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Great Shepparton City Council
Building, Planning, and Compliance Department

By email: council@shepparton.vic.gov.au

Attention: Geraldine Christou
Director Sustainable Development

20 December 2023

Dear Ms Christou,

Re: Notice of Intention to Sell Land – Part 45 Parkside Drive, Shepparton.

We appreciate the opportunity to comment on the current proposal to sell land at Parkside Drive Shepparton, to GV Health. The extract from the Minutes of the Ordinary Council Meeting on 21 November 2023, provides relevant background. That material confirms the proposed use of the land, if the sale goes ahead, would be to establish an Early Parenting Centre (EPC).

FamilyCare has been a long-standing and consistent supporter of a regional EPC, located in Shepparton. Our support is ongoing and unwavering, consistent with clear evidence of need for a service of this type. The announcement of funding in the 2022 Victorian State Budget was welcome and we are keen to participate in community consultation to ensure prompt establishment and smooth transition. We are pleased to note arrangements to recommence consultation in January 2024, are underway.

Unfortunately, we do not believe the proposed site at 45 Parkside Drive, is an appropriate location for an EPC. Further detail explaining the rationale for our objection is attached. FamilyCare would be happy to help in any way with efforts to locate a more appropriate site.

In the event that the sale does proceed, we recommend urgent attention to address the short-comings of the location as far as practical, in consultation with the community and key stakeholders.

Yours sincerely,

David Tennant
Chief Executive Officer

Summary of reasons for objection

FamilyCare's service role:

FamilyCare is the main provider of child and family services in the Goulburn region. Our service area includes the LGAs of Mitchell, Murrindindi, Strathbogie, Greater Shepparton and Moira. We have offices in Shepparton, Wallan, Seymour and Cobram, with outreach to Kinglake, Alexandra and Kilmore.

Relevant to the development of an EPC, FamilyCare provides a number of targeted Early Years services and is an active participant in the Best Start Alliance hosted by the Greater Shepparton City Council.

In 1995, FamilyCare established a Parent/Child Day Stay service (formerly known as the Mother/Baby Day Stay) in Shepparton. The service also operates in Cobram and Kilmore on a regular, rotational basis.

FamilyCare's Day Stay service has operated continuously in the years since 1995, with a mix of funding provided by the Commonwealth Government, directly and through Communities for Children and the Victorian State Government. Additional resources have been provided from time to time and for several years, the Frank and Flora Leith Memorial Trust has assisted with funding, which provides extra support to parents and carers of very young children, in their homes.

The Day Stay service, as the name suggests, provides in-centre support for a full day, covering two feed and sleep cycles. A range of issues can be considered depending on the needs of the parents, or carers and their children, including attachment, behavioural concerns, reading baby's cues, feeding and sleeping.

The COVID 19 pandemic caused significant disruption to the operation of the Day Stay. The 2022/23 financial year saw service delivery return to normal levels, with the Parent Child Program, incorporating Day Stay, experiencing consistently high demand. Last financial year, FamilyCare's Parent Child Program supported 234 families in Shepparton alone, with 212 attending the Day Stay. To provide context for the level of service and its local relevance, in the same period GV Health reported 838 births.

In 2016, FamilyCare commissioned the Centre for Community Child Health at the Murdoch Children's Research Institute to conduct an evaluation of the Day Stay service. A copy of the evaluation report is provided, as Attachment A.

The Day Stay service is particularly relevant to the discussion of an EPC, because it is an activity frequently included in the services offered at such a facility. That is the case with other EPC-like services, in Victoria and elsewhere in Australia, including those offered by QEC and Tweddle.

Brief background on advocacy for an Early Parenting Centre (EPC):

The original goal when FamilyCare established its Day Stay service in 1995, was to offer a residential service as well. The resourcing available at the time was not sufficient to realise that goal. Whilst not the start of the advocacy for an EPC in the Goulburn Valley, establishing an in-region Day Stay option was a step on that journey. It meant we had a viable support service that could meet some of the local need, where the alternatives might be travelling to Melbourne, or missing out altogether.

In 2012, with financial assistance provided by the GV Health Foundation, a scoping study to develop a more complete Parent Child facility was commissioned. The consultant, Lesley Yates of RADNO Ltd, produced two staged reports. Copies of both are provided and marked Attachments B and C.

The RADNO reports included a summary of the evidence, which established the need for an EPC based in Shepparton. Reports since, including a QEC analysis released in 2022 which suggested the need in Shepparton was the highest in the State, have been entirely consistent. All the more reason why FamilyCare and other long-term advocates warmly welcomed the announcement of funding to establish an EPC in Shepparton in the 2022 Victorian Budget.

