Strong Start – Northern Pilot

Evaluation Report

Report prepared for DECD
December 2015

A COLLABORATION BETWEEN

FRASER MUSTARD CENTRE

Telemthon Kids Institute

Government of South Australia
Department for Education and Child Development
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1. Executive Summary

Strong Start in the North is a pilot program targeted at first time mothers who are experiencing numerous complex issues. The program seeks to engage pregnant women to help them prepare emotionally and practically for the arrival of their infant. By working with mothers to develop their skills to cope with challenges, connect them to resources, and increase their parenting capacity, Strong Start seeks to support the development of children who may otherwise be at risk of adverse outcomes.

The Telethon Kids Institute, through the Fraser Mustard Centre was contracted to conduct a mixed methods evaluation to examine both process (how well the program was being delivered) and early indications of likely impacts (improved outcomes for mothers and their infants) of Strong Start. Evaluation activities included interviews with program staff and clients along with an examination of the program’s administrative data.

Interviews sought to understand the experience of staff working in the program, the experiences of families in the program, what was working well and where improvements might be made. Additionally, interviews sought to draw out information about the perceived impacts of the program to enable these to be better understood and to allow the evaluation to recommend suitable measurement of outcomes as the program matures.

An audit of the program’s administrative data was conducted to examine the activities of the program, the characteristics of clients recruited into the program, the issues facing clients and the extent to which the program activities are likely to be appropriate to need.

Taking into consideration the time it takes for programs to mature and become established in the community and the number of clients completing the program, the evaluation was not designed to measure impacts on children and families. Instead, the evaluation seeks to inform service provision in order to best meet the needs of clients. Additionally, the evaluation seeks to support the collection of data relevant to client impacts to enable future measurement of program impact.

The evaluation findings presented herein highlight a few key areas for improved service provision, namely:

1) **Clarification of program aims expressed as a program logic**
2) **Transparent care planning led by staff who have the skills to have difficult but affirming conversations with families**
3) **Increased connections with community based services to promote ongoing parenting support such as Children’s Centres and playgroups**
4) **Establishment of referral networks to support the most common issues facing families that Strong Start is not equipped to deal with**
5) **Re-examination of drop-out rates as the program matures**
6) **Focus on assessment and data collection quality to monitor program inputs and outputs**
2. Introduction

2.1. Background

The Department for Education and Child Development funded the implementation of a pilot program targeted at improving health and wellbeing outcomes for women, children and families. The program was initially implemented in the northern metropolitan Adelaide, and was expanded to the South of Adelaide in 2015. The Northern pilot program is initially funded until 30 June 2016. The Southern program is initially funded through to 30 June 2018.

The service seeks to engage first time mothers with complex issues to address the barriers to parenting within a family and to support infants and children grow and develop in safe and nurturing environments. The service seeks to engage mothers with five or more issues through active and assertive engagement practices (Health, 2012).

Strong Start is best described as a home-based service that seeks to provide an early intervention response, commencing during pregnancy, to support first time parents to prepare for their infant. The program is underpinned by an approach that recognises that all children have the right to health, wellbeing and safety in a supportive family and community environment. The program model recognises that families who are already overburdened have a high level of need requiring additional support from a range of community and government service providers. Many of these families present with multiple issues or in crisis (or both). The program seeks to work with families to identify goals that will assist them to build their parental capacity, and in doing so, strengthen opportunities for improving outcomes for the infant.

Providing culturally appropriate care and assistance to all families, is an integral part of the model. Maintaining a connection to family, community and culture is essential for continuing and sustained wellbeing. There is a need for partnerships between Aboriginal and multi-cultural agencies, mainstream agencies and governments, to build on existing strengths, match expectations with appropriate supports and recognise the importance of locally led solutions.

2.1. Home-visiting for at risk families

Indicators of infant vulnerability are able to be identified in the antenatal period and are associated with premature labour and birthing, low birth weight, risk to brain development and other child wellbeing issues. Parental financial stress, unstable housing, lack of social support and poor mental and physical health can have downstream effects on children’s development. Vulnerabilities in early life are predictors of poor later social, behavioural and psychological outcomes (i.e., attachment disorder, mental illness, antisocial behaviour) and subsequent poor education achievements. Research indicates that highly disadvantaged children are more likely to be unemployed, have low levels of education and become involved in the juvenile and adult justice systems when adults than their more advantaged peers. The Strong Start program aims to identify families in the antenatal
period who have such multiple risk factors in a bid to then support the family, in turn hopefully prevents the likely poor developmental outcomes of the child.

The Strong Start Program takes a home visiting approach to delivering the intervention. Home visiting for highly disadvantaged families can be a flexible delivery method that breaks down barriers to accessing institutional services (McDonald, Moore, & Goldfeld, 2012). Additionally, home visiting, as a delivery method, is thought to enable a holistic whole of family approach. Home visiting has been used in the past to deliver a range of program types, from casual support to structured parenting interventions. A review of the evidence for home visiting summarised the following seven elements of successful programs (Council on Child and Adolescent Health, 1998):

1. A focus on families in greater need of services (as opposed to universal programs that may avoid stigmatizing families but might dilute scarce resources), including families with low-birth-weight and preterm infants; children with chronic illness and disabilities; low-income, unmarried teenage mothers; parents with low IQs; and families with a history of substance abuse;
2. Intervention beginning in pregnancy and continuing through the second to fifth year of life;
3. Flexibility and family specificity, so that the duration and frequency of visits and the kinds of services provided can be adjusted to a family’s need and risk level;
4. Active promotion of positive health-related behaviours and specific qualities of infant caregiving instead of focusing solely on social support;
5. A broad multi-problem focus to address the full complement of family needs (as opposed to a focus on a single domain such as increasing birth weights or reducing child abuse);
6. Measures to reduce family stress by improving its social and physical environments; and
7. Use of nurses or well-trained paraprofessionals.

Of the interventions that take a home visiting service delivery model, the models most evaluated are those that are nurse-led programs, and the results of these evaluations are mixed. Research trials evaluating nurse-led home visiting models under strict fidelity and monitoring conditions have been shown to be effective (Watson, White, Taplin, & Hunstman, 2005) and the most cited evidence supporting the model comes from a trial by Olds et al. (Olds et al., 2007), where mothers with at least two demographic risk factors were visited at home during pregnancy for two years after the birth of the child. Control mothers received routine care. The program reported impacts on a range of mother and child outcomes, but these results have not been replicated elsewhere. A recent systematic review of nurse-led home visiting programs for vulnerable pregnant women reported limited evidence of any economic benefit of these programs (Stamuli, 2015).

The Strong Start program, however, is not a nurse-led program and it differs from such models in that it utilises Family Support Workers (unqualified staff) who are supported by a Social Worker and a Nurse. Differences in staffing were intentional and they were intended to address a gap in service provision for families who are difficult to engage in existing services delivered by nurses and are not yet involved with the child protection system but are at risk of becoming involved. A mix of qualified and unqualified staff was trialled as a way to deliver support to families who are traditionally difficult
to engage. Family Support Workers were considered to be peer mentors who would be considered less threatening to families.

2.2. **Strong Start Pilot program**

Funding was provided for a set staffing ratio for the pilot program. A description of the program rationale, the structure of the program, an organisational chart, and the intended outcomes is included in Appendix A (Health, 2012). During the establishment phase of the pilot program, the need to deliver a structured program was identified. To this end the Parenting Under Pressure program (PUP) was employed as the foundation for the delivery of the service. Family support workers were all trained in the delivery of PUP and received ongoing training from the developers of PUP throughout the pilot.

PUP is a home-based intervention designed for families with complex difficulties (e.g., mental health challenges, substance misuse, financial stress, domestic conflict). PUP seeks to improve parental emotional regulation and parent-child interactions. The program draws on attachment theory and mindful parenting to help parents gain greater control over their emotional responsivity in disciplinary situations (Harnett & Dawe, 2008). The program includes 10 modules that FSWs can work through with families in a flexible way. That is, modules can be selected that fit the presenting parenting needs of the families. The entire program can be conducted in the home over 10-12 weeks with a weekly visit, and other case management (e.g., support for housing, liaison with other services, building connection to community, etc.) can be provided in addition to these modules. Parents are provided a parent workbook where achievements are noted to help families identify their goals and the behavioural changes needed to achieve them.

There is limited early evidence of the effectiveness of PUP. To date there have been four published studies of the program, which have involved small samples. PUP program creators have conducted three small pilot studies (two with n= 10 and one with n=12; (Dawe, Harnett, Rendalls, & Staiger, 2003; Frye & Dawe, 2008; Harnett & Dawe, 2008)) and one RCT of the program (n=64; (Dawe & Harnett, 2007)). The pilot trials were for methadone maintained families, for women prisoners and for families identified by social services. A slightly larger randomised control trial (RCT) using PUP involved a group of methadone maintained families. In the RCT the mean age of mothers was 30.33 years and the mean age of their children was 49 months. The program was delivered over 10 weeks and outcomes were assessed at 3 and 6 months using a number of self-report questionnaires (Child abuse potential questionnaire, child behaviour problems with the Strengths and difficulties questionnaire, rigid parenting attitudes). The program had a positive impact on parental stress (PSI), child abuse potential (CAP Abuse score) and child behaviour (SDQ problem score). Modest program effects were reported for rigid parenting (CAP rigidity) and methadone dose. No impact was found for children’s pro-social behaviour (SDQ Pro Social).

More recently a study protocol was published for a larger multi-centre RCT of the program in the UK (Barlow et al., 2013). Findings of that evaluation have not yet been published.

As far as is evident from the published literature, Strong Start is the first use of the PUP in a group of mothers in the antenatal period through to early childhood. The children of mothers in the
published trials were toddlers and pre-schoolers. It is unclear what difference this is likely to make to the effectiveness of the program, but this difference should be considered when comparing the outcomes of the use of PUP in Strong Start to other published evaluations.

The present evaluation is not, however, an evaluation of PUP, instead it is an evaluation of the Strong Start program and the use of PUP within the program context. The scope of the evaluation is described in the next section.

2.3. Evaluation

The Telethon Kids Institute, through the Fraser Mustard Centre, was engaged by the Department for Education and Child Development to undertake an evaluation of the Northern pilot program. As a pilot program, Strong Start has evolved and continues to do so. Through working in partnership with the program providers, the evaluation seeks to actively inform continued program implementation and increase its potential to improve the outcomes of parents and their children. An earlier review of factors impacting referral and engagement was conducted in 2014 and that report is included in Appendix B.

The evaluation works outlined in this report sought to measure both the process of the program implementation and early outcomes for parents and children.

The evaluation is supported and guided by an Evaluation Committee comprised of key service providers, government officials, and experienced evaluators as identified below. The group has provided strategic and expert advice to inform the evaluation.

Figure 1 below gives an overview of the components of the evaluation. The works are organised under the headings of Process and Outcome, although there is overlap, with activities addressing both aspects of the evaluation.

<table>
<thead>
<tr>
<th>Process</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Qualitative</strong></td>
<td><strong>Quantitative</strong></td>
</tr>
<tr>
<td>Semi-structured Interviews with Strong Start Staff (n=10), including:</td>
<td>Data base support</td>
</tr>
<tr>
<td>1. Family support workers</td>
<td>Data cleaning</td>
</tr>
<tr>
<td>2. Coordinator</td>
<td>Administrative data</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Qualitative</strong></td>
<td><strong>Quantitative</strong></td>
</tr>
<tr>
<td>Semi-structured Interviews with Strong Start clients (n=27)</td>
<td>Data collection support</td>
</tr>
<tr>
<td></td>
<td>Data cleaning</td>
</tr>
<tr>
<td></td>
<td>Analysis of outcomes data held in administrative</td>
</tr>
</tbody>
</table>

Figure 1. Evaluation overview

This report presents the findings of the process evaluation alongside the early impacts of the pilot program. The report concludes with recommendations for future impact evaluation and program reporting.
3. Method

For ease of presentation, the following section describes the qualitative and quantitative methods separately.

3.1. Qualitative methods

3.1.1. Sampling

Strong Start staff and clients were recruited for interviews. Given the small size of the program, all staff were given the opportunity to take part in an interview. Clients invited to take part in an interview were randomly selected from the list of past and current program clients.

3.1.2. Method of approach

The method of approach for staff and clients varied due to the differing nature of the groups and these are described below. Each group was provided with an invitation letter outlining what was involved in participation and an associated consent form (see Appendix C).

Staff

Family support workers (FSWs), the program nurse, and the social worker were sent an email from the program coordinator inviting them to take part in an interview. All interested staff were asked to make contact via email with the evaluators to book a time for an interview. A list of all staff who were currently or had previously been involved with the program was also provided to the evaluators to make contact with past staff who may wish to take part in an interview. The evaluators attempted to contact with each of these staff where appropriate to do so.

Clients

The program coordinator generated a random list of past and present clients to invite to take part in an interview. The program coordinator attempted to contact each of these clients. The program coordinator explained the evaluation to past and present clients who were able to be reached and asked if they would be interested in taking part in an interview to share their experience of the program. Once the initial list of randomly selected clients had been exhausted, an additional list was created until 20 past or present clients had volunteered to take part.

3.1.3. Participants

Clients who participated in an interview were roughly representative of the population from which they were drawn with the exception of mothers with a culturally and linguistically diverse background who were underrepresented in the interview sample.

Around 60% of the past and present program staff took part in an interview and this included staff who had ceased their involvement with the program, staff at all levels of the program delivery, and staff who had been with the program for a short time or a longer time. Thus the staff sample is considered to be representative of the staff as a whole.

Demographic data for clients and staff who took part in an interview are summarised in Tables 3-1 and 3-2 below.
**Clients**

Table 3-1. Clients (N=19) demographic characteristics

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-22</td>
<td>8</td>
<td>42</td>
</tr>
<tr>
<td>22-26</td>
<td>6</td>
<td>32</td>
</tr>
<tr>
<td>26-30</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>30-35</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>35-40</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Above 40</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aboriginal or Torres Strait Islander</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-ATSI</td>
<td>17</td>
<td>90</td>
</tr>
<tr>
<td>ATSI</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Culturally and linguistically diverse background</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>No</td>
<td>17</td>
<td>90</td>
</tr>
</tbody>
</table>

Note: Due to rounding percentage totals may not equal 100%. In three instances fathers sat in on interviews but were not the main interviewee. These fathers contributed their thoughts and in some cases prompted the mothers to remember experiences. In these exchanges, the father’s experiences of the program were not explored and are thus not reported.

**Staff**

Table 3-2. Staff (N=13) characteristics

<table>
<thead>
<tr>
<th>Gender</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Female</td>
<td>13</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aboriginal or Torres Strait Islander</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-ATSI</td>
<td>13</td>
<td>100</td>
</tr>
<tr>
<td>ATSI</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time in role (years)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>39</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>23</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Role</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>Program management</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>FSW/Nurse/Social worker</td>
<td>7</td>
<td>54</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current or past</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current</td>
<td>11</td>
<td>85</td>
</tr>
<tr>
<td>Past</td>
<td>2</td>
<td>15</td>
</tr>
</tbody>
</table>
3.2. Data collection - Qualitative

3.2.1. Setting

All interviews were conducted in a private setting that was convenient for participants. Most client interviews were conducted in their homes. Two client interviews were conducted by phone, where these clients had relocated to regional towns. Interviews with staff were conducted in private meeting rooms in their usual workplace.

3.2.2. Number and duration of interviews

A total of 19 client and 13 staff interviews were conducted. Interviews lasted between 12 minutes and 1 hour. Staff interviews tended to be 45-60 minutes in duration. Client interviews varied but tended to be shorter in duration ranging from 12-45 minutes in duration.

3.2.3. Determining data saturation

Data saturation is the point at which no new information emerges in interviews than that which has already been heard in previous interviews. To determine whether data saturation was likely to have been reached, the evaluator reviewed field notes and discussed the interviews with the social worker who attended all client interviews.

The evaluators are confident that data saturation was reached with the large number of interviews conducted for the program size. Additionally, themes were repeated across the two participant groups, providing confidence in data saturation having been achieved. Information gained from each subsequent participant corresponded with information already heard, but provided a different perspective around the central themes, thus providing a rich data set for thematic analyses.

3.2.4. Audio recording

Interviews were audio recorded in all but two instances. In one case the participant did not consent to be audio recorded. In the second instance the audio recording failed.

3.2.5. Interview notes

In all interviews, notes were taken that summarised the statements made by participants. Following interviews with no recording available, interview notes were expanded to more wholly summarise the participant’s answers.

3.2.6. Transcription

Interview data were transcribed in full.

3.3. Data collection – Quantitative

3.3.1. Database development

At the time of planning the evaluation, Strong Start did not have an electronic database. The evaluators were therefore tasked to develop a Microsoft Access database to record administrative and outcomes data until the program’s administrative data could be collected in a centralised government database. The database was designed in consultation with Strong Start staff and management to collect client demographic information, program service activities, referrals into and out of the service, and baseline and outcomes measures for clients. The database also allowed for infant outcomes at 6 and 12 months of age.
In addition, staff entered data into a Parenting Under Pressure (PUP) database for the purposes of assessing clients’ support needs and tracking these over time. Assessment scores generated from the PUP system were also entered into the administrative database to enable the evaluation to access this data.

### 3.3.2. Measures

A number of assessments are administered at four time points (antenatal, postnatal, 6 months, closure) and entered into a PUP online database for the purpose of case planning and progress monitoring. Scores for each of the assessments were then entered into the administrative database for the purposes of the evaluation. The following measures were collected in this way for the Strong Start program:

**Social support scale**

The social support scale is comprised of two components, Part A and Part B.

