, and in 2012 this had decreased significantly to 13.9% a change of -8.7% [46]. While the Western Region of Adelaide is still behind the Australian average of 6.8% [46] however, initiatives such as the CfC programs aim to address children's vulnerability.

Significance of the research

Programs targeting parents of children who are at risk aim to decrease the impact of the SDH and address the children's potential level of complex vulnerabilities that accumulate to produce poorer adult health outcomes [6, 8, 10-15, 47]. Importantly, the use of parenting

programs has effectively decreased emotional and behavioural problems in children [48, 49]. This includes children with behavioural conduct disorder, oppositional behaviour, attention-deficit hyperactivity disorder, and anxiety disorders [48, 49]. In addition, there is evidence that investing economically in early childhood programming for children in disadvantaged circumstances has sustained benefits for the community and from a human resources perspective [1, 48, 49].

The CfC program offered through UnitingCare Wesley Port Adelaide, provides early intervention and prevention programs, to target the most vulnerable and disadvantaged members in society, with the goal of reducing risk factors and improving family functioning and wellbeing. This report details research that aimed to explore the relationship between CfC programs delivered in Western Adelaide and the social determinants of health for the children and families who have used the service. Whilst such programs appear sound from a theoretical perspective, unless there is evidence of the outcomes of the program, the work cannot be validated for continued funding or for wider application. This type of analysis and research provides the bridge between policy objectives and the practice applications of policy. This research provided the next keystone step in examining the broader impact of individually tailored programs

Aim and objectives

The research evaluated the relationship based programs that were delivered to at risk children in Western Adelaide region (2014-2015).

AIM

To explore the relationship between CfC programs delivered in Western Adelaide between 2014 to 2015 and the social determinants of health for the children and families who have used the service.

OBJECTIVES

1. To identify the SDH impacting on the children and families using the service
2. To assess the correlational relationships between the services provided and the extent to which these address the SDH.

3. To develop a set of recommendations that would enhance the programs' capacity to improve the SDH for this population group.

These objectives represent the first step in determining the extent to which the CfC programs impact on the children broader social outcomes.

Ethics

Flinders University's Social and Behavioural Human Research Ethics Committee approved the ethics protocol on the 6th of February 2015 and is valid for three years (SBREC 6719). Subsequent ethics and authorisation was also granted from the Queen Elizabeth Hospital, Research Ethics & Governance Office to analyse previously collected de-identified pre and post Western Perinatal Support Group questionnaires. This was received on the 17th of March 2015 (HREC/14/TQEH/284).

Approach to research

This mixed methods research project was undertaken in two stages. The first stage involved:

1. A literature review to explore the theoretical and evidence bases for the programs provided.
2. Correlational analysis of previous local and national CfC program evaluations and comparison against the SDH identified for the populations using Western Adelaide regional services.
3. Analysis of quantitative data provided by UnitingCare Wesley Port Adelaide to inform the development of interview questions for the second qualitative stage.

Stage two included:

1. A combination of interviews and focus groups with providers, staff, parents and children.
2. Thematic analysis to provide an in-depth understanding of the impact of these programs on several SDH outcomes.

Quantitative Methodology

Data was only analysed quantitatively when data met adequate standards. For example, the quantitative data in the WPSG was of good quality and consistent with international standards on the use of the quantitative collection instrument provided to participants of the program. Further, the analysis performed on the data was consistent with approximate data analyses technique for the data provided [50]. Conversely, quantitative data may lack the depth in information regarding issues that influence choices on many aspects of family life that can be addressed through in-depth interviews or other qualitative approaches. This is addressed by the inclusion of narratives that allow families to express how these SDH impact on their children and families.

For example, aspects of the Edinburgh Postnatal Depression Scale (EDS), and anxiety scores and the information from the in-depth interviews, observation data, and focus groups methods of data collection each informed the use of different types of analysis. These characteristics were explored further in the qualitative data collection process. The qualitative data will inform future survey questions and evaluations. This circular process ensures triangulation and robustness of all data collection and the research process.

The predominant research methodology used in this evaluation is qualitative. However, quantitative data collected by Western Perinatal Support Group staff as part of their program performance analysis and quality improvement of their programs and was fundamentally in the analysis in the first instance as it informed the qualitative data collection. Using this mixed-method approach [51] ensures that this evaluation will be more robust. The inclusion of qualitative data is important as it bridges the current gap in evidence provided by quantitative data.

Qualitative Methodology

The qualitative component of the study was undertaken within a broad framework of critical social theory. This enabled the researchers to consider multiple positions, such as gender, race and poverty as they affect the SDH outcomes of children and families. Importantly, it situates the research as inquiry to inform change.

The subjective nature of qualitative enquiry has a number of relatively stable criticisms. The qualitative researcher selectively collects and analyses data that is not representative [52]. Generalisations are consequently not appropriate. Qualitative enquiry is only appropriate as a research design where an in-depth understanding is required of a group of people who have been purposefully selected [53]. Here the data selected specifically explores the outcomes of the UnitingCare Wesley Port Adelaide programs on the mothers, infants and children's outcomes.

While quantitative data provides a broad understanding of some influences on family circumstance, such as perinatal depression, qualitative data, stories and narratives provide a personal perspective on life and family circumstances. Both sources of information are useful and highlight the influences on how children and families cope with adverse life circumstances and make decisions [52]. Given this, this research employed a mixed method approach.

Data Management and Analysis

All copies of transcripts and any other pertinent qualitative and quantitative data sets are kept in a locked cabinet at Flinders University for seven years and then destroyed to comply with A.F.I. legislation.

Quantitative data analysis used correlations and regression analysis allowed for the relationships between for example, the Edinburgh Postnatal Depression scale data and the anxiety score data to be explored to provide an understanding of the interactions between the variables and explore for changes in these measures occurring during participation in UnitingCare Wesley Port Adelaide CfC programs. The researchers used databases, such as ABS to determine the SDH present in the areas targeted by the CfC programs and establish the SDH as measurable variables. The inclusion of qualitative data is important as it bridges the current gap in evidence provided by quantitative data.

Qualitative data management and analysis were completed in two separate but related steps in a procedure recommended by Patton [53]. The recordings were transcribed verbatim and pseudonyms assigned as the initial step to managing and analysing the data.

Qualitative data was analysed manually. Transcripts were disseminated into their component parts with reference to the original question categories. Respondent selections were separated and colour coded in a procedure outlined by Cavana et al [54]. Care was taken at this point as all data taken at the first instance as relevant and useful. There was a need to carefully identify statements that were made by the participants on issues that were not core to the focus of study, yet remained important, and those statements that were more clearly relevant.

The data was then inductively analysed. Patton [55, p.306] describes inductive analysis as patterns, themes and categories of analysis come from the data; they emerge out of the data rather than being imposed on them prior to data collection and analysis. Themes that emerged from the data were analysed in terms of the constant comparative method as described by Glaser and Strauss [56]. This method requires that themes be examined as they emerge directly from the raw data and compared to each other to ensure they are not different aspects of a previously designated theme [54, 56].

Marshall and Rossman [57] note that an alternate understanding will always exist and the job of the researcher is to argue and reason why the explanation associated with the data is a better explanation than the alternate understanding. Patton [53] warns that researchers are always at risk of being accused of imposing an understanding that reflects the researcher's world better than the world being studied. The search for alternate understandings was considered and one method that could be used was to counter this accusation.

Selection of participants

The use of multiple sources of information and informants enhances the validity and robustness of the findings [58]. Therefore, selecting the participants in the qualitative phase consisted of an evaluation of their provision or use of the programs which then resulted in their inclusion due to their key informant status. Furthermore, the managers of the programs provided important theoretical knowledge and background on program development and implementation.

Interview questions

Questions asked were open ended and simple in structure to elicit the participant's in-depth responses and to obtain responses unconnected with the researchers experience or bias. The interview and focus groups covered several characteristics highlighted by the quantitative evaluation:

- The type of program;
- The usefulness of the program;
- The impact of the program[s] on other aspects of the participants lives (e.g. the SDH);
- Implications for changes;
- Impact on health (mental and physical);

The above considerations were used as a guide for the design of the questions. The initial data collection took place in the westerns region of metropolitan Adelaide South Australia.

Community engagement strategies

A research reference group was established from the various agencies delivering the CfC programs. This enabled the collaborative involvement of the service providers into the research process ensuring the final recommendations are usable. The research reference group verified the variables definitions for stage one and assist in the development of the qualitative questions for stage two interviews.

The researchers analysed the interview responses from staff, parents and children. The analysis was presented to the reference group for consideration and comment. The results of the first two phases informed the development of a set of recommendations for future service delivery of interventions of children at risk and their families. As well as provide a framework for future service evaluations and data collection. These could be used to ensure the effectiveness and viability of the CfC programs using an evidenced based perspective.

This report is divided into four sections with each section reporting on one aspect of the research evaluation. The first section reports on an evaluation of the Western Perinatal Support Program delivered at Seaton Central. The second section reports on an evaluation of the Cultural Community Capacity Builder Programs delivered at St Patrick's School. The

third section evaluating the Save the Children programs delivered through Seaton Central. The final section reports on an evaluation of the Refugee Community Capacity Builder intensive supported playgroup 'Hand in Hand' delivered through Seaton Central.



Section one:

Western Perinatal Support Group (WPSG)

Introduction

This section reports on research with the Western Perinatal Support Group (WPSG); a program coordinated by Communities for Children (CfC). The research explored the relationship between Communities for Children (CfC) programs delivered in Western Adelaide and some of the Social Determinants of Health (SDH) for the children and families who have used the service [8, 25]. Communities for Children (CfC) provide prevention and early intervention approaches to improve outcomes for children (0-12 years old) and families who are considered to be at risk. These programs are sound from a theoretical perspective. The WPSG Post Natal Depression program incorporates fundamental theoretical aspects of care, such as Cognitive Behavioural Therapy, Perinatal Depression and Anxiety therapy, Attachment Theory, the Circle of Security Parenting, along with addressing the broader constructs of the Social Determinants of Health (SDH) such as education, access to services and aspects of service delivery [25]. Further, the Social Determinants of Health (SDH) frameworks provide a means of exploring the impact of social phenomena, for example limited: income, health access, community capacity, and family support, on individual aspects, such as health and wellbeing outcomes. The type of analysis

and research undertaken for this evaluation provides the bridge between policy objectives and the practice applications of policy on SDH outcomes [43].

