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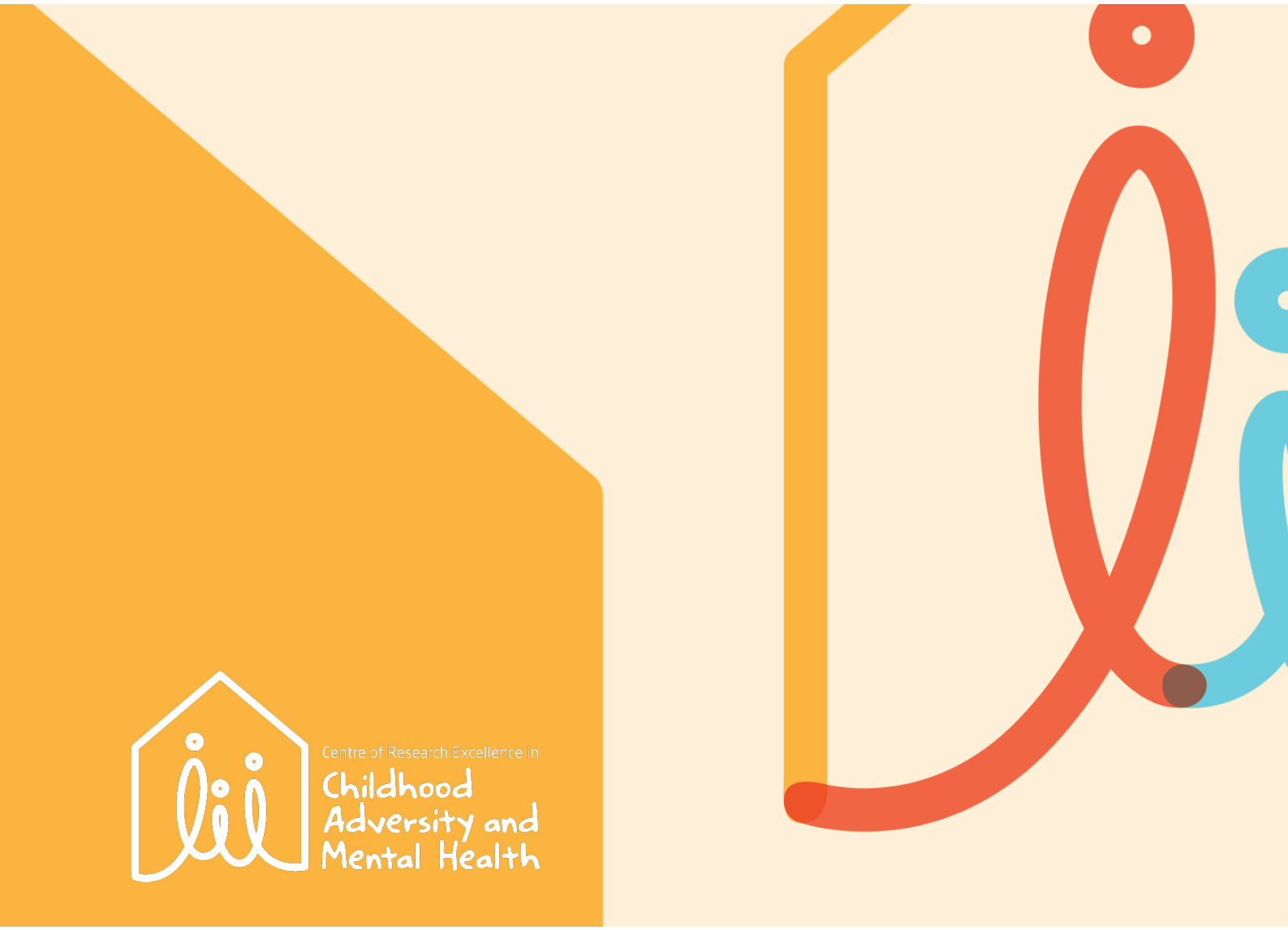

Centre of Research Excellence in
Childhood Adversity and Mental Health

Final Report

July 2024

Working in partnership

Beyond Blue

Centre for Research Excellence in Childhood Adversity and Mental Health

Final Report

The Centre of Research Excellence (CRE) in Childhood Adversity and Mental Health is a five-year research program (2019-2023) co-funded by Beyond Blue and the National Health and Medical Research Council. The CRE brings together families with lived experience of adversity, practitioners, researchers and policy makers from health, education, social care, and legal sectors with an aim to prevent the mental health burden experienced by children and families experiencing adversity.

We aim to create Child and Family Hubs, co-designed with end users, that seek to improve children's mental health by earlier detection and response to family adversity.

We have partnered with universities, government agencies and non-government organisations to develop and deliver this program of work, including: Murdoch Children's Research Institute, Beyond Blue, The University of Melbourne, Parenting Research Centre, Monash University, University of New South Wales, Wyndham City Council, North Western Melbourne Primary Health Network, Queensland Children's Hospital, Sydney Local Health District, University of Sydney, Healthy Homes and Neighbourhoods, IPC Health, Sydney Institute for Women, Children and their Families, PANDA and Health Justice Australia.

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Contents

Glossary

ACE	Adverse childhood experiences
CFH	Child and family hubs
Glue	Foundational components that support hub integration
HJP	Health Justice Partnership
LER	Lived experience researcher
PWLE	Person with lived experience
RiR	Researcher in residence
WBC	Wellbeing Coordinator

Main Messages

Adverse childhood experiences (ACEs) are common and double the risk of child anxiety, depression and suicidality

ACEs such as maladaptive parenting, emotional abuse, discrimination, conflict between parents, low socio-economic status, bullying and exposure to violence are common and equally harmful to the mental health of children as physical and sexual abuse. They consequently merit increased attention.

There is good evidence that parenting programs, home-visiting programs (birth to age 2 years), school-based anti-bullying programs and psychological interventions for children exposed to trauma can prevent or mitigate the impacts of ACEs. It is essential to support families to access such programs. Hubs present an important implementation and delivery opportunity as outlined below.

Adversities can be addressed via integrated health, legal and social care Hubs and this is associated with improved child mental health and parenting

Child and Family Hubs are non-stigmatising platforms as “one stop shops” that can address adversities and improve child mental health by engaging with local families to deliver or link to effective programs and services.

Our co-designed core components of Hubs include: family friendly Hub entries; partnerships with families; workforce training in asking about and responding to adversities; mapped referral pathways to services to address adversities; regular activities to bring practitioners together and grow capabilities to address adversities; parenting support; and ideally, co-location of Hub practitioners.

Key Hub practitioners include health (e.g. general practitioners, paediatricians, allied health, nurses etc.) legal and social care (e.g. lawyers, care navigators, financial counsellors) practitioners. Critical to Hub functioning is a Hub coordinator to support setup and ongoing improvements to ensure successful and effective implementation.

Long-term funding is needed to support Child and Family Hubs if we are to meet the needs of families experiencing adversity

As a result of our research two critical areas have emerged that require immediate funding for sustained action:

1. The National Child and Family Hubs Network has leveraged "hub" activity across Australia. It brings together families, Hub implementers and practitioners, state, territory and national organisations, government and philanthropy around a united vision and is working to ensure there is a robust evidence base and community of practice to ensure that Hubs can support children to thrive.
2. In order for Hubs to be successful it has become clear they require core "glue" or infrastructure that can support the integration of services and supports. 'Glue' funding includes the people and processes necessary for staff supports, community engagement, the collection and use of data for ongoing monitoring and improvements, and shared technology systems. These are missing in various degrees almost everywhere. Without funding for this critical component, Hubs will co-locate but not integrate with undue administrative complexity, and an unsustainable trajectory for success.

Executive Summary

About the CRE

The Centre of Research Excellence (CRE) in Childhood Adversity and Mental Health is a five-year research program (2019-2023) co-funded by Beyond Blue and the National Health and Medical Research Council. The CRE brings together families with lived experience of adversity, practitioners, researchers and policymakers from health, education, social care, and legal sectors with an aim to prevent the mental health burden experienced by children and families experiencing adversity.

The CRE timeline (Figure 1) summarises our key CRE activities over the 5 years.

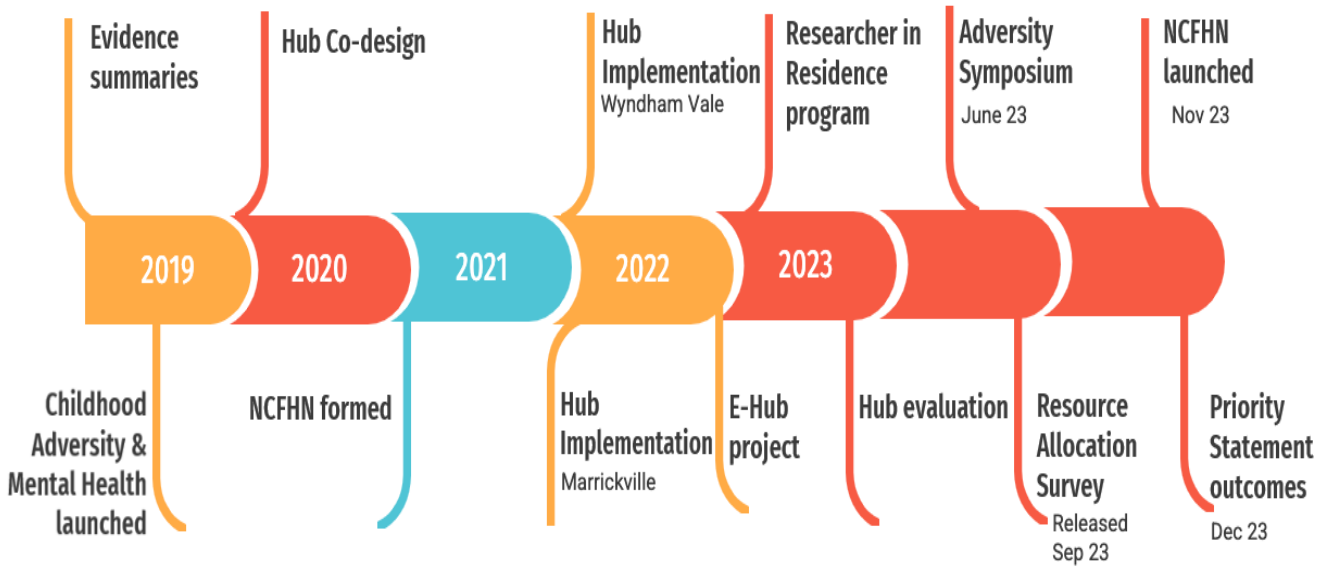

Figure 1: CRE timeline

NCFHN: National Child and Family Hub Network

In the last 5 years we have searched the literature and identified practices and programs with the potential to prevent adversities and their effects (Aim 1). We then co-designed, implemented and evaluated two Child and Family Hubs to bring these practices to life. The Hubs are in Wyndham Vale (VIC) and Marrickville (NSW). The Hubs co-locate health, social care and legal practitioners to create a 'one stop shop' to better detect and respond to child and family adversity. Our research teams in VIC and NSW have supported Hub practitioners to ask about and assist families experiencing adversity via training, lunchtime learning collaboratives, lived experience engagement, reflective practice, light touch 'parent coaching', mapped referral pathways to services and supports, and use of real-time data to inform change. We asked families and Hub practitioners about their experiences and measured detection of adversities, referrals for adversity and uptake of referrals by families attending the Hubs. We looked at Hub impacts on child and caregiver mental health and caregiver quality of life (Aim 2).

We have scoped the Australian policy environment and identified many policies across a range of childhood and family adversities. We took this and other evidence into a two-day national symposium on *What should Australia do about Childhood Adversity*? generating a wealth of policy, practice and research ideas that were then prioritised by lived experience and health, education, legal and social care experts around Australia in our national resource allocation survey. Recognising the need to scale our response to childhood adversity beyond this CRE, we have set up a National Child and Family Hubs Network to assist the 460+ Hubs in Australia to support leaders, service providers, policymakers and academics to advance research, advocacy and learning. We have also co-designed an e-version of our physical Hubs and are piloting eHubs in Victoria and New South Wales. Finally, recognising that practitioner change is complex and takes time, we have secured philanthropic and organisational funding to establish a Researcher in Residence program to support 3 Child and Family Hubs in Victoria (with a 4th in Norfolk Island) to bring evidence into care for children and families with a learning health system approach (all - Aim 3).