Part A is a measure of how much support a person feels they get. This scale has three subscales that measure support separately for family, friends and significant others. A high score (greater than 4.68) suggests that the person is feeling quite well supported by her family /friends/significant others at the time of the assessment. A mid-range score (between 3.57 and 4.68) suggests that the person is not feeling well supported at the time of the assessment. A low score (less than 3.57) suggests that the person is feeling very unsupported at the time of the assessment. A total score for Support Scale A is an averaged score across the three subscales.

Part B is a measure of how much emotional and practical support a person experiences. Part B generates four scores: actual practical support, ideal practical support, actual emotional support, ideal emotional support. Comparison of actual and ideal scores shows whether people are receiving the level of support they would like to receive.

**Life Events**

The Life Events scale is an eight item measure that asks people to indicate which stressful events they have experienced in the past year and how they felt they coped with the stress. Response options are: This did not happen (0), this happened but I have been coping OK (1), this happened and I am not coping (2). The scale is scored by counting the number of 0, 1, and 2 responses. People are also able to list up to two other stressful events that are not covered in the list of eight events (major relationship problem, major money problem, housing problem, serious health problem, serious health problem of a close friend or family member, death in the family or of a close friend, legal problems, trauma from an accident, assault or crime). Thus people can score up to 10 on any one of the response categories or a total of 10 divided across the response categories.

**Hassles**

The Parenting Daily Hassles Scale (PDH) (Crnic & Greenberg, 1990) is a measure of parental perceptions of the frustrating, annoying, and distressing demands on parents. The PDH includes a rating of the frequency and intensity of a number of daily hassles. The scale is comprised of 10 items that parent(s) rate on a scale of 0 (not a hassle at all) to 4 (a huge hassle). An average score is calculated across the 10 hassles.

**Depression, Anxiety and Stress Scale (DASS)**

The DASS 21 is a 21 item self-report questionnaire designed to measure the severity of a range of symptoms common to both Depression and Anxiety. The measure asks people to rate on a scale of 0 (did not apply to me at all) – 3 (applied to me very much or most of the time) the presence of each
symptom over the past week. Scores are calculated for three subscales: Depression, Anxiety and Stress. The 21 item DASS scores are then multiplied by two to get a score. Severity levels for each of the subscales is presented in Table 3.3.

Table 3.3. Severity levels for the DASS subscales

<table>
<thead>
<tr>
<th>Severity</th>
<th>Depression</th>
<th>Anxiety</th>
<th>Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>0-9</td>
<td>0-7</td>
<td>0-14</td>
</tr>
<tr>
<td>Mild</td>
<td>10-13</td>
<td>8-9</td>
<td>15-18</td>
</tr>
<tr>
<td>Moderate</td>
<td>14-20</td>
<td>10-14</td>
<td>19-25</td>
</tr>
<tr>
<td>Severe</td>
<td>21-27</td>
<td>15-19</td>
<td>26-33</td>
</tr>
<tr>
<td>Extremely Severe</td>
<td>28+</td>
<td>20+</td>
<td>34+</td>
</tr>
</tbody>
</table>

Alcohol

The Alcohol Use Disorders Identification Test – Consumption (AUDIT-C) is a shortened version of the 10-item AUDIT tool, first developed by the World Health Organization in 1989 (Bush, Kivlahan, McDonell, Fihn, & Bradley, 1998). AUDIT-C has been validated for use with pregnant women. The measure is comprised of three questions that estimate alcohol consumption in a standard, meaningful and in non-judgemental manner. The total score from these questions provides an indication of the risks to the woman’s health. Scores between 0 and 3 indicate low risk of harm. Scores between 4 and 7 indicate a medium risk of harm. Scores above 8 indicate a high risk of harm.

Mindful parenting

The Mindful Parenting Scale utilised in PUP is a self-report measure of parent’s ability to reflect on their own emotional state, to manage their emotions and to identify and respond to their baby/child’s emotional state. There are 27 Items each scored on a 5 point scale. Each of the items are scored on a scale of 0-4 (never true, rarely true, sometimes true, often true, always true), with a number of items reverse scored. For the Strong Start program the measure is scored online through the PUP system and an average score is presented between 0-5.

3.3.3. Data collection issues

Strong Start staff did not initially use the Access database routinely. In part this was due to changes in leadership and management that caused delays to staff database training and staff being instructed to use the database. The Strong Start program overview (see Appendix A) assigned responsibility for data management to the program clinician (a qualified social worker). In reality the program clinician did not conduct ongoing assessments, nor collect or enter data. Once data entry was commenced historical data needed to be entered retrospectively and an administrative staff member was tasked with this. This may have impacted on the completeness of the data, particularly for client contact points and referrals where this data is difficult to ascertain entirely from case notes.

3.4. Data analysis

3.4.1. Qualitative - Interviews

The first author and a research assistant thematically analysed interview data using deductive analysis (described by Crabtree & Miller, 1999). Thematic analysis is the process by which data is organised into themes. Deductive thematic analysis is guided by pre-existing ideas about the data – in this case the program aims and structure, which formed the basis for the evaluation questions, were used to guide the organisation of interview data. Analysis involved reading and re-reading all
interview transcripts; identification of codes that addressed the research questions; and organisation of codes into broader themes. As a consequence of the analysis strategy, themes corresponded to the key research questions.

To ensure consistency of thematic coding, the first author and research assistant reviewed initial coded data and discussed any discrepancies. Coding was in agreement for 90% of coded data. For the remaining 10% consensus was reached through clarification and generation of additional nodes, where new themes were identified through discussion.

Section 4 of this report summarises these themes and relates these to the research questions.

3.4.2. Quantitative - Administrative audit

The program’s administrative data was provided to the evaluators for the purpose of auditing the program’s service activities. Administrative program data is insufficient for the determination of the impacts of the program on client’s and their infant’s outcomes. Instead, the administrative audit enables identification of likely impacts through analysis of trends in the data and has the potential to highlight supports that are working well within the existing program framework as well as opportunities to enhance service provision.
4. Qualitative Findings

Themes emerging from interviews are presented in relation to process and impact separately. For both process and impact, themes are broken down into subthemes to elaborate on factors that were said to be impacting on the service.

4.1. Process

Process refers to the operation of a service. In the case of Strong Start, process refers to the way in which family support workers engaged with first time mothers, the support family support workers received in their role to enable them to work with high-risk families, and program establishment issues that may have impacted on the service provided. Thus, the themes identified herein relate to the facilitators and barriers to providing first time mothers with support during the antenatal period.

4.1.1. Factors impacting engagement

Staff said that clients who were engaged with and enthusiastic about the program and willing to make changes in their lives were more likely to have positive outcomes. A number of factors were said to impact upon the degree to which families engaged with the program; and both clients and staff identified barriers and facilitators to engagement.

**Barriers**

A number of themes emerged around the factors impacting on clients’ engagement with the program. These factors can be grouped into three broader themes: barriers to initial engagement, to remaining engaged, or to making positive changes.

**Barriers to initial engagement**

- Previous experience of service providers
  
  Clients reported being sceptical of the service before engaging due to their historical engagement with various government departments and service providers. Clients reported that other services they had previously been in contact with had been restricted in what they could offer or in some cases perceived as unhelpful. They contrasted this to the family support worker who was friendly and could help in a range of ways.

  “Yeah you go to some things and they just give you attitude. Like when I went to the counselling thing and they’re not the nicest and say stuff you don’t like...Where they’re the opposite, they were trying to come up with ways that he could stay. So yeah it’s definitely a lot better, a lot nicer.” (client)

  “‘Cause I know even with domestic violence services, they’ve got their core focuses, and it was just nice to have that more personal...And flexible program. Not that I’m saying that DV (domestic violence) services are not like that, they’ve got their core focus and they’re very helpful and everything in every way, they’ve been amazing. It’s just a different sort of support. Where this has been more around, it’s primarily around helping me, work out ways to help me and [my child].” (client)

  “Yous would probably explain things better than what other people do. And probably [have] more patience, heaps more patience.” (client)
• Lack of perceived need for the service
  Staff reported that mothers who declined the service tended to feel that they did not need the support. Similarly, some mothers who had engaged with the service reported that they didn’t think they needed parenting support, but that they had been struggling with a particular issue (such as lack of housing) that they felt they could use help with. For these mothers it was the practical support that drew them to the service.

  “Originally I just thought I don’t really need that type of thing. But once I spoke to them I was like “nah” and it worked out for the best.” (client)

• Lack of information about the program
  Clients spoke about their initial hesitation to use the service as they were unclear of what the program could provide for them or the extent to which the worker would be involved in their lives. Only clients who had engaged with the service were interviewed, thus it is difficult to gauge the impact this may have had on mothers who were referred into the program but chose not to engage. Nevertheless, mothers reported that they decided to “give it a shot” and it is likely that others may not have been so open.

  “You get told so much [and] your mind is in overload, you don’t remember clearly half of the things you get told. Whereas an information pack or even a magnet with your office times and that type of thing”. (client)

  “It was a lot different to what I expected, but not exactly in a bad sense. I didn’t really like the idea of someone coming once a week or twice a week to constantly pay attention to everything going on” (client)

  “To be honest the CAFHS nurse didn’t explain any of it so I didn’t have a good knowledge of it until I met [coordinator] and she spoke to me and put me in touch with [FSW]... and they explained most of it to me. And said it was just a way to help build you up, bring you up, help you look after [child], all that sort of stuff.”(client)

Barriers to remaining engaged

• Reliability of the worker
  A few clients noted that their visits became short, hard to come by, prone to cancelation, or skipped. Clients who spoke about this usually associated this with workers being too busy or having personal issues that took them away from work. Reliability of the worker was spoken about as being important for clients who relied on the program for support. Lack of reliability of the worker impacted upon the ability of clients to remain engaged with the program. It should be noted that this was not reported as a wide spread issue across all FSWs in the program.

  “Or sometimes she never rocked up at all, like we’d have appointments booked and she’d never rock up.”(client)

• Staffing changes
  Staffing changes were noted by a number of clients. Some clients reported that the new worker was not as helpful as the old worker who they had become familiar with. The transition between workers was said to have been sudden and without a handover period.
“When (old worker) stopped, it wasn’t like a gradual thing to meeting her. She just came and then that was it.”

**Barriers to making positive changes**

- Negative influences from family members or partners
  Clients who were said to be unlikely to make positive changes were often said to be hindered from doing so by being closely connected with a partner, family member or friends who continued to engage in destructive or unhealthy behaviour. This was most noted for clients with substance abuse or domestic violence issues.

**Facilitators**

Facilitators to engaging with the program were spoken about as being either facilitators to initial engagement or facilitators to building a relationship with the family support worker. Here, themes are presented that supported clients to engage initially. The relationship between client and family support worker is discussed as a separate theme with a number of subthemes in the next section.

**Facilitators of initial engagement:**

- **Word of mouth**
  Clients reported that they had heard good things about the program from a friend, the midwife at the hospital or another service provider and that this had made them receptive to letting a stranger into their home.

  “My friend told me about ..’cause a support worker used to come see my friend. And she talked to me about her and I thought I should try” (client)

- **A feeling of needing support**
  A number of engaged clients reported that when they were first offered the service they accepted the offer because they felt they needed as much support as they could get.

  “’Cause I knew being a single parent that I’d need all the help I can get. So I thought: a support person, great, sweet, done.” (client)

  “I thought it might come in handy for some parts, with the baby.” (client)

  “I just got a phone call and a girl said that she wanted to help me and I was like “ok”, getting some help. I didn’t really have any ideas of what she was going to help sort of thing I just thought I’d get some help.” (client)

  “I was in deep distress so they linked me with the service.” (client)

- **Voluntary nature of the program**
  Staff reported that building a relationship with clients was easier because the program was voluntary. Mothers who chose to engage with the service were receptive to building rapport with family support workers because they wanted this support.
**Client/Worker relationship**

The connection between the client and their family support worker was said to be one of the key facilitators in engagement. The relationship can be categorized into four key themes, and these are discussed in turn below.

- **Friendship**
  For many of the interviewed families, the family support workers were viewed as a non-threatening, non-judgemental ‘friend like’ source of support.

  “She was really helpful, sometimes we didn’t sit there and talk about what I was feeling and what I was doing. It started feeling like more of a new friend that was coming to visit – and that’s what I enjoyed.” (client)

  “We talk about everything. Were that comfortable we talk about our own lives openly as if we’d been friends for like 20 years or something. It’s really good.” (client)

  These clients said that they were able to talk to FSWs about issues that they weren’t comfortable discussing with their friends for fear of judgement or embarrassment. The client-worker relationship was characterised by mutual respect and lack of judgement.

  “You don’t feel embarrassed, you don’t feel like “am I asking the wrong thing?” You don’t have to feel awkward about asking something like ‘is this an ok age to feed them this?’” (client)

  “She makes suggestions and like I’m an adult and an actual person not like a kid or a young mum to her. You feel equal really, ’cause a lot of people look at you a bit funny. I’m short and I’m only twenty and they’re like “you’ve got a kid already?” She’s not like that at all.” (client)

  These attributes played a role in clients developing trust of the worker. For these clients the friendship-like relationship may also have acted as a catalyst for making changes in the client’s life because the worker was not seen as an authority figure but an equal who cared. The sense of safety this relationship created for clients allowed the worker to challenge the client on difficult issues.

  “Well she made me stop and think about myself. All in a good light. She never criticized me, she never told me off.” (client)

  “Mainly, she’s really easy to talk to. I can’t sit there and talk to my friends about half of the stuff that I can talk to (FSW) about... Stuff that I can’t talk to my friends about, like things that worried me and things that really got to me – cause I get very overwhelmed very easily.” (client)

- **Role model**
  Staff often reported that clients had limited or no positive role models in their lives. Staff talked about how they provided a positive role model for those who were in need or could not envision a life outside of what they/their family had experienced. Clients echoed this role model theme.
“They’re like a mum if you don’t have a mum.“ (client)

- Reliable support
  Both clients and staff reported the importance of the reliability of the worker. Reliability of the worker helped bring some stability to client’s lives. Clients frequently described the family support workers as ‘someone they could count on’, a reliable source of support. This was reflected by the staff, who recognised the importance of being predictable, regular and consistent.
  
  “That’s been helpful for them, that there is actually a service that follows through ‘cause I also hear about other ones that have been referred to other services and they just haven’t even been there for them.” (staff)

- Professional boundaries
  Although the relationship between client and family support worker was a key engagement facilitator, this friendship-like relationship was also reported as being potentially problematic. Concern was raised that it blurred the professional boundaries between client and worker and that it potentially created a reliance on the family support worker.

4.1.2. Program Delivery

The pilot program appeared to lack clarity and transparency in the way it was delivered to families. Mothers who were engaged with the program reported that they were unsure about what the program provided, even after being involved for some time, and would like clarity about the areas in which they can be supported.

“They handed me a piece of paper with nothing much on it. I wasn’t really told much at the start. I still don’t know what you guys do properly” (client)

The nature of Strong Start’s support to first time mothers was discussed as being unclear by both clients and staff. Much of this was said to have stemmed from a number of leadership changes, changing service provision parameters, and lack of centralised support (e.g., cars, email, etc.). At the time of the interviews, these earlier problems appeared to be largely resolved. Family support workers reported that with current leadership and professional supervision structures they now felt better supported and clearer about their role. Nevertheless, the informal nature of the program was something clients appreciated.

Mothers spoke about the service as a causal form of support that was non-intrusive, did not push them and allowed them to take the lead.

“When they speak to you they don’t try to overstep their boundaries and what they talk about…Sometimes when I’m sad I like to discuss with other people how I’m feeling about situations instead of being contradicting, I guess, or too involved or nosey, they just give a little bit of advice and leave it there.” (client)

“…basically given the support “you’re doing a good job, you could think about doing ‘this’ or ‘that’ differently”. Just getting the general support and ‘you’re
doing a good job” type of thing, given the encouragement that you quite often need.” (client)

Parenting Under Pressure (PUP) framework was brought in to give the pilot program some structure. Insufficient support around implementing that program was reported by staff to have been a barrier to working effectively with that model of service delivery. Given the varied backgrounds of staff in the Northern Pilot, they may not have previously been exposed to working with case plans or assessment tools and thus the training provided was said to not have been enough on its own. Conducting assessments and developing case plans with the family was envisaged to be the role of the program clinician (See Appendix A). In actuality, it was implemented differently in the program whereby FSW conducted this work with families once families were assigned a worker after the initial assessment.

Some FSWs spoke about the way they used the assessment tools and modules from PUP to assess client’s needs and then work through issues. In spite of some staff approaching their work in this way this was not echoed by clients. When asked specifically about the forms they filled in with the worker, clients reported that this was for the worker to help understand the client’s situation and what the client needed. Clients did not identify that the process was related to goal setting or planning. When asked specifically about what goals clients were still working toward a few clients identified longer term goals of gaining qualifications or employment, or building social connections but these were not discussed as specific aims of working with the program. When probed further about how the family support worker was helping clients work towards these goals, mothers often responded that the worker was helping them find information.

While some staff spoke about working with families towards independence, others when asked about how they plan immediate and longer term goals with clients said that problems were addressed as they arose or once they were identified by the client. This reactive style of support appeared to result from the complexity and chaos of client’s lives and the flexibility of the workers to work within a broad framework of support.