The WPSG perinatal depression program commenced in 2007 and provides an evidence based prevention and intervention program that uses the Edinburgh Postnatal Depression Scale (EPDS) as a perinatal depression assessment tool [59-63]. The Edinburgh Postnatal Depression Scale (EPDS) enables quantitative analysis of the program due to the use of this world renowned pre and post participant assessment scores and its subsequent treatment and data [59-63]. The positive impact of programs addressing perinatal depression on a mother, infant and child's development is well documented [63-65]. The extent, to which the perinatal depression program meets the aims of reducing mother's depression and anxiety, and the subsequent, child developmental issues, isolation, and negative community outcomes, is evaluated by this research project through analysis of the EPDS data, and focus group and interview data.

The Communities for Children WPSG perinatal depression and anxiety program is auspiced by the Queen Elizabeth Hospital (QEH) is a unique and important program as it provides coordinated responses to the number of health challenges faced by mothers with perinatal depression and anxiety. The program responds to, and manages the multiple services required to circumvent the mental health impacts involved in perinatal depression and anxiety [61, 64, 65]. The use of multiple local health, education and social support services is managed by the QEH and Seaton Central staff. This program addresses the detrimental aspects of alternative walk-in episodic care provided by other services that are ineffective in the treatment of perinatal depression [61, 64, 65].

Economic rationale / Social return on investment

The WPSG program provides intensive and comprehensive support for mothers diagnosed with perinatal depression and their children. The combination of the supportive care of the mothers and an intensive playgroup and crèche for their children is vitally important in providing a successful intervention to mitigate the profound negative impacts of perinatal anxiety and depression on parents and children [4, 64-66]. In Australia, perinatal depression affects over 100, 000 new parents, and costs the Australian economy over

\$433.53 million per year in lost productivity [4, 66]. For every \$1 spent in Australia on early intervention programs for perinatal depression there is a \$15 saving [4, 66]. Research has shown that programs that directly address depression, anxiety and attachment for mothers with perinatal depression improve depression and anxiety by 50% [64, 65]. The use of early detection, prevention and intervention programs for parents and children has the potential to save public expenditure.

Theoretical Basis for the Program Model

Literature review

Edinburgh Postnatal Depression Scale (EPDS)

The Edinburgh Postnatal Depression Scale (EPDS) has been validated to use in pregnancy and postpartum to reliably measure depressive symptoms [59-63]. The EPDS provides concurrent and predictive validity and high test-retest reliability [59, 61]. Further, the EPDS provides a tool that specifically and sensitively measures perinatal depression longitudinally [59, 61]. Thus the EPDS demonstrates reliable, valid and sensitive measure of perinatal depression over time.

The effect of Perinatal Depression on Parental Health and Wellbeing

The adverse impact of perinatal depression on mother, infant and child has been well documented and researched. Maternal physical complications of perinatal depression include: premature birth, surgically assisted births, impaired obstetric outcomes, and obstetric complications [59, 64]. Along with the maternal psychological impacts including: self-harming thoughts, suicidal ideation, and psychosis [59, 64]. Therefore, perinatal depression impacts on the interaction between the infant, mother and family both physically and psychologically. Attending to the needs of the infant is impacted by perinatal depression.

The effects of Perinatal Depression on Early Childhood Development

For infants the consequences of maternal depression include: premature birth, low birth weight, lower Apgar scores, poor weight gain, increased admissions to Neonatal Intensive Care Units, and prolonged irritability [59, 64]. The outcomes for children of mothers with

perinatal depression include ongoing physical, psychological, emotional, social, behavioural, cognitive, and developmental problems [59, 64]. Additionally, the longitudinal consequences of untreated perinatal depression and its impacts compound accumulatively and exponentially for the mothers, infants, children, and families [59, 61, 64, 65]. The aforementioned research illustrates the pathophysiological links between perinatal depression, and maternal, infant, and child outcomes. Importantly universal and effective screening using tools, such as the EDS, identifies perinatal depression in a timely fashion [59, 61]. Further, programs that do not directly address perinatal depression have been shown to be ineffectual and detrimental to the families dealing with perinatal depression [65]. Given the accumulative detrimental impact of perinatal depression on mothers, infants, children, and the family, programs that address perinatal depression have the ability to significantly change deleterious physical, psychological, behavioural and social outcomes for mothers, infants, and children.

Targeted relationship based programs

The WPSG interventions are also based on the targeted relationship based approaches to parenting and family support. As per the discussion in the introduction section of this report, targeted relationship programs recognise the importance of early child development, the social determinants of health and accumulative harm of childhood adversity [8-25]. Targeted relationship based programs have been effective in decreasing emotional and behavioural problems in children [26]. Several behavioural disorders can be addressed using targeted relationship based programs and these include: behavioural conduct disorder, oppositional behaviour, attention-deficit hyperactivity disorder, and anxiety disorders [9, 26].

Therapeutic Models of Care

Western Perinatal Support Group (WPSG)

The Western Adelaide Region has been recognised as an area where the children experience high rates of developmental vulnerability [46]. The Western Perinatal Support Group (WPSG) specifically targets prevention and early intervention for perinatal depression. All pregnant women using the local medical and hospital services are routinely assessed using the Edinburgh Postnatal Depression Scale (EPDS). The EDS score measures the level of perinatal depression in the presenting pregnant woman [59, 61, 64].

Those assessed as having perinatal depression are referred to the WPSG. Mothers can also self-refer.

This program is delivered by speciality perinatal mental health professionals (psychologist and maternal/mental health nurses) and child development specialists (for the supported play group and crèche). This unique early intervention program provides an evidenced based targeted program addressing and preventing the impact of perinatal anxiety and depression on families and children [59, 61, 64, 65]. The WPSG delivers a four part intervention program which consists of:

1. Part 1: The 'Circle of Security Parenting' program
2. Part 2: A Perinatal Depression Therapy Group
3. Part 3: A Supported Playgroup,
 - a. Occurs during the parent's attendance in part 1 and 2 of the program. It also involves instruction for parents on developmental activities and play.
4. Part 4: Home assessment and follow up session.

Each of the components incorporate activities based on validated methods of engagement, group therapy and recovery that have developed over time in consultations with the families receiving the WPSG program. The WPSG uses Mindfulness Therapy, Cognitive Behaviour Therapy, Narrative Therapy, Systemic Therapy, and Solution Focused Brief Therapy. These strategies promote maternal infant attachment and support the reduction of depression and anxiety. Importantly, the program is free at point of use and includes inter-sectoral and inter-professional delivery. The liaison between health, education, and social support services delivered by mental health and child development experts is important to the outcomes of the intervention. The perinatal depression program also includes, community based, 'in-kind' inpatient and parent services, ensuring the safest management and delivery of mental health interventions. This ensures this program provides a cost effective service model. As it brings together long standing effective pre-established pathways of care, networks, and sponsored community supports in an evidence-based practice model of care to address the specific needs of families dealing with perinatal depression and anxiety.

In keeping with evaluative research methods this section of the research project sought to elicit both the quantitative and qualitative perspectives of the broad range of stakeholders impacted by perinatal depression program delivery. The stakeholders included: program managers, mothers, and community staff. This report discusses the findings of this evaluation.

Research Methods used in the WPSG evaluation

Mixed methods research processes are provided in the introductory section of this report. The use of mixed methods here provides a knowledge base that enables deeper understandings of complex factors involved in providing services to children [67]. Additionally, mixed methods research design have the potential to provide an evidence-informed understandings of public policy issues [67]. Furthermore, the concurrent use of mixed methods enabled the quantitative data analysis to complementary collection of the qualitative data and the final use of the qualitative analysis to inform future quantitative data collection [46, 68]. Other sections of this report do not contain the mixed methods evaluation process used here.

The WPSG evaluation used a concurrent mixed methods research project design to explore the use of targeted Mindfulness Therapy, Cognitive Behaviour Therapy, Narrative Therapy, Systemic Therapy, and Solution Focused Brief Therapy along with support and relationship based programs that aim to intervene with perinatal depression. Stage one involved the analysis's of the pre and post Edinburgh Postnatal Depression Scale (EPDS) scores and pre and post anxiety scores. This quantitative data source is from evaluation data already collected by Communities for Children. The quantitative data was analysed using correlational and multiple regression analysis to determine the impact of the EPDS program on the mother's levels of anxiety and depression. This analysis provided insight into the strength and direction of the relationship between variables rather than causal relations. The analysis of the quantitative data performed concomitantly with the qualitative data collection and analysis; interviews and focus groups. Qualitative data included interviews with providers (managers and staff) and focus groups with parents. Data were analysed thematically to provide in-depth understandings of the impact of these programs on the families. These two stages together will provide a broader and deeper understanding of

whether the Communities for Children (CfC) program improved health, education and social outcomes for children and families.

Findings

General information

The methods used in the data collection inform the analysis used in the evaluation. Table one illustrates the types of participants involved in each stage and step of data collection. The table also highlights the method of data collection required for each participant group. The role of the participants indicates their basis for recruitment and where appropriate, their level of involvement in the WPSG program.

Table 1: the type of participants and method of data collection used

Participant Type	Numbers	Basis for Recruitment	Component of Research Involved In (e.g. survey, interview, focus group, observations)
Providers (managers and staff)	4	Responsible for delivery of the CfC programs	Face-to-face interviews and observational information (on behavioural changes in mothers and children)
Mothers	25	Participation in CfC program	Short surveys (pre and post Edinburgh Postnatal Depression Scale (EPDS) and Maternal Postnatal Attachment Scale and the Anxiety Scales). Focus group

The intensive support provided by the CfC WPSG assists families and their children to deal with perinatal depression by using proactive, complete, targeted and inclusive community based program delivery. The results of this research illustrate the importance of this program. The WPSG programs use reliable and validated internationally renowned practices and measurement instrument.

Inclusion and exclusion criteria for the WPSG analysis

In total 612 women had been referred to the WPSG. Of these, 454 mothers were eligible and have completed the WPSG program since 2007. However, of the 454 only 233 had

completed both the EDS pre and post program questionnaires. Therefore, only the participants that had completed both questionnaires had their data included in the quantitative research analysis. Those participants completing one questionnaire, either the pre or post WPSG questionnaires were not included in the data set.

It has established above that the use of multiple sources of information and informants enhances the validity and robustness of the findings [58]. The key informants in the WPSG program were the managers of the programs who provided the theoretical knowledge and background for the program development and implementation. Further, the managers and the staff provided insights via professional and clinical observations (e.g. use of EDS) and assessments of mother's and children's development, emotionally and socially, during the course of the WPSG program. The parents from the WPSG were selected due to their status as participants and also as a source of critical evaluation for the WPSG program.