Along the way, 4 students have conducted PhDs, with topics including:

- Improving responses to childhood adversity: A mixed methods assessment of barriers and facilitators of practice change (Dr Sarah Loveday, University of Melbourne and MCRI)
- Interagency Collaboration within Community Healthcare for Families Experiencing Adversity in Australia (Manisha Balgovind, Monash University)
- Engaging Parents with Technology-Assisted Programs to Prevent Internalising Problems in Children with Adverse Childhood Experiences (Dr Grace Aldridge, Monash University)
- Co-designing a technology-assisted parenting program for parents with mental health issues, to prevent child internalising problems (Meg Bennett, Monash University).

We are delighted to present this Report as a summary of the 5 years of work via the CRE with the generous funding of Beyond Blue and the National Health and Medical Research Council. It has been a privilege to work with lived experience, practitioner, policymaker and academic experts to make a difference to the lives of the Australian children and their families with adversity.

Professor Harriet Hiscock, MBBS, MD, FRACP, GAICD on behalf of the CRE Investigators.

Chief Investigator, Centre of Research Excellence in Childhood Adversity and Mental Health Group Leader, Health Services and Economics, Centre for Community Child Health, Murdoch Children's Research Institute

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Synthesising the Evidence (Aim 1)

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To develop optimal interventions for reducing ACEs, we needed to know:

- what ACEs are associated with depression, anxiety and suicidality
- how commonly they occur and what impact they have on the Australian population
- what interventions have been shown to reduce these ACEs
- which of these interventions are most suited to the Australian health, human services and education context.

To achieve these aims, we carried out the following four research projects.

We define child and family adversity as a range of adverse childhood experiences such as childhood maltreatment (e.g. physical, verbal, or sexual abuse), household dysfunction (e.g. parental mental illness, family substance abuse), community dysfunction (e.g. witnessing physical violence, discrimination), peer dysfunction (e.g. stealing, bullying) and socio-economic deprivation.

We define prevention of adversity as solutions aimed at:

- tackling the upstream drivers of adversity (primary prevention)
- reducing the impact of adversity on children currently experiencing adversity (secondary prevention)
- better support for children detrimentally impacted by adversity (tertiary prevention).

Umbrella review of the associations between ACEs and mental health

An umbrella review is a systematic review and synthesis of published systematic reviews. We found 68 existing systematic reviews, covering over 30 different types of ACEs and their associations with depression, anxiety, internalising problems or suicidality.

The ACEs most consistently associated with the four outcomes were: childhood maltreatment, physical abuse, sexual abuse, bullying and maladaptive parenting. Associations were also found for low socio-economic status, discrimination, exposure to violence and parental incarceration.

We were expecting that some ACEs would have a stronger impact than others and that the impact might vary with the age and the gender of the child. However, all ACEs were associated with approximately two-fold increase in risk for all outcomes and the associations did not vary by gender or age of exposure.

A key learning is that while it is widely recognised that physical and sexual abuse of children harms their mental health, other ACEs such as maladaptive parenting, emotional abuse, discrimination, conflict between parents, bullying and exposure to violence are equally harmful and consequently merit increased attention.

Estimating the contribution of ACEs to depression and anxiety in Australian children

We analysed data from the Longitudinal Study of Australian Children (LSAC) to find out how common ACEs are in Australia and the size of the contribution they make to depression and anxiety symptoms. We found that 69% of the children had experienced two or more ACEs by age 18 years. The most common ACEs were bullying victimization (54%), interparental conflict (23%), parental financial distress (23%) and parental psychological distress (14%). A limitation of these data is that the LSAC study did not measure various types of child abuse, so the results underestimate the frequency of ACEs in Australian children.

Because ACEs frequently occur together, we carried out a statistical analysis to estimate the independent effect of each ACE. This found that, of the ACEs covered, bullying victimisation and parental psychological distress had significant effects.

At ages 16-17 years, a history of bullying victimisation accounted for 47% of anxiety symptoms and 21% of depression symptoms, while parental psychological distress accounted for 17% of anxiety symptoms and 15% of depression symptoms.

These findings show that bullying and having a parent with mental health problems are powerful risk factors for depression and anxiety in Australian children and merit increased targeting for intervention.

Review of interventions to prevent or ameliorate ACEs

A review was conducted to identify the types of interventions most likely to prevent or ameliorate the impact of ACEs on children's mental health. Evaluation data was found on 26 interventions—9 parenting, 8 home visiting, 3 community-wide, 3 economic, 2 school-based and 1 psychological therapy.

A report was prepared describing each type of intervention, its target population, the resources required to implement it, the duration and intensity of the intervention, the level of evidence on its efficacy, and any evidence on cost-effectiveness.

High or very high evidence for efficacy was found for 7 parenting programs, 6 home visiting programs, and 2 school-based programs (one focused on bullying and one on child sexual abuse prevention) (Sahle et al., 2020).

Delphi expert consensus study of priority interventions for Australia

The review of interventions considered the evidence on efficacy, but could not indicate whether or not an effective intervention was needed or appropriate for Australian families. We therefore carried out a Delphi expert consensus study focusing on what interventions are most appropriate for Australian children under 8 years.

Fiftly-one experts on childhood adversity were recruited, including 15 researchers, 9 policy experts, 7 educators and 3 consumer advocates. The experts were presented with our report on the efficacy of interventions and asked to rate their priority for Australia. Consensus was defined as 75%+ of all experts rating an intervention as a 'high' or 'very high' priority.

There was consensus that the following are priorities:

- parenting programs (specifically Triple-P)
- home-visiting programs
- school-based anti-bullying programs
- psychological interventions for children exposed to trauma.

Improving access to such programs is key and Hubs (see section following) may be one vehicle to support improved access.

Future Directions from Aim 1

To determine messages for the public that can lead to behaviour change, Aim 1 researchers have teamed up with Beyond Blue and other industry partners to submit an ARC Linkage grant application on 'Building the evidence on public communication strategies to prevent and respond to child emotional abuse'.

Emotional abuse has as negative an impact as physical and sexual abuse, but its prevention has been neglected. Emotional abuse is less amenable to legal approaches than other forms of abuse, so community campaigns on its impact are needed.

Co-design, implement and evaluate Child and Family Hubs (Aim 2)

Contributors: VIC - Harriet Hiscock, Tess Hall, Sarah Loveday, Ashraful Kabir, Leanne Constable, Natalie White, Loan Huynh, Lingling Chen, Manisha Balgovind, Lena Sanci, Loan Huynh, Anne Truong, Hayley Loftus, Renee Jones, Cate Bailey, Suzy Honisett, Sharon Goldfeld; NSW - John Eastwood, Sue Woolfenden, Rebecca Bosward, Kate Ebbett, Tamara Morris, Ming Liu, Alicia Montgomery, Anna Calik.

What did we do?

Figure 2 describes the activities we conducted to develop, implement and evaluate our two Child and Family Hubs. We began by developing a deep understanding of practitioner and caregiver perspectives on barriers to asking about and receiving help for adversities. We then co-designed and ran our Hub approach over 12 months in each Hub. We evaluated outcomes at 6 and 12 months post Hub commencement across the Wyndham Vale and Marrickville sites.

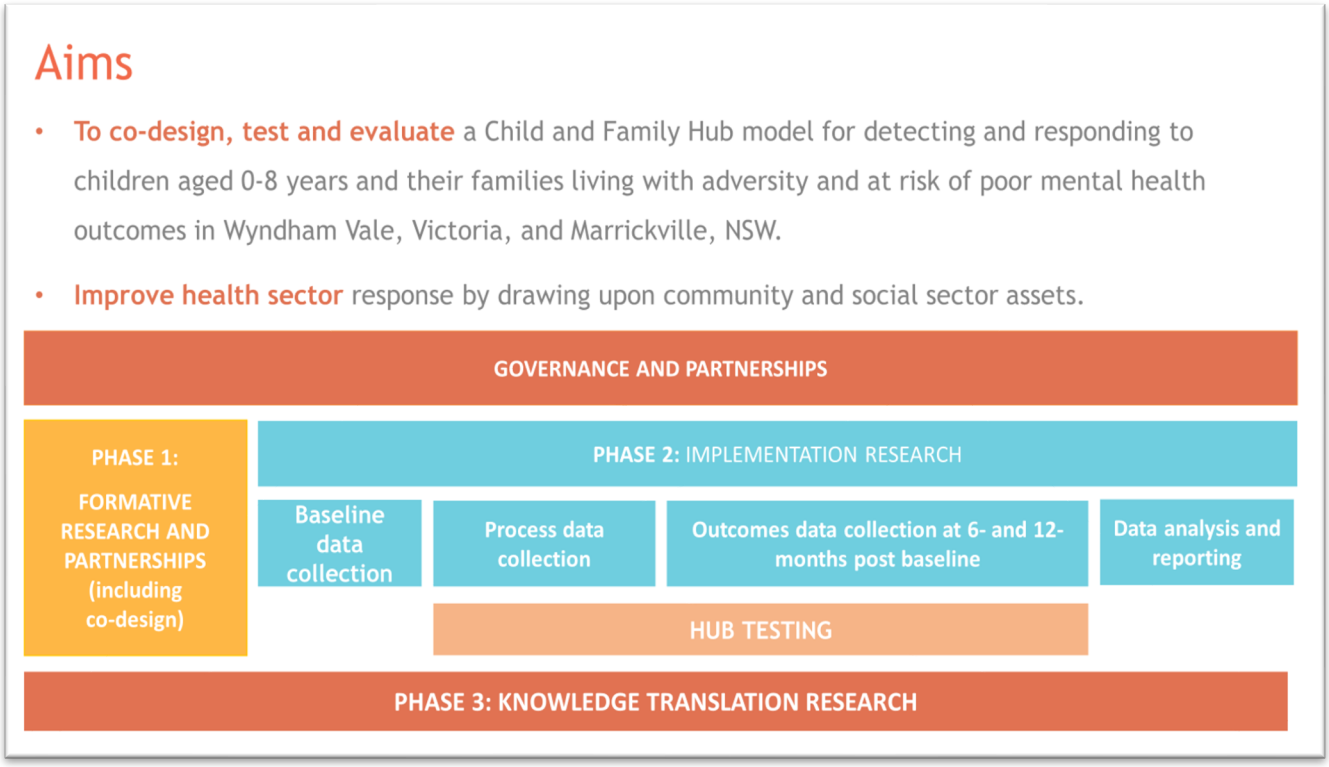

Figure 2: Key phases in co-design, implementation, evaluation and knowledge translation for the Hub approach

Understanding barriers to receiving help - caregiver perspectives

Wyndham Vale (VIC)

We started by exploring caregivers' experiences and challenges of accessing help for 'life challenges' - the caregivers' preferred term for adversity - across both health and social care sectors. We conducted semi-structured interviews with 17 families living in the city of Wyndham, Victoria, Australia.

Five main themes emerged:

1. **Emotional work of getting help.** Caregivers described that getting help for life challenges was both emotionally taxing and effortful.
2. **Trusting relationships are key**. Engagement was related to the degree of relational practice and whether caregivers felt judged or demeaned.
3. **Wanting to manage on your own.** There was a strong desire by caregivers to be independent and to only seek help when it was absolutely necessary.
4. **Importance of knowing help** was available and how to access it.
5. **Overcoming service access barriers** including long waiting times, restricted service criteria, transport issues and out-of-pocket expenses.

Understanding barriers to giving help - practitioner perspectives

We also conducted interviews with 26 practitioners across health and social care sectors to understand their experience and perceived barriers to asking about and responding to adversity.