“If I needed any help with anything I could just ring her up a couple of days before hand and say “look can you get some information on this’ or some information on that”. (client)

“But they came over every three weeks and we usually just had a normal conversation, it wasn’t really relevant to anything. So it makes me feel more comfortable.” (client)

In summary, clients appeared to view the family support worker as a flexible, non-intrusive and responsive source of information and support.

4.1.3. Referrals/building connections to community

Building client’s capacity to draw on resources available in the community is one of the aims of the Strong Start program. Connection to community and the capacity to navigate and utilise available community based supports is an important outcome for parents that can be of benefit to them and their children beyond their time with Strong Start. Clients and staff talked about connections to

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community as being important, but there appeared to be room to grow these connections further and also to make transparent this aim of the program. In addition, connections to other specialised services can support clients to work through complex issues that Strong Start alone is not well equipped to deal with. Supporting parents to make these connections and work through these issues while also working with Strong Start to increase their parenting capacity provides a holistic approach in complex cases.

“We probably also learnt that being a standalone program is not beneficial” (staff)

“Some of our challenges are a little bit about getting some counselling or get them into a therapeutic program that can support them with their mental health” (staff)

“They may need some other professional help as well, especially with relationship counselling or maybe linking to a DV service or something” (staff)

“Just having a good community understanding as well as connections with other programs outside of our program has been really helpful ‘cause you have an idea of where to offer them if need be or get advice from.” (staff)

Staff expressed that they felt more work needed to be done with service providers in the service delivery area to establish referral pathways. A number of challenges were noted to connecting with other agencies.

“I think that it’s been, it feels like it’s been fairly closed. In terms of, people go out and do their work with the families but don’t necessarily engage with a whole lot of other services” (staff)

“trying to encourage workers to find out a bit more information from other services if they’re working with the family and from the referral agencies and doing more things together.” (staff)

A number of parents reported being supported throughout the program to connect with community, other parents, navigate services, and be advocated for when they were having difficulty working with a service.

“We’d be home and going nuts [if we did] not have the access to playgroup. I wouldn’t have thought about actually going out in the community and finding something” (client)

“They come in and see how you’re going and help you find mothers group, where other things and information that they could go to. Like in my case, with trying to get the legal aid information. Strong Start may be able to point you in the right direction and cut out a lot of the “I’ll transfer you to this department” and then get transferred to another department only to be transferred to four departments only to be transferred to the one that you first started at because the person you initially spoke to didn’t have any idea.” (client)
Parents often spoke about the difficulty they had overcoming various barriers to engaging with their community (anxiety, lack of confidence in using public transport, not know what was available, etc.). Clients spoke about the benefits of meeting other mums and having the opportunity to speak with other families. Clients spoke about how FSWs encouraged them to overcome their social anxiety, went with them, or gave up their time to try to support them to connect. This informal support was spoken about as helpful. Community centres and playgroups were among the most common connections mentioned.

“Strong Start have definitely helped me gain confidence, ‘cause I wasn’t very confident. And helped me get out of the house more often and try and talk to people. (Interviewer: How did they help you to do that?) Encouragement.” (client)

“And because I suffer from real bad anxiety as well she’s kind of helped me push my boundaries to go places I never thought I would go, like playgroups and stuff.” (client)

In addition to speaking about their desire to connect with other parents, some mothers noted they would have liked more opportunities to see the program nurse. Although the nurse visits clients twice during the 2-year program, clients said that it would be nice to see the nurse more so they could ask her more questions. Staff members reported being able to approach the nurse for advice when necessary.

4.1.4. Historical implementation issues
Staff discussed a number of historical issues which were said to have influenced the implementation of the program.

- Workers initially weren’t clear on how the program differed from Early Child Parent Service (ECPS) with staff having come from ECPS and new staff originally going out with ECPS staff. Workers were trained in PUP however the clinical lead (Coordinator) was not trained and could not provide the professional development required to integrate PUP into the service. Consequently not all workers utilised the program.

- Family support workers noted that assessments from PUP were difficult to do with some clients, but no interviewed clients reported this. When probed specifically about assessments clients identified the value of these and that the assessments helped family support workers to gauge where support was needed.

- The family support workers felt that trying to do assessments when they are clearly not appropriate had the potential to do more harm and also prevents clients from engaging with the service.

- Staff reported difficulty in working across two departments; trying to align processes within the program to each department and ensuring you’ve met both sets of guidelines.
• The client intake criteria caused difficulty for some staff due to the cut off for eligibility, particularly when a client was transient. A more extensive discussion of referral issues from earlier evaluation works is included in Appendix B.

“It is difficult when people are referring and you can see a need but you have to say no because it doesn’t fit the criteria”

These issues were largely resolved at the time the interviews were conducted.

4.1.5. Staff – qualifications and training

Staff discussed how their qualifications, professional supervision and PUP support their work. These discussions can be summarised in four distinct themes, described in turn below. Much of the discussion was pre-empted by staff. This was a salient issue for many staff since the establishment of a Strong Start program in the South of Adelaide with Social Workers in the roles filled by differently qualified staff in the North.

• Previous experience
Family Support Workers are employed with no formal social work qualifications. The program also employs one clinical lead who is a qualified social worker. Role descriptions for these staff can be found in Appendix A. Staff reported coming to the FSW role with different educational backgrounds or experiences. In general, FSWs believed that their past experience, skills and understandings helped them work with Strong Start Clients. While some staff identified ways in which they had grown in the role others felt they had come to the role with all the necessary experience (gained in previous roles) and their work practices and experience had not changed as a result of working in the program.

• Parents Under Pressure
A number of themes arose around the use of PUP in the Strong Start Northern pilot. The structure of the program was spoken about as useful but it was not being used in its entirety.

Some staff reported that the assessment processes and tools within PUP were useful to structure their work with clients.

“I feel the benefit of the first assessment is really, it really gives us more of an understanding of our client; where there supports are at, where they are at with their mental health and that sort of thing. When we do several I find them really interesting to look at. In between that time we’ve had sessions where we discuss things, or we’ve problem solved, we’ve done a variety of things. And that assessment allows me to see if there’s been any changes and if my work is having impact. So really the assessments are the most useful thing I find from it.” (staff)

Nevertheless, staff expressed the need for more clarity around how they ought to be implementing PUP. Some staff reflected that no support was given to work out how to use PUP with families that were not responding well. Staff spoke about how the clinical lead and the program coordinator were themselves unfamiliar with PUP and that this meant there support was not readily available when they had questions about the program.
“I think we really need more support around how to use PUP with our clients. I think we have a general idea, obviously we’ve done training but I think we need, or I personally need more guidance of how to use that with clients. Are we using the whole handbook, taking it out? Are clients supposed to be receiving a handbook? Just more clarification around what we um, yeah, how to use that with our clients.” (staff)

- **Staff qualifications**
  The service mix of staff was said to provide a holistic team in terms of allocating clients and matching them to specific workers. This variation in qualifications was also seen as necessary for the different tasks associated in care plans and benefited clients as staff had a broad range of knowledge and skills on the team to draw upon.

- **Professional supervision**
  Staff frequently mentioned how present support from senior/supervisory staff improved their work and confidence in decision making processes. Staff also reported learning from each other about how to help clients with specific circumstances and how to negotiate various systems (Centrelink, housing, childcare, etc.).

  “Quite often I’ll come back from a client and just be ... not knowing what to do and I’ll sit down and I’ll talk it through with them and we’ll come up with a plan.”

  (staff)

  “There have been clients that have been harder to work with but having that support from the coordinator and from the social worker have really helped me to be able to do my job.”

  (staff)

### 4.2. Outcome

#### 4.2.1. Building capacity

Strong Start’s stated aim is to improve the outcomes for children by working with first time mothers to build their parenting capacity. Capacity building was spoken about in a number of ways and these are discussed in turn.

- **Growth in confidence and independence**

  When asked about what the program does for families, staff spoke about teaching clients the skills they needed to be independent. Similarly, clients spoke about their increased independence and ability to navigate systems. Parents stated that they did not always know exactly where to go for things but that they at least knew now that there is something they could be doing.

  “They’ve helped me to get my independence and create my own family”

  (client)

  “Cause I didn’t know what we were going to do beforehand ‘cause we don’t get any help or support from anything. So her helping me through all that stuff was good. Showing me places I can go like to the Salvation Army and stuff. And get food parcels and they can help you out with stuff like that. We probably wouldn’t have food or anything.”

  (client)
Parents also spoke of having increased confidence in making decisions for themselves and for the benefit of their children.

“And then all of a sudden then your confidence builds and your confidence builds you’re making decisions on your own” (client)

“I used to get very stressed out, I used to say “Nuh, I’m not doing this anymore” and now it’s, “Nuh, I have to do this and I have to stick with it”...It’s been a big change for me.” (client)

- Improved parenting/interaction with their child

Staff also spoke about helping parents keep their baby at the centre of their thinking and supporting parents to build healthy attachments with their infants. Less focus was placed on children’s holistic developmental outcomes. Similarly, families referred to attachment, feeding and settling support they had received through the program. Generally, clients reported greater confidence in parenting and in handling situations on their own. A number of parents spoke about the benefits of having been able to do the Circle of Security parenting course to help them better bond with their child.

When probed clients could talk about what they had learned in regards to their child’s development but saw the program as being more about supporting them. For example, when asked about what is better now for their baby than if they hadn’t been involved with the program, clients often said “s/he has a happier Mum”.

“They give you tips on what to do; tips on easier bed times, and food and stuff like that. Things that you wouldn’t be able to work out yourself.” (client)

“I had no idea what to do. Like when she was crying, the first time I was crying with her too. Now I’ve become so strong.”

“I didn’t know I had a bond with him, at all. I didn’t understand the bond. But going through especially the (circle of) security I can see that we have a bond, I can feel the bond now.” (client)

“I’ve been pretty good with kids my whole life. So I’ve known everything mainly it’s more with the teething and all that. I got explained by [social worker] how things go and all that. But most things I know about myself already.” (client)

In spite of gains made in the program, a number of clients reported being anxious about finishing up with the program. Clients said that they weren’t sure where they might get support from next. Mothers mentioned that although it was a two-year program they still felt like they needed support after exiting. When probed mothers were able to identify some links to community that workers had supported them to build, but this wasn’t spoke about as a clear exit strategy.

4.2.2. Improved health and wellbeing

Mother’s often spoke about a reduction in stress being an outcome of the program specifically as it related to the practical support provided to them. Support was spoken about in terms of transport,
advocacy with other agencies, help arranging housing, furniture and so forth. Some mother’s recognised that this was helpful because it reduced their stress during pregnancy.

“I think it just helped heaps because I was stressing because had this big bill that I had to pay for but at the same time I was pregnant so I had to get stuff for bub so it was really stressful. But because she was there and I knew she was helping, it just took some of that stress away. It was still there, I still had to pay for it but ‘cause she was helping it took a lot of that stress away and made it a bit easier.” (Client)

“Basically the fact that I would have been struggling to find the information for legal aid, I would have just been stressed out, he would have been sensing it and it would have been even harder for him to fed etc.” (Client)

This theme of practical support was spoken about differently by FSWs who reported helping clients with practical issues but also with emotional and mental health concerns. Staff reported that if the mothers were a bit better prepared, they would be able to manage the birth process and what happens afterwards more successfully. Staff and clients reflected that it is difficult to deal with the emotional aspects until the practical concerns are addressed and the chaos in the client’s life is reduced.

“But it’s about how long can you do that for before you’re wanting to cross over into addressing those underlying issues. Sometimes you can kind get stuck in just meeting peoples immediate needs” (staff)

Nevertheless, when staff were asked which issues were difficult to impact upon or change the most frequent responses were mental health issues, substance abuse and domestic violence.

“So making real in roads into domestic, people who might be in domestic violence or choosing partners that are violent or have other histories. And I think that is because there seems to be a lot of intergenerational poverty and dysfunction and abuse.” (staff)

“I think where there’s a mental health issue, sometimes just change in general is very difficult depending on the complexity of the mental health issue” (staff)

“Which is quite difficult with some clients – to keep them on track. Definitely if they’ve got [mental health] disorder, they’re quite focused on their crisis at the time and where they’re at, rather than trying to work through a change process.” (staff)

“You often can’t stop clients from taking drugs. Sometimes it is more about harm minimisation. So rather than focusing on clients not using drugs at all it is about helping them to see how it will impact on their child and making sure that children are safe and cared for if the parent is going to use drugs.” (staff)

In spite of staff reporting difficulties in impacting on mental health issues, a number of clients said they felt supported by workers when they were struggling emotionally. A number of clients likened the FSW to counsellors.
“So the emotional side she’s really really helped with, because I get frustrated easily, I’m just an angry person sometimes in general. And she helps me with all of that. If I’m feeling upset or anxious or anything like that I can always give her a phone call and she’s always there to talk me through it and just kind of put my mind back onto a normal path, instead of thinking that everything is going to explode on me.” (client)

“Definitely the councillor coming to see to me. Is that what they’re called councillors?...I wasn’t sure ’cause I’ve been telling everyone they’re my councillors and they’re coming!” (client referring to FSW)

5. Administrative audit

5.1. Client characteristics

5.1.1. Demographic characteristics

Table 3 details demographic characteristics of clients referred to the program. Complete demographic data were not captured for all referrals. This is especially true for education, income and to a lesser extent housing.
Table 5.2-1. Demographic characteristics of mothers referred to Strong Start

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gestation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First trimester</td>
<td>46</td>
<td>24</td>
</tr>
<tr>
<td>Second trimester</td>
<td>63</td>
<td>33</td>
</tr>
<tr>
<td>Third trimester</td>
<td>57</td>
<td>30</td>
</tr>
<tr>
<td>Postnatal</td>
<td>26</td>
<td>14</td>
</tr>
<tr>
<td><strong>Mother’s Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13-17 years</td>
<td>57</td>
<td>30</td>
</tr>
<tr>
<td>18-22 years</td>
<td>84</td>
<td>44</td>
</tr>
<tr>
<td>23-27 years</td>
<td>31</td>
<td>16</td>
</tr>
<tr>
<td>28-32 years</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>≥33 years</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td><strong>CALD</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>139</td>
<td>67</td>
</tr>
<tr>
<td>Yes</td>
<td>70</td>
<td>33</td>
</tr>
<tr>
<td><strong>ATSI</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>164</td>
<td>78</td>
</tr>
<tr>
<td>Yes</td>
<td>26</td>
<td>12</td>
</tr>
<tr>
<td>Unknown</td>
<td>19</td>
<td>9</td>
</tr>
<tr>
<td><strong>Mother’s education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never attended school</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Still at school</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Year 8 or below</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Year 9 or equivalent</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Year 10 or equivalent</td>
<td>16</td>
<td>26</td>
</tr>
<tr>
<td>Year 11 or equivalent</td>
<td>12</td>
<td>20</td>
</tr>
<tr>
<td>Year 12 or equivalent</td>
<td>19</td>
<td>31</td>
</tr>
<tr>
<td>Trade/TAFE/some University</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Completed Undergraduate degree</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Income source</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Student - Youth Allowance</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Unemployed-Youth/Newstart Allowance</td>
<td>48</td>
<td>21</td>
</tr>
<tr>
<td>Disability Support Pension</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>Parenting Payment</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Special Benefit</td>
<td>1</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Employment</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Rental</td>
<td>67</td>
<td>45</td>
</tr>
<tr>
<td>Family/Friends</td>
<td>43</td>
<td>29</td>
</tr>
<tr>
<td>Private buying</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Homeless</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>SAHT-Public Rental</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Supported Accommodation</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Short term/emergency</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: Per cents are rounded and may not sum to 100

5.2. Service provision

5.2.1. Duration of program

Strong Start is a voluntary program and it is available to mothers for up to 2 years. Of the clients enrolled in the program, approximately one third were enrolled for fewer than 6 months and approximately another third were enrolled for more than 15 months.
5.2.2. Program referrals

Of the 228 clients referred to the program, 116 clients were recorded to have been enrolled in the program, 97 were recorded not to have been enrolled in the program and data specifying enrolment was missing for 21 referrals. This section outlines the reasons for referral, the number of issues clients were facing at the time of referral and how this differed for mothers who were enrolled in the program when compared with those who were not enrolled.

Reference issues

Referral issues were recorded for all 116 clients enrolled in the program and for 78 of the first time mothers who were not enrolled in the program. On average first time mothers referred to the program had 4.59 issues (SD=2.77, range 0-19). Where issues at referral were recorded, the most prominent issues facing first time mothers were mental health, social isolation and unstable housing/homelessness. Figure 3.2 details the prevalence of recorded referral reasons. Compared to enrolled first time mothers, mothers who were referred but not enrolled had fewer presenting issues (5.60(SD=2.90) and 3.14(SD=3.12), respectively) and the difference in number of issues was statically significant (t=7.45(189), p<.001). Although enrolled mothers presented with significantly more issues, a large proportion of missing data for non-enrolled mothers reduces the confidence in this finding. Examining the prevalence of referral reasons for enrolled and non-enrolled mothers shows a similar pattern of issues, with the most prevalent issues being mental health and social isolation. Figures 5.2-3 and 5.2-4 present the prevalence of referral issues for enrolled and non-enrolled mothers.

Table 5.2-2 Length of time in program

<table>
<thead>
<tr>
<th>Length of time in program</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3 months</td>
<td>17</td>
<td>15</td>
</tr>
<tr>
<td>4-6 months</td>
<td>22</td>
<td>19</td>
</tr>
<tr>
<td>7-9 months</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>10-12 months</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>13-15 months</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>16-18 months</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>19-21 months</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>22-24 months</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>25-27 months</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>27-30 months</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>115</td>
<td>100</td>
</tr>
</tbody>
</table>
Figure 3-1 Prevalence of issues at referral - enrolled and non-enrolled mothers
Reasons for not enrolling were recorded for 96 of the 118 referred mothers who were not enrolled in the program. Reasons for not enrolling are presented in Figure 5.2-4 below. Only 13% of mothers referred but not enrolled were recorded as not being eligible for the program due to having low issues. Thus it appears that service providers referring into the program were doing so in line with the program’s stated target group.