Quantitative Results

Across the duration of the WPSG program 454 mothers have participated in the WPSG. On average the participants attended 8.16 times. Of the 454, 233 (51%) participants have completed both the pre and post Edinburgh Postnatal Depression Scale (EPDS), questionnaires. The quantitative data collected by the WPSG staff provides the initial descriptive statistical information. The statistical means provide an average and an illustration of the changes that have occurred before and after participation in the WPSG program. The mean (average score) for the 233 participants levels of depression was $\bar{X} = 16.10$ on the pre-program score and the mean following (post) the intervention program was $\bar{X} = 10.95$ which is a change of more than two Standard Deviations (SD). This clearly demonstrates improvement in the level of depression experienced by the parents with the depression score on average 6 points lower following the WPSG. These results are consistent with the international research assessing programs that effectively address perinatal depression [61, 64, 65].

The regression analysis found a positive correlation between attending the WPSG program and the post program depression score using the Edinburgh Postnatal Depression Scale

(EPDS) showed a strong relationship between the two variables $r = 0.582$. Further, this relationship was statically significant with $p < 0.01$, and a $R^2 = 0.339$. Therefore, as the number of times the women attended the program increases, the levels of depression decrease. The relationship between the two variables accounts for 33% of the variance between attendance and depression.

The results found that when comparing the pre EDS intervention score and post EDS intervention score showed a strong relationship between the two variables $r = 0.533$, and a significant difference between the pre and post scores of $p < 0.001$, with a $R^2 = 0.280$. This indicates a strong positive correlation between the two variables with 28.0% of the variance explained by the relationship of these two variables. Therefore the domains measured by the Edinburgh Postnatal Depression Scale (EPDS), score remain consistent over time and a statistically significant change in the pre and post scores with the post score being lower than the pre WPSG program participation score.

The recent introduction in 2012 of the anxiety score and its accompanying program of intervention to the WPSG program resulted in 179 parents completing both the EDS and the anxiety questionnaires. Of the 179 participants also receiving the anxiety program and completing both sets of data, the pre-program mean score was $\bar{X} = 40.94$ and the post intervention program scores was $\bar{X} = 33.69$ and change is of more than one standard deviation (SD). Consequently, participation in the WPSG program is proven to address perinatal depression and anxiety and provides an effective intervention that diminishes depression and anxiety [61, 64, 65].

Moreover, the Maternal Postnatal Attachment Scale questionnaire was introduced at the same time as the as the anxiety scoring questionnaire. The correlational analysis found a positive correlation between attending the WPSG and the Maternal Postnatal Attachment Scale, as the pre intervention score and post intervention scores indicated a strong relationship between the two variables $r = 0.536$, and a significant difference between the pre and post scores of $p < 0.001$, with a $R^2 = 0.339$. This indicates that there was a strong positive correlation between the two variables with 33.0% of the variance explained by the

relationship of these two variables. Therefore 33% of the improvement in the Maternal Postnatal Attachment Scale score could be attributed to attending the WPSG program. However, 67% of the score change may be attributed to other factors.

Qualitative Results

Further, while method of data collection varied as the managers and staff participated in face-to-face interviews and the parents participated in a focus group the fundamental premise of questions regarding the WPSG program remained the same. The themes arising from the interviews and focus group are summarised below.

Themes

There were nine main themes found within the data. As there were a high number of members in the focus group and a small number of interviews, there was some data saturation in certain areas. Interestingly, there did not appear to be much difference in comments between the program staff and managers, and the parents around the effectiveness of these programs in delivering support that addressed aspects of the SDH and changed the participants and their children lives for the better.

Theme 1: Improved care of children

The views presented in this theme have been derived from all participants. That is, the staff and managers, and the parent's views are acknowledged here. In many instances, there were positive comments claiming that the WPSG program had driven changes in their lives that would not have been achievable without the program. Examples included being able to 'attend to' and 'attach to' their children in developmentally meaningful ways which did not happen prior to the parent attending the programs. The comment below reflects a number of staff, managers and parents responses to the WPSG program:

The groups and programs are excellent... they teach you how to bond with your baby ... and how to manage your depression ... help with loads of community support... it's made heaps of difference... the circle of security stuff is really important for children.

I bring my son and daughter too ... the playgroup gives them activities they enjoy and they're learning stuff... it's good for them to interact with other children... with no extended family here children need to interact with other children its important.

We do things like story time... sing songs... make pancakes it helps me understand what children need... for a gold coin donation we couldn't come otherwise. The crèche is absolutely fantastic for all of us... it's the best thing they have here and it's so beneficial for us to know your kids are cared for so well... with the same staff each week... it's important for the kids and us.

Most of the parents discussed their isolation from other families and services and the WPSG program had provided a means for them to connect to others with perinatal depression, supportive staff, other families with children and their community. This enhanced the support the parents and children received. The therapeutic interventions were constructed to alleviate the impacts of perinatal depression and anxiety, and enhance maternal attachment. The playgroup and crèche activities undertaken were purposeful and constructed to meet the children's developmental milestones such as fine and gross motor skills. The playgroup and crèche staff modelled exemplary parenting and attachment behaviours and provided one on one support for parents having difficulties with parenting skills. Further, the interaction in the play group allowed the parents to explore the anxieties around childcare and social interaction, enabling them to successfully transition to work.

Theme 2: Returning to Employment

The views presented in this theme derive from all participants. Thereby, acknowledging the views of the managers, staff and parents. The participants had found the WPSG program provided the encouragement and support needed to return to work or to improve their qualifications to obtain better paying work. In many instances, there were positive comments claiming that the WPSG program 'had driven changes in the mother for the better'. Examples included more confidence to pursue further education. However, there was variance around the benefits depending on who was commenting. For example, the majority of parents had very good working knowledge of the WPSG program and playgroup strategy. The parent's knowledge varied from very little to a great deal, regarding the role of

Communities for Children in facilitating the program. This comment reflects the positive changes to the mother's capacity to engage productively in education and work:

We have women... after attending the program they are better ... more confident and can return to do further study and get a better job or return to work... they couldn't do that without the program.

The groups have given me the confidence to reach out and join other groups and return to study and work.

In this instance, the manager and the parent have highlighted not only the improvement in capacity of the parents to engage meaningfully in education but also confidence to participate in other programs such as tertiary education. Improvement in employment prospects can result in better participation of the mothers in the employment sector improving the family's Social Determinants of Health outcomes.

Theme 3: The Cost Effectiveness of the Program

The views presented in this theme have been derived from the professional delivering the WPSG program. The comments reflect the professional observation that the program was delivered in a cost effective manner. The program provides for larger numbers of mothers than it would be possible to clinically assess and treat individually. Additionally, the method of therapeutic intervention allowed the women to receive support from one another in a purposeful and constructive manner. These aspects are illustrated in the quotation below:

We feel it's cost effective... we have 8-10 women per group and their children... its 2 hours in the group and 1 hour set up time and 1 hour debriefing... To provide that kind of support individually would be over 80 hours per week per staff member.

The cost of untreated perinatal depression are just immense... there's an overwhelming amount of research on the detrimental effects of untreated perinatal depression and anxiety on the mothers, fathers, and children...going on to late adolescents and adulthood and then the trans-generational effects... are enormous and costly to the community and society. This program helps, it saves money in the long term as all these problems caused by depression and anxiety can be addressed early on.

This comment captures that for families dealing with perinatal depression and anxiety the impacts of the maternal, infant and child physical, psychological and social problems are costly. Documented costs of perinatal depression and anxiety on the productive of a national, society and local community are well known. The comments above also illustrate the cost savings for the health system due to the programs effective and efficient use of staffing resources.

Theme 4: Theoretically Based

The views presented in this theme derive from the professionals delivering the WPSG program. The use of sound theories in the programs development is evident in the positive measurable outcomes (discussed in a later theme). The focus of the four key stone activities and interventions based on the Circle of Security, Perinatal Depression Therapy Group work, Supported Playgroup and Home Visiting based on Attachment theory, Cognitive Behavioural Therapy and Solution Based Brief Therapy. The use of theoretically verified interventions believed by the staff to add to the program's success. As is evident in the comment below:

The program focuses on the mother's mental health and attachment theory ... the focus is on the relationship with the child ... mother's journaling ... and the professional staffed crèche. That's why it works ... we work through the theories over the weeks and provide the mothers with strategies that work.

The theme above outline the main objective of the program is to improve the mothers and infants mental health. Achieving this by the use of qualified staff across all areas of service delivery. For example, the use of the psychologist, maternal/mental health nurses, and the professionally trained crèche staff ensure the use of the WPSG theory based program remains sound. There is also a consistency of staff used to provide the programs (as mentioned in theme 1) and this assists with consistent delivery and in building trust with this vulnerable group of mothers, infants and children.

Theme 5: Evidence Based Programs and Participant Change

The use of standardised measurement tools to determine the extent to which there is any change has been outlined above and verified by the quantitative analysis above. The managers, staff and parents positive comments claimed that the WPSG program had

precipitated the change in the participant's mental health and improved their relationship and bonding with their infants and children. This is highlighted in the quotation below:

We provide standardised assessments pre and post... we use psychosocial risk assessments and attachment measurements ... we're improving their [parents] mental health.

In many instances the parents spoke of profound changes and improvements in their ability to function as a parent, mother and spouse. The mothers recognised the importance of the program in changing their interpersonal relationships with their infants, children and families. The mothers identified the role the program had played in improving their attachment with their infant and children. The use of reliable and valid assessment tools has reaffirmed the improvement in the positive outcomes for the participants. This is also evident in the comments below.

Theme 6: Substantial differences after the program

The views presented in this theme have been derived from all participants. That is, the program managers, staff and parents views are acknowledged here. The comments highlight the debilitating nature of perinatal depression and the positive results from participation in the WPSG program:

We had an older mum 34 she was barely functioning... at the time she didn't know if she would survive...she was suicidal... she came to our group and the other women were so supportive ... the group gave her hope that she would recover. This is a common situation with our families.

I was in a bad way but coming here, the other mums, the staff, the crèche workers have all helped ... if it wasn't for them ... it's too frightening to think where I would be.

They help me connect with my baby. I was barely functioning before I didn't want to get up in the morning. Without this group I dread to think where I would be, I have learnt so much, you know, about caring for baby and me.

The managers, staff and parents clearly recognise the outcomes for the mothers, infants and children. In many instances the mothers believed that the WPSG CfC perinatal program had instilled the confidence and support required by the women to assist them not only with parenting but also in other aspects of their lives. As the Social Determinants of Health

impact on a broad range of lived experiences and health outcomes, such as income and education, then this program may change aspects of the SDH impacts. However, this requires further investigation.