Four main themes emerged:

1. **Get clues as you go along**. Practitioners relied on gut instinct or caregiver disclosure to identify adversity.
2. **Out of my contro**l. Practitioners identified systems barriers that were out of their control including a lack of service availability and funding.
3. **Navigating complex systems**. Practitioners acknowledged challenges in knowing about available services and how to access these services.
4. **Opportunity to engage**. While practitioners identified trust as important for relationships with families, they could not describe how to improve trust.

Overcoming the barriers for practitioners to identify and respond to childhood adversity will require an improvement in practitioner confidence and capability to directly ask families about adversity and knowledge of community services.

Hub Co-Design and Implementation

Co-design and test service approaches

Building on the evidence, we developed integrated, community-based approaches to health and social care. The approaches took the form of Child and Family Hubs. They targeted families with children aged 0-8 years, seeking to reduce the impact of childhood adversity. We worked with families and practitioners from our two Hub sites - IPC Health at Wyndham Vale, Victoria and Marrickville Community Centre at Marrickville, NSW - to co-design our Hubs. These sites were chosen because they are known to have large populations of families experiencing disadvantage.

Wyndham Vale (VIC)

In Wyndham Vale, co-design involved four stages from February 2020 to November 2021 using a human-centred design framework:

1. partnership building and stakeholder engagement
2. formative research to understand service delivery and community context in providing care for families experiencing adversity
3. persona development to act as the launch pad for co-designing solutions
4. co-design workshops and consultations.

Figure 3 illustrates the Wyndham Vale Hub and its health and social care practitioner mix.

Figure 3: The Child and Family Hub at Wyndham Vale

Figure 4 outlines the core components of the Hub as developed in the co-design. Whilst our two Hubs had a mix of existing staff including general practitioners, allied health, paediatricians, and nurses, we engaged with Health Justice Australia to bring lawyers into the Wyndham Vale Hub (at no cost to the Hub) and co-located a financial counsellor and a Wellbeing coordinator to support social prescribing and care navigation for families. Our initial plans to also involve education were curtailed by the COVID-19 pandemic and rolling school closures/pivots to online learning.

Marrickville (NSW)

In Marrickville, co-design involved a series of workshops and semi-structured interviews with intersectoral practitioners and families in March-November 2021. Two key stakeholder groups were recruited via the Marrickville site: 1) Primary caregivers (parents and/or guardians) of children aged 0-8 years (including in utero) and 2) Service providers from community, health, welfare, social, education, and legal services. The workshops and interviews resulted in six hub components being developed (Figure 5). Streamlining access to services and increasing communication and collaboration between services were identified as priorities for implementation. Key hub components for implementation reflected key priorities for service enhancement in recognition of the existing services available via the Marrickville Community Health Centre at baseline.

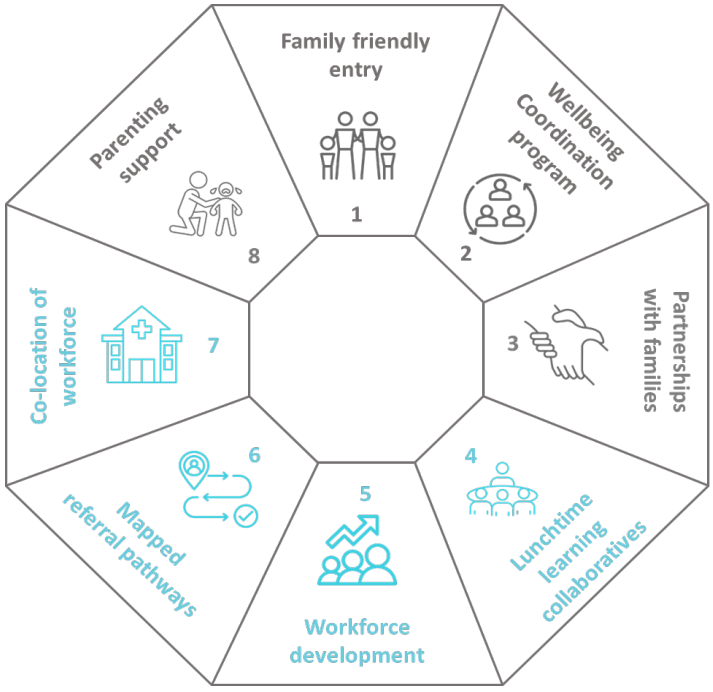

Figure 4: Co-designed core components of the Wyndham Vale Hub (Hall et al., 2023)

Figure 4: Co-designed core components of the Marrickville Hub

Workforce Development, Lunchtime Learning Collaboratives and Mapped Referral Pathways

Wyndham Vale (VIC)

Practitioners were trained to ask difficult questions using a Family Partnership approach as well as the Parent Engagement Resource, which is a tool to encourage practitioners to directly ask about adversity. Over the course of the project it became clear that there were barriers to using the Parent Engagement Resource and training was adapted for new practitioners to include a wider range of tools to help to identify adversity. These included the WE CARE tool and PANDA toolbox.

Following training, practitioners participated in monthly Lunchtime Learning Collaborative meetings. These meetings were facilitated by members of the research team. They were designed to engage practitioners in ongoing learning and reflective practice, and to identify and address barriers to implementation of the Hub. Practitioners were encouraged to develop collaborative practice through regular meetings. This support was essential both for practice change as well as reducing practitioner burnout.

'I think it's fantastic that there's an investment in connecting health professionals to each other and to support each other in asking about adversity, and also having that sort of peer support…Because if you are connected it's a happier place, it's a thriving place, and then the families get the benefit.' **Health practitioner**

'We also really like this approach of partnerships as well, because we think you can provide better holistic care for people.' **Legal Practitioner**

Systematic mapping of available health, community and social care services was undertaken before implementation of the Hub in Wyndham Vale. A hard copy Community Directory was collated and provided to Hub practitioners to improve practitioner confidence in responding to adversity. Conversation generated through the Lunchtime Learning Collaborative revealed that practitioners' preference was to use a soft copy of the directory and for it to have more information included about each member of the Hub, their contact details, and the services they provided. Prompt questions to help identify adversity were also included upon request. The practitioners were able to access this resource when it was placed in a shared location and a Microsoft Teams site hosted it along with other relevant resources to the topics of the Lunchtime Learning Collaboratives.

'They made up a folder [community directory] which was a great reference to work. If you got instances where you need help, then that has been very helpful. Finding other people and where are they? How to refer to them? That's been helpful.' **Health Practitioner**

Building a sense of trust and community was essential during implementation of the Child and Family Hub. Supplying food and homemade treats for each meeting built a sense of community and was one of the things most enjoyed by practitioners.

Image: Wyndham Vale Hub practitioners at Child and Family Hub Training Day 1 (left), Training Day 2 (right)

Practitioners were encouraged to approach all families with curiosity, connection and partnership and were given cups to use to remind them of these key principles of the Hub.

Marrickville (NSW)

Multidisciplinary training in how to ask questions about adversity (life challenges) and use of the Parent Engagement Resource (PER) tool was undertaken with medical and allied healthcare providers at Marrickville. It became apparent that some of the health disciplines would find it difficult to ask about additional social disadvantage in the context of their very tight model of care, scope of practice and comfort levels around trauma-informed care. The PER tool was also felt to be too long to be practical within existing appointment time constraints. As such, the WE CARE screening tool was proposed as an alternative and adopted.

Monthly multidisciplinary clinical meetings/collaboratives were intended to be implemented at Marrickville Health Centre, including case-based discussions and peer-support research and training webinars to embed learnings into practice and facilitate intersectoral collaboration. Barriers to implementing collaboratives included difficulty in securing a regular time for part-time staff and the burden of clinical workload. Instead, Marrickville CRE staff attended existing clinical and allied health meetings in 2023 to strengthen relationships and promote Hub services. This approach was acceptable to service providers and improved engagement with Hub services. A social prescribing community of practice was developed and implemented in 2023, which was well attended by service providers. The Marrickville CRE staff also implemented peer-support research and monthly training webinars from August 2023. Internal and external speakers were invited to present on

topics including ongoing research projects, ethics and governance, grant writing and other research activities.

A similar mapping of services across health, community and social sectors was completed in Marrickville. These were collated into a Community Resource Directory. Process data (Plan Do Study Act Cycles) and qualitative feedback from staff revealed a preference for a digital version of the resource directory, which was disseminated to staff by email. The resource was highly acceptable to staff due to comprehensive, relevant, and easily accessible information. Suggestions for improvement included placing the Community Resource Directory in a central and easily accessible location e.g. SharePoint.

Use of the WE CARE tool, regular learning collaboratives and mapping of local referral pathways for adversity are key to supporting practitioners to ask about and respond to family adversities.

Hub Evaluations

We conducted a mixed methods repeated measures evaluation. This included caregiver and Hub practitioner surveys at baseline and at 6 and 12 months post Hub commencement, and caregiver and practitioner interviews at 12 months post Hub implementation. Surveys were conducted across both Hubs. As there was a low response rate to the caregiver follow up surveys from families who went to the Marrickville Hub over the whole 12 months, only data from caregiver follow up surveys from Wyndham Vale are presented.

We hypothesised that our approach would improve Hub practitioners' identification and response to family adversities, lead to better child and caregiver outcomes, and improve practitioner confidence in asking about and responding to adversities.

We asked about 3 groups of adversities:

1. **Adversities outside the home** i.e. challenges with social support, finances, housing and employment.
2. **Adversities inside the home** i.e. challenges with family physical health or disability, mental health, parenting, relationships, family violence, alcohol and drugs, child neglect and child abuse.
3. **Societal adversities** i.e. challenges with visas or migration, interaction with the criminal justice system, and discrimination or harassment.

Our primary (quantitative) outcomes included changes in:

- caregiver-reported (i) identification of, (ii) interventions received and/or (iii) referrals received for adversity from Hub practitioners
- practitioner-reported (i) identification of, (ii) interventions offered and/or (iii) referrals made for families experiencing adversity.

Our secondary (quantitative) outcomes included changes in:

- caregiver uptake of referrals received and caregiver-reported child and caregiver mental health, parenting, infant temperament (0-2-year-olds only), caregiver quality of life, and overall child health
- practitioner-reported competence and comfort to ask about and confidence to respond to adversity.

Appendix 1 shows the measures we collected in our evaluation (Hall et al., 2022).

Qualitative caregiver interviews at 12 months explored caregivers' experiences, views, and opinions about being asked about life challenges (i.e. adversities) by Hub practitioners and the services offered, as well as additional services required to address them effectively.

Qualitative practitioner interviews at 12 months explored practitioner experiences of barriers and enablers of practice change.

We also evaluated the new service roles across the two Hub sites. These included the Wellbeing Coordinator (Wyndham Vale), Service Navigator (Marrickville) and Health Justice Partnership (HJP) across the Hubs. These evaluations included

collection of quantitative data on caregiver demographics, referrals and family adversities, extracted from standardised referral forms and electronic medical records, and semi-structured interviews to explore caregiver experiences of service navigation and legal outreach services.

What did we find?

Wyndham Vale (VIC)

Two hundred and thirty-four families completed the baseline survey, of whom 205 (88%) completed the 6 month survey and 176 (75%) completed the 12 month survey. Families who indicated they had been to the Hub in the previous six months (i.e. consistently attend the Hub) numbered 158 at 6 months and 127 at 12 months. Families who consistently came to the Hub were more likely to report 3 or more adversities at baseline than families who did not.

Adversities were common. At baseline, 12% of families reported 4 or more adversities outside the home, 23% inside the home and 3% reported 3 or more societal adversities.

Changes in our primary outcomes from baseline to 12 months

For the **overall caregiver sample**:

- More families reported experiencing *no* adversities between baseline and 12 months (reduction in adversities - Inside = 9%; Outside = 7%; Societal = 5%).
- There was no change in Hub practitioners asking about adversities or in families receiving extra support from Hub practitioners.
- There was an increase in receiving referrals for support for challenges inside and outside the home.
- Caregiver uptake of referrals was stable.