![Figure 5.2-4 Reasons for not enrolling mothers into the program](image)

### 5.2.3. Clients contacts

The intensity of support provided to mothers throughout their enrolment in the program can be estimated from client contact data. Client contact data is derived from records of home visits, client transports, phone calls, text messages and so forth. Figure 5.2-5 shows that the majority of client contacts happened in the first 9 months of the program and then reduced incrementally across the life of the program; although this included contacts with mothers who were referred but not enrolled into the program. As seen earlier in Table 5.2-2, the data suggest that a third of clients were active in the program for only 0-6 months, thus a drop in the number of contacts beyond that time is to be expected.
To examine the distribution of client enrolment into and engagement with the program and how this has changed over time, Figure 5.2-6 below plots the length of time clients stayed in the program against their enrolment date. Dots below the red line are clients who ceased their engagement with the program and dots above the red line represent clients who are still engaged with the program. From this we can see that clients tended to remain engaged with the program, and this tendency to remain with the program has become more evident as the program has matured (i.e., fewer clients who enrolled in the program after July 2013 have ceased their engagement. The higher density of dots across the bottom of the graph between Jan 2013 and July 2013 shows that most clients who have exited the program at various stages of their engagement enrolled with the program in the first six months of its establishment. The length of time these clients stayed in the program varied. Clients who enrolled after Jan 2014 have tended to stay in the program. Graphs detailing the frequency of client contacts for each of the length of program groups is presented in Appendix D.

**Issues addressed during contact visits**

Examining the issues dealt with during client contacts provides some indication of the prevailing issues for enrolled mothers. For each client contact the issue being dealt with and the type of
contact made (email, phone call, home visit, client transport, etc.) were recorded. A total of 5208 contacts were recorded. Clients may have been supported for more than one issue at any contact, thus 11,865 issues were recorded. One quarter of these records were noted as ‘client engagement’ or building/maintaining a relationship with the client. Table 5.2-3 details the issues for which clients received support during contacts. It should be noted that data for client contacts was entered into the administrative database retrospectively from client case notes and this may have compromised the integrity of this data in two ways. Firstly, it is unclear how consistently client contacts were recorded and filed in each client’s case files. Secondly, case files are dense and sorting through these for contact notes is likely to result in some missed records. Thus, given the large volume of client contacts made there is a likelihood that there may be omissions in this data. Had family support workers recorded each contact directly into the database at the conclusion of the contact, confidence in the data may be increased. Nevertheless, proportion of issue prevalence is likely to be a reasonable reflection of the true proportion and what may be missing is the true volume of contacts. Moreover, it is more likely that particular types of client contacts will have been missed if recording varied across contact types.

Table 5.2-3 Issues clients were supported with during contacts

<table>
<thead>
<tr>
<th>Issue discussed at contact</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting</td>
<td>989</td>
<td>8.3</td>
</tr>
<tr>
<td>Other</td>
<td>902</td>
<td>7.6</td>
</tr>
<tr>
<td>Physical Health - child</td>
<td>766</td>
<td>6.5</td>
</tr>
<tr>
<td>Relationships</td>
<td>732</td>
<td>6.2</td>
</tr>
<tr>
<td>Housing</td>
<td>730</td>
<td>6.2</td>
</tr>
<tr>
<td>Income/financial management</td>
<td>628</td>
<td>5.3</td>
</tr>
<tr>
<td>Physical Health - adults</td>
<td>538</td>
<td>4.5</td>
</tr>
<tr>
<td>Child Development</td>
<td>496</td>
<td>4.2</td>
</tr>
<tr>
<td>Mental Health</td>
<td>365</td>
<td>3.1</td>
</tr>
<tr>
<td>Emotional Health</td>
<td>320</td>
<td>2.7</td>
</tr>
<tr>
<td>Home management</td>
<td>257</td>
<td>2.2</td>
</tr>
<tr>
<td>Birthing</td>
<td>236</td>
<td>2.0</td>
</tr>
<tr>
<td>Education/employment/skill development</td>
<td>231</td>
<td>1.9</td>
</tr>
<tr>
<td>Review</td>
<td>212</td>
<td>1.8</td>
</tr>
<tr>
<td>Legal issues</td>
<td>191</td>
<td>1.6</td>
</tr>
<tr>
<td>Feeding/Breast feeding</td>
<td>167</td>
<td>1.4</td>
</tr>
<tr>
<td>Groups</td>
<td>164</td>
<td>1.4</td>
</tr>
<tr>
<td>Self esteem/personal development/confidence</td>
<td>142</td>
<td>1.2</td>
</tr>
<tr>
<td>Drug and Alcohol issues</td>
<td>124</td>
<td>1.0</td>
</tr>
<tr>
<td>Family/Domestic violence</td>
<td>113</td>
<td>1.0</td>
</tr>
<tr>
<td>Isolation - linking to support</td>
<td>106</td>
<td>0.9</td>
</tr>
<tr>
<td>Child abuse/protection</td>
<td>103</td>
<td>0.9</td>
</tr>
<tr>
<td>Nutrition</td>
<td>68</td>
<td>0.6</td>
</tr>
<tr>
<td>Childcare</td>
<td>60</td>
<td>0.5</td>
</tr>
<tr>
<td>Attachment</td>
<td>35</td>
<td>0.3</td>
</tr>
<tr>
<td>Disability - physical and intellectual</td>
<td>27</td>
<td>0.2</td>
</tr>
<tr>
<td>Child Behaviour management</td>
<td>19</td>
<td>0.2</td>
</tr>
</tbody>
</table>
The way in which support was provided was recorded for 5099 of the 5208 client contacts. More than one method of support could be recorded for any contact, thus the total number of reported ways in which support was provided was recorded 8433 times. Table 5.2-4 details the counts for each method of support provided.

<table>
<thead>
<tr>
<th>Type of support provided</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussion/listening/counselling</td>
<td>3324</td>
<td>39.4</td>
</tr>
<tr>
<td>Advocacy</td>
<td>388</td>
<td>4.6</td>
</tr>
<tr>
<td>Group work</td>
<td>76</td>
<td>0.9</td>
</tr>
<tr>
<td>Provision of information/education</td>
<td>2992</td>
<td>35.5</td>
</tr>
<tr>
<td>Referral to other service/group</td>
<td>580</td>
<td>6.9</td>
</tr>
<tr>
<td>Practical support</td>
<td>385</td>
<td>7.3</td>
</tr>
<tr>
<td>Research</td>
<td>3</td>
<td>0.6</td>
</tr>
<tr>
<td>Social action/Community Capacity building</td>
<td>42</td>
<td>0.0</td>
</tr>
<tr>
<td>Planning for group</td>
<td>30</td>
<td>0.5</td>
</tr>
<tr>
<td>Other</td>
<td>613</td>
<td>0.4</td>
</tr>
</tbody>
</table>

Referrals out of service
A total of 120 referrals out of the service were recorded and these were recorded against only 36 clients and this small number of referrals appears to be a result of missing data. The number of referrals for each client out of the service ranged from 1 to 12, as detailed in Table 5.2-5. The mean number of referrals per client was 3.33 (SD=2.95). Referrals were recorded separately from contacts. In the administrative data set, a referrals information was collected in a table that provided for information on the reason for the referral, the agency/service referred to, the date of the referral and whether the referral was active (e.g., appointment made for client, client take to service) or passive (client given information about a service/program). The number of referrals recorded in the referrals table are a fraction of the 580 reported referrals in the client contacts table – where a client contact was assigned a method of support. This indicates that there is likely a great deal of missing data in the referrals table of the administrative data base. Thus caution is advised in interpreting the data presented in this section of the report.
Table 5.2-5 Number of referrals each client received

<table>
<thead>
<tr>
<th>Referrals per client</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>80</td>
<td>69.0</td>
</tr>
<tr>
<td>1</td>
<td>13</td>
<td>11.2</td>
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<tr>
<td>2</td>
<td>5</td>
<td>4.3</td>
</tr>
<tr>
<td>3</td>
<td>7</td>
<td>6.0</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>2.6</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>12</td>
<td>2</td>
<td>1.7</td>
</tr>
</tbody>
</table>

Clients were recorded to have been referred to a range of community, health and parenting support services as detailed in Table 5.2-6. Looking more closely at the reasons for referral, Figure 5.2-7 details the reasons for which clients were referred to other services. To gain a clearer understanding of the service that Strong Start workers connect clients with and the reasons for these, Table 5.2-8 details the services referred to for each of the referral reasons.

Table 5.2-8 Frequency of referrals to service types

<table>
<thead>
<tr>
<th>Agency/Service</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Centres/Services</td>
<td>26</td>
<td>21.7</td>
</tr>
<tr>
<td>Centrelink</td>
<td>17</td>
<td>14.2</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>9</td>
<td>7.5</td>
</tr>
<tr>
<td>Hospitals</td>
<td>9</td>
<td>7.5</td>
</tr>
<tr>
<td>Housing</td>
<td>8</td>
<td>6.7</td>
</tr>
<tr>
<td>GP</td>
<td>8</td>
<td>6.7</td>
</tr>
<tr>
<td>Other Health Services</td>
<td>7</td>
<td>5.8</td>
</tr>
<tr>
<td>Financial</td>
<td>7</td>
<td>5.8</td>
</tr>
<tr>
<td>Non-Gov Organisations</td>
<td>6</td>
<td>5.0</td>
</tr>
<tr>
<td>Legal</td>
<td>4</td>
<td>3.3</td>
</tr>
<tr>
<td>Education - Adult</td>
<td>4</td>
<td>3.3</td>
</tr>
<tr>
<td>Education - Child</td>
<td>3</td>
<td>2.5</td>
</tr>
<tr>
<td>Community Health - Parents</td>
<td>3</td>
<td>2.5</td>
</tr>
<tr>
<td>CFIS Groups</td>
<td>3</td>
<td>2.5</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>Disability Services</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>Recreation</td>
<td>1</td>
<td>0.8</td>
</tr>
<tr>
<td>Child Protection</td>
<td>1</td>
<td>0.8</td>
</tr>
</tbody>
</table>
Table 5.2-8 Services referred to for specific issues

<table>
<thead>
<tr>
<th>Referral Reason</th>
<th>Referred to</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal</td>
<td>Hospitals</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>GP</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Other health services</td>
<td>1</td>
</tr>
<tr>
<td>Attachment issues</td>
<td>Community Health - Parents</td>
<td>1</td>
</tr>
<tr>
<td>Child care</td>
<td>Education - Child</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Community Centres/Services</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Centrelink</td>
<td>1</td>
</tr>
<tr>
<td>Child health</td>
<td>Other Health Services</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Mental Health Services</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>GP</td>
<td>1</td>
</tr>
<tr>
<td>Cultural factors</td>
<td>Community Centres/Services</td>
<td>1</td>
</tr>
<tr>
<td>Current domestic/family violence</td>
<td>Non-Gov Organisations</td>
<td>1</td>
</tr>
<tr>
<td>Current mental/emotional health issues</td>
<td>Non-Gov Organisations</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Community Health – Parents</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Community Centres/Services</td>
<td>1</td>
</tr>
<tr>
<td>Disability/learning difficulties</td>
<td>Disability Services</td>
<td>1</td>
</tr>
<tr>
<td>Education</td>
<td>Education – Adult</td>
<td>1</td>
</tr>
<tr>
<td>Family planning</td>
<td>Other Health Services</td>
<td>2</td>
</tr>
</tbody>
</table>
| Financial difficulties | Centrelink | 12  
|                        | Community Centres/Services | 11  
|                        | Financial                  | 7   
|                        | Non-Gov Organisations       | 4   |
| Health                 | GP                        | 6   |
| Legal                  | Legal                     | 4   |
| Literacy issues        | Education – Adult          | 3   
|                        | Centrelink                 | 1   |
| Parenting course       | Community Centres/Services | 2   |
| Past domestic/family violence | Other | 1 |
| Past Mental / Emotional Health (>2yrs) | Mental Health Services | 2 |
| Social/family isolation| Community Centres/Services | 10  
|                        | CFIS Groups                | 3   
|                        | Recreation                 | 1   |
| Struggling with household management | Centrelink | 2 |
|                        | Disability Services        | 1   
|                        | Other                      | 1   |
| Struggling with pregnancy/parenting issues | Community Health - Parents | 1  
|                        | Hospitals                  | 1   |
| Unstable housing/homelessness | Housing                   | 8   
|                        | Child Protection            | 1   
|                        | Centrelink                 | 1   
|                        | Non-Gov Organisations       | 1   |

### 5.3. Outcomes

As part of the PUP assessment framework, data on client issues and progress was collected at four time points: baseline, postnatal, 6 months and closure. Data was, however, not consistently entered for all clients and it is likely that not all assessments were conducted to schedule. Missing data highlights the opportunity to improve consistency in program delivery.

Moreover, the outcomes data presented here ought to be considered preliminary and should be interpreted with caution. From the available data, it is not possible to draw conclusions about program efficacy. No comparison group is available, thus no causal influence of the program can be made from the data presented herein. Instead, the data can be used as an indicator of what might be working well and where there are opportunities to change practices to work toward optimal outcomes for mothers and their infants.

Measures are presented here as life circumstance measures and outcome measures separately. It is proposed that impacting on Social Supports, Life Events, Hassles are largely out of the reach of program. Whilst the program may improve parents’ capacity to cope with adverse events, the program is unlikely to reduce the frequency with which life events are experienced. Similarly, the
program is unlikely to be able to impact the social support received from outside the support provided by the FSW. Thus the social support scales are considered here as a measure of life circumstance rather than a measure of outcomes. Again, Strong Start may support clients to make changes in their relationships but the quality and frequency of support provided to parents through their familial and friendship networks is largely beyond the influence of the program. Outcomes measures were also collected as part of routine service provision to understand and respond to clients’ presenting issues. The program can, however, have been expected to impact on mothers’ depression, anxiety and stress, substance misuse, and mindful parenting. These measures are thus included as outcomes measures in this report.

5.3.1. Life circumstance

Trend data for all clients is reported in Figures 5.3-1 to 5.3-4 below. It is important, when looking at this trend data to consider the sample sizes at each time point. This is especially important for time point four because this sample of parents assessed is likely to biased by clients who stayed in the program for longer due to a greater level of need or more complex circumstances. Time 1 was collected at intake (antenatal), Time 2 collected once the baby had been born (postnatal), Time 3 was collected at around six months in the program, and Time 4 was collected at closure.

Social support

On average social support fell in the high-range for special person support and family and in the mid-range for friends. This suggested that mothers generally felt well supported by a significant person and their families, but less felt unsupported by friends. This fits with the themes of social isolation discussed by staff and clients in interviews. Scores were relatively stable over the course of the program with the exception of those mothers assessed at Time 4. For this group all support scores fell in the mid-range – suggesting that these families were feeling unsupported. This is likely to represent a bias where those families who remained in the program longer tended to be the families who most needed support.

![Figure 5.3-1 Support Scale A scores across the four assessment times](image-url)
Table 5.3-1 Support Scale A scores across the four assessment times

<table>
<thead>
<tr>
<th>Support Scale A</th>
<th>Antenatal</th>
<th>Postnatal</th>
<th>6 months</th>
<th>Closure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>M</td>
<td>SD</td>
<td>N</td>
</tr>
<tr>
<td>Family</td>
<td>65</td>
<td>4.65</td>
<td>1.71</td>
<td>46</td>
</tr>
<tr>
<td>Friends</td>
<td>65</td>
<td>4.29</td>
<td>1.77</td>
<td>46</td>
</tr>
<tr>
<td>Special person</td>
<td>65</td>
<td>5.52</td>
<td>1.51</td>
<td>46</td>
</tr>
<tr>
<td>Total</td>
<td>65</td>
<td>4.82</td>
<td>1.26</td>
<td>46</td>
</tr>
</tbody>
</table>

There was a consistent gap over the course of the program between the level of emotional and practical support mothers received and how much of this support they would like to receive. Emotional support appeared to remain reasonably stable over the course of the program, while practical support appeared to increase before a decrease at Time 4. This again potentially indicates that mothers with less support stayed in the program longer.

Table 5.3-2 Support Scale A scores across the four assessment times

<table>
<thead>
<tr>
<th>Support Scale B</th>
<th>Antenatal</th>
<th>Postnatal</th>
<th>6 months</th>
<th>Closure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>M</td>
<td>SD</td>
<td>N</td>
</tr>
<tr>
<td>Practical - Actual</td>
<td>67</td>
<td>2.13</td>
<td>1.71</td>
<td>46</td>
</tr>
<tr>
<td>Practical - Ideal</td>
<td>67</td>
<td>2.58</td>
<td>2.06</td>
<td>46</td>
</tr>
<tr>
<td>Emotional - Actual</td>
<td>67</td>
<td>4.28</td>
<td>1.82</td>
<td>46</td>
</tr>
<tr>
<td>Emotional - Ideal</td>
<td>67</td>
<td>4.97</td>
<td>1.83</td>
<td>46</td>
</tr>
</tbody>
</table>
**Stressful life events**

The Life Events Scale measures the number of stressful life events that a person has experienced in the past year and how they felt they coped with these events. Zero scores indicate that an event did not occur, a score of one indicates the event occurred but the person feels they were coping with it, and a score of two indicates that the event occurred and the person felt they were not coping with it. The instrument is scored by tallying the number of zeros, ones and twos. On average it appeared that most clients reported experiencing approximately one stressful event that they did not feel they coped with. Clients reported, on average, experiencing 2.5-3.5 stressful events they thought they had coped with over the course of the program. The number of stressful events clients reported not coping with appeared to increase over the course of the program as the alongside a proportionate decrease in the number of stressful events clients felt they were coping with. That is, the number of stressful events did not change but clients felt they were coping less with the stress. The smaller group assessed at Time 4 reported the fewest stressful events at this time. Again this needs to be interpreted with caution and no clear conclusions can be drawn from this data.