Theme 7: Physical Space

The views presented in this theme derive from all participants and reflect the importance of place. The venue is very important to vulnerable populations, such as women with perinatal depression. The mothers who attend WPSG, in the Seaton Central grounds, like the venue. The spaces for the mothers, infants and children are conducive to the types of therapy and activities that are associated with the program and its ultimate success. That is, using a different venue may not accommodate the needs of mothers who are anxious and depressed. The physical space allows the rooms to be used flexibly. Its close locality to a school provides an outside safe space for the children to play and its long distance from a hospital ensures it is viewed as a community setting. This is captured in the comment below:

Yeah it works well being at Seaton Central... women don't want to come here [hospital] with their babies... it's a hospital it's not an appropriate environment... Seaton Central is great there are toys and rooms for the toddlers ... so I tend to do my clinical work down there... there's no stigma attached its part of the community

For the mothers with separation anxiety issues the flexibility of the space allowed them to manage their fears in a productive manner. The mothers also spoke of the stigma attached to having perinatal depression the feelings of being a 'bad mother' and the usefulness of attending Seaton Central in a setting that was community based. Many mothers noted that if the program were provided in a hospital that they would not attend due to the physical environment not being conducive for infants and children and the stigma involved in attending a hospital mental health unit.

Theme 8: Stigma

The views presented in this theme have been derived from all participants. The role of stigma in minimising the ability of mothers, infants, and children to receive the support they need was acknowledged by the managers, staff and parents. Mothers with perinatal depression and anxiety are socially isolated and stigma further excludes mothers from successfully managing their depression and anxiety issues. The participants related that

the Communities for Children programs reduce stigma and provided supportive therapeutic interventions. This is evident in the quotation below:

So I tend to do my clinical work down there... there's no stigma attached its part of the community... the parents can then hook into all the other community services.

You know coming here, you won't be judged, and there are people here who have issues like you do, so you can talk about it, and someone can say hey, I'm feeling like this, and they totally get it. And that includes the workers. I found the facilitators and the child care workers so approachable, they're interested in you and your kids, they love their job and it shows. It feels like a community.

According to the participants the WPSG CfC program provides safe, therapeutic programs that enhance feelings of social and community connections. The professional engagement of the staff with the mothers in a non-judgmental manner also enhances the strategies for overcoming perinatal depression and anxiety. The connections of the program to other community and health based services links the mothers and children into care in a timely fashion.

Theme 9: No Alternative Service

The participants were concerned with the possible cessation of the program. The uniqueness of the program whilst explaining its success is of concern if the program were to cease. The views presented in this theme derive from all participants and is captured in the comment below:

I mean there are just no viable alternative services for these women. The mental health plan and individual sessions would not meet these women or their children's needs. You need specialist trained staff [maternal mental health] in this area... with established links in the community ... this program has that... we are dealing with directly improving health outcomes for the mums, family and children.

We have the program and the staff and we have CaFHNs here too so you know everyone is looking out for you and the baby... we have it all here ... its better ... and if you're having a bad day, the staff notice, and they take you aside, and talk to you one-on-one, and it's a great help. That doesn't happen in other places like the hospital, or GP, they might be good but they just don't get it.

The participants were aware of possible changes to the programs provision and were concerned given the uniqueness and profound (they felt) benefits of this program. The program addresses the needs of this vulnerable population group in a positive and helpful manner that enhances the mothers, infants and children's ability to link with their community in productive ways.

The case study below illustrates a typical profile of the mothers using the WPSG and the outcomes of the WPSG program interventions.

Case study

Case scenario

- 24 year old married mother of first baby referred at 3 weeks post natal by CYWHS nurse with increasing signs of anxiety and depression. Poor attachment to baby. Family history of suicide, referred to WPSG and attended the perinatal depression support group. Her infant now attends the play group. She has also attended Fatherhood evening with her husband he is now more supportive. Improved relationship with her mother since birth of baby. Edinburgh Postnatal Depression Scale score on initial visit was 26/30 (severe depression). Post group 6/30 (nil depression).
- Linked with counsellor, to work through problems, made friends and now attachment with child clearly good loving, caring good eye contact, enjoying playing with him laughing. She has returned to work part time in 2015.

The case study illustrates one woman's journey through perinatal depression. The staff and managers use a variety of processes and therapeutic practices, such as journaling, cognitive behaviour therapy, and attachment theory's, circle of security, to bring about change and decrease the impact of perinatal depression.

Discussion

Irrefutably, perinatal depression and anxiety is associated with negative outcomes for mothers, infant children and families. All of the managers, staff and parents have discussed the Communities for Children WPSG perinatal depression program with a great deal of

positivity. Particularly when questioned on the notion that the mothers and fathers attending the program activities now had a set of strategies which assisted them in supporting their infants and children's development and health. All the participants explained the strategies in detail and the stated how these strategies had improved outcomes for themselves and their families.

For the families dealing with perinatal depression and anxiety the impacts of the maternal, infant and child physical, psychological and social problems are costly. The cost of perinatal depression and anxiety on the productive of a national, society and local community are also well documented. Therefore it is not inconceivable to suggest that the cost savings for the health system and society are effectively offset by the provision of the program.

The qualitative data explored also illustrates that the debilitating impact of the mother's perinatal depression limited access to other services or programs. Therefore, in alignment with the international data, a reduction in the levels of perinatal depression is possible by attending a community base targeted program, such as the WPSG, Communities for Children perinatal depression programs [61, 64, 65].

Additionally, all the participants had described how the WPSG perinatal program had improved the broader aspects of the Social Determinants of Health (SDH). The program had improved access to health services (a SDH). Often mothers on completion of the program pursued higher education (a SDH). Furthermore, mothers with the lower levels of depression and anxiety felt comfortable in returning to employment (a SDH). The families engaged with the local community thus decreasing social isolation (SDH). While the evaluation of the SDH has not been exhaustive in this report further research would explore the impact of the Communities for Children programs on the SDH outcomes.

The managers and staff highlighted the changes for the infants and children attending with the WPSG program with their mothers. Overall the infants and children had become calmer and the incidence of behavioural problems and anxiousness in the children had decreased as the mothers progressed through the program. The intensive supported playgroup and

crèche provided the children with supportive learning environments and activities based on the Early Years Learning Framework, such as language development and enhancing motor and cognitive skills through play, drawing and reading. Additionally, the managers and staff modelled appropriate child engagement behaviours and strategies for the mother and fathers to use at home. Furthermore, the playgroup and crèche staff provided one-on-one sessions for parents who appeared to be distressed or struggling thereby circumventing future parenting problems and providing a strengths based approach to parental skill development.

There was a great deal of discussion on the need for the program to continue. Given the media reports of funding cuts the mothers were quite distressed by the possibility of the program folding. The mothers were very forthcoming in describing the level of disability and incapacity caused by perinatal depression and anxiety and the large levels of improvement they experienced by their participation in the WPSG program. The significant improvement in the decreased levels of perinatal depression and anxiety as an outcome is supported by the quantitative data analysis. The outcome is also maintained by the literature, in particular, the longitudinal studies of Ji et al (2011) and Bowen et al (2014). Both these studies found that the use of EDS effectively measured changes in perinatal depression and the use of appropriate structured prevention and intervention programs, such as the WPSG significantly improve, depression and anxiety outcomes for mothers and their families. Furthermore the research has outlined that only evidence based therapeutic prevention and intervention program circumvents the negative effects of perinatal depression and anxiety for mother, infants and children. The Communities for Children WPSG is one such program.

The CfC WPSG program illustrates the success of a whole community approach to a mental health problem. The use of this theoretically based prevention and intervention program along with the structured educational and developmentally based playgroup and crèche provides the broader family supported needed to address complex mental health problems such as perinatal depression. The use of one type of program or a program lacking in the number of elements used in this program would arguably be unsuccessful. The inclusion of father's sessions is also beneficial as it enhances spousal and family support for the mothers with perinatal depression.

Conclusion

The use of theoretical and therapeutic based protocols is paramount to the success of the WPSG perinatal depression program. The development of the program since 2007 has included the responsiveness of the professional staff required to change the program meet the needs of mothers experiencing perinatal depression. The inclusion of the strategies to address anxiety and the circle of security to address the attachment issues for this group is testament to the willingness of the staff to provide evinced based prevention and intervention for this unique needs group. The attitudes and responsiveness of the managers and staff promote an atmosphere of acceptance and support thereby promoting attendance of this vulnerable population to the WPSG perinatal depression program and ensuring the myriad of positive experiences. The ongoing success of this program relies on the ongoing funding of the CfC initiative.

The importance of prevention and intervention in perinatal depression and anxiety is paramount to the effective circumvention of the negative impacts on mothers, infants and children. Research outlines the importance of evidence based interventions and therapeutic group work and individual sessions. The Communities for Children WPSG program addresses the needs of this vulnerable group using the recommended interventions. The program is cost effective, theory based and therapy and treats mothers, fathers and offspring. The program has been instrumental in alleviating the negative impacts of perinatal depression and anxiety for the mothers involved in this research. There are several recommendations evident from this research and evaluation.

Facilitator Qualifications

Lead Clinician: Bachelor/Degree in any of the following Nursing, Midwifery, Psychology, Social Work, Occupational Therapy, and Counselling. Additional training required - Circle of Security

Clinician Support/Co facilitator:

Knowledge and skills for the roles of Lead Clinical and Clinician Support is essential for implementing the Therapy Group Home Visiting and Circle of Security components of the

program, working with clients experiencing perinatal depression, collaborating with Early Childhood Educators for the Intensive Supported Play group and establishing and maintaining referral pathways.

Specific perinatal training can include but not be limited to workshops on a broad range of evidence based therapies including: Dialectical Behavioural Therapy, Acceptance and Commitment therapy, Mindfulness based Cognitive Behavioural therapy, Cognitive Behavioural Therapy.

Limitations

This research project did not interview the fathers involved in the program and this is a limitation. Further research needs to explore the experiences of fathers in more depth. Also one-on-one interviews would provide a deeper level of understanding into the mothers experiences.





Section two:

Cultural Community Capacity Builder Programs

Introduction

The Cultural Community Capacity Builder programs provide various child and family support initiatives. The Cultural Community Capacity Builder programs are funded by CfC as part of the CfC initiative. The program is auspiced by St Patrick's School which is located in an area of higher than average numbers of the Vietnamese cultural group. It is important to note that the Cultural Community Capacity Builder programs are accessed by a wide variety of people from a broad range of cultural backgrounds including Australian, Asian, African, and European.

Theoretical Basis for Program Model

Literature review

As above in the WPSG section a thorough review of the literature was undertaken, however in order to minimise repetition only new theories and programs are presented here. The staff conducting the programs outlined the theoretical basis and evidence-based practice which informed the development and the implementation of the Cultural Community

Capacity Builder programs. The literature review for the Cultural Community Capacity Builder programs was conducted using the following literature data bases: Google Scholar, CINHAL, PubMed and PsycINFO. The three main theoretical premises for the Cultural Community Capacity Builder programs are Attachment Theory, Circle of Security, and Tune in to Kids are discussed below.