In contrast, for the **subgroup of families who consistently attended the Hub**, we found they were:

- more likely to receive additional support from Hub staff
- more likely to receive referrals to other services
- other outcomes were similar.

Practitioners reported:

- asking more frequently about adversities, especially social care needs outside the home
- making more referrals for adversity with the largest improvement in social support and financial challenges – i.e. referrals to Hub co-located practitioners including lawyers and financial counsellors.

Changes in our secondary outcomes from baseline to 12 months

We also found improvements in some of our secondary outcomes. Specifically, the proportion of:

- children meeting the cut point for mental health problems decreased from 42% at baseline to 35% at 12 months
- caregivers reporting warm parenting improved over time from 67% at baseline to 76% at 12 months.

Over 90% of children were reported to have good general health and most infants were also reported to have 'average' or 'easier than average' temperament. Low risk of probable caregiver mental illness was observed over time.

The Child and Family Hub at Wyndham Vale is associated with an increase in support and referrals for families experiencing adversity, a reduction in children's mental health problems and an increase in warm parenting.

Caregiver experiences of the Wyndham Vale and Marrickville Hubs

We conducted 29 in-depth interviews with caregivers of children living with adversities across our 2 Hubs. Five recurring themes were identified that reflected the caregivers' experiences of being asked about adversities, how they linked to support and services in the Hubs, and the facilities outside the Hub. The caregivers described that:

- **trusting relationships** with the practitioners were central to their experience of being asked about adversities and receiving support. Most caregivers believed that practitioners showed keen interest in listening to their issues warmly and attentively.
- **a welcoming and compassionate practitioner attitude and non-judgmental stance** allowed caregivers to engage in-depth and helped them feel comfortable to openly share their adversities
- they felt there was **little or no scope for bringing up issues related to broader adversities at the household level**, such as the family's financial status or parenting, because practitioners mainly focused on the child
- being **overwhelmed by multiple adversities was a challenge for complete disclosure and accessing support**. This, compounded by limited language capacity, made some caregivers less likely to disclose their issues during the consultations.
- **supply-side factors** such as a shortage of service providers, insufficient time for clinical consultations, long waiting times for referral services, and high out-of-pocket expenses for referral services were barriers to maximising support and asking about adversities.

The potential for Hub practitioners to address family adversities is great. A supportive relationship, where caregivers feel heard and are provided with necessary support and services, are crucial factors in addressing child and family adversities.

Practitioner experiences of the Wyndham Vale Hub

We conducted semi-structured interviews with 21 Hub practitioners to understand the key drivers of practice change to increase practitioner identification and response to adversity. Six themes were identified:

- **Connection matters** - connection was a key driver of practice change as practitioners were motivated to ask about adversity when they felt supported and were able to learn from each other. Having a strong supportive network decreased the emotional burden of asking about adversity.
- **Knowledge provides assurance** - knowledge of services was a key facilitator of practice change with practitioners reporting greater confidence to respond to adversity by knowing the available services and how to access them. In addition, knowing 'the person' and being able to make a 'warm referral' was even more important in changing practice.
- **Confidence in ability** - practitioners were more likely to ask about adversity when they had confidence in their ability. This was enhanced when they had confidence in the language they used to directly ask.
- **Choosing change** - practitioners made deliberate choices to change practice which were supported by reflective practice and being more mindful.
- **Never enough time** - health practitioners felt that the main barrier to changing practice was time pressure which was related to how community practice is funded.
- **Opening Pandora's box** - practitioners were fearful of directly asking about adversity in case they unleashed unforeseen problems such as damaging their relationship with families or causing harm.

Marrickville (NSW)

Results of the baseline (n=115), 6 month (n=106) and outcomes (n=87) surveys identified that caregivers experienced adversities inside the home, outside the home and experienced social adversities. Qualitative evaluation showed most Hub services were feasible and acceptable to caregivers and services providers, with Service Navigation (see below) being the most acceptable. This service also needed the most work for implementation e.g. working with clinicians, attending clinical meetings, and promoting referrals.

Wellbeing Coordinator and Service Navigator Programs

Wyndham Vale (VIC)

The Wellbeing Coordinator (WBC) program aimed to enhance engagement of families with services through a combination of care navigation and social prescribing.

This role was co-designed with local families, community members, and Hub practitioners, and aimed to meet the area's specific needs. It was hypothesised that it could help resolve barriers to meet the complex needs of families.

Care navigation involved guiding patients through health and social services to optimise their use of the system, while social prescribing provided non-medical support, such as financial advice or group activities, to enhance wellbeing. A WBC with a professional background in social work provided support to caregivers as outlined above. Referrals to the Wellbeing Coordinator could be via self-referral from a caregiver, from a practitioner within the Hub, or from a practitioner outside of the Hub.

The program elements and the role of the WBC included:

- providing families with support which could include up to six appointments
- care navigation including developing a wellbeing care plan with family goals and linking families to necessary health and social care services
- social prescription including co-creating a non-clinical social prescription e.g. helping find them a walking group or library rhyme time session
- running monthly Community Connect Drop-in sessions where caregivers had an opportunity to engage with a Hub practitioner in a casual environment and learn about the Hub services in a non-confronting way.

The evaluation was guided by a framework for feasibility studies, as follows:

- *Reach*: Did the program reach its intended audience?
- *Fidelity*: Was the program implemented as intended?
- *Acceptability*: Was the program acceptable to those delivering and receiving it?
- *Feasibility*: Was it possible to deliver the program with the resources allocated?
- *Preliminary effectiveness*: Did the program improve caregiver engagement, social connection, and confidence in managing their family's health and wellbeing?

We used a mixed-methods study design to evaluate the program.

Quantitative data comprised demographic data from caregivers and validated caregiver-reported outcome measures of general health, loneliness, social connectedness, health confidence and parent enablement.
Qualitative data comprised semi-structured interviews with practitioners and caregivers exploring their experience of the WBC referral pathway or program.

Evaluation outcomes (Chen et al, submission pending IJIC 2024)
We conducted interviews with caregivers who did not receive any services from the WBC program (n = 18), caregivers who participated in the WBC program (n = 11), and Hub practitioners (including the wellbeing coordinator; n = 21).

Fifty-six families were referred to the WBC, of whom 36 were contactable and attended. 26 (72%) had up to 6 appointments. Most caregivers were referred given their overwhelming experiences navigating community services and the need to engage with services (n = 50, 89%), and/or their need for support in connecting with the National Disability

Insurance Scheme (NDIS) to access funding for early childhood early intervention (n = 35, 63%), and/or the need for support whilst on wait lists to access care for their children (n = 25, 45%).

Caregivers and practitioners found the WBC program acceptable and mostly feasible, demonstrating the potential to alleviate caregivers' loneliness and enhance their health, connection to the community, and knowledge and confidence in supporting child and family health and wellbeing.

Findings included:

- Compared to the intake survey, upon exiting the program caregivers reported relatively lower levels of loneliness, and higher ratings of general health, quality of life, mental health and social activities and relationships. Confidence in controlling and managing health increased.
- Most caregivers achieved their goals set in the wellbeing plan and indicated feeling more connected to the community. (Chen et al., paper under review 2024)

Marrickville (NSW)

A Service Navigator was situated in Marrickville Health Centre from 2022 to March 2024. Co-design workshops and interviews were conducted with families, health, legal and social service providers to identify research priorities and develop the model-of-care logic underpinning the program. The Service Navigator was a clinical research nurse with a professional background in community nursing. The Service Navigator used a social prescribing approach to support and empower families to link in with community and health services. Elements of the program and referral processes included:

- providing families with support for up to 6 appointments, however, this model was flexible and could be extended depending on caregiver needs
- referrals made from a practitioner within the Hub or from a practitioner outside of the Hub. Once referred, a participant could re-refer themselves to the program.
- a social-prescribing model of care as described above
- attending interagency meetings within the Inner-West Sydney Council.

Evaluation outcomes

We used a mixed-methods study design to evaluate the Marrickville program.

Quantitative: Quantitative data on caregiver demographics, referrals and family adversities were extracted from standardised referral forms and electronic medical records. Thirty-three families were referred to service navigation, with a total of 39 episodes of navigation. Common needs included financial (25/33, 64%), housing and mental health/substance use, both (49%), disability support (46%), medical/nursing/allied health (39%), child protection and wellbeing (33%), and parenting (28%). Most families (62%) engaged with at least one service the navigator referred them to.

Qualitative: We conducted semi-structured interviews with 9 caregivers and 8 service providers. The program was highly acceptable and feasible to both caregivers and service providers due to trust in the service navigator, flexibility of the program and streamlined referral processes. Barriers to using the program included complex care needs requiring intensive navigation, high staff turnover, and uncertainty about the sustainability of the navigation service.

Conclusions and next steps

- Integrated models of care and services need to be designed to accommodate for a spectrum of complex care needs and changing workforce capacity.
- Approaches to inform sustainability and scalability of the service include exploring early identification strategies and the use of digital platforms for integrated care and service navigation.

Care navigation and social prescribing have the potential to improve caregiver outcomes, but further evaluation is required with larger samples of families facing adversity.

Health justice partnerships

Wyndham Vale (VIC)

A Health Justice Partnership (HJP) was integrated into the Hub at IPC Health Wyndham Vale. Two legal partner organisations - West Justice and Victoria Legal Aid - provided legal support with a lawyer working onsite one day a week. Caregivers were referred for legal support by Hub practitioners. Thirty-eight caregivers were seen over the first year of the HJP with most referrals for family law matters and family violence.

Practitioners valued the legal support within the CFH and improved in confidence to identify and respond to legal issues. Having lawyers co-located enabled practitioners to build relationships which were critical to the HJP. Caregivers were empowered to access legal support but had an expectation that legal support would be able to solve problems.

We demonstrated that with investment from both partners, HJPs can improve access to legal support and improve practitioner confidence. It is crucial for future HJPs to secure adequate funding, enabling lawyers to provide the appropriate level and range of assistance to meet the needs and expectations of caregivers. Investment in building relationships between HJP lawyers and practitioners, and capacity building for practitioners on how to effectively use legal supports, could help mitigate issues with legal services being underutilised and help maintain functional and lasting HJPs.

Marrickville (NSW)

Lawyers from Marrickville Legal Centre were located on-site at Marrickville Health Centre once a fortnight between August 2022-December 2023. Caregivers reported improved confidence in addressing their own needs. Service providers found the HJP acceptable due to more streamlined referral pathways and improved ability and confidence to identify and respond to legal issues of clients.

Barriers to using legal services included poor understanding of legal services, practitioner discomfort around asking about legal issues, and time constraints and clinical workload. There were several changes to the HJP during the study period which also affected implementation, including changing workforce infrastructure e.g. staff turnover, the physical infrastructure of the Marrickville Health Centre and the impact of COVID. Overall, the HJP facilitated early intervention for legal issues, improved practitioner confidence in addressing unmet legal needs, and improved family access to legal support services.

Both Health Justice Partnerships provided a range of legal assistance, including civil and family law and violence matters.

Lived Experience Involvement

Lived experience involvement refers to the active participation of individuals who have first-hand experience with the condition or situation being studied. These individuals, often referred to as experts by experience, contribute their unique insights and perspectives. Involving individuals with lived experience across all phases of research, project design, implementation, evaluation, and quality improvement ensures that health and community projects are more inclusive, relevant and effective.

A Lived Experience Researcher (LER) was recruited to the CRE. Their experience as a researcher and as a Person with Lived Experience (PWLE) was used in the design, implementation and quality improvement of the project (Figure 6).