![Figure 5.3-3 Life Events Scale scores across the four assessment times](image)

Table 5.3-3 Life Event Scale scores across the four assessment times

<table>
<thead>
<tr>
<th></th>
<th>Antenatal</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>M</td>
<td>SD</td>
<td>N</td>
<td>M</td>
<td>SD</td>
<td>N</td>
<td>M</td>
<td>SD</td>
<td>N</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Life Events 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not happen</td>
<td>62</td>
<td>4.08</td>
<td>1.98</td>
<td>44</td>
<td>4.05</td>
<td>2.61</td>
<td>31</td>
<td>3.87</td>
<td>2.28</td>
<td>15</td>
<td>4.73</td>
<td>2.19</td>
</tr>
<tr>
<td>Life Events 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Happened but coping</td>
<td>62</td>
<td>2.65</td>
<td>1.62</td>
<td>44</td>
<td>3.14</td>
<td>2.11</td>
<td>31</td>
<td>3.48</td>
<td>2.25</td>
<td>15</td>
<td>2.47</td>
<td>1.92</td>
</tr>
<tr>
<td>Life Events 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Happened not coping</td>
<td>62</td>
<td>1.27</td>
<td>1.59</td>
<td>44</td>
<td>0.82</td>
<td>1.50</td>
<td>31</td>
<td>0.65</td>
<td>1.02</td>
<td>15</td>
<td>0.80</td>
<td>1.27</td>
</tr>
</tbody>
</table>
**Parenting hassles**

The Parenting hassles scale used in the program as a means to identify aspects of parenting that clients find challenging. This scale lists typical hassles that families face (feeding time, bed time, children getting underfoot when trying to complete chores, and so forth). The measure has 10 items that the parent rates on a scale of 0 (not a hassle at all) to 4 (a huge hassle). Predictably, during the antenatal period, parents did not experience parenting to be much of a hassle. The scale is best applied postnatally, as is evident by the rise in perceived hassle at Time 2. There are no published clinical-cut offs for the scale so it is difficult to interpret the scores in this way. What is evident form the data collected is that parents perceived parenting challenges remained reasonably stable over the course of the program.

![Hassle Total Score](image)

*Figure 5.3-4 Daily Parenting Hassle Scale scores across the four assessment times*

<table>
<thead>
<tr>
<th></th>
<th>Antenatal</th>
<th>Postnatal</th>
<th>6 months</th>
<th>Closure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>M</td>
<td>SD</td>
<td>N</td>
</tr>
<tr>
<td>Hassles total score</td>
<td>62</td>
<td>1.50</td>
<td>3.90</td>
<td>44</td>
</tr>
</tbody>
</table>

*Table 5.3-4 Daily Parenting Hassle Scale scores across the four assessment times*

### 5.3.1. Outcomes

Trend data for client outcomes was measured across three domains as part of the PUP program as is presented below in Tables and figures 5.3-5 – 5.3-7. Outcomes were measured for depression and anxiety (DASS-21), substance misuse (AUDIT-C), and mindful parenting. This data should be
considered preliminary and interpreted with caution. No comparison group is available, thus no causal influence of the program can be inferred from this data. Given the small sample size it is not possible to separate the data by length of time in the program, the degree to which families were referred to other services for support, or the dose of the program (number and type of contacts families received). These exploratory analyses were conducted but added no value to the report given the very small sample sizes and the amount of missing assessments data.

**Depression and anxiety**
The 21 item Depression, Anxiety and Stress Scale was administered during the course of the program to assess clients’ mental health needs. This data can also be considered outcomes data, so far as the program’s aim to improve parent wellbeing and resilience. The data again echoes themes of anxiety reported by clients during interviews. Depression scores, on average, fell in the normal range, anxiety scores fell in the mild to moderate range and stress scores fell in the normal to mild range. Scores across the sub-scales remained reasonable stable with some fluctuation that might be expected with small group numbers. No program impact trends were evident for any of the three sub-scales.

![Figure 5.3-5 Depression, Anxiety and Stress Scale (DASS-21) scores across the four assessment times](image)

**Table 5.3-5 Depression, Anxiety and Stress Scale (DASS-21) scores across the four assessment times**

<table>
<thead>
<tr>
<th></th>
<th>Antenatal</th>
<th>Postnatal</th>
<th>6 months</th>
<th>Closure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>M</td>
<td>SD</td>
<td>N</td>
</tr>
<tr>
<td>Depression</td>
<td>67</td>
<td>9.52</td>
<td>8.48</td>
<td>48</td>
</tr>
</tbody>
</table>
**Substance misuse**

Drug and alcohol use was measured using the AUDIT-C, a three-item measure that has been validated for use with pregnant women. The measure asks women about their drug and alcohol consumption. Scores between 0-3 represent a low risk of harm. Data captured by the program shows a general increase in average alcohol consumption over time, with the lowest use report during pregnancy. On average scores fall in the low risk of harm category, indicating that on average women in the program had low risk alcohol use. Thus, while there may have been clients experiencing substance misuse, it appeared that on the whole drug and alcohol issues were not overly prevalent in the client group for which assessment data was recorded. At referral just under a quarter of mothers referred into the program were reported to experiencing issues of substance misuse. At Time 1 only two out of the 52 mothers with AUDIT scores fell in the ‘high risk of harm’ category. All others fell in the ‘low risk of harm’ category. Similarly, at times 2, 3 and 4 the large majority of mothers with AUDIT scores fell in the ‘low risk of harm’ category, indicating that alcohol and drug misuse was not a prevalent issue for clients.

![Alcohol abuse total score](image_url)

Figure 5.3-5 6 Alcohol consumption (AUDIT-C) scores across the four assessment times

Table 5.3-6 Alcohol consumption (AUDIT-C) scores across the four assessment times

<table>
<thead>
<tr>
<th></th>
<th>Antenatal</th>
<th>Postnatal</th>
<th>6 months</th>
<th>Closure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>M</td>
<td>SD</td>
<td>N</td>
</tr>
<tr>
<td>Alcohol consumption</td>
<td>52</td>
<td>0.77</td>
<td>2.19</td>
<td>37</td>
</tr>
</tbody>
</table>
Mindful parenting

Mindful parenting has been described as a fundamental parenting skill or practice (Steinberg 2004; Kabat-Zinn and Kabat-Zinn 1997) referring to parents’ capacity to pay attention to their child, interact purposefully, be present in the moments of interaction and to be attuned to the experience of interaction. The Mindful parenting scale used in the program measures parents’ capacity to reflect on their emotional state, manage their emotions and identify and respond to their child’s emotional state. Scores for the scale range from 0-5 with higher scores indicating greater mindfulness.

Mindful parenting scores were lowest at Time 1 but it is difficult to interpret whether increases in this score at Time 2 are evident of the program’s impact or are due to the presence of a child after this time and therefore a reference point for responding to the questions. Nevertheless, there appeared to be a slight but steady increase across the remaining time points. Without a comparison group it is difficult to attribute this increase to the activities of the program rather than a maturation effect that comes with children becoming older and their interactions and emotional cues becoming more evident.

![Mindful parenting total score](image)

**Figure 5.3-5.6 Mindful parenting scale scores across the four assessment times**

**Table 5.3-7 Mindful parenting scale scores across the four assessment times**

<table>
<thead>
<tr>
<th></th>
<th>Antenatal</th>
<th>Postnatal</th>
<th>6 months</th>
<th>Closure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>M</td>
<td>SD</td>
<td>N</td>
</tr>
<tr>
<td>Mindful parenting</td>
<td>62</td>
<td>1.50</td>
<td>3.90</td>
<td>44</td>
</tr>
</tbody>
</table>
6. Discussion

Strong Start in the North is a pilot program targeted at first-time mothers with complex needs. In interpreting the findings of this evaluation, it is important to keep in mind the experimental nature of the program. This is the first time in South Australia that a therapeutic program for high-risk families has been delivered across government departments and by workers not requiring formal qualifications. The evaluation findings should be considered as learning about what is currently working in the model and where further improvements can be made. For the program to have the best chance of positively impacting on mothers and their infants, the evaluation sought to examine factors impacting delivery as well as early client outcomes. The evaluation examined the extent to which the pilot program is meeting the needs of its clients, the barriers to providing supports to these families, what’s working well and where the program may benefit from changes. Key findings of the evaluation are discussed here in turn.

6.1. Program delivery during pregnancy

Strong Start aims to recruit mothers as early as possible during pregnancy. Whilst most mothers were referred during the antenatal period, a small proportion of mothers presenting with complex issues were referred to the program once their infant was born. Although the aim is to recruit mothers while they are pregnant, this was not always possible. For programs aiming to impact on parenting and early child health and developmental outcomes, there aren’t any comparative studies aiming to determine if interventions initiated in the antenatal period are more effective than interventions initiated in the postnatal period. Indeed, the most robust RCT of a structured and intensive home visiting intervention in early pregnancy with teenage mothers found no short-term impact on targeted intervention outcomes (smoking during, infant birth weight, child hospitalisations in the first two years, or subsequent pregnancy within 2 years). Importantly, the premise of recruitment as early as possible may preclude the program benefiting mothers who present with issues only once their infant is born, mothers who have not previously engaged with health care during pregnancy, and mothers who birth early. Nevertheless, recruitment during the antenatal period is likely to have benefits for mothers’ engagement with antenatal services as well as provide more opportunity to connect mothers with additional supports or work through issues before the baby is born. It is out of scope of this evaluation to comment on the likely benefit of limiting recruitment to the antenatal period or having some flexibility to recruit mothers who have given birth and whose challenges become evident during their stay in hospital. Given small sample sizes and incomplete data, it is not possible here to compare the outcomes of mothers who were recruited at various times during pregnancy and after birth, but this analysis in the future could help to inform the optimal time to recruit and engage mothers.

Clarity about what the program seeks to improve in mothers and their infants is needed to best define intake parameters. Clearly stated program aims (such as an aim to improve parent-child attachment, or to improve developmental literacy and enhance parent’s stimulation of children) can
help refine the referral and recruitment process and ensure that clients accepted into the program understand the aims of the program.

6.2. Referrals into the service

Strong Start’s original operating premise was to work with mothers with 5 or more complex needs (see Appendix A). The number of needs recorded for each client on referral forms was likely to vary depending on the extent to which pregnant mothers had been open with the referring service provider. Data collected by the program suggests that service providers were referring all first time mothers who have a crisis that was creating a great deal of stress (e.g., housing or financial). In the earlier work conducted with service providers about referral to Strong Start (see Appendix B) service providers referring to the program highlighted that there were mothers who needed support who did not fit the referral criteria for Strong Start. This was echoed in client interviews with clients who reported needing support to find accommodation when their child was first born so they were able to leave hospital. These mothers may well have had other issues also, but there ought to be a clear mechanism for assessing whether Strong Start is the best fit or whether another service is better suited to the client’s needs.

Reflections from Strong Start staff were that once mothers were engaged with the program a greater number of issues became evident than those listed on referral forms. Nevertheless, on average mothers who enrolled in the program tended to have a greater number of recorded needs than mothers who declined the program or were unable to be contacted. Mothers who did not enrol in the program still had a high number of needs and these tended to be similar in nature to those of enrolled mothers. It is likely that reliance on referral forms alone to make intake assessments will miss eligible mothers who may benefit from the program. Intake procedures have changed as the program has matured and the workload of the family support workers has increased. Current intake procedures prioritise clients and this may lead to changes in the characteristics of clients accepted into the program in the future.

6.3. Prevailing client needs

Generally, mothers referred into the program faced multiple challenges that were likely to impact on their ability to parent effectively and also to provide positive environments for their child’s development. The most common issues faced by mothers referred to the program were mental health issues, social isolation, financial stress, and unstable housing. This was true for both the group of mothers who enrolled into the program and also, but to a lesser extent, the mothers who declined the program or were unable to be contacted.

Indeed, mothers reported appreciating having someone to talk to, someone to support them to overcome their anxiety, and someone who would sit and listen to them. Practical support in finding and securing housing was also a commonly discussed benefit of the program. Nevertheless, impacts on mental health were not clearly evident in the data and staff reported that this was among the most difficult challenges to overcome. The data presented in this report from the assessments
conducted as part of the program suggest that anxiety was the most prevalent mental health condition experienced by mothers. FSW are not clinically trained to deliver mental health interventions nor is the clinical program lead. To support mothers to manage their mental health the program ought to be making appropriate referrals to clinical support services or General Practitioners for assessment and management. Instead, FSW appeared to be taking on the role of counsellor, perhaps unwittingly. Indeed client’s reported using FSW in this way. Referrals data suggest that these types of connections were not routinely made for clients and this is an aspect of service delivery that warrants further examination.

6.3.1. Program appropriate to need

The needs of mothers referred into the program are likely to be reflective of the challenges faced by mothers in the community that Strong Start aims to support because service providers are referring complex cases to the program as these arise. Consideration of these presenting needs can help shape service delivery so that it is best placed to address prevalent issues. Mapping other services available in the community and the health system can help to identify service gaps and the role Strong Start might play in the region.

The nature of complex and persistent disadvantage means that it is unlikely that clients in the program will go on to have uncomplicated lives. Instead of aiming to solve client’s crises the program’s stated aim is to improve parenting. Arming parents with good information about parenting and the needs of children, connecting them to resources in their community that will support them in their role as parents, and building their resilience to cope with the stresses they will face in the future is the most feasibly way to achieve the program’s aims. Resilience can help to promote and protect wellbeing in the face of adverse conditions and stress. Intervention strategies that promote resilience include the use of a family goal setting system, regular follow-up and reassessment (de la Rosa, Perry, Dalton, & Johnson, 2005).

PUP utilises assessments to understand the needs of clients and promote discussion and goal setting. As such, assessments should be routinely collected for each client and this information should be actively used to work with the client to set goals in a transparent way and monitor progress. Although clients and staff both identified that the work of the program was very responsive to the client’s need, this seemed to be in relation to the FSW working to help the client resolve issues and crises as these arose rather than longer term planning, capacity building, and goal setting. Program staff spoke frequently about the aim of increasing the independence of clients so that when the program finished these clients would be able to cope with future parenting and personal challenges. Whilst some clients reported becoming more capable themselves through this process of dealing with crises, others reported feeling at a loss when the program was soon due to finish because they wouldn’t know who would help them next. This highlights the opportunity for greater consistency in working to set longer term goals, defining the program’s parameters and communicating these clearly to clients. With recent changes to training and professional support structures it is appears that this practice of using assessments and creating a structure for setting
client goals is changing. The program now appears to have a greater emphasis on the development of care plans to engage in longer term planning with clients.

In order to assess whether the program delivered interventions appropriate to need, data was collected about the issues discussed at each contact and also referrals out of the program to other service providers. Both these facets of the program are likely to be poor, but it is not possible from the data to make this determination. Reflections from the service suggest that the way this data was captured and recorded is not reliable. Another issue was the inclusion of an ‘other’ category. For issues discussed ‘other’ was the second largest issue recorded which makes it difficult to assess what support was provided.

Nevertheless, examining the data that was available it appeared parenting was the most frequent issue discussed. It is unclear what was classed as a discussion about parenting. These may have been informal discussion about parenting challenges rather than structured support to improve parenting capacity. Social isolation was the most common issue faced by mothers entering the program but was one of the least frequent issues discussed during contacts. Only 14% of referrals out of the service were the purpose of addressing social isolation but this was an issue for approximately two in three mothers enrolled in the service. These are only a few examples of the ways in which accurate data about the program activities could be used to ensure the program is providing appropriate services and building relevant referral networks. In reviewing the program aims and activities, service providers should consider this data and discuss how it fits with their interpretation of the supports families entering the program need and how these are best met.

Data was also collected about the length of time in the program. The majority of clients who dropped out of the program did so in the first 6 months. This fits with the literature around dropout rates for clients with complex needs. Nevertheless, when the program is appropriate to need and valued by clients, dropout rates are likely to be lower. Monitoring of program dropout rates and reasons for leaving the program can help Strong Start address issues that impact client engagement and retention.

