DO AUSTRALIAN POLICIES ENABLE A PRIMARY HEALTH CARE SYSTEM TO IDENTIFY FAMILY ADVERSITY AND SUBSEQUENTLY SUPPORT THESE FAMILIES? - A SCOPING STUDY

BACKGROUND

Family adversity is a broad term that refers to a wide range of circumstances or events that pose a serious threat to a child's physical or psychological well-being.

Family adversities may include adverse childhood experiences (ACEs) as well as social determinants of health and wellbeing. ACEs include childhood maltreatment (e.g., physical, verbal or sexual abuse) and household dysfunction (e.g., parental mental illness, family substance abuse). These intersect with the broader social determinants focusing on where children and families live, work and play, and include broader community dysfunction (e.g., witnessing physical violence, discrimination) and peer dysfunction (e.g., stealing, bullying) as well as socio-economic deprivation. Family adversity has well established negative impacts on health and, in particular, mental health, increasing the risk of anxiety, internalising disorders, depression and suicidality in childhood and across the life course.

A focus on prevention and early intervention for family adversity is critical, as the cost to the Australian government of not intervening early is significant—$15.2 billion annually.

In Australia the primary health care system provides prevention and early intervention opportunities, and a non-stigmatising entry for families into the health and social care system. General practitioners, maternal and child health nurses, allied health professionals and social service providers in community health services (CHSs) are well placed to identify and respond to family adversity.

AIMS

This paper seeks to determine whether Australian policies support a primary health care system to not only identify family adversity but also to provide support to such families following identification.

METHODS

This study used a mixed-methods design incorporating:
(i) policy scoping to identify and prioritise current policies (for the year 2020) related to family adversity within two states—Victoria and New South Wales (NSW), and within federal government; and

(ii) thirteen semi-structured interviews with state policy makers and CHS staff, to confirm the policies identified in the scoping review were important and relevant and inform how policies framed the language of adversity. Interviewees were recruited via snowball sampling.

Utilising the Stages Model,the current policy context informed by policy scoping (i) and semi-structured interviews (ii) were subsequently examined across the stages of policy making, including agenda setting, policy formulation, decision making or policy adoption, policy implementation and evaluation.

KEY FINDINGS

In total, 188 policies were identified that had varying links to family adversity including 44 federal policies, 97 Victorian and 47 New South Wales policies. Of these, 37 policies met the eligibility criteria (i.e. included a focus on early intervention within primary care) and were therefore included in the review.

Most policies were developed within health departments (78%) and included a wide range of adversities, with the majority based within maternal and child health, and CHS platforms. Most policy development included consultation with stakeholders.

Although the majority of policies received some level of funding, few included funding details and only a third included evaluation.

NEXT STEPS...

There are many policies related to family adversity in Australia, with most focused within existing primary care platforms. Given these policies, Australia should be well positioned to identify and respond to family adversity.

More work needs to be done to ensure policies are adequately implemented, evaluated and transparently and appropriately funded. It will be important to utilise this opportunity to move beyond policy rhetoric to accelerate our response to family adversity and create accountable and measurable action.

CITATION

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