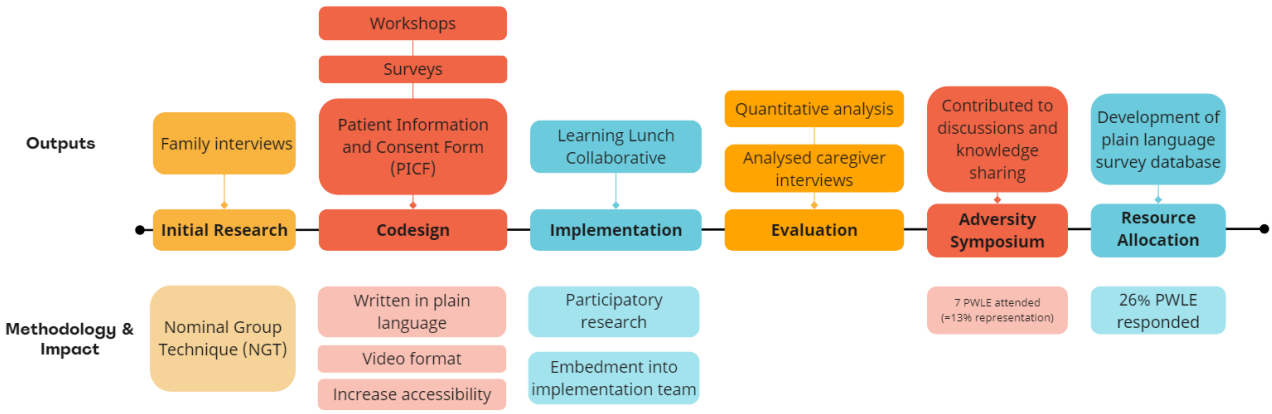

Figure 5: Involvement of Lived Experience Researcher (LER) and Person with Lived Experience (PWLE) in the CRE

Why involve people with lived experience as part of a research team?

The LER ensured families' experiences were kept at the forefront of the CRE team's approach. As a core member of the research team, her involvement included development of the evaluation and the implementation of the Child and Family Hubs. Recruiting representative samples in research is a challenge. The LER was instrumental in advocating for the development of additional resources that accompanied the caregiver consent forms which helped to make the process of consent accessible to a wider audience.

In the Wyndham Vale Child & Family Hub study, 33 countries of birth were represented and 31% of participants spoke a language other than English at home. Families in this area also had significant levels of adversity - 89% having one or more life challenges and 55% having 4 or more.

Lived experience in co-design

The LER was actively involved in the co-design team that engaged families to voice their needs for a Child and Family Hub. Their role also included guiding the project on how to talk or ask about adversity in a trauma informed way, using destigmatising and normalising language. An example of this was using terminology such as 'life challenges' when referring to 'adversities', rather than adversities or adverse life experiences or ACEs as researchers commonly refer to them.

Several resources were developed for the Hubs. The LER's advocacy ensured all resources were presented with information in plain language. In particular, during the development of the Participant Information and Consent Form, the LER led a 2-minute informational video that potential participants could watch to help them understand what the Hub was and what becoming an evaluation participant of the Hub would entail. The video explained simply and clearly the important information about our project and used voiceover and pictures or symbols to enhance understanding.

Lived experience within the implementation team

During the implementation phase, using participatory research methodology, the LER engaged with Hub practitioners in the Lunchtime Learning Collaboratives (a Hub core component) and used their lived experience to enhance practitioner understanding of engaging with families who have life challenges.

A common theme discussed among practitioners was whether families wanted to be asked about challenges. The LER was able to share her experiences of frustration when asked about adversities in consultations as a 'checklist exercise', compared to being asked about adversities and then the practitioner following through with appropriate help or referral. Hub practitioners reported the value of the involvement of lived experience:

'One of the best things…was being able to work with different organisations in the community and also the community members. It was really valuable to hear the lived experiences from the community members and be able to work together in a really collaborative and friendly setting.'

Social Care Practitioner (Hall et al., 2023)

'I have changed the way I think about it, to not try and solve the problem. It's one of the things I really took away from that [lived experience talk] people don't want you to solve the problem they want you to hold it...I feel more confident doing the holding now.'

Health Practitioner (Loveday et al., 2023)

Involvement in National Adversity Symposium

In June 2023, the CRE hosted a two-day national symposium (see Priorities for Impact). It united experts - including professionals and those with lived experience of adversity - to consider Australia's approach to addressing childhood adversity. Of the 54 attendees, 7 people had lived experience of adversity. Their views were highly valued both at the symposium and in the subsequent national resource allocation survey, as illustrated by a symposium attendee:

'I felt that my lived experience was highly valued and I was able to participate in the workshops without feeling prejudiced, not being employed in the mental health sector.'

PWLE reflection on Adversity Symposium attendance

In the national resource allocation survey, 2 of the top 10 priorities for research involved lived experience, i.e. embedding genuine lived experience in research and funding integrated child and family hubs that are codesigned with those with living and lived experience.

There is more work still to do in the research sector, but our CRE has shown it is imperative to involve people with lived experience.

Our lived experience researcher strengthened recruitment of families experiencing multiple adversities and improved Hub practitioner confidence to ask about adversity.

Support Policy and Scale Implementation (Aim 3)

Contributors: Suzy Honisett, Sharon Goldfeld and partners.

What did we do?

Lasting change - such as improved child and family health and wellbeing - is the goal of creating impact at scale. It is due, in part, to expanding the reach of evidence-based practice, embedding systems change, and society and culture shifting their perspectives.[1] The Knowledge Translation (KT) Logic Model, developed by the KT reference group, aimed to guide work to create impact at scale (Figure 7).

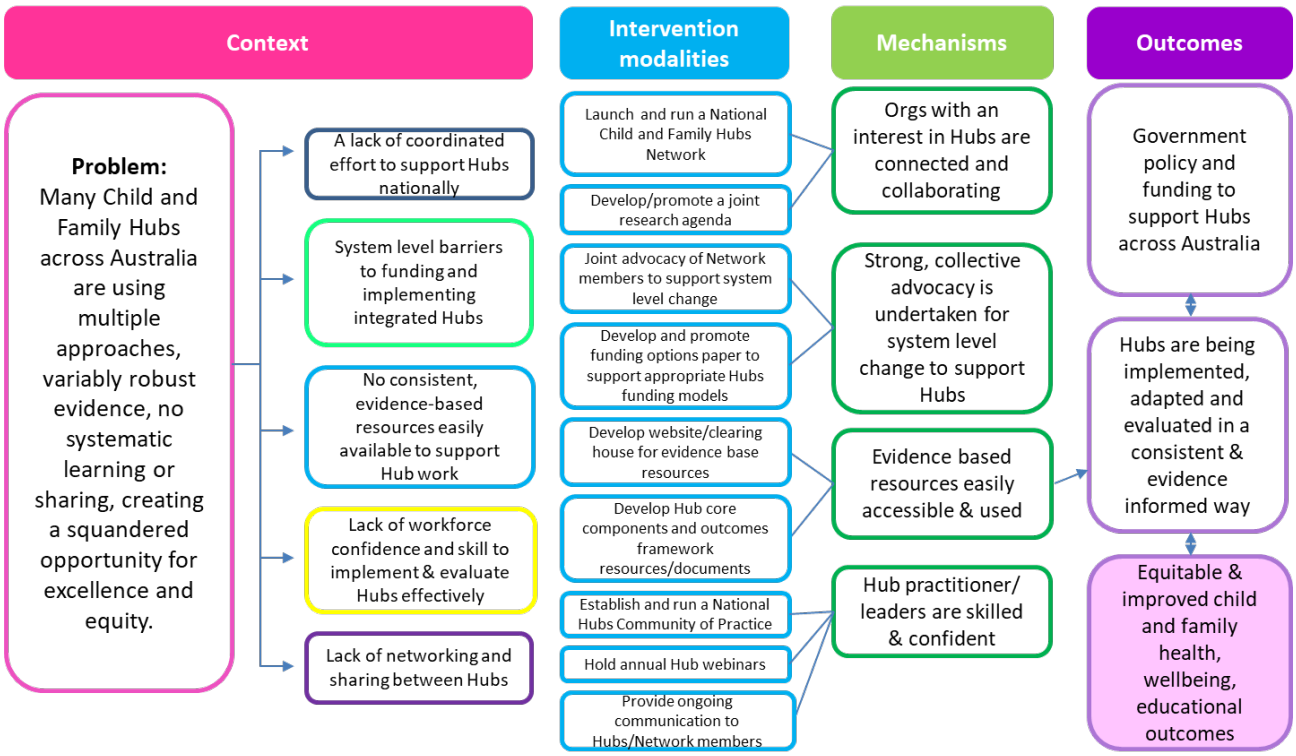

Figure 6: Knowledge Translation Logic Model

CHS: Community Health Service

A range of KT strategies were undertaken to support Child and Family Hubs.

Context - Building the evidence base

To understand current evidence, as well as the Australian state and federal policy environment and service systems that influence Child and Family Hubs, we conducted a:

- systematic review of current evidence on integrated health and social care Hubs and their impact on child mental health
- scoping study of the current federal and state policy environment relating to childhood adversity and Hubs

[1] Social Finance UK. Changing lives, changing systems. Building Routes to Scale. Available at URL: https://www.socialfinance.org.uk/assets/documents/building_routes_to_scale.pdf

- qualitative feasibility study exploring the feasibility of Child and Family Hubs within the Victorian and NSW jurisdictions.

The systematic review identified international evidence of Hubs, suggesting effective integration of care could improve mental health outcomes for children experiencing adversity. This is the first publication to break down integrated care in Hubs and identify key integration elements (Honisett, 2022).

The scoping study provided a clear picture of the policy environment in Australia relating to childhood adversity and informs future advocacy and knowledge translation work in the field (Honisett et al., 2022).

Qualitative research explored policymaker and community health service managers' perspective' of how feasible the Hubs would be in Victoria. We identified barriers and enablers for a Hub model of care at a system level to inform future scale and sustainability of hubs (Honisett et al., 2022).

As a result of this formative work, we were able to map the barriers and enablers to service and system level change for childhood adversity and Hubs, informing future strategies (Figure 8).

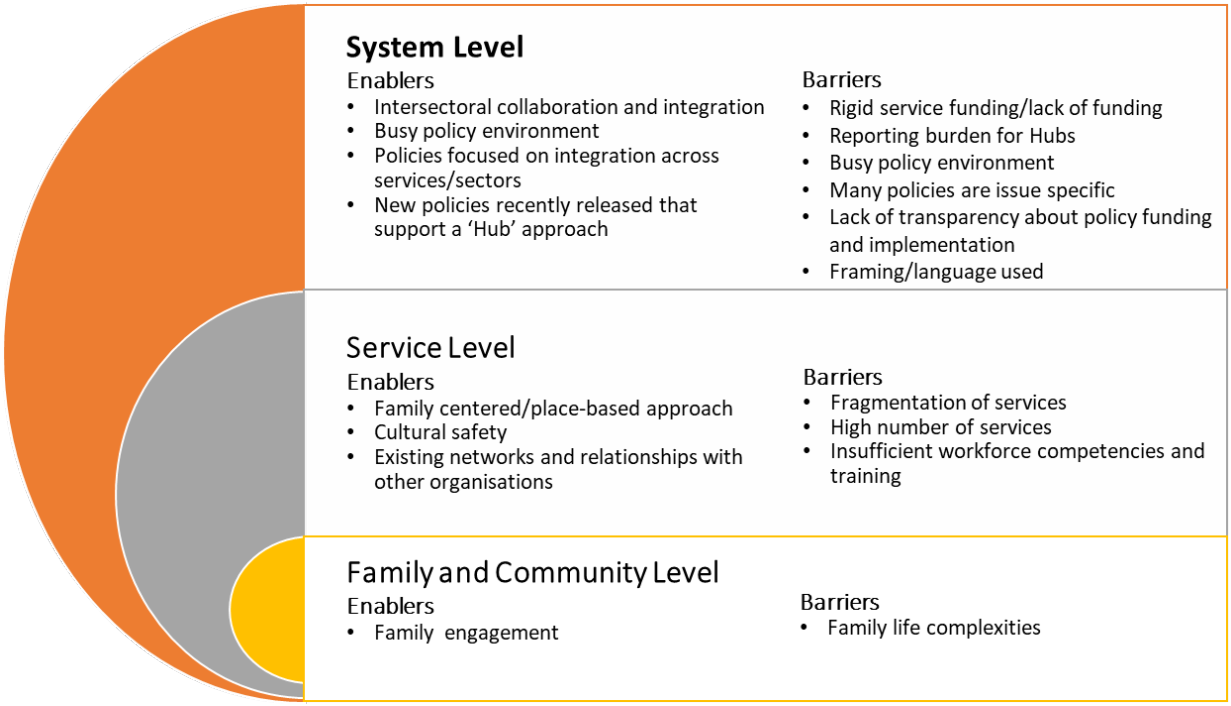

Figure 7: Map of barriers and enablers to change

Interventions

Key interventions were undertaken to support KT across the CRE. Many of these interventions are interlinked and support a number of KT outcomes.