6.4. Child outcomes

In order to develop to their full potential, children need appropriate engagement, stimulation, and warm, nurturing and responsive parenting. The earliest years of a child’s life are marked by rapid development of neural networks that set the stage for later development. Positive early interactions and environments help children develop the foundations for later emotional regulation, social skills, communication, literacy and numeracy, and health outcomes. When mothers who were enrolled in the program were asked about what they think is better now for their child, most replied that the child had a more stable home life or a happier, less stressed mother. When probed for information specifically about whether they had learned anything about child development, mothers mentioned having had help with feeding and settling, feeling less distressed by their baby’s crying and feeling they had a better relationship with their child.
It is important to note that FSW were not necessarily qualified in child development service provision. A community health nurse is employed as part of the Strong Start team, but this is a recent addition to the program. Mothers in the program reflected that it would have been good to have more visits from the nurse so they could ask more questions about their children. A few mothers spoke of being connected to playgroups or child care, but this was not extensively reported. Staff also spoke infrequently of their networks with early childhood service providers. One noticeable area for building better community connections to support child development was with Children’s Centres. These centres play a large role in the State’s early childhood service provision for children from birth to five years of age. Centres provide a range of parenting supports and are concentrated in the Northern suburbs of Adelaide. Moreover, these centres are well equipped to support families with complex needs. There is an opportunity to consider the role of the program in relation to child development. The program should consider whether it is well placed to impact child development within the service provided by Strong Start (i.e., through enhanced parent-child attachment, through improved parenting practices, or enhanced early home environments that promote child development) or whether the program should seek to connect families to other services. Indeed once clients are graduated from the program the way in which ongoing parenting support needs are catered for should be considered.

The evaluation was not able to measure the program’s impact on child outcomes at the present time. Child outcomes, parent-child relationship, and the home environment were not measured in the program. Moreover, no comparison group was available against which to assess these outcomes. Future evaluations of the program ought to endeavour to follow mothers who do not receive the program and their infants to enable measurement of impact on children and the related cost benefit of providing this intensive support. The program should also consider using measures of child-parent attachment, of the richness of the home environment, and of parenting styles in order to assess whether the aim of improving parental attachment and parenting is being met.

7. Recommendations

Strong Start Service providers along with the evaluation advisory group were provided with the opportunity to reflect on the evaluation findings and provide reflections on recent changes to the program, many of which echo the recommendations made herein. The evaluation team sought to include a section in this report allowing for the service providers to reflect on the results of this evaluation and to make mention of the changes that have already been put in place (particularly in the Southern Area Pilot) that address some of the issues raised, however this opportunity was not taken up. As such, the following recommendations are made in light of the evaluation findings on the basis of the Strong Start Program as it was still maturing.

7) Clear program aims expressed as a program logic

A clear program logic that outlines:
- the needs of clients,
- the programs resources available,
how these resources should be applied to meet the clients’ needs, and intended short term, medium term and long term outcomes would provide program staff a clear structure within which to assess how they are faring and where they may need to make changes. The program has been working toward developing a program logic, but this should be formalised, shared with all program staff and routinely referred to in staff planning and training.

8) Transparent care planning led by staff who have the skills to have difficult but affirming conversations with families

For families to have the best chance of engaging with the program actively and purposefully, the program needs to clearly state its aims, way of working and expectations of families at the outset. Assessments should be clearly articulated as formulating part of shared goal setting and planning. Parents should be active partners in planning their parenting and personal goals and should be supported to track their progress toward their goals in a meaningful way. Staff should work with families around issues impacting their children’s development and make clear the environments and parenting practices that enhance child development and their relationship with their child.

9) Increased connections with community based services to promote ongoing parenting support such as Children’s Centres and playgroups

Children’s Centres are a flagship early years program of the Department for Education and Child Development and well-resourced to support families with complex needs. Children’s Centres also provide a place where families can meet other families in a non-threatening environment. Moreover, staff in Children’s Centres are skilled early educators and have the capacity to model positive parenting practices and environments that support children’s holistic development. Forming connections with Children’s Centres may be one way of graduating parents to appropriate services that can help facilitate improved parenting and child outcomes.

10) Establishment of referral networks to support most common issues facing families that Strong Start is not equipped to deal with

Clients who present with issues that are beyond the scope of the program team should be referred to appropriately qualified professionals. In order to facilitate client engagement with other professionals the program should seek to build professional relationships with trusted service providers who are effective at working with clients with complex needs. These referral networks can help to create a sense of professional boundaries and remove the pressure of FSW to ‘be everything’ to clients.

11) Re-examination of drop-out rates as the program matures

As the program matures and client recruitment processes and guidelines change, the program should examine how this impacts the clients’ retention rate in the program. A high
dropout rate is characteristic of programs provided to highly complex clients, but this is less so when the program is a good fit that is meeting client needs.

12) *Focus on assessment and data collection quality to monitor program inputs and outputs*  
To best facilitate ongoing review of the program, it is important to consistently collect high quality data. In the program overview there is an indication that this is the role of the clinical lead in the program. It may not be feasible for the clinical lead to conduct all assessments and enter this data. The program ought to review data protocols and ensure staff have the appropriate training to record data.
8. References


9. Appendices

Appendix A – Strong Start program overview
Appendix B – Review of Strong Start family engagement
Appendix C – Invitation letters
Appendix D – Client contact trends for each length of program group
Appendix A
Strong Start program overview
Strong Start Program
Overview of the Program

Background

The 2012-13 South Australian State Budget announced funding of $3.3 million over four years for a new program ‘Strong Start’ to be established in the northern Adelaide metropolitan area, specifically suburbs in the Playford area; Davoren Park; Elizabeth, Elizabeth Downs; Elizabeth Grove, Elizabeth North, Elizabeth South, Smithfield and Smithfield Plains. These suburbs have been identified as a priority to focus interventions aimed at addressing socioeconomic disadvantage and inequality in child wellbeing.

Strong Start is operated through the Department of Education and Child Development which brings together education, health and welfare. This integration of Departments provides a strengthened focus on early intervention and a co-ordinated approach to service delivery.

The program is locally managed by Child and Family Services, Early Childhood Parent Service.

Strong Start will work with vulnerable families in the ante-natal period to enable women birthing in the Northern Metropolitan area of Adelaide and their families greater access to services and in home family support. The program focus is to strengthen families capacities and engage them with community supports to maximise their abilities to meet the needs of their children.

Program approach

Strong Start is an intensive home based family support approach employing strategies that empower families.

The program will utilise a range of strategies and methods to engage and partner in an ongoing way with families. These strategies will include unstructured relationship building, opportunistic modelling and parental education and structured module based programs in particular the Parents under Pressure model (See Appendix 1)

The program will implement both structured and unstructured strategies, using the processes of engagement, assessment and reflective practice to determine which approach best suits the family at any given point in time.

The program approach is strengths-based focusing on the skills and abilities of families rather than focusing on their shortfalls. However the program will ensure that a comprehensive assessment of the families’ situation occurs in an ongoing manner. Staff will have an understanding of risk assessment and will address this with families in an open and transparent manner to secure the infants safety

The new program will support partnerships between Aboriginal and multi-cultural agencies, mainstream agencies and governments, to build on existing strengths, match expectations with appropriate supports and recognise the importance of locally led solutions.

Strong Start Program December 2012
The staff in the program will work in partnership with families throughout the length of the service. This approach will operate along a continuum of family lead and directed service intervention through to family support if a statutory agency is required to intervene.

The following principles guide service provision to families through:

- Enhancing families awareness of infants and children’s health and development needs
- Enhancing the development and learning capacity of infants and children
- Improving the health and well being outcomes for infants, children and families
- Facilitating access to networks of family support services
- Facilitating services within the network to have a prevention orientation
- Strengthening the voice of infants, children and families in the community

The program objectives are to:

- Strengthen families and engage them with community supports to maximise their abilities to meet the needs of their children
- Engage with pregnant women and families in the antenatal period in order to maximise opportunities for effective intervention
- Improve families capacity to parent their children through building strength and resilience and reducing vulnerabilities

**Staffing**

Strong Start is a small team working within a defined geographical area. The staff will be required to be flexible and assertive in their engagement of women and families. Personal and professional qualities and skill sets will include:

- A sound theoretical base, including a theory of change, which enables a practitioner to think about or conceptualise the practice. The theoretical foundation can respond to four areas:
  - the conceptualisation of the problem
  - the change theory that informs how that problem can be addressed
  - the theory that guides the critical contribution and influence of the relationship or partnership between the worker and the family and
  - the core practice values that underlie the approach to families and the problems they experience
- Cultural competence and the ability to deliver culturally appropriate practice.
- Ongoing professional development to strengthen practice skills, knowledge and expertise.
- Awareness of current legislative and regulatory requirements.
- Life skills in working with children, families and the community
- Strong written and verbal communication skills

The staffing arrangements for the program are:
1 AHP 3 Coordinator
1 AHP2 Clinician
4 OPS4 Family support workers (1 designated Aboriginal specific)

The role definitions are attached (Appendix 2)

The Family Support Workers provide a key role in building long term rapport and trust by supporting families by addressing their identified needs. Family Support Workers offer non-judgemental, flexible hours, family support which will be delivered in the family’s home, in the first instance. The Family Support Worker provides significant time to the family to help them build on existing strengths and identify current needs, whilst modelling parenting skills and building the family’s knowledge of and access to community resources. They can provide transport and to be part of the family’s journey as they navigate complex health, community and other service systems.

Strong Start will carefully match the family to an appropriate Family Support Worker.

Access to the program

Referral pathways
The program is a voluntary program where the staff in the program will provide a flexible, timely, opportunistic and assertive response to engaging with families.

Initially families will be identified from the ante-natal assessment undertaken by midwives at the Lyell McEwen Hospital (LMH) and the Women’s and Children’s Hospital. It is anticipated that as more antenatal services are provided from community settings referral pathways may increase. Staff from the program will work closely with all staff in the key referral sites.

The criteria for the Start Strong reflect the high levels of vulnerability experienced by some women and families, who currently are unable or maybe unwilling to engage with services (See Appendix 3.)

The engagement process will provide a first point of contact for staff to meet with the woman and family. This will enable staff to engage in conversation with the woman to understand her thoughts and needs and to talk about the benefits, opportunities and support that may be available. It is anticipated that this engagement process will vary based on the approach required to build a level of engagement and rapport with families.
Referrals will be discussed at the Northern Footprints interagency meeting to improve information sharing and service coordination. (See Appendix 4 referral flow chart)

These processes will enable the program to provide flexible and timely responses to families.

Initial Contact with families

Engagement is the process to consent and time is needed to build rapport with the family and enable comprehensive information to be gathered. Information gathering will be purposeful and mindful of the both the needs of the parent and infants. Inclusive practice allows for stronger engagement and opportunity to explore and understand the current and previous difficulties as well as the strengths and resources utilised by the family to overcome issues.

Opportunities for information to be gained from the family will be undertaken in a stepped process. This will commence with the initial assessment undertaken by hospital staff and an immediate connection will be made with staff from the program.

Interagency review and discussion

A request for service will be communicated to the coordinator of the program Where families have been referred to the program and subsequently identified as already having significant service support this will be reviewed through the Northern Footprint process or a separate case conference to determine whether there is a role for the program.

Assessment, Action and Review

Assessment of need should be driven by the woman and her family as the cornerstone of action and review, exploring not only the infant and family's needs and issues, but also each family member's strengths and resources.

Assessment is an ongoing process and the Common Assessment Framework (CAF) (Appendix 5) will be used to support staff in the initial and ongoing assessments. The clinical staff will lead the assessment process but will be supported and informed in an ongoing manner by the allocated family support worker.

An important focus of the CAF is the capacity to begin the conversation with the family about the unborn infant to assist the parent’s “working model” of their relationship with their baby.

Strong Start Program December 2012
This model is already being used by Families SA and the Women’s and Children’s Health Network.

The action plan requires careful consideration of what planning mechanisms are required to enable purposeful and action orientated service and support plans tailored to the individual needs of the family. Goals need to be concise and behaviorally based, the worker and the family must be able to identify what behavioral changes will occur if the goal is achieved. Where the goals are clear and the family has been included in the development and review of the case plan progress can be matched with the family and program goals and outcomes.

As well as professional decision making, a suite of tools, provided by “Parents Under Pressure” to support the assessment will be applied at critical points during the intervention period.

The utilisation of reflection, supervision and review, including the opportunity to bring back to the interagency group “Northern Footprints” will occur. This will provide the opportunity to ensure that case plan is relevant and consistent with the addressing the identified issues and will support the overall direction of case management and support provided to the family.

**Escalation of care**

Strong Start has been identified as a preventative program in that it is hoped, families identified early in the antenatal period will have the opportunity and support to address issues of vulnerability or stress that are impacting on their capacity to provide the best possible opportunities for their child, when it is born. While issues of vulnerability and risk will be present for many of the families engaged in this program there will be different processes that may need to be engaged.

Strong Start is designed to work with families where there are high and complex levels of vulnerability including, drug and alcohol use and mental health issues. The program will work with the women, partners and families identified and develop goals and interventions to reduce the impact of these issues and increase the parents capacity to address their and their children’s needs. Processes of regular supervision, case reviews and case conferences will be used to ensure that the constant reflection on the support provided to families is appropriate and relevant.

In some circumstances the issues of vulnerability may not have reduced significantly by the time of the babies birth or there maybe challenges in engaging with families regarding the issues that impact on parental capacity. In these circumstances there are concerns of risk raised. This program will continue to work with the family to address these issues but in addition pathways with Families SA and the Northern Footprints will be formalised to support appropriate intervention.

Again the response to risk exists on a continuum and process to reflect the level of response required, roles and responsibilities, review and monitoring

Strong Start Program December 2012
mechanisms need to be clearly documented and understood by the program and
Northern Footprints

Supervision

Staff will be supported through peer support and individual supervision sessions. Staff will meet on a regular basis with the Program Coordinator/clinician for the purpose of reviewing work with individual families, reflecting on personal and professional values, knowledge, reasoning skills and practice wisdom. A key component of supervision will focus on managing the emotional demands of the work being undertaken.

In addition to individual sessions, staff will also participate in group reflective practice sessions facilitated by an external provider.

Hours of Contact

The design of the program is to provide a flexible and responsive service delivery to families.

The program will operate during normal working hours, from 8.45am until 5.00pm. However, the service will negotiate with each family regarding contact. Where needed evening work or weekend contact will occur, as determined by each families individual circumstances. Staff in the program will have mobile phone that families are able to contact them on and use of this number will be negotiated with individual families. This program is not able to provide a crisis response but will ensure families are aware of the crisis support services and how to contact them.

Closure and /or transition

The length of service provision will be dependant on the individual circumstances of the families engaged in the service. It is envisaged that many families may need a significant period of engagement with the program.

Planning for Closure or transition should be part of the initial assessment and ongoing review. Case workers and families need to understand the purpose of the service and also recognise points for transition and /or closure.

The transition of families from the program will occur in a supportive and consultative manner; ensuring families are well engaged with other community services as needed.
If families move out of the Playford area the program will only be able to continue to provide the previous level of support if the family has still remained located geographically close to Playford. If the distance is too great the program staff will to assertively engage the family with new local supports.

Training
An initial orientation and induction program has been developed for the staff. (Appendix 6)

All members of the team will receive formal training in;
1) The Parents under Pressure Program
2) The Certificate of Infant Mental Health
3) Access to the DASSA ASSIST program
4) South Australian Safe Infant Sleeping Standards Certificate
   http://www.safesleeping.net.au/moodle/

Governance

Strong Start sits under the Department for Education and Child Development. Locally CaFHS will manage the program. There will be ongoing oversight from the Program management Board and local support from an operational group.

Evaluation
An evaluation framework has been developed for the program. See the document Strong Start Evaluation Design 2012.
References

Department for Communities, Government of Western Australia, Parenting WA
Home visiting literature review 2012


Department for Families and Communities and Department of Health (2006) Safe Infants, Healthy Future: The Vulnerable Infant Services Plan.


Australian Research Alliance for Children and Youth (ARACY), (2010) “Working Together to prevent Child Abuse and Neglect – a Common Approach for identifying and responding early to indicators of need”, Report on the Common Approach to Assessment, Referral and Support project to the Minister for Families, Housing, Community Services and Indigenous Affairs, the Hon Jenny Macklin MP, ACT


Mcfanwy McDonald (Sept 2010) Are disadvantaged families “hard to reach”...Engaging disadvantaged families in child and family services. Communities and Families Clearinghouse Australia


Strong Start Program December 2012
Overview of Parents Under Pressure (PuP)

The Parents Under Pressure (PuP) program combines psychological principles relating to parenting, child behavior and parental emotion regulation within a case management model. The program is home-based and designed for families in which there are many difficult life circumstances that impact on family functioning. Such problems may include depression and anxiety, substance misuse, family conflict and severe financial stress. The program is highly individualized to suit each family. Parents are given their own Parent Workbook. For many parents, this becomes a personal journal of their treatment experience.

The overarching aim of the PuP program is to help parents facing adversity develop positive and secure relationships with their children. Within this strength-based approach, the family environment becomes more nurturing and less conflictual and child behavior problems can be managed in a calm non-punitive manner.

Professor Sharon Dawe and Dr Paul Harnett have been working with students and fellow researchers for over 10 years on the development of the PuP model.

The PuP program is intended to be delivered on a one to one basis, preferably in the family's home. A Therapist Manual provides the theoretical overview behind the PuP program and the Parents Workbook is given to the family and forms the basis of the treatment program.

Modules contain many different exercises that help the parent work towards their own parenting goals. The Parent Workbook is seen as a buffet of options to choose from rather than a recipe to follow.
Role Definition: clinician and Family Support Worker

Work will be conducted in partnership with families and co-working will strongly encouraged with all cases.