Attachment theory

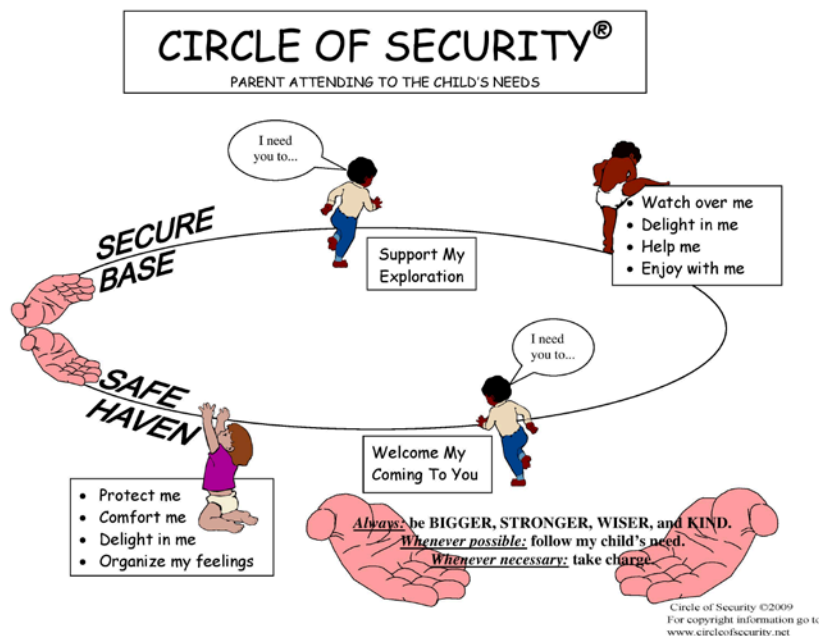
Attachment theory was developed in the 1970s by John Bowlby to explain the carer/child connection in terms of biological and psychological functioning [69]. The theory describes the sensitivity and responsiveness of the parent or caregiver to meet the child's developmental needs as early attachment impacts on lifelong functioning [69-71]. Additionally, the measures used in the attachment assessments illustrate dysfunctional parent or caregiver responses to infants and children [69, 70]. Responses from prolonged separations, either physically or psychologically impact on the child and their subsequent adult functioning and behaviour [69-71]. Longitudinal international research supports the use of attachment theory to predict infant, child and adult outcomes for appropriate parental responses to children's needs and for the development of adults' significant interpersonal relationships [69-71]. Further, attachment theory research explains the cognitive organisation and representations of interpersonal relationships and parenting behaviors [69, 70]. The predicative capacity of the attachment theory measurements provides self-report and professional assessment items that consistently calculate levels of attachment and identify intervention pathways for program implementation [69-71]. Successful interruption of, reactive-attachment disorder, insecure-resistant, insecure-avoidant, or insecure-ambivalent attachment, through target programs is evidence-based and well documented [69, 70]. The CfC programs offered through UnitingCare Wesley Port Adelaide directly address manifestations of interrupted attachment that subsequently decrease levels of vulnerability for children. Working with parents and children using evidenced-based parenting and child in supported play groups and crèche assists in the development of new positive relationships that have lifelong impacts for the children and their families' [69, 70]. Consequently, the UnitingCare Wesley Port Adelaide, Seaton Central organised programs delivered by the Cultural Community Capacity Builder Programs, Save the Children, and the Refugee Community Capacity Builder Hand in Hand program, are collaborative, interdisciplinary, and professional programs that provide an environment that supply

consistency, professional supervision, personal support, and commitment to the development of productive, positive and therapeutic relationships with the parents, caregivers and children using the programs.

Circle of security

The CCCB program delivers a program that includes the circle of security as a theoretical basis for evidence based practice and uses the practical activities provided by the circle of security training. The circle of security is an internationally based early intervention program based on attachment theory and relationship theory [72]. The circle of security is one component of the many relationship based type programs used in the CfC programs as described in the introductory section at the beginning of this report. The circle of security theory explains the importance of secure attachment and relationships for early child development. Acknowledging that child development is ongoing, not linear and dependent on quality caregiver relationships [72, 73]. The theory is based on international academic research which confirms the key role of the use of increased empathy towards children and childhood as well as developing enhanced attachment between parent and child [72, 73].

Figure 2.1 The circle of security: attending to children's need



The figure 2.1 above is used as a basis for the Cultural Community Capacity Builder programs and explains the interactions between child and parent/care giver. The use of diagrams and easy to understand language ensures that the programs are accessible for a variety of parents regardless of their cultural backgrounds.

Tuning in to Kids

The CCCB staff deliver activities for parents and children based on the theoretical underpinning of the 'Tuning in to Kids' program. The Tuning in to Kids intervention is an international program developed in Australia to address emotional competence, emotional socialisation, and emotional regulation in children and adults [74]. The original Tuning in to Kids program evaluation using randomized control trials indicated that children's behavior had significantly improved due to the parental emotional coaching, mentoring, and attunement [74]. Early childhood is an important developmental period for the intersection between children's emotional processing, language, and cognitive augmentation [74]. The evidence-based internationally researched and delivered program provides key skills to infants and children in periods of developmental and social transition, namely, prior to school thereby enhancing the preventive intervention [74]. The program prevents some of the child behavioural problems associated with poor emotional regulation [74]. The Tuning in to Kids program provides activities that are structured around the emotional, social, physical and cognitive engagement with children which is also seen as imperative for normal development and 'school readiness' [75].

It should be noted that all staff engaged in providing the programs offered by the Cultural Community Capacity Builder programs have received training the each of the theoretical areas. Along with the practical application of the theories into activities for children and parents. The structure of the programs provided are updated annually to ensure compliance with the latest research in the areas of attachment theory, circle of security and tuning in to kids. Further, the workers receive ongoing training in the theoretical and practical comments of their work.

Therapeutic Models of Care

Models of service delivery (applying the theories)

The Cultural Community Capacity Builder programs use several models of service delivery. All families attending the Cultural Community Capacity Builder programs can assess the variety of programs designed to enhance children's early development. The goal of the program is to use evidenced-based theories that develop early learning strategies in children, support and identify the assistance that is needed for the family to connect and build a stronger community. This is achieved using the following activities:

- Playgroup (Wednesday and Friday)
- Home visiting
- Family support
- Thursday women's group
- Family play sessions
- Full moon festival
- Parks Playgroup Activity Networks

These activities are based on the theories outlined above and as such provide significant changes and improvements in parenting capacity, children's behaviour and community engagement and participation. This provides services that are holistic and meet the needs of the program participants.

The programs address the needs of socially isolated parents and caregivers, established migrant groups, new arrivals, and refugee families, fathers, mothers and children. The Cultural Community Capacity Builder programs consist of:

- Early Childhood Learning program
- Children's observational assessments
- Children's transition from home to school program
- Enhancing children's development programs
- Individual support
- Linking with the broader community services, such as housing, council services (i.e. public library), centre link and tertiary education providers

The programs are based on sound theoretical premises, for example, targeted relationship based programs, attachment theory, circle of security parenting programs, and tuning into kids. Targeted relationship based programs are described in the introduction. Attachment theory is discussed in the literature review above.

Research methods for the evaluation of the Cultural Community Capacity Building Programs

Stage one of the evaluation of the Cultural Community Capacity Builder programs consisted of a literature review of the theories and service delivery models used in order to determine the evidence base for these aspects of the intervention programs involved. Stage Two included interviews with providers (managers and staff) and focus groups with parents. The collected qualitative data was analysed thematically to provide in-depth understandings of the impact of these programs on the families. These two stages together will provide a broader and deeper understanding of whether the Communities for Children (CfC) initiatives provided by the Cultural Community Capacity Builder programs improved the health, education and social outcomes for children and families.

Research process

The research processes have remained consistent for all the qualitative data collection throughout this research project. The initial research processes, such as inclusion and exclusion criteria, data analysis, participant inclusion etc. have been outlined in the introduction and WPSG sections previously. The Cultural Community Capacity Builder programs are also provided by professional staff with a background in interpersonal relationships, child learning, child development, and parenting programs. The professional knowledge and support ingrained in the programs ensures the interventions within the programs are theoretically sound. The theoretical base and application processes embedded within the programs provides a robust practice consistent with the theoretical underpinnings. The information provided by the key informants adds to the validity and robustness of the programs delivered.

Findings

General information

The methods used in the data collection inform the analysis used in the evaluation. In 2013-2014 a total 119 parents (mothers and fathers) have attended the Cultural Community Capacity Builder programs. Also a total of 138 children attended in 2013-2014. Table 2.1 illustrates the types of participants involved in each stage and step of data collection. The table 2.1 also highlights the method of data collection required for each participant type. The basis for recruitment outlines the role of the participants and implies their level of involvement in the Cultural Community Capacity Builder programs.

Table 2.1: the type of participants and method of data collection used

Participant Type	Numbers	Basis for Recruitment	Component of Research Involved In (e.g. survey, interview, focus group, observations)
Providers (managers and staff)	2	Responsible for delivery of the CfC programs	Face-to-face interviews and observational information (on behavioural changes in fathers, mothers and children)
Fathers and Mothers	22	Participation in CfC program	Focus group which provided insights into the impact of the Cultural Community Capacity Builder programs on their lives and their children's lives.

Table 2.1 above provides an explanation for the type of data collected and the level of involvement of the participants. The information collected outlines the intensive support provided by the Cultural Community Capacity Builder Programs assisting families and their children to deal with social and cultural isolation that often accompanies moving to a new country. The Cultural Community Capacity Builder programs uses proactive, complete, targeted and inclusive community based program delivery. The results of this research illustrate the importance of this program.

Themes

There were a number of main themes found within the data. The interviews and focus group data provided some data saturation. The themes discussed below represent the main

themes. Again there were no differences between the comments made by managers, staff, and parents or caregivers.

Theme 1: Well supported programs building families

The views presented in this theme have been derived from all participants. That is the staff, managers and parents/caregivers views are acknowledged here. In many instances, there were positive comments about the comprehensive nature of the individual support, parenting support and supportive playgroup format. The quotations below reflect English as a second language and a numbers of staff, managers and parents/caregivers responses to participating in the Cultural Community Capacity Builder programs:

I received as many support from Ms HOUNG and Ms CHAU for my children support. I had a problem being English is our second language they supported very well for me. This community services make me more comfortable for relationship and parenting. More comfortable with helping children school.

I strongly recommend the service to other parents with young children because of the welcoming, friendly and endless support environment in which we not only could learn a lot of new things but also help us to manage stress in our life. Help build our family better.

The staff are very helpful and give a supportive service with a friendly and caring environment and staff. There are many different activities for the children's learning and development.

We came to play group ... there is support here like for mothers, the cooking group, fitness group ... and with the play group it is different to other play groups ... it is suitable for families and they provide structure ... routine ... building relationships with the children ... we use the skills learnt here at home.