Government Knowledge Brokering

Knowledge brokering facilitates the exchange and translation of knowledge between researchers, experts, policymakers and politicians. It helps inform decision making and drive positive societal outcomes. Within the CRE we focused on government knowledge brokering to support system level changes that were identified throughout the context setting phase. These included government leadership and support, and appropriate funding models to support Hubs as outlined in Figure 8.

Leadership and Support

The following activities were undertaken to engage and facilitate government leadership and support for Child and Family Hubs:

Symposiums attendance/organisation

- Support organising the National Childhood Adversity Symposium.
- Attendance at the Centre for Community Child Health (CCCH) Mental Health Roundtable.
- CCCH 30th year anniversary presentations.

Advisory group membership

- National Early Years Strategy Advisory Panel (Goldfeld)
- Health and Wellbeing Qld Research Advisory Committee member (Goldfeld)
- National Service Model for the Head to Health Kids Hubs Expert Reference Group (Goldfeld)
- Head to Health Kids advisory and evaluation advisory group (Goldfeld and Honisett)

Regular government meetings with state and Federal members of government

Government Submissions

Support policy, legislation or regulation

To support funding and system level change to scale and sustain Hubs, a series of submissions have been made to government departments by the National Child and Family Hubs Network:

- National Early Years Strategy.
- Productivity Commission Inquiry into Early Education and Care.
- NSW Inquiry into improving access to early childhood health and development checks.
- Putting Queensland Kids First.
- South Australian Royal Commission into Early Childhood Education and Care.
- Independent Review Commission.

Researchers in Residence Program

Shape sector practice, create feedback loops, develop talent

Contributors: Suzy Honisett, Sharon Goldfeld, Natalie White, Lauren Heery, Kelly Naess

The Researcher in Residence (RiR) program aims to make evidence available and actionable in community organisations to inform service model design and practice. The program also seeks to generate evidence about what works in these organisations to engage and support children and families, particularly those experiencing adversity. The RiR program focuses on collaboration, active participation of stakeholders and a commitment to shared learning. The researchers in these roles are helping to build a learning health system, responsive to the needs of children and families.

In partnership with the Brian M Davies Charitable Foundation, Sunraysia Community Health Service, IPC Health and DPV Health, we have embedded two researchers across three organisations. The program supports the development and growth of the Child and Family Hubs model.

Defining Appropriate Funding Models

Contributors: Cate Bailey, Suzy Honisett, Harriet Hiscock, Kim Dalziel, Jacinta Dermentzis, Sharon Goldfeld

Alter the reallocation of funding

Funding models to support integrated primary care was a consistent barrier identified through the formative work. Integrated primary care brings together health and social care services to intervene early and support children and families. Funding of integrated care is a barrier to care provision, but evidence is limited for which funding models are most appropriate.

We undertook a **resource allocation survey** to provide expert judgment on what funding model - or mix of models - is most likely effective for integrating primary care for families with children aged 0-12 years in Australia. Participants were purposively sampled experts in primary health, social care and mental health care. Outcome measures included ranking of funding model preferences and qualitative analysis from open-ended questions. Six funding types were included in the study. Block-funding, alternative-payment methods, and incentive-payments were preferred models for integrated care individually and within a blended model. Fee-for-service, capitation and pay-for performance were least preferred models. There was agreement Fee-for-Service may hinder integrating care. (Bailey et al., [*under review*] 2024).

Blended funding models, including alternative-payment-methods, incentive-payments and block-funding, was rated best for providing integrated care for children. A fee-for service approach is no longer considered appropriate.

Costing the Child and Family Hub

Contributors: Ameer Lambrias, Suzy Honisett, Kim Dalziel

Estimate the cost of a Child and Family Hub model as implemented, cost the 'glue', and scale up

There were three objectives of estimating the cost of a Child and Family Hub model:

1. estimate the cost of the model as it was implemented (upfront and ongoing costs).
2. cost the 'glue', comprising the foundational components underlying the integration of the model, and to inform the cost of a national framework.
3. estimate the cost of the model per population or site.

The total cost of the Wyndham Vale Hub as implemented included establishment and ongoing operation costs (Hub services and ongoing core services for Hub families including practitioner salaries) for one year was estimated to be $2,746,308.

The upfront cost of establishing the Hub through co-design workshops, consultation with stakeholders and infrastructure works was estimated to be $160,356 or 5.8% of the overall costs.

Ongoing services included salaries for staff providing core services in the Hub. $2,085,470 or 78.0% of the estimated overall costs went towards the wages of staff including general practitioners, paediatricians, maternal and child health nurses, family services workers, speech pathologists and dieticians. A flexible bucket for services was required to meet the demands and needs specific to the community: totalling $132,286 in salaries and $42,650 for infrastructure.

The 'glue' was defined as the core Hub foundational components to support integration. The cost of the glue included salaries for coordination and integration staff, running training sessions for Hub practitioners, and materials for community outreach and engagement at a total cost of $325,545 (12.2% of overall costs).

It is estimated from the Wyndham Vale Hub costs that $6,379,536 would be required to scale up and roll out the Child and Family Hub model of care across Australia annually across 10 existing primary care or community hubs identified. Utilising already existing services and facilities as the basis for a Hub can allow for significant savings to be made in comparison with establishing a Hub from scratch.

National Child & Family Hub Network

Contributors: Suzy Honisett, Sharon Goldfeld, Molly Peterson

Mobilising a shared voice, harness collective effort, use data for transparency and insight, establish new institutions

There are approximately 460 Hubs operating across Australia (Figure 9). These Hubs provide a local and welcoming 'front door' for families within their community, across early years centres, primary schools, community/non-government organisations, Aboriginal Community Controlled Health Organisations, primary health care, and virtual/digital settings.

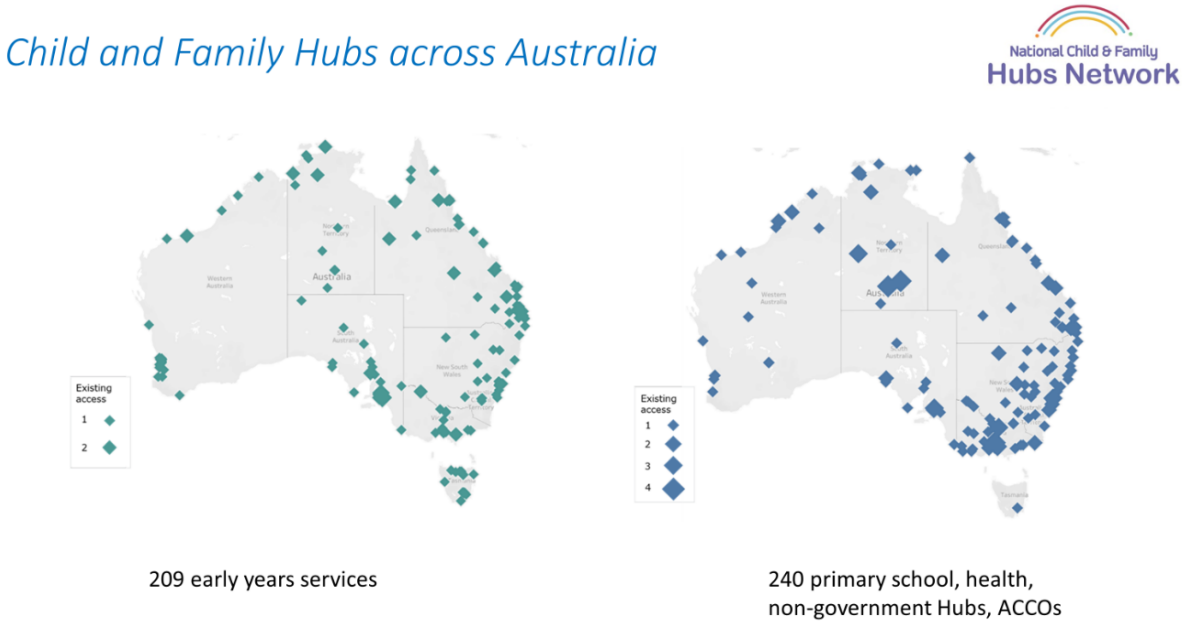

Figure 8: Map of current Hubs across Australia

Despite increasing interest in Child and Family Hubs across most Australian jurisdictions, there has been no coordinating group for these Hubs. We secured philanthropic funding to establish The National Child and Family Hubs Network. The Network was established in late 2021 by Prof. Sharon Goldfeld and Dr Suzy Honisett, and is a multidisciplinary group that brings together Australian universities, research centres, medical research institutes, non-government community-

based organisations, commonwealth, and state government departments. The Network is guided by 20 state and national organisations. The following organisations are represented on the Network Steering Committee* and additional organisations that are critical friends:

Over the coming three years the Network aims to:

- build collective capacity by linking Hubs across Australia to support a shared language, networking and collective learning
- define child and family Hubs and develop a common approach across Australia based on evidence-informed core components
- develop an implementation and outcomes framework for Hubs
- develop and advocate for sustainable funding models to ensure optimal investment of Australia's public dollar.

Additional funding will be required to engage in these activities and to significantly accelerate this work.

Image: The Minister of Early Education and Minister for Youth, The Hon. Dr Anne Aly, (left) attended and spoke at the national launch of the National Child and Family Hubs Network in November 2023.

In February 2024, the Network brought together critical friends, including families with lived experience of adversities, researchers, philanthropists, government policymakers and professionals from education, justice, health and social sectors; as well as Hub implementers for a planning day. The purpose of the day was to co-design and prioritise the future activities of the Network, reinforcing a shared vision and collective action, to support Hubs over the next 2-5 years. The outcome - a Strategic Plan 2024-2029 - is informed by the Network and its members.

Capacity Building Activities to Harness Collective Effort

Contributors: Suzy Honisett, Molly Peterson, Sharon Goldfeld.

A vision for a better system: the role of Child and Family Hubs **webinar** explored the pivotal role of Hubs in connecting families to the services and social supports they need to thrive. The webinar covered the diverse Hub settings of Australia, good practices in Hubs and the benefits of boosting Hub investments, particularly for families experiencing adversity. Over 740 people registered for the webinar.

Through the Network, shared language on the definition of Hubs has occurred through the development of the document published on Analysis Policy Online: *Child and family hubs: an important 'front door' for equitable support for families across Australia* (Honisett et al., 2023).

Regular National Child and Family Hubs **Newsletters** are distributed to the over 950 members of the Network on a quarterly basis.

A **Community of Practice** is being developed to support Hub implementers to build their capacity and share their knowledge and experience. In addition, in collaboration with CCCH and Social Ventures Australia, a deep learning and leadership development group was established to support Hub implementers who are leading change to further support their work and share their learnings.

Overseas Fellowship - In mid-late 2023, Dr Honisett was awarded a travelling Fellowship through the Creswick Foundation, to travel to the UK and US to visit Hubs and Hubs Networks. The following is an excerpt from her report:

'In the United Kingdom, Hubs adhere to guidelines set by the Anna Freud Centre. Ground-level Hubs face tensions regarding the recognition of their work and the reliance on a set of evidence-based interventions. In the UK, Hubs operate within funding-based parameters, necessitating adherence to somewhat flexible guidelines.