<table>
<thead>
<tr>
<th>Clinician</th>
<th>Family Support Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Initiate and maintain collaborative, cooperative relationships with local service providers and agencies and facilitate appropriate referrals of clients</td>
<td>1. Initiate a range of strategies to engage with families (including after hours and weekend visits)</td>
</tr>
<tr>
<td>2. In collaboration with the Coordinator and manager, liaise with the Families SA Office regarding involvement or notification of escalating risk.</td>
<td>2. Initiate and maintain collaborative, cooperative relationships with local service providers.</td>
</tr>
<tr>
<td>3. The coordinator will allocate cases through the team process to appropriate team members</td>
<td>3. Provide casework/key worker role to families.</td>
</tr>
<tr>
<td>4. Appointed as Case Manager throughout the team involvement as required.</td>
<td>4. Provide primary practical support, guidance and education to families.</td>
</tr>
<tr>
<td>5. Ensure that there is a care plan developed in partnership with the family that adequately addresses the vulnerability and risk factors present in the family.</td>
<td>5. Assist in the development of a case plan in partnership with the family.</td>
</tr>
<tr>
<td>6. Conduct Assessments and reviews with the family.</td>
<td>6. Assist the family to develop their goals and the actions needed to meet those goals.</td>
</tr>
<tr>
<td>7. Provide assessment, consultation and interventions as required regarding Co morbidity issues</td>
<td>7. Consult with the clinician regarding any issues in developing the case plan.</td>
</tr>
<tr>
<td>8. Coordinate the care and protection plan of intervention with the family including involvement by the Family Support Worker and other services.</td>
<td>8. Review the goals and plan regularly with the family and clinician.</td>
</tr>
<tr>
<td>9. Work with the family to develop goals that address the complex issues currently experienced by the family.</td>
<td>9. Participate in supervision (including reflective practice with the clinician/Coordinator).</td>
</tr>
<tr>
<td>10. Provide and/or source therapeutic support to families.</td>
<td>10. Provide the practical support required to assist the families to achieve their goals.</td>
</tr>
<tr>
<td>11. Provide supervision (including reflective practice) to family support workers</td>
<td>11. In conjunction with the clinician input into the development of the assessment</td>
</tr>
<tr>
<td>12. Participate in supervision (including reflective practice with the Coordinator)</td>
<td>12. Write case notes of all contact with families.</td>
</tr>
<tr>
<td>13. Responsible for ensuring that Case plan, case notes and other assessment reports are up to date.</td>
<td>13. Engage in activities that support families to link with other services as needed.</td>
</tr>
<tr>
<td>14. Ensure that data recording is up to date and that regular assessments occur at least 3 monthly.</td>
<td>14. Provide family with practical assistance to facilitate access to services.</td>
</tr>
<tr>
<td>15. Write referrals to other services for and with the families</td>
<td>15. Seek out and liaise with other agencies working with the family.</td>
</tr>
<tr>
<td>17. Ensure that the transfer of the family to another service is transparent and the family is supported through this period.</td>
<td>17. Seek out and provide culturally appropriate services for the family.</td>
</tr>
<tr>
<td>18. Seek cultural consultation as needed.</td>
<td>18. Develop and co-facilitate groups.</td>
</tr>
</tbody>
</table>

Strong Start Program December 2012
Appendix 3

Referral criteria

The client group for this program are defined as women/families birthing their first baby, living in the Playford area and experiencing significant and complex vulnerabilities. The families are further identified or characterised by experiencing a number of vulnerabilities and the impact that these issues present for the parents’ capacity to provide a stable, safe and nurturing environment for the baby, when born.

The issues of vulnerability include:
- serious substance misuse
- domestic/family violence situation;
- diagnosed mental illness to the degree that it significantly impairs parent/caregiver capacity;
- assessment of intellectual disability to the degree that it significantly impairs parent/caregiver capacity;
- significant attachment issues;
- a history of child protection or experiences of poor parenting practices
- previously or currently under the Guardianship of the Minister
- significant financial difficulties
- at risk of homelessness or transience
- limited or lack of social supports
- young maternal age
- ambivalence regarding the pregnancy
- poor attendance at antenatal services
- recent or current trauma

The more vulnerability factors that are present increases the impact of those factors on the families’ capacity to provide a safe and nurturing environment for the baby to be born into. The program will work with families where there are 5 or more of these issues present.

For some families the presence of vulnerabilities may be mediated by protective factors. These may include:
- Supportive family/community networks
- Acknowledgment of adversity and commitment to engage with support services
- Active engagement with services to address psycho-social and/or mental health disorders
- Evidence of psychological and practical preparation for the birth of infant and caregiver role

Protective factors may not necessarily preclude families with high levels of vulnerability from receiving support from the program however, other services and supports may be more helpful and better reflect the needs of the family.
5. Families who cannot or will not meet their children's needs, or cannot make the changes to meet those needs in the child's developmental timeframe. The state is in loco parentis and is required to facilitate children's needs being met.

4. Families who are not meeting all of their children's needs, but may be able to meet those needs with assistance. They are not open to receiving support, but will comply with statutory involvement.

3. Families who are not meeting all of their children's needs, but are open to receiving support and can meet their children's needs if they are provided with assistance.

2. Families who are meeting their children's needs, but are vulnerable to future problems. They will benefit if they are supported with targeted assistance to prevent problems from occurring.

1. Families who are meeting their children's needs. They will benefit from formal and informal supports available to all families.

Source: Northern Territory Government, 2010
Engagement flow chart

Women present at antenatal clinics, LMH, WCH

Midwife makes contact with Strong Start to discuss

A plan for initial contact is developed

Strong Start makes contact with the family

Information sent to Northern footprints for information sharing

Multiple agencies involved - no further action needed

Referral to other services

Strong Start engaged with family

Multi agency case conference occurs
Common assessment framework

Appendix 5

Pregnancy and unborn child's needs
- Previous birth history and anticipated gestation
- Unborn child:
  - Health & development
  - Special needs & anticipated needs post birth
  - Antenatal health concerns relating to
    - Drug/alcohol abuse by mother
    - Poor antenatal care
    - Physical safety
    - Domestic and Family violence

Parenting capacity and strengths
- Mother:
  - Aboriginal & Torres Strait Islander
  - Physical Health Assessments
  - Previous history of the mother
  - Culturally & Linguistically Diverse backgrounds
  - Nature of relationship with father and/or current partner
    (history, quality, presence of domestic violence)
  - Drug/alcohol use current/past
  - Involvement in antenatal care/compliance/attitude
- Father:
  - Presence of adversity
    - Mental health
    - Intellectual disability
    - Physical disability
  - (past and current...if current how are these being addressed?)
- Previous child protection concerns/abuse of any other children previously/presently involved with Families SA
- Preparation for birth — safe, physical environment, necessary baby equipment
- Belief/attitude to the unborn child
- Sensitivity to the unborn child's needs recognition of
  these needs and the quality of the response
- Psychological involvement/connection disregarded to the
  unborn child
- Domestic and Family Violence
- Acceptance of pregnancy and psychological preparation
  — attachment, internalised, ideas/experience, needs
- Working model of relationship with unborn child
- Expectations, fears, hopes, dreams
- Physical connection

Unsurpassed by: reflexive practice

Impact of violence & abuse

Family and Environmental Context
- Family and relationships, wider family and kinship, housing, employment, income, cultural identity, formal and informal support systems, Scaffolding —
  - Internal, community services, involvement, transport, rural, regional and
  - remote, housing/housing, financial issues, criminal activity, Domestic and
  - Family violence

Source: Women's and Children's Health Network Strengthening Links

Strong Start Program December 2012
Strong Start staff training and induction

The initial orientation and training for the staff will occur over a two week period and include the following areas.

1) Orientation to:
   - DECD
   - CaFHS
   - Kids and You
   - Administrative procedures
   - Occupational Health and safety
   - Human resources

2) Assessment and Intervention competencies
   - Assessment of parenting capacity and infant need
   - Impact of drug and alcohol issues on parenting
   - Safe work practices, worker safety and assessing the home as an infant safe environment
   - Cultural safety
   - Maternal mental health issues
   - Impact of Domestic Violence on parenting

3) Working with families
   - Supporting the dads relationship with infants
   - Use of self
   - Reflective practice

4) Interagency partnerships
   - Families SA Elizabeth Office
   - Families SA safe babies Team
   - Lyell McEwen Hospital midwifery and social work departments
   - Northern Domestic violence service
   - Shine SA
   - Northern Division of GPs
   - DASSA

In addition to the initial two weeks of training all staff will be provided with the following training.

- Certificate of Infant Mental health
- Parents under pressure training and clinical supervision
- Access to the DASSA ASSIST program
- South Australian Safe Infant Sleeping Standards Certificate
  http://www.safesleeping.net.au/moodle/
Appendix B
Review of Strong Start family engagement
Engaging pregnant mothers:
A qualitative investigation of the barriers and facilitators to engagement

Report prepared for:
Child and Family Health Service
May 2014
Acknowledgements:
The evaluation team would like to acknowledge the support provided by Strong Start staff in gathering information to help inform the research activities. We also thank those service providers who participated in interviews for giving up their time to share their experiences with us.

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1. Context

The Department for Education and Child Development has funded the implementation of a new program in Northern Metropolitan Adelaide that targets first time mothers in the antenatal period with the aim of improving health outcomes for women, children, and families. The home visiting program works intensively with women exhibiting vulnerabilities in the Playford area to prepare them for the arrival of their first child, to connect them with community supports, and to engage them with antenatal health care.

The program commenced in 2012 and is initially funded until 30th June 2016. The Telethon Kids Institute through the Fraser Mustard Centre and along with an evaluation group consisting of key stakeholders and leading academics in child development and child protection, have been engaged to evaluate the Strong Start program. A detailed evaluation of process and outcomes is presently being developed by the evaluation group.

In the interim, the Child and Family Health Service, who are leading the implementation of Strong Start, have requested a qualitative investigation of the factors impacting referrals to the service and engagement of clients to help inform their engagement strategies and any extension of the program in other geographical regions. The target population group for Strong Start is characteristic of families typically termed ‘hard-to-reach’ and this presents challenges for recruiting pregnant women into the service. Therefore, as part of the investigation reported herein, we have undertaken a literature review of the sorts of factors that impact engagement of families termed ‘hard-to-reach’. This literature review is presented as an introduction to this report. We then describe the works conducted, summarise the findings, discuss these in relation to the literature, and make recommendations for engagement strategies going forward.

2. Introduction

2.1 Defining hard-to-reach families and children

The definition of hard-to-reach families and children, sometimes referred to as ‘complex’ families, is varied. In general, the term is used to refer to population groups who are eligible to access services and programs but do not usually participate or are difficult to involve (Brackertz, 2007). A qualitative evaluation of hard-to-reach groups in the UK (Doherty, Hall, & Kinder, 2003) revealed three different subgroups of hard-to-reach populations – each which included people not engaging in services, but whom service providers believe would benefit if they were to participate:

- **Underrepresented:** groups who are marginalised, economically disadvantaged or socially isolated
- **Overlooked:** groups who may “slip through the net” when service providers overlook these individuals or do not cater for their needs
• Service-resistant: groups who choose not to participate in programs and services, including individuals who may feel suspicious about engagement, as well as those unwilling to seek help due to a lack of awareness of needs and services.

In the Australian context, typically the term hard-to-reach can include:
• Aboriginal or Torres Strait Islander families
• fathers
• teenage, young or single parents
• families on low incomes
• culturally and linguistically diverse groups
• mentally or physically ill parents or parents with a disability
• parents of mentally or physically ill children or children with a disability
• homeless or highly mobile families
• parents who abuse substances

Research conducted by Cortis, Katz, and Patulny (2009) demonstrated that Australian service providers perceived Aboriginal and Torres Strait Islander families to be the most challenging to engage due to their experiences of multiple disadvantages and cultural differences. Further, it was found that while service providers had similar concepts of hard-to-reach groups as described above, their responses extended beyond this by portraying who is hard-to-reach as largely context dependent.

2.1 The challenges and facilitators for engaging hard-to-reach families
In order to improve the access and engagement of hard-to-reach families in child and family services, it is important to first understand the challenges and facilitators that impact upon engagement. McCurdy and Daro (2001) developed a framework consisting of four domains thought to influence initial engagement with available services and maintenance of engagement with services. The four domains include: individual characteristics; provider factors; social and neighbourhood factors; and program characteristics. These are described in detail below.

2.1.1 Individual Characteristics
Research suggests that those who are typically the hardest to engage are often the people with the greatest need, needs which adversely impact their capacity to engage (Cortis et al., 2009). Moreover, the beliefs, attitudes, and needs of parents directly affect whether or not they seek out and utilise services (McCurdy & Daro, 2001). Willingness to engage with services may be dependent upon previous experiences with other services in the past, and on the approval of family and friends. Further, attitudes towards services may be determined by a parents’ perception of the potential risk, cost, and benefit of involvement.

For example, a London study exploring why vulnerable women refuse to take part in early interventions found that women who refused engagement often did not understand the information about the service that was given to them, while others felt their lives were already too complex...
without the addition of a new responsibility (Barlow, Kirkpatrick, Stewart-Brown, & Davis, 2005). Barlow and colleagues (2005) also found that misperceptions and misgivings, for example in relation to the aims of a service or the support involved, played a role in refusal to engage.

Importantly, engagement with services is most difficult for families with complex circumstances. A range of factors contribute to complexity in the lives of families and research has reported each of these impacting upon program and service utilisation, including:

- physical or psychological illness or poor literacy skills (Garbers, Tunstill, Allnock, & Akhurst, 2006)
- daily stresses and chaotic routines (Unger, Jones, Park, & Tressell, 2001)
- sole parenting (Unger et al., 2001)
- lack of social confidence or distrust of staff and other parents (Avis, Bulman, & Leighton, 2007)
- frequent changes of residence (Doherty et al., 2003)
- involvement in criminal activity (Doherty et al., 2003)

2.1.2 Provider factors

The available research suggests that simply increasing the quantity or capacity of services, or targeting hard-to-reach families does not always result in higher levels of access and engagement for hard-to-reach families (Ware, 2012). An explanation for why more resources and a more targeted approach may not result in higher engagement is that both provider as well as client factors affect parental involvement. However, the practical aspects of recruitment as well as the way services are perceived have been reported to have an impact whether or not families engage with services.

One practical aspect that plays a role in how readily families are engaged is the way in which a service is promoted to hard-to-reach families. For example, visual advertisement and promotion of services was found to be most effective amongst hard-to-reach groups, potentially owing to literacy difficulties, whilst using technology was most effective for those living in rural areas (Cortis et al., 2009). Others emphasise the importance of flexibility and informality, for example, accepting referrals from outside the area and having flexible opening hours, as important factors that at entry points make it practically easier for hard-to-reach people to engage with services (Doherty et al., 2003; Ware, 2012). These examples illustrate the importance of understanding the range of practical aspects that are likely to impact differing groups.

Aside from practical aspects about the way the service is promoted or accessed, the way services are perceived has, predictably, been reported as a key factor influencing engagement. This begins with the way in which the service is advertised. Research suggests that promotion of programs to parents in positive terms, for example, in order to help parents raise happy and healthy children, results in better perceptions and, in turn, better engagement when compared to strategies aimed at making up for parental deficit (Stanley & Kovacs, 2003). Further, parents are likely to refuse a service when stigma is clearly attached. Anecdotal data indicates that programs linked with state departments involved in child welfare or social services have difficulty in attracting service users and that private or not for profit providers have higher enrolment rates (McCurdy & Daro, 2001).
Moreover, if a service targets ‘disadvantage’, it increases the sense of failure that hard-to-reach families are likely to experience (Watson, 2005). Subsequently, reaching out to families by offering soft entry points (non-stigmatising, non-threatening, indirect and informal ways to engage parents in their own communities) is a key strategy that has been reported to be used by service providers in order to increase reach and engagement (Cortis et al., 2009; Doherty et al., 2003). Examples include outreach services such as mobile playgroups, natural gathering places such as parks or shopping centres, or through existing neutral, often universal services such as health clinics, child care centres or schools.

It has been widely identified that once initial engagement with families has been achieved, relationship building is critical to maintaining engagement with vulnerable families. A number of factors have been said to enable relationship building with families. According to service providers in Australia, smaller caseloads enable service providers to spend more time building relationships and developing trust with hard-to-reach families (Stanley & Kovacs, 2003). Similarly, a community-based outreach service for disadvantaged pregnant women in Australia found that continuity of care is essential, allowing for relationships to be formed and trust to develop (Dwyer, Cooke, & Hort, 2004). Stanley and Kovacs’ (2003) research also highlights the importance of engaging people directly, in person, as well as engaging all family members, especially male authority figures, and providing incentives like food and social activities. Building relationships prior to intervention, for example, through home visits, enables users to build self-esteem and overcome any anxieties about participation (Avis et al., 2007).

For particular population groups, cultural factors additionally impact engagement. That is, parental perceptions of services are related to a provider’s awareness of and sensitivity and responsiveness to a family’s cultural background (McCurdy & Daro, 2001). For Indigenous families in particular, a lack of cultural sensitivity has been said to foster resistance to a service (Ware, 2012). Similarly, for culturally and linguistically diverse groups, initial contact is widely recognised as difficult to achieve. Studies in this area report staffing factors that can help to recruit and retain hard-to-reach populations who are culturally diverse, such as: having appropriately experienced staff, employing bilingual staff, or involving community leaders (Garbers et al., 2006; Unger, Cuevas, & Woolfolk, 2007). For Indigenous families in particular, employing Indigenous service providers has been said to be essential for reaching and engaging with Indigenous families (Cortis et al., 2009; Scougall et al., 2008). Despite this, the ethnic matching of staff to service users is not on its own an effective engagement strategy. The efficacy of ethnic matching can be context dependent. For example, research in the UK has found that having workers with shared ethnic backgrounds could either encourage or discourage people to use local programs, especially where communities were small and privacy may be compromised (2007). Moreover, although similarities between parents and workers may improve engagement, this strategy has not been shown to be closely associated with better outcomes (Barrett, 2008).