They build confidence of the mum, and the children feel very comfortable. They get skills for school. They help our family be good and strong.

The Cultural Community Capacity Builder programs delivery modes reflect the holistic and wrap around nature of the individualised service delivery. The parents and children attending the various activities are provided with support that is evidenced base through the use of theoretically sound program models while being individually focused so that nuances of people lives and the care of their children can be incorporated into the program delivery. The theme below illustrates the link between attachment, circle of security and tuning into kids based programs and preparing the children for school.

Theme 2: The programs prepare children for school

The views presented in this theme have been derived from all participants. That is the staff, managers and parents/caregivers views are acknowledged here. All the respondents remarked on the 'school readiness' of the children and given the English as a second language for most of the families attending they believed the relationship building programs and the activities for the parents and children had assisted in boosting their child's development to make them 'school ready'. This is captured in the quotations below:

They build confidence of the mum, and the children feel very comfortable. They get skills for school. They help our family be good and strong.

My son he has no friends, he's only one at home, now he knows children, he has friends, he learns to do things, he reads story. I learn English so I can read to him. He has routine and he's more independent now.

My little one is very shy, and she does not know how to speak and communicated for everything, she has learnt to talk out for herself. so she is happy now and happy at school. This place is not just for children but for the parents they teach you what to do for your children. I have a lot of Vietnamese friends now I've never met any before.

I'm a dad and things are hard but other dads bring their children here. I learn ABC here and numbers, so I can my daughter later she is much better now she can be more independent. If not for here when she went to school she would be no good enough. But we come here and she learns lots of things she is good at school now.

My son has been coming here since he was 8 months old now he is at school. He was clinging, crying all the time, I could not cook because he would cry but we come here he plays with toys, learns things, plays with friends, learn songs now, he is very happy, and wants to go to school he says "School, school, school, I love school" that's the difference if we did not have this program he would not like going to school. And I am confident to say that.

For me, our family, my kid newly adopted to Australia, you know, so I am not familiar with school and everything at all. So for me, and child (3 year old boy), it is important to be familiar with your places and faces, and different people and that play group means so much, so meaningful, because he can familiarise with other people. He feels easier with others now so he will be better at school.

The Cultural Community Capacity Builder programs provide programs that create linkages with the local community, broader community and wider Australia institutions and services such as the schooling system. This is important for isolated members of the community. Additionally, the programs strengthen families due to the theoretical frameworks that are incorporated into service delivery. The programs used also encourages activities with the children that enhances the child's school readiness and improves the parents English reading and writing skills.

Discussion

There were a number of main themes found within the data that are consistent with the themes in the other CfC funded programs evaluated here. Further these findings are consistent with the broader approach to service delivery in the CfC initiative, such as the benefit of the programs to intervene, and provide support. With families noting that without the interventions, the outcomes for themselves, and their children, would be limited, and often negative. The interviews, and focus group data provided data saturation. The importance of providing programs that are targeted and intervene early in the life of the child supports the economic assertions made in the WPSG section of this report.

Further, the changes evident in the parenting behaviour support the use of theoretical bases for the program interventions and program models used. These models and therapeutic

intervention practices are well researched, and established as best practice. The establishment of quantitative measures will enhance the evidence for the positive outcomes delivered by these programs. Therefore, providing the required measurable outcomes for the parents and children.

The use of Attachment Theory, Circle of Security, and Tuning into Kids, ensures that the changes in parents and children are consistent and standardised due to the use of validated and reliable intervention techniques and practices. The use of staff trained to deliver consistent intervention is central to the success of the program.

Furthermore, given the vulnerability of the target populations attending this St Patrick's, the stability of the staff has also enhanced the use of this program. Vulnerable populations can present as difficult to engage, however, the staff have successfully gained the support of the community and the target participants.

Conclusion

There were a number of main themes found within the data. The interviews and focus group data provided some data saturation. The success of the theoretically substantiated and evidence based programs has been enhanced by the delivery of staff well connected with the target population

Facilitators Qualifications

The staff have tertiary qualifications: BAs in Education and Early Childhood Education and have received the relevant training for all the programs being delivered.

Limitations

The research design has provided robust qualitative data and findings. The inclusion of mothers and fathers in the focus group has provided a boarder understanding on the usefulness of the programs reviewed in this section. However, the lack of quantitative data is being addressed through the development of specific evaluation tools. Future research will pilot and evaluate the quantitative instrument designed to measure the change in parents, infants and children attending these programs.





Section three:

Save the Children Programs

The services provided by the Save the Children include the work of family support workers. The families attend the UnitingCare Wesley Port Adelaide, Seaton Central based Intensive Play Scheme address areas of child development vulnerability, for example, those outlined above measured by the Australian Early Development Census (AEDC), such as the development of fine motor skills required for school. Further, Save the Children provides intensive family support for parents. Each family and individual child is assessed and their targeted needs and goals collaboratively determined. The programs used by Save the Children are direct responses to the assessments made by the staff and delivered in a cost effective play group format. This process is similar to the WPSG where mothers are assessed for depression and anxiety, and the targeted interventions are developed and delivered in a group session format.

Unlike the WPSG portion of the research project, the Save the Children program provides case management for individual family based interventions, with family home visits, and attendance at the Intensive Supported Play Scheme. Therefore, a quantitative analysis of

pre and post data is not available. However, in the 8 months since the introduction of this program, mothers, fathers, and grandparents, 26 adults in total, and 33 children have been assisted. Save the Children provided family interventions that directly impact on family functioning by reducing children's vulnerability. As a consequence the data collected included interviews with providers (managers and staff) only at this stage. Further, research involving parent focus groups will be completed in the next round of evaluations in 2016. The collected qualitative data was analysed thematically to provide in-depth understandings of the impact of these programs on the 26 families that participated in the programs from a management and staff perspective. The case study below examines the use of the Australian Early Development Census domains to provide before and after assessments of child development improvements above and beyond the normal developmental changes. The Save the Children Intensive Supported Play Scheme is provided to the children whose parent has a mental illness or another condition that impacts on their capacity to parent effectively. The Save the Children Intensive Play Scheme provides a broader and deeper understanding of whether the Communities for Children (CfC) program improved health, education and social outcomes for children and families.

Theoretical Basis for Program Model

Literature review

Infant-Parent Relationship Measures

The programs used by Save the Children are based on the Infant-Parent Relationship Measurement tools are used during the pre access initial referral stage. The Infant-Parent Relationship Measurements are also used at designated intervals during home visits with the family to determine the level of progress of the Infant-Parent relationship beyond that of normal development [76-78]. As the children and families commence the programs from the position of developmental delay and limited attachment any progression towards normal Infant-Parent attachment is a vast improvement. The Infant-Parent relationship model of intervention is based on Attachment theory (see the Cultural Community Capacity Builder Support Programs section), and relationship theories (see the introduction), and assesses and treats the interaction between the parent and infant, recognising that this interaction is paramount to healthy infant mental health. The evidence based program is endorsed and used by the South Australian state based Mental Health Services (Southern CAMHS) [76, 77]. The Infant-Parent relationship intervention (PIR-GAS), measures the interaction

between the infant and parent, in order to address the risk factors for the development of infant mental health issues [76-78]. The interventions focus on developing a nurturing and sensitive adult-child interaction that is capable of responding to, and meeting, the infants needs [76-78]. The measurement determines the necessity for intervention and the improvement of the relationship post intervention [76-78] (see case study below). The measures used have been validated to determine the international and relationship of 0-18 years with their parents/care giver [76-78].

The PIR-GAS provided clinician-rated, breuty, consistency, objective and are efficient and easy to use measures that identify parental views, parental behaviour over time [76-78]. Further, the PIR-GAS identifies Dyadic Mutuality, Emotional Availability, and Problem Solving activities [76-78]. These measures have a high degree of inter-rater reliability and standardisation [76-78].

Therapeutic Models of Care

Models of service delivery (applying the theories)

The Save the Children Intensive Supported Play Scheme uses several models of service delivery. These models apply several theories of child development and family support. The theories have been outlined in this section, and previous sections of this report. The focus of Save the Children on using validated and tested interventions has assisted in the delivery of reliable programs. The Save the Children use of internationally and national recognised intervention programs ensures the programs deliver sound interventions that are of therapeutic benefit to the children and parents. The interventions consist of:

- Case management
- Therapeutic interventions
- Intensive Play Scheme
- Family Home Visiting
- Specific family focused behavioural interventions e.g. sleep hygiene training, and sleep routines
- Child and parent social competency training
- Nutritional advice
- Referrals

Thus the program is flexible enough to meet the families' and community's needs. The families targeted by this program are 'vulnerable families and those assessed as 'at risk'. The engagement of these families is often difficult, however the staff provide an atmosphere of acceptance and support in the programs.

Economic Rationale / Social Return on Investment

Further, the programs are cost effective as currently 33 children are supported by 3 staff. There is an Early Childhood Educator, Assistant Child Educator and Family Support worker delivering 1.5 hours of family interventions per week, per family. To provide this level of interventions to each family individually would require 5.2 FTE staff and 198 hours per week. The case studies below illustrates the level of support and the types of interventions provided.

Findings

General information

The methods used in the data collection inform the analysis used in the evaluation. Table 3.1 illustrates the types of participants involved in each stage and step of data collection. The table also highlights the method of data collection required for each participant type. The basis for recruitment outlines the role of the participants and implies their level of involvement in the Save the Children Intensive Play Scheme program.

Table 3.1: the type of participants and method of data collection used

Participant Type	Numbers	Basis for Recruitment	Component of Research Involved In (e.g. survey, interview, focus group, observations)
Providers (managers and staff)	2	Responsible for delivery of the CfC programs	Face-to-face interviews and observational information (on behavioural changes in mothers and children)
Parents	2	Participated in the Save the Children programs	Case study
Child assessment	1	Participated in the Save the Children	Case study

Participant Type	Numbers	Basis for Recruitment	Component of Research Involved In (e.g. survey, interview, focus group, observations)
		programs	

The Save the Children Intensive Supported Play Scheme staff were interviewed as per table 3.1 above. The theoretical links discussed during the interviews included attachment theory, and targeted relationship theories are explained in previous sections of this report. However, the PIR-GAS and AEDC measurements of child development used by the Save the Children Intensive Play Scheme are discussed in the section above.

Case study

The following case study was provided by the Save the Children Intensive Play Scheme staff and describes the typical presentation and progress of families using the services. The case study forms a lived experience of a family attending the Save the Children Intensive Play Scheme organised through Seaton Central. The Save the Children program receives referrals from other services, such as the Western Mental Health Service, and provides programs that give support to the referred parents. The case study represents the child's and the family's progress through the programs.