In the United States, some states, like California, support Hub-like initiatives such as Community Schools, actively assisting schools in changing practices. However, a lack of national government policy support poses barriers, including funding challenges. In the UK, Hubs receive support from two government departments, indicating significant backing for overcoming systemic barriers to Hub implementation. Nevertheless, there exists a risk that Hubs might be marginalised as a separate intervention or fall off the government agenda with a change of government.

The Australian Network possesses the capability to engage in system-level evidence and advocacy, guiding government funding and policy decisions to reinforce Hub support. Additionally, philanthropy within the network plays a pivotal role, showcasing a steadfast commitment to funding and supporting Hubs. This involvement extends to shaping government funding and support strategies through the Investment Dialogue for Australia's Children. This dynamic creates a substantial opportunity for the National Network to enhance its on-the-ground support for Hubs, fortifying the nationally coordinated approach focused on elevating exemplary practices and influencing systemic support structures.'

Additional activities

Child and Family eHub

Contributors: Suzy Honisett, Lisa Minton, Sharon Goldfeld.

Design for mass reach, adopt a business model for scale

Digital solutions offer great potential to provide high reach, low stigma strategies to deliver information, programs and services, which can be tailored to a family's needs. While there are many digital apps and platforms available, very few have been developed with families specifically offering service navigation support for child mental health problems and family psychosocial needs across the wider age range of 0-12 years.

To address this need, our team developed a minimum viable product for a digital Child and Family eHub (Figure 10) through a user-centred design process involving local service providers and families experiencing adversities. The eHub provides a tiered response to service navigation. It connects families to information and a range of health, education and social services using an online platform. It is:

- tailored to the specific needs of families with young children aged 0-12 years
- designed to deliver varying levels of supported navigation based on individual need/capacity
- integrated to meet the needs of local communities by addressing the social determinants of health, diversity and reach.

The Child and Family eHub is being piloted and evaluated in Wyndham Vale (VIC), Fairfield and Marrickville (NSW). It builds on the work of the CRE to improve access, engagement and use of the existing community, social and mental health services system through a digital platform. It aims to better connect families with children aged 0-12 years, to information and services to meet their child and family needs.

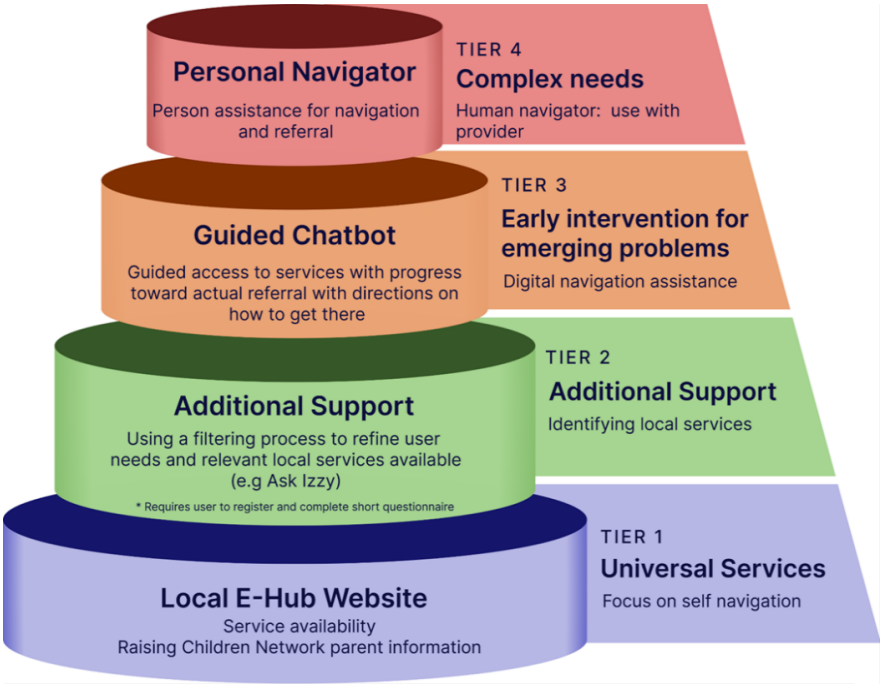

Figure 9: Child and family eHub (Honisett et al., {*under review* } 2024)

What next?

- Based on the Strategic Plan, the Network seeks funding to expand the support of Hubs and develop a robust evidence base to guide further work.
- The Researcher in Residence program is developing a business model for this way of working to inform supports and costing for additional RiR roles in the community.
- The eHub team have submitted grants to extend the development and functionality of the eHub to scale to further areas across Australia.

PhD projects

The CRE supported 4 students to undertake PhDs. This section describes the PhDs and findings to date.

Improving responses to childhood adversity: A mixed methods assessment of barriers and facilitators of practice change

Dr Sarah Loveday
Supervisors: Harriet Hiscock, Sharon Goldfeld, Lena Sanci

Improving the identification and response to childhood adversity is key to changing the long-term outcomes for children. However, research shows that practitioners are reluctant to address adversity due to a perceived lack of community resources, time pressures and a deficit of training or confidence to ask and respond. Moreover, practitioners report that responding to adversity is emotionally taxing. Integrated health and social care hubs have the potential to address some of these barriers.

Practitioners across health and social care were trained to identify and respond to adversity and were supported to develop integrated practice through lunchtime learning collaboratives and mapped referral pathways as part of an integrated health and social care Child and Family Hub. Practitioners completed surveys of self-reported competence and comfort to ask about and confidence to respond to adversity. They participated in semi-structured interviews to explore the facilitators and barriers to practice change.

Practitioners reported increased competence and comfort to directly ask, and confidence to respond across a range of adversities over the 12 month intervention. Practitioners discussed the importance of social connection, knowledge and the confidence in their ability to ask as key drivers of practice change. The barriers to practice change were the environmental context and resources i.e. time pressure as well as practitioner fear of 'opening Pandora's box'. While practitioner confidence can be improved through training, education and providing opportunities for practitioners to practice skills, practitioners report improved skills with social connection and learning from one another.

Changing practice takes more than just education and training. Opportunities for social connection and coaching to improve practitioner confidence and competence are needed as are flexible funding models that support training.

Co-designing a technology-assisted parenting program for parents with mental health issues, to prevent child internalising problems.

Meg Bennett
Supervisors: Marie Yap, Andrea Reupert

This PhD project focuses on co-designing, integrating and evaluating an adapted technology-assisted parenting program for parents with mental health concerns, who have primary school aged children (5-11 years). It comprises a systematic review, co-development and a pilot evaluation (Figure 11). The adapted parenting program will be integrated into the existing mental health services at IPC Health, a health service in Melbourne's western suburbs, to ensure the program is as useful and accessible as possible.

Project aims

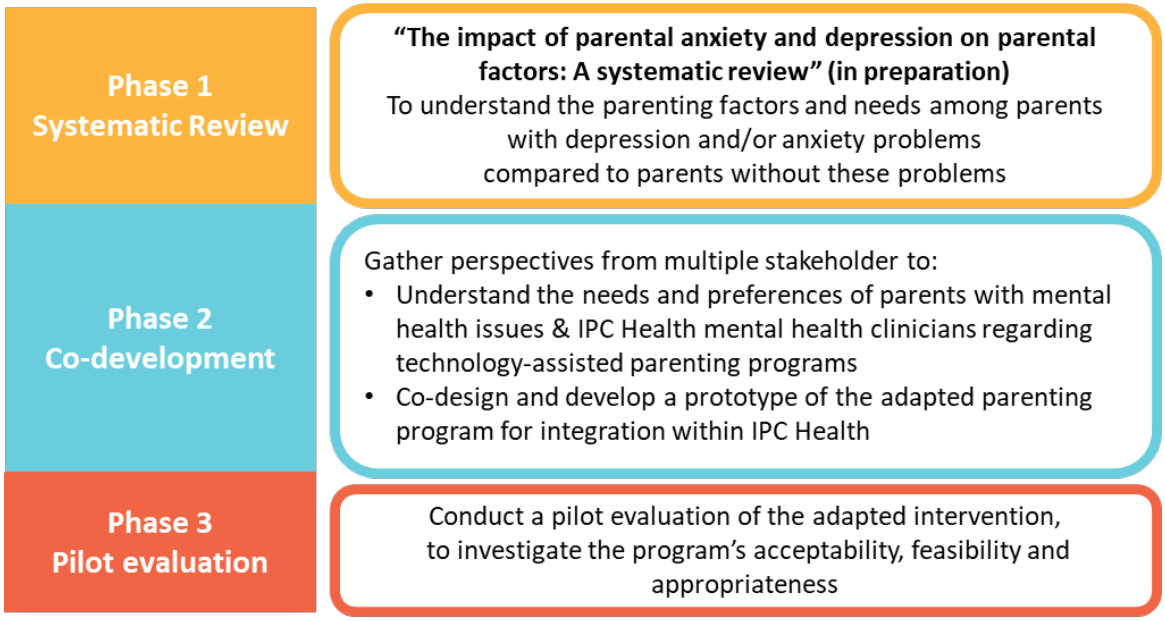

Figure 10: Project phases

Findings indicate multiple needs to be addressed by a parenting program for parents with mental health issues. Needs include promoting parent autonomy, clinician support, validation and normalisation of experiences, tailoring to individual circumstances and strengths-based activities.

A prototype of the parenting program and the associated clinician training package are being developed. The program will involve parents completing online self-directed modules containing evidence-based parenting content and being supported by their existing mental health clinician to problem solve and implement parenting strategies in their life. Next steps include finalising the intervention prototype and conducting a preliminary evaluation of the program's usefulness.

Engaging Parents with Technology-Assisted Programs to Prevent Internalising Problems in Children with Adverse Childhood Experiences

Dr Grace Aldridge
Supervisors: Marie Yap, Tony Jorm, Patrick Oliver

This research aimed to deeply understand how technology can engage parents of children who experience adversity with parenting interventions that help protect their child's mental health. Three studies were undertaken, which have been either accepted or submitted to academic journals (Figure 12).

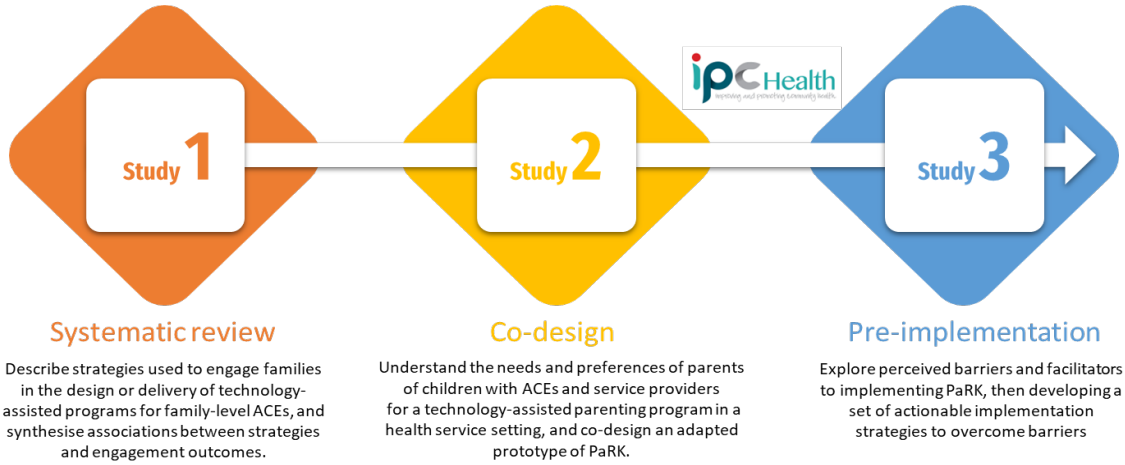

Figure 11: Study overview

- First, we reviewed the scientific literature and found that designing interventions with those who use them can make them more engaging.
- We then co-designed adaptations to an existing technology-assisted parenting intervention (Parenting Resilient Kids) with the IPC Health service accessed by parents of children who experience adversity. The adapted intervention was named Parenting Resilient Kids – Lite Version or 'PaRK-Lite' (Figure 13). It consists of podcasts for parents, complementary micro-coaching sessions between parents and service providers, and a training session for service providers (which can be delivered online or face-to-face).
- Lastly, we investigated potential barriers and facilitators to its implementation and developed strategies to address potential barriers.