2.1.3 Program Characteristics
In addition to service provider factors, service and program stability are important for ongoing engagement. Ghate and Hazel (2002) highlight that it is vital to engage parents for long enough so
that the service can actually have an impact, and in order to do so, long-term funding is required. Lack of funding was said to lead to overworked staff and staff shortages, lack of flexibility of opening hours as well as the inability to provide any necessary transport and child care in order to promote service use (Stanley & Kovacs, 2003). Conversely, sufficiently resourced, stable, ongoing programs and services were said to be essential in engaging hard-to-reach families as it helps to promote smooth service delivery and reduce staff turnover, subsequently minimising disruption to services and disengagement with families (McCurdy & Daro, 2001). For some population groups continuity has been found to be especially important. As Ware (2012) explains, for Indigenous families building strong communities can only be attained through long-term interventions with sustained funding.

In addition to service stability, the characteristics of the way programs and services are provided influence families’ decisions to engage with a service. Programs and services that are delivered with a client-centred approach are reported to better engage families. A client-centred service with a strengths-based approach was reported to empower parents and help maintain engagement (Cortis et al., 2009). Similarly, Dwyer and colleagues (2004) reported that having a holistic view of a hard-to-reach family, respecting individuality, family context, socioeconomic and relational circumstances was particularly important to program participants. In order to work holistically with families, it can be important to work collaboratively in multi-agency teams, and this approach can also extend the reach of a service and increase engagement of families (Doherty et al., 2003).

Mixed reports exist with respect to the targeting of services or eligibility criteria for a service. Although targeted services have been said to be more stigmatising than universal services, some degree of targeting has been found to be helpful in reaching families. For instance, time based targeting, such as targeting families before children are born has been found to be a good engagement strategy (McCurdy & Daro, 2001; Watson, 2005). Likewise, targeting based on special needs or a disability has also been reported effective (Pinney, 2007). Given the lack of evidence around the range of ways services can be targeted, it is important to consider whether particular strategies will affect client perceptions of the service or potential exclude populations who could benefit from the service but may not fit targeting criteria.

### 2.1.4 Social and neighbourhood factors

Finally, although hard-to-reach families can reside in all neighbourhoods, families in areas of high socioeconomic disadvantage tend to have a greater susceptibility for vulnerability. Thus, in addition to individual factors and service factors impacting on their ability to engage with services, area factors will also impact upon their capacity to engage. Some area factors are related to social perceptions, whilst others are related to shared neighbourhood characteristics. For example, research on fathers in child protection cases reported that well-established social norms and expectations regarding the roles of males and females resulted in men avoiding social or health workers as they considered child wellbeing to be a woman’s role (2006). Another example comes from McCurdy and Daro (2001) who proposed that social disorganisation contributes to refusal to engage with services. On the other hand, the resources and environmental supports available in a community can improve engagement with services (McCurdy & Daro, 2001). Whilst geographical factors, social isolation, and associated transport difficulties have been identified to negatively
impact service use for hard-to-reach families. For example, interviews with Australian parents found that, for mothers with small children in particular, lack of public transport and lack of knowledge of available public transport present major barriers to access (Davies & Oke, 2008).

This report will now describe the works conducted to identify potential factors impacting on engagement with the Strong Start program.

3. Method

3.1 Recruitment

Potential participants were identified through a list of service providers provided by Strong Start staff. This was a comprehensive list of all service providers that had been identified as working with clients that may also be eligible for Strong Start. All service providers on the list had, during the course of normal operations, been contacted by Strong Start in the past to inform them of the service and make connections to enable referral pathways to be established. Thus this list was considered to be an appropriate list of all service providers who were likely to be aware of and refer to Strong Start, and therefore suitable to use for sampling participants.

The contact list contained 35 service providers. Given the small number of service providers, it was deemed appropriate to make contact with each service to recruit participants.

For approximately half the service providers, a contact person was listed, but for the remaining service providers no contact person was listed. Where no contact person was listed, the service was phoned, the purpose of the contact was explained, and an enquiry was made as to who in the service was most likely to work with clients who might be referred to Strong Start.

Given the short time frame available to conduct the work, two contact attempts were made before striking a service from the recruitment list. In total, we attempted contact with 24 of 35 service providers and 12 of these contact attempts were successful. When it was deemed that data saturation had occurred, and it was expected that no new themes would be identified through the conduct of additional interviews, no further service providers were contacted.

3.2 Participants

The recruitment strategy resulted in 12 interviews being conducted. No person who was contacted refused to take part. Service providers from both government and non-government agencies were interviewed and were considered to be broadly representative of the mix of services and service providers, and included:

- Midwives
- Social workers
- Program managers
- Mental Health Clinicians
- School principals
- Nurses
3.3 Data collection
Structured interviews lasted between five and 20 minutes. The duration of the interview largely depended on the familiarity of the participant with the Strong Start program. Prior to interview, the purpose of the investigation was explained along with how the data would be used. Service providers were asked if they were willing to talk to us about their knowledge of the program and their experiences of referring to the program. Participants were also assured of the confidentiality of the information they wished to share.

Interviews consisted of five questions, asking about knowledge of the program, decision making about referring into the program, and experience of the referral process. Participants were also given the opportunity to add any other comments.

4. Findings

4.1 Understanding of the program and its aims
Nine of the 12 interviewed service providers knew of the program. Of those who said they didn’t know much about the program, one service provider worked alongside another staff member in her organisation who tended to refer clients out of the service and this person was said to have good knowledge of the program and was said to refer clients; one had received a pamphlet from the service but had no other contact with Strong Start, and the third hadn’t heard of the service and rarely worked with pregnant women due to their resistance to engage with the service her organisation provided.

Where service providers knew of the program they were able to use this knowledge to identify whether their clients would be suitable candidates for the program. Moreover, service providers who knew of the program and were actively referring to the program, their understanding of the program and its aims were in accordance with the actual program and its aims. This highlights the effectiveness of the communications from the Strong Start staff with those service providers.

Where service providers were not aware of the program, the only contact between Strong Start and the service had been the sending of a cover letter and brochures about the program to the organisation. The contact list detailed no other contacts between Strong Start staff and the service provider. This highlighted the importance of conversations between relevant staff in organisations and Strong Start staff, and the ineffectiveness of pamphlets for forming working relationships with service providers.

Although unlikely, where we were unable to make contact with service providers, it is possible that these service providers were less knowledgeable about the service and this may have impacted whether they responded to messages left by us. Given the number of contacts and contact attempts made, we are, however, confident that the sample was representative of the service provider landscape.
4.2 Factors impacting whether or not service providers refer clients

All but one service provider who had good knowledge of the program said they referred clients to the service. The service provider who had knowledge of the service but reported that she had not engaged with Strong Start explained that this was because her organisation’s own program provided a similar service to pregnant mothers. Additionally, a mental health clinician working in the Strong Start catchment area who did not have a great deal of knowledge of the program, and was therefore not referring to the program, noted that pregnant women who were identified by their GP as needing extra supports were referred to her and that she would likely refer to the program if she knew more about it.

Those service providers who referred to the service mainly noted that they based referrals to the service on the eligibility criteria stated by Strong Start. Four of the eight service providers who referred to the service noted that they worked with clients who did not fit the eligibility criteria but needed extra supports. One of these service providers said it wasn’t clear why some client’s vulnerabilities didn’t qualify them for the service after making contact with Strong Start. The second service provider, a social worker, explained that the benchmarks to be eligible for Strong Start are too high, in terms of what suburb a client can reside in and the level of complexity of risk factors that needed to be present. The service provider thought an expansion of the program with more flexible criteria would be beneficial. This social worker also believed that if Strong Start staff were to assess women who at first did not appear to meet the eligibility criteria they would likely find that the client has a greater number of vulnerabilities than his team are able to identify. The remaining two service providers noted that when a client did not quite fit the eligibility criteria, or if they were not sure whether the client would meet the eligibility criteria they still made contact with Strong Start staff to discuss the client’s situation. These service providers noted that in these instances Strong Start staff members were still able to give the service provider advice to support these clients. One of these two service providers also explained that many pregnant mothers were struggling in their pregnancies and were failing to connect with their babies – including second time mothers who had their first child removed – and could benefit from a child youth health service that is not Families SA. Young women were said to be resistant to working with Families SA because they viewed it as a service that only takes children away.

Service providers also noted that they discussed referrals to the service with clients before making contact with Strong Start, and that they only made contact with Strong Start if they had client consent to do so. Some clients were said to not engage because they were resistant to government programs. In the examples provided, clients were said to at times agree to a referral but then after going home and “googling” Strong Start they found information that linked the program to Families SA. This concerned some young mums who as children had themselves been removed from their parents and they became concerned about their own child being removed, which prevented them from engaging with the service. One service provider working with teenage mothers noted that if at first her clients weren’t happy to be put in contact with Strong Start, but that she still thought it was important for them to do so, she would try over time to encourage and support the client to engage with the service. Other clients who were not referred due to discretion of service providers included:
• women who were ambivalent about keeping the pregnancy
• women in the very early stages of pregnancy
• women who were unlikely to keep the baby
• low risk women
• women outside the catchment area
• women who have strong relationships and support from other services
• young women living at home who have family supports

4.3 Referral experiences
Service providers who had experience of referring to the service noted that their experiences had been largely positive. Strong Start staff were said to be helpful and friendly when service providers made contact to enquire about referrals. Service providers noted it was helpful to be able to phone Strong Start staff to discuss referrals when women appeared not to meet eligibility criteria. Referral forms were said to be self-explanatory and provided a good amount of information from which to base referrals. Referral forms were said to be somewhat time consuming but this was not noted as being very problematic.

Service providers liked that Strong Start staff communicated with them about the progress of clients who were engaged with the service, but also about clients who did not engage with the service or were referred but not eligible for the service. Service providers working in the regional hospital noted that good communication between themselves and Strong Start staff made it feel like they were working as a team, and this also meant that when a child was born they felt comfortable letting Strong Start know.

A final note from a number of service providers was that a face-to-face presence of Strong Start staff at their service would be useful for engagement of women into the service. Some provided examples of where face-to-face presence of Strong Start staff had encouraged engagement of women with the program. Others noted this had not happened at their service, and these service providers suggested that such an approach would be a useful strategy for better engaging pregnant women. This strategy was thought to be beneficial for engaging women who are initially interested but lose interest by the time Strong Start staff make contact or for women who are difficult to recontact. There was, however, no explanation of why women are initially keen to be referred but then do not follow through. It may be that women either change their mind or that they lose interest. Another referral avenue was noted by a service provider who thought it would be beneficial for Strong Start staff to attend staff meetings where clients with high needs are discussed.

5. Recommendations

Overall the themes identified by service providers fit with the literature reviewed. Thus, it is appropriate here to consider recommendations of engagement strategies identified in the literature. It is, however, important to note that it is evident that challenges in engaging hard-to-reach groups
in child and family services remain largely unresolved. For instance, service providers have explained that in spite of the engagement strategies employed they still faced challenges, particularly related to making initial contact with target groups, encouraging participation in ways that were not stigmatising, attracting the appropriate staff, reaching groups where transport is lacking, working effectively with those with multiple disadvantages, ensuring sufficient time so that relationships can be built, and developing partnerships with other agencies in order to promote reach and engagement (Cortis et al., 2009). Service providers have rightly identified that whilst engagement strategies show great potential, the majority of this research has been based on anecdotal data and evaluative evidence is required in order to determine the effectiveness of these strategies (Cortis et al., 2009). Nevertheless, at this stage, the best available evidence on which to base engagement strategies comes from the experiences of those people working with hard-to-reach families.

Although a broad range of strategies have been identified for facilitating the engagement of hard-to-reach families in child and family services, only those relevant to the findings outlined in this report are discussed here.

The first recommendation we make is that Strong Start continues to utilise engagement practices where these are working well (i.e., good communication channels with service providers and clear referral processes), but that these are supplemented with additional strategies to reach those women who are not engaging for the reasons discussed in this report (i.e., fear of removal of children, losing interest or changing their mind). Supplemental strategies that might be considered include:

- providing greater opportunities for pregnant women to engage in non-stigmatising, face-to-face soft-entry points in their communities – this might be creating opportunities for Strong Start staff to have conversations with women in hospital waiting rooms, in schools, or by perhaps establishing small support groups for pregnant mothers with a Strong Start staff presence
- before formally enrolling women who may feel overwhelmed or uncertain about enrolling, that Strong Start allow time for relationships to be built between pregnant women and Strong Start staff before any formal enrolment process in the program

In addition to these client engagement strategies, we recommend that Strong Start consider creating more strategic links within the community. This is not necessarily about contacting all service providers, but trying to contact those most likely to have clients to refer but who have not yet made contact with Strong Start after information was mailed to their service. For instance, some services listed on the contact list do not often work with pregnant women, so time and resources are best spent establishing relationships with those services most likely to refer.

A final recommendation is for the Strong Start Management to consider their eligibility criteria. This should of course only be done in consideration of current staffing and workload, however if there is flexibility to loosen the eligibility criteria then there is indication that this would be supported by the service providers we consulted with.
In conclusion, we would like to note that this literature review and series of stakeholder interviews can only provide insight from the perspective of the current literature and the stakeholders consulted. It is the aim of those considering the evaluation of the Strong Start program more broadly to undertake further investigation of the impact of the program and as such the results presented in this report should be considered preliminary findings.

6. References


Watson, J. (2005). Active engagement: Strategies to increase service participation by vulnerable families: New South Wales Centre for Parenting and Research, Department of Community Services, Ashfield.
About the Fraser Mustard Centre

Working together to improve the development, education, health and wellbeing of young Australians, the Telethon Kids Institute and the South Australian Department for Education and Child Development have joined forces in a unique approach to research translation. The Fraser Mustard Centre collaboration aims to:

- Improve and promote the health and wellbeing of all children and young people in South Australia through the unique application of multidisciplinary research
- Help shift focus from the historical delineation between health and education services to an integrated approach with a focus on child development
- Build capacity amongst public sector staff and academic researchers to design, undertake and use research to improve the environments in which children live and the service systems which support families
- Attract funding for shared priorities for research that leads to improved developmental, education, health and wellbeing outcomes for children

The Fraser Mustard Centre brings forward-thinking policy makers and world class child health researchers. It reflects a shared view of policies and outcomes for children and young people. The Centre is a unique collaboration between two organisations passionate about making a difference.
Appendix C
Invitation letters
Information letter - Staff

Strong Start North Evaluation

Strong Start is a new program in South Australia. So that the program can best support families, it is important to understand what works well and where changes might be needed.

As a person who has worked or is working with the Strong Start program, we would like to invite you to have your say in an interview to gain an understanding of your experience.

Participation
Participation will involve answering some questions about your experience with Strong Start. Participation in this interview is voluntary and will take up to 1 hour at your work place or over the phone. Participating in an interview or choosing not to participate will not affect your current or future employment.

Audio Recording
The interview will be audio recorded for data collection purposes only. Recordings will not be made public. If you would like to take part, but do not wish to be audio recorded you may still choose to take part and the interviewer will take notes about what you say.

Risks
There are no known risks in your participation in this interview.

Confidentiality
All information you provide will be kept confidential and you will not be identified in the evaluation report. The information collected from the interview will be kept in a secure environment for seven years at the Telethon Kids Institute.

Right to withdraw
You can choose to withdraw from the interview at any time or you might decide not to answer a question.

If you have any questions about taking part in this interview, please feel contact Dr Yasmin Harman-Smith on (08) 8207 2089.

If you would like to receive a copy of the evaluation report, please contact Dr Yasmin Harman-Smith at yasmin.harman-smith@telethonkids.org.au

Ethics approval for this study has been granted by SA Health Human Research Ethics Committee.

If you have comments or concerns resulting from your participation in this study, please contact Andrew Alston (8226 6367, SA Health Human Research Ethics).
Information letter - Parent

Strong Start North Evaluation

Strong Start is a new program in South Australia. So that the program can best support families, it is important to understand what works well and where changes might be needed.

As a parent who participated in the Strong Start service, we would like to invite you to have your say in an interview to gain an understanding of your experience.

Participation
Participation will involve answering some questions about your experience with Strong Start. Participation in this interview is voluntary and will take up to 1 hour at a location in your local area or home. Participating in an interview or choosing not to participate will not affect any services you currently receive or any future services you may need.

Audio Recording
The interview will be audio recorded for data collection purposes only. Recordings will not be made public. If you would like to take part, but do not wish to be audio recorded you may still choose to take part and the interviewer will take notes about what you say.

Risks
There are no known risks in your participation in this interview.

Confidentiality
All information you provide will be kept confidential and you will not be identified in the evaluation report. While a support person will be available during the interview your Strong Start Family Support Worker will not be present. The information collected from the interview will be kept in a secure environment for seven years at the Telethon Kids Institute.

Right to withdraw
You can choose to withdraw from the interview at any time or you might decide not to answer a question.

If you have any questions about taking part in this interview, please feel free to discuss these with the Linda Ramsay on 0418 632 957, or later, by contacting Dr Yasmin Harman-Smith on 0438 112 418.

If you would like to receive a copy of the evaluation report, please contact Dr Yasmin Harman-Smith at yasmin.harman-smith@telethonkids.org.au

Ethics approval for this study has been granted by SA Health Human Research Ethics Committee.

If you have comments or concerns resulting from your participation in this study, please contact Andrew Alston (8226 6367, SA Health Human Research Ethics).
Appendix D
Client contact trends for each length of program group
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