The child- Sally

Sally aged 2.5 years, is the child of young parents in their early 20's, this alone places Sally in the 'at risk' category. A family assessment determined that both parents had mental health issues requiring several crisis mental health interventions. Sally was assessed using the Australian Early Development Census domains, PIR-GAS, and Attachment Theory assessments, and these assessments of Sally found:

- Physical wellbeing
 - Sally would arrive late to the Intensive Play Group
 - Hungry,
 - mother acknowledged she could not afford food
 - the family struggled to pay bills, and
 - afford their necessary medications
 - Tired

- Dressed inappropriately e.g. no shoes or ill-fitting clothes
- Sally was not sleeping more than 4 hours per night
- Language and cognitive skills
 - Below age group average
- Social Competence
 - Sally had difficulty interacting with other children in an age appropriate way
 - Sally had difficulty sustaining eye contact or connections with adults
- Emotional maturity
 - Sally was often restless and impulsive and had difficulty settling into activities
 - Hyperactivity and inattention
 - Sally is easily frustrated and
 - Exhibits aggression
- Communication and general knowledge, and,
 - Poor communication
- Attachment
 - Sally was both resistant and sort comfort from her mother and exhibited disorganised attachment

Sally and her family have limited social support as most extended family members also have mental health issues. The family has been referred to the 'Family by Family' program which provides additional support, mentoring and role modelling for at risk children and their families. Sally's progress during her participation in the Intensive Play Scheme has been remarkable e.g. her language and cognitive skills have accelerated to kindergarten 'advanced' level. This is despite a further deterioration in her parent's mental health and an increase in family instability.

The family

The family consists of a mother, father and child in this case a daughter aged 2.5 years.

- Universal home visit identified postnatal medical problems and mental health issues
- The mother is referred to the Save the Children Intensive Play Scheme by the Mental Health Social Worker and the Mental Health Support Nurse
- Mother diagnosed with Postnatal medical problems
- Father injured at work with a corresponding decrease in family income

- Mother struggling to work part time as a nurse
- Difficulties sleeping (parents and child)
- Difficulties with nutrition (parents)
- Family often ill and lacking in energy to complete routine daily tasks

Program intervention consistent of

- Home visiting (Universal plus Save the Children Intensive Play Scheme)
- WPSG for postnatal depression
- Supported play group (Save the Children Intensive Play Scheme)
- Financial counselling
- Sleep routines (Save the Children Intensive Play Scheme)
- Family support worker (Save the Children Intensive Play Scheme)

This assistance was provided by the organisations listed above who worked collaboratively and in conjunction with each other. This level of support is necessary given the high level of potential risk to the child and ensured the family's strengths are enriched to provide the necessary environment for child raising. The comments and feedback from the family included:

I appreciate your (Save the Children Intensive Play Scheme) support in assisting my family when at times I feel there is no one looking out for me.

You follow up regularly on how my family and I are going and that has meant a lot to me and my husband because we have been in the middle of a very difficult time.

The playgroup is a safe place where I can talk to other parents and K (daughter) loves coming to play.

The child and family in the above case studies illustrate the positive impact and change precipitated by participating in the Save the Children programs. The themes derived from the interviews and case studies is explored in more detail below.

Themes

Theme 1: improved care of Children

The two staff members interviewed, and the comments from the parents in the case study, illustrates the improvement of care for the children attending the program. This theme is

consistent in all the programs reviewed in this evaluation. The Save the Children improvements in children's care are captured in the quotations below:

We see children here who are in high risk situations, and you know, if their families do not get support, then the outcomes for the child is bleak.

Once the child is in or program it's amazing the difference you can see, in the child, and in the family. It always astounds me the difference. A lot of times I noticed myself just having lots of conversations to build that trust. Other times I will be playing with the children and role modelling some play because I have noticed there is a lot of parents they are lovely but there is a real struggle for them to know how to be a parent ... or how to play with your child.

I know I'm a better parent for coming here. I understand my daughter's needs more and she is much better we have a sleep routine, bath, feeding it's much easier and I'm happier working now too.

Improvement care of the child and increased capacity of the parents to meet the child's needs can assist in the development of confidence for the parent in returning to work. The parents are more confident in the child being happy and safe in appropriate child care. Further, the children are happier to attend child care having attended the Save the Children Intensive Supported Play Scheme. Additionally, the parents are more aware of how to evaluate a playgroup or childcare in order to discern the necessary support to meet their child's needs.

Theme 2: Returning to employment

The case studies and staff members highlighted the impact of returning to employment is another theme that is consistent across all the programs provide by CfC. This theme in relation to the Save the Children findings is illustrated below:

We helped the parents deal with a range of parenting issues, such as getting baby to sleep etc. and well then, the family functions better, and, mum and dad could go out to work.

Furthermore, the variety and comprehensiveness of supports provided by the Save the Children program ensures that the needs of the children and families are met. Access to the

program by families is enhanced through the open access policy. The families also benefit from the open access to the programs.

Theme 3: Soft entry

Two staff members were interviewed for the CfC evaluation. The programs provided are described as 'soft entry' programs that enable support to be given to families that do not traditionally use skill building programs. This is captured in the quotation below:

An early childhood educator and an early childhood assistant ... with a social worker or of somebody with a similar discipline attached to provide the programs. So using playgroups as a 'soft entry' and getting ready for school and early childhood education type initiative, but also providing those wrap around services. So the family support worker would provide case management, therapeutic support but also those referrals to other agencies.

It's families with I guess high risk needs and I guess being Save the Children the emphasis is on the child and that there may be some issues of the child being at risk or yeah that there's some issues around parenting and helping with parenting to make it a safer more better functioning place ... their own parenting or their own family histories or whether it's circumstances or it's poverty or current issues to do with employment or mental health, drug and alcohol. So a whole range of factors?

The programs use a range of professionals to provide inter-disciplinary, and holistic, family interventions. These types of 'soft entry' initiatives are important as it connects the programs with the isolated families and prepares the family and child for integrations into the schooling system. Also the family and child are prepared for recognising and providing learning opportunities. The programs provided to families are evidenced based.

Theme 4: Theoretically based programs

The programs delivered by Save the Children, in the Intensive Support Playgroup, for the high risk families in the program use theoretically based interventions from areas such as, trauma, strengths based, and attachment activities are theoretically sound. Further the models of intervention used are also based on the rights of the child and this is captured in the quotation below:

So I suppose really looking at our program logic two fold – three fold; improved early learning outcomes for children is very much a focus and I don't like the term school readiness but helping children become ready for school and we do our programming based on the early years learning framework to improve parenting competence and attachment between parent and child and then improved family inclusion and whether that's access to service or whether looking at the playgroups as an opportunity to develop peer support networks as well. So that's sort of the three outcomes that we aim for and that we measure as well.

A lot of the work is based on trauma specialist, and lots of stuff on attachment, and I remember going to a seminar ... some of the most effective parenting programs for parents that are really struggling are those coaching kind of programs, where you're a professional, or a whoever, and is working alongside the family as they have a daily routine, and so I kind of think this is a little snippet in a playgroup where you can do a little bit of that. You're actually role modelling on the ground without being threatening. I'm seeing that rolled out before my eyes. It's really effective with these high risk families.

Save the Children I think is unique as it is based on the rights of the child framework.

This quote links to the case studies above and the literature in this and previous sections outlining the importance of using professional staff, attending ongoing education, and using evidence based programs.

Theme 5: Evidence based programs

The programs are used by Save the Children are designed to meet internationally sound markers for evidence based best practice. The save the Children programs are evaluated in house Australia wide. As captured by the quotation below:

So as an organisation we would do evaluations across the country – various programs would be evaluated on a rotating basis basically depending on how much funds we've got but we've got a structured MIL framework as well with a range of indicators that we report on both output and outcome indicators that we would report against and they are applied nationally. So improvements in – changes in early

childhood development; whether parents feel like they're parenting capacity has increased as a result of playgroup; number of children that are ready for school in that age 4-5 cohort. So I think there would be about 15 indicators. I'm just looking at our log frame that we would measure against and report against quarterly.

The quotation above highlights the use of extensive evidence collection and a quality improvement framework used to ensure the programs provided by Save the Children are evidence based and the outcomes measured.

Discussions

There were a number of main themes found within the data. The interviews and the case studies data provided some data saturation. The inclusion of focus group data in the next stage of data collection in 2016 will provide further support and evidence for the programs used by Save the Children. Additionally, the in-house evaluation will be assessed to determine if the evaluation is of a standard to be included in the 2016 report. The themes found in this evaluation that are consistent across all the programs provided by CfC are: 1) Improved Care of Children; and, 2) Returning to Employment.

The themes in the data analysis are also consistent with the themes in the literature that provide the theoretical bases and the therapeutic models of care used in the interventions. This provides an internal validity for the themes, and research robustness, for the research design and processes used.

Conclusions

The programs and therapeutic interventions provided by Save the Children, in the Intensive Support Playgroup, Family Home Visiting, Nutritional Advice and Coaching, Financial Counselling, and individualised Family Focused Workers, are of a high standard, and provide the necessary referrals; supports, professional practices, and modelling that reduce the risk for children in high risk families. The importance of these interventions cannot be overstated for the children and families involved.

Facilitators Qualifications

The staff employed by Save the Children have the following qualifications:

- Bachelor of Social Work
- Trauma Intervention and Support Practice
- Child Development
- Early Childhood Education

The programs are delivered by an Early Childhood Educator, Assistant Child Educator, and Family Support worker.

This staff mix provides an interdisciplinary approach to child focused approach to the therapeutic interventions provided by the programs.

Limitations

The case study presented above is limited as it is one experience although that said it was chosen by the staff as it was representative of many families attending the Save the Children, Intensive Supported Playgroup. Future evidence will be collected in 2016 on the experiences of parents through focus groups and interviews.



Section four:

Refugee Community Capacity Builder

African women's Hand in Hand group

and Support Programs

The program Refugee Community Capacity Builder is delivered by the facilitating partner. There are two key components of this program including the weekly Intensive Supported Playgroup and Individual Family Support. This section of the evaluation will focus on the weekly Intensive Supported Playgroup 'Hand-in-Hand'. The group provides women with the opportunity to learn English, and connect with their local community. Further, the program provides the opportunity for migrant and refugee women to become involved and included in Australian culture and society. The women using this program are isolated by limited English and knowledge of Australian society and community. For example, the program provides the women with proactive skills such as how to access and use the local library. As

outlined in the introduction children there are links between social isolation and children being 'at risk'. The program focuses on building stronger families.

The Hand in Hand program also provides the women with resources to promote both personal growth and community involvement that enable preventive interventions, such as immunization, child development assessments, and services, to be accessed and used. For example, the Community Support Workers assist mothers to access the CAFHNs service that is also situated at Seaton Central. This ensures that the children are assisted in meeting their developmental and immunization targets.