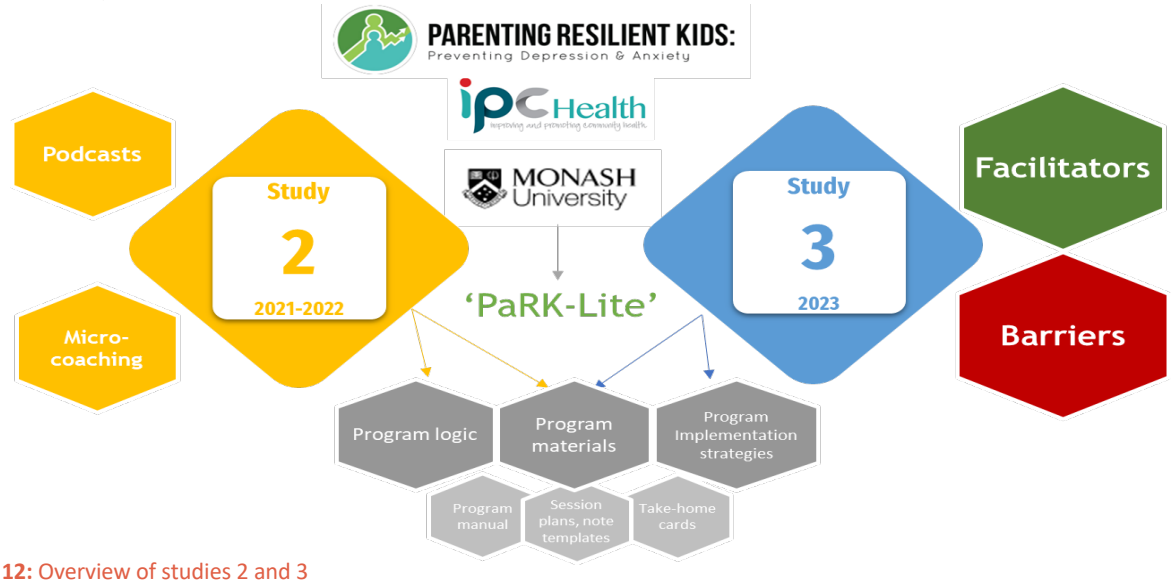

Figure 12: Overview of studies 2 and 3

PaRK-Lite has the potential to empower parents with strategies to protect their child's mental health and be delivered widely at low cost. We hope to see future research and practice evaluate the impact of PaRK-Lite on engaging parents and changing target parenting and child mental health outcomes. Successfully evaluating new interventions and preventing research-to-practice gaps depends on strong partnerships between researchers, health services and other stakeholders. However, we know that health services are often strained for time and human resources. We strongly recommend:

- embedding a researcher within services early to coordinate implementation and evaluation
- conducting interactive forums between researchers and services at the outset. This allows services to learn about current evidence underpinning the intervention and the benefit of evaluating new interventions in contributing to the evidence base, and for researchers to learn about services' current priorities and objectives that might influence implementing a new intervention.

Parents and service providers involved in this research also wondered about how podcasts could be presented to children as well as parents, to support parents in initiating and scaffolding conversations about the podcast topics (such as managing emotions). More broadly, we hope to see future research and practice involve children as well as parents in designing novel, audio-based parenting support media and evaluating the impact on parenting and child mental health.

Interagency Collaboration within Community Healthcare for Families Experiencing Adversity in Australia

Manisha Balgovind
Supervisors: Andrea Reupert, Zoe Morris, John Eastwood

This research investigated how Australian community health services use interagency collaboration to support families experiencing adversity. The research comprised three studies:

1. Models of Interagency Collaboration when Supporting Families Experiencing Adversity: A systematic review (in preparation)
2. Qualitative inquiry on interagency collaboration within community healthcare from the perspective of caregivers, with young children, experiencing adversity
3. A qualitative examination of interagency collaboration from the perspective of community health services supporting such families.

From studies 2 and 3, both caregivers and service providers described their experiences of interagency collaboration as unidirectional referrals with no follow-up, and a lack of communication and information sharing between services. Consequently, caregivers indicated that it was their responsibility to initiate and facilitate interagency collaboration between services. In addition, service providers recommended a central coordinator position to facilitate interagency collaboration and overcome collaboration barriers. While such a position has been shown previously to benefit families accessing support for complex care and social needs (Dewhurst et al., 2018), it requires funding, sufficient resourcing, infrastructure, and professional development to ensure that service coordination and collaboration is provided to each family (Atkinson et al., 2007; Williamson et al., 2022). Finally, findings indicated that service providers who valued collaborative practice were more likely to participate in collaboration even when barriers made it difficult to do so.

Priorities for impact

National Resource Allocation Survey Outcomes

What did we do?

A two-day national symposium was hosted in Melbourne (June 2023) by the Centre of Research Excellence in Childhood Adversity and Mental Health. It united experts - including academics, practitioners, administrators, policymakers, researchers and people with lived experience of adversity - to consider Australia's approach to addressing childhood adversity. With a focus on how to prevent or mitigate the impact of adversities on children and families, the symposium aimed to:

- identify service research and policy areas of most significant importance
- prioritise action across the service, research and policy areas
- determine whether priorities vary for those with lived experience.

A value-weighting approach was then used to identify priorities for action across health, education, justice and social care sectors (Figure 14).

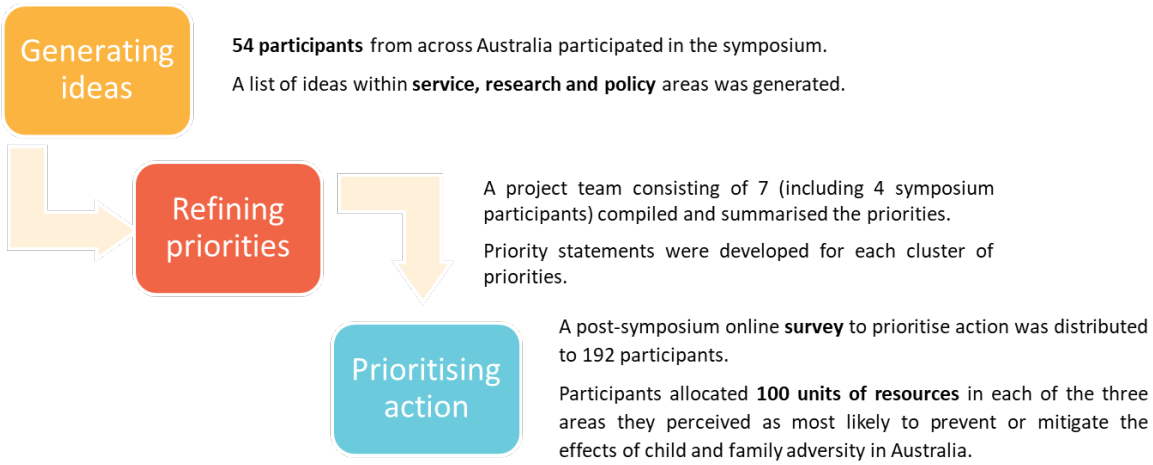

Figure 13: Process for identifying actions to prevent or mitigate the impact of adversity

Preventing or reducing childhood adversity requires collective and integrated policy-level solutions (McEwen & McEwen, 2017)

What did we find?

From the more than 100 priorities generated in the national symposium, we identified 32 service, research and policy priorities for action. Eighty-six respondents completed the survey and allocated resources (i.e. money, time and people) to their top priorities in each of the service, research and policy areas. Over 40% of survey respondents identified the top 10 policy, research, and service priorities (Figure 15).

Figure 14: Top service, research and policy priorities identified in the national survey

The top 10 priorities did not vary significantly for those with lived experience. There was consistent alignment of priorities between individuals with lived experience and other stakeholders, and a shared understanding of community needs.

Integrated care child and family hubs were the only action prioritised across all domains, highlighting the importance of and readiness for this strategy in the Australian context.

Additional considerations for policy and practice

The national survey also suggests considering the following to address childhood adversity:

- Take a multi-sector (education, health, legal, social) approach across policy and practice
- Scale up best practices and evaluate new strategies or untested initiatives, particularly in sectors that lack strong evidence
- Ensure schools shift from a punitive approach (e.g. suspension and expulsion) to a social-emotional and relational approach
- Ensure that lived experience is genuinely embedded in research and co-design with associated funding and clear performance indicators
- Ensure evidence is accessible and actionable – e.g. establishing a national clearinghouse for research into ACEs to reduce duplication of effort
- Evaluate the role of service navigators

Appropriate and integrated responses across sectors, populations and contexts are crucial to addressing adversity. This is the first Australian study to use a formal consensus methodology to establish agreed priorities across service, research and policy areas to prevent or mitigate the impacts of ACEs. It provides guidance for integrated actions to reduce the long-term effects of adversities on child mental health and highlights the most promising solutions.

Additional Resources

Publications

Adversity

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Co-design

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Evidence Briefs

Community-wide interventions

Positive Parenting Programs

Home-visiting programs

Psychological interventions

School-based programs

Videos

Caregiver Information video

Screening for Adverse Childhood Experiences in Children: A Systematic Review (abstract)

Nominal Group Technique workshop (video presentation)

Findings from the Wellbeing Coordinator Program

Appendix 1

Primary and secondary measures at baseline, 6 and 12 months for Hub evaluation

	Measure
Caregiver	
Identification of adversity	Proportion of caregivers who report being asked by a service provider about adversity faced at home, outside the home, and broader societal sphere.
Intervention for adversity	Proportion of caregivers who report spending extra time with or receiving an intervention from a Hub service provider for adversity.
Referrals for adversity	Proportion of caregivers who report receiving a referral to a service for adversity.
Uptake of referrals	Proportion of caregivers who report uptake of referrals to other services.
Mental health	Caregiver psychological distress assessed by 6-item Kessler Psychological Distress Scale 6 (K6). A standard cut-off score of 13 or higher was used to indicate probable serious mental illness.
Global health	Caregiver general health; assessed through a single item of the Short Form Health Survey (SF-12). Dichotomised as Good/Very good/Excellent or Fair/Poor.
Parental warmth, parenting hostility and efficacy	Parental warmth (6-items), parenting hostility (5-items) and parenting efficacy (4-items) from the Longitudinal Study of Australian Children.
Quality of life	EuroQol Health and Well-being Instrument Short Form (EQ-HWB-S); 9-items.
Caregiver experience	Caregiver reported acceptability and feasibility of the Hub as measured by three items from the Australia Bureau of Statistics Patient Experiences in Australia Survey. Responses were on a five-point scale: 1 = Always, 2 = Often, 3 = Sometimes, 4 = Rarely, 5= Never.
Personal well-being	Personal well-being outcomes measured by the Personal Well-being Index; 7 items.
Child	
Child general health	Single item (GHQ-S1) from the Child Health Questionnaire. Dichotomised as Good/Very good/Excellent or Fair/Poor.
Infant temperament	Caregivers who report their infant (0-2 years) is easier/much easier than average; assessed through a single caregiver-reported item on infant temperament; has a moderate correlation (r=0.51) with the Easy-Difficult Scale of Australian version short form of Revised Infant Temperament Questionnaire.
Child mental health	Proportion of children meeting clinical thresholds for poor mental health. For children aged 0 to <2 years: Ages & Stages Questionnaire Social- Emotional Second Edition (ASQ- SE2). For children aged ≥2 to 8 years: Strengths & Difficulties Questionnaire.

*Caregivers with more than one child responded to questions pertaining to one child in their family based on the child they were most concerned about.

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