Parental support and training is the main focus of the Refugee Community Capacity Builder intervention programs. The aim is to ensure that the children are provided with supportive and aware parents that are capable of meeting the children's needs. The migrant and refugee parents are aware of the parenting practices in Australia, such as no hitting but they are often not aware of alternative behaviours used for child rearing.

Theoretical basis for the Program Model

Literature review:

The Hand in Hand programs use theoretical models, such as Targeted Relationship Based Programs, Attachment Theory, and Tuning into Kids (outlined previously), which are relationship and developmental programs for parents to enhance 'school readiness' (outlined in the CCCB program above) in children. As all of the theoretical bases, and therapeutic models used in the Hand in Hand program have been outlined already, only the finding will be presented in this section of the report.

Findings:

General information

The methods used in the data collection inform the analysis used in the evaluation. Table 4.1 illustrates the types of participants involved in each stage and step of data collection. The table also highlights the method of data collection required for each participant type. The basis for recruitment outlines the role of the participants and implies their level of involvement in the Hand in Hand program.

Table 4.1: the type of participants and method of data collection used

Participant Type	Numbers	Basis for Recruitment	Component of Research Involved In (e.g. survey, interview, focus group, observations)
Providers (managers and staff)	2	Responsible for delivery of the CfC programs	Face-to-face interviews and observational information (on behavioural changes in mothers and children)
Mothers	25	Participation in CfC program	Focus group

Table 4.1 above highlights the involvement of the participants in the research process. The intensive support provided by CfC in the, Hand in Hand program, assists families and their children to deal with the isolation experienced through migration and refugee resettlement. The Refugee Community Capacity Builder program uses proactive, targeted, and inclusive community based interventions focused on community inclusion and involvement. Isolation can negatively influence mental and physical health of mothers, fathers and children, by directly impacting on access to services. The program provides information on health issues, such as HIV/AIDS, breast problems, and other women’s and men’s health issues by providing access to information, services and specific cultural needs, such as female doctors for the mothers.

The Refugee Community Capacity Builder programs also provides child development knowledge, such as the importance of play for children’s learning. Developmental knowledge assists the parents in providing a home environment that aids child learning and safe development. Neurobiological and brain development information is also given to the parents. This can aid in the understanding of children’s behaviour and needs. The use of the Intensive Supported Playgroup Hand in Hand also aids in the decreases of separation anxiety from the children, and parents, and ensures the transition to school is easier and productive.

There were a number of main themes found within the data. The interviews and focus group data provided some data saturation. The support the previous themes found in the first three sections of this report.

Themes

Theme one in the WPSG, CCCB and Save the Children; 'Improved Care of Children' was a strong theme in this program as well. Both the parents and the staff found that there was less use of physical means of control of children's behaviour, such as pinching and slapping after participating in the program, and more use of engagement with the children. The program helped parents to achieve appropriate child behaviour and cooperation from the children without using physical violence. This also demonstrates a large shift in the parent's behaviours towards non-violent parenting techniques and an embracing of the in-depth understanding of children's developmental and emotional needs. This has improved the treatment of the children, and lessens the children's risk of physical abuse. This is captured in the quotations below:

When the mum's come here they are not judged... they soon learn that we engage with the children and use other techniques to get the children to do what you need them to do. Some of the mums used to pinch or slap their children when they first attend, now they talk to the children. The staff here model appropriate child engagement behaviour.

I treat my children better now ... I didn't understand before ... it's very hard for a long time when we were in the refugee camps there is no help ... it's hard to parent there, there are so many bad things. I'm a much better parent now and my children are happier and I enjoy parenting now. I not smacking all the time. I feel bad for my older son but I don't hit him now either. Before I didn't know what to do.

The theme above was present in all the findings from every program provided by CfC UnitingCare Wesley Port Adelaide. Here the theme is explicitly outlined as a benefit for the children and the parent/child interactions.

Discussions

The themes of: Improved Care of Children; Returning to Employment and Cost Effectiveness were also the main themes found within the data for the Hand in Hand evaluation. With the parents and staff outlining that this service provided links to other services including; health, welfare and education for the parents and children. Furthermore

the parents believed that without the service they would not be able to participate in tertiary education and employment. The program employs three staff and the services provided through the workshops and therapeutic groups would take 5 FTEs to deliver individually. Additionally, the parents recognised the importance of the program in increasing their productivity and inclusion into Australian society. Therefore the programs provide are cost effective on a number of fronts: the decrease in isolation, the increase in parenting skill to prevent accumulative harm in children,

There were a number of main themes found within the data. The interviews and focus group data provided some data saturation. The

Conclusions

The repetition of the theories, evidence based practices, activities and data themes reinforce the findings from the programs featured above. The interviews and focus group data provided some further data saturation providing robustness to the research data and process. Even though this program is specifically targeted to African and middle eastern descent families and is culturally appropriate to their needs the outcomes of the group work and supported play groups remains consistent. This illustrates the flexibility of the practical application of the theories of child development and infant-parent relationship based programs.

Social Determinants of Health

The CfC programs provide some improvements for some aspects of the SDH for example: mental illness, low income, low parental educational attainment, and the impacts of these on children are addressed via the programs evaluated here. Further the programs used target children development including the: importance of children emotional competence, and their physical, emotional, social, cognitive, and educational development. By addressing these aspects of children's lives early on the programs can go some way to prevent the deleterious impact of accumulative harm as the children grows.

The Social Determinants of Health (SDH) offer a way of explaining and understanding differentials in health across different population groups. The distribution of power and the

socio-political features of health are the structural aspects of the health of a society and mediate access to health care [8]. The consistency, timeliness and appropriateness of health, social, welfare and educational access for infants, children and their families form intermediary characteristics of the SDH that have influences on lifespan health outcomes both physically and psychologically, and are manipulated at a community and individual level [8]. For example, research has found that the levels of education as determined by education policy and its availability, regardless of income, are key determinants of mental health outcomes [33, 79]. The programs provided by CfC in the North West Adelaide region address the intermediary SDH directly.

Further, as the social determinants of health (SDH) are multi-causal and have lifespan consequences there is a need to define, explore and clarify their underpinnings and the causal pathways involved within the family of origin basis [8]. Therefore, the CfC programs respond to at risk children by providing interprofessional, and multidisciplinary responses, that require higher level case management, individual and family therapeutic interventions, and strategic and well development referral networks and collaborations.

Conclusions from all the programs evaluated

The importance of children emotional competence, cognitive, language and psychological development is assisted by positive evidenced-based parenting, playgroup, and crèche programs. Children's success in school is also based on children's social adjustment. The CfC programs provide interventions that are successful and evidence-based in aiding children's social, emotional, physical, psychological and educational development. Also the CfC programs assessed here build parental capacity to parent, parental confidence, and decrease parental mental health issues and parental isolation. These findings are supported by the literature, previous research and this research evaluation project.

Further, the extent to which programs succeed depends on the engagement of families with the programs offered. All of the programs provided by CfC delivered on this important aspect of service provision. All the programs made a difference and this has been evident in the comments from the participants evaluated here. Many of the research participants had come to use the CfC programs auspice by UnitingCare Wesley Port Adelaide as the programs made a difference. The provision of non-theoretical based playgroups made very

little difference to the family functions and children's behaviour. In contrast the parents and staff noted that the CfC UnitingCare Wesley Port Adelaide programs made a positive difference in the lives of their families. These factors have seen the expansion of the programs is evident through the longevity and increasing levels of participation in the programs offered. Further, the programs provided by UnitingCare Wesley Port Adelaide, CfC successfully engage with the difficult to reach populations. At risk children often come from families that refuse to engage with service provides yet the CfC programs successfully navigated family disadvantage and engaged successfully with at risk families.

The Child and Family Centre Seaton Central managed by the Facilitating Partner provides the physical setting and community based environment for many of the programs offered and seem to be an integral part of the program's success. The staff of Seaton Central offers a welcoming and accepting atmosphere. They also offer extended support services and a liaison hub for families dealing with perinatal depression, social isolation, and children's behavioural problems.

The theoretical basis of the programs provided and the use of evidence-based interventions based on world renown and well formulate interventions is also paramount to the success of the program evaluated in this report. The professional staff are trained in the programs offered.

The results of this research illustrates the importance of the programs in engaging with parents and changing the behaviour of parents, and children, that results in, a decrease in the level of risk for the children attending the programs. The information from the in-depth interviews, observation data, and focus groups supported the evidence that there had been sustained change in how the parents respond to their children, and an increased capacity in the parents ability to meet their children's needs.

The methods used to collect the data have informed and enhanced the use of different types of analysis. This process has further validated the results and provided evidence that is substantiated and corroborated from many sources. The similarities in the themes, such as 'improved care of the children', and 'returning to work', is consistent across all programs. This is testament to the use of theoretically based, and evidence based interventions, and

methods of working with at risk families and children. Additionally, the use of multiple informants and key stakeholders has provided a circular process that ensures triangulation and robustness of all data collection and the research process.

The predominant research methodology used in this evaluation is qualitative. However, quantitative data collected by WPSG staff as part of their program performance analysis and quality improvement of their programs and was fundamentally in the analysis in the first instance as it informed the qualitative data collection. Using this mixed–method approach [51] ensures the robustness of the evaluation.

Therefore the programs provided are cost effective on a number of fronts: the decrease in isolation, the increase in parenting skill to prevent accumulative harm in children,

A note of caution is needed however, as the economic, social, and policy changes will impact on the community and families of this area. The consequence for the area and the families of the lessening of these interventions and therapeutic programs would place the at risk children in higher risk of deleterious health, wellbeing, welfare and educational outcomes. Additionally, changes to the programs could diminish some positive outcomes for children and their families provided by these programs. Further, research and the development of robust measures of change are required to improve the collection of quantitative data in some of the programs.

Recommendations

The following recommendations are in accordance with the guidelines from the Communities for Children initiative website and resource materials:

- Explicit identification of the objectives of all programs offered to ensure programs meet the stated objective
- Training manual for all programs to be developed by staff to enable replication of the all program provided to assist in the dissemination of proven programs

Future research questions will address in more detail the following aspects of the CfC programs:

- Explicit measurement of key performance indicators;
- Views and perception on the term 'health'
- Specific indicators of parental and child behaviour change
- Specific indicators of improved outcomes for children
- Pre and post testing of the CfC programs

Further, research into the findings of the Maternal Attachment Scale score and attendance in the WPSG program is warranted as there is a dearth of research exploring the relationship between depression and anxiety programs for mothers, and the impact of these on attachment levels. This said research shows that improving maternal attachment can improve infants and children's physical and psychological health, as well as, emotional, and social wellbeing.



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