Why the location of the EPC matters:

The second RADNO report noted the following, in relation to design:

> Construction of the *Parent Child Unit* will address more than the physical building itself. The facility will also be integrated into the community and positioned as a place of healing, help and support. Privacy and natural light are both important considerations for bedroom spaces, and the facility will include communal dining, play and outdoor spaces. The facility itself will be centrally located nearby to places to eat, shop and play.

Ensuring people and families utilising the services of the EPC feel connected to community is vital. Often, a sense of isolation is prominent in the list of reasons for referral, or for seeking support. Being able to walk to local shops or get a coffee plays an important role in normalising the experience of accessing assistance.

Both main facilities operated by QEC and Tweddle at Noble Park and Footscray respectively, are within easy walking distance of shopping areas. FamilyCare's Shepparton Day Stay operates from a cottage in Welsford Street, two blocks from the CBD.

The proposed site at 45 Parkside Drive, is not close to any facilities. It is around half an hour walk to the centre of town, along streets ill-suited to families with small children. There are also limited public transport options available for people who do not have their own vehicles.

Attachment A

Evaluation of the FamilyCare Mother-Baby Day Stay service

Final report

The Centre for Community Child Health

Date: 7 October 2016
Version: 1.0

Prepared by:
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The Centre for Community Child Health is a research group of the Murdoch Childrens Research Institute and a department of The Royal Children's Hospital, Melbourne.

Acknowledgements:
The project team would like to thank staff at FamilyCare, particularly Rosemary Rutledge, Janet White and Alison Mastin for their engagement and assistance throughout the evaluation. Thank you also to the project's expert advisor, Dr Tim Moore, for valuable input and feedback. Many thanks are extended to all the Day Stay families, staff and stakeholders who shared their thoughts with us throughout this project.

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Glossary

Child	Day Stay targets infants aged 0 to 12 months
KPCS	Karitane Parenting Confidence Scale
MCHN	Maternal and Child Health Nurse
PASDS	Parent Assessment and Skills Development Service
The Centre	Centre for Community Child Health

Executive summary

Background and evaluation overview

The FamilyCare Mother-Baby Day Stay service (Day Stay) was established in November 1995. It offers support to carers of newborn infants (0-12 months), primarily through a one-day education and support session. Families undergo a pre-session assessment by phone prior to attending, and are supported after their Day Stay with follow up phone calls and a variety of associated activities, including referrals to other services and activities in the community.

In 2016, FamilyCare contracted the Centre for Community Child Health (the Centre) at Murdoch Childrens Research Institute to undertake an evaluation of Day Stay. Broadly, the evaluation sought to clarify the Day Stay service model, its evidentiary base and consider whether it has been delivered as intended; as well as investigate program impact and the value of the service as part of the local child and family support system. The evaluation was conceptualised into three core components. Key questions addressed by each evaluation component are summarised in Table 1.

Table 1. Key evaluation questions presented for each evaluation component

Evaluation component	Key evaluation questions
1. To analyse alignment of the service model to the evidence	• What is the service model? • How does it align to the evidence and best practice?
2. To evaluate the delivery (process) and impact of Mother-Baby Day Stay	• Was the service model delivered as intended? • Did the initiative have the immediate impact on the recipients that was expected? • Is the initiative making progress towards the longer term outcomes identified?
3. To determine the contribution of Mother-Baby Day Stay to local parent and child supports	• To what extent is Mother-Baby Day Stay valued as an important local parent and child support?

Methodology

To address evaluation component one, the Centre facilitated a program logic workshop with FamilyCare staff to develop an updated Day Stay program logic (see Appendix A). Following the workshop, the program logic was cross-checked against existing research evidence by the project's expert advisor.

To address evaluation components two and three, a range of qualitative and quantitative data was gathered to evaluate the delivery, impact and contribution of Day Stay in the local community. Data sources are summarised in Table 2.

Table 2. Evaluation data sources

Data source	Sample size	Year of collection
Administrative data	1441 referrals	2011 to 2016
Family interviews	n=8	2016

Family service surveys • Pre-service • Mid-service • Follow up	 n=129 n=40 n=45	2015 and 2016
Family satisfaction survey	n=35	2016
Staff focus group	n=3	2016
Stakeholder interviews	n=4	2016

Findings

Service model

The primary Day Stay activity is the delivery of one seven and a half our session at the Day Stay facility (house), which involves Day Stay staff providing carer-infant dyads with practical, flexible, individualised support to meet the challenges of caring for a new baby. Families receive a phone call within 24 hours of referral from Child FIRST to Day Stay, in which staff conduct a pre-session assessment and arrange a time for the family to attend. On the day of the session, Day Stay staff use seven core strategies in delivery of Day Stay sessions. Families are also offered material aid to meet immediate needs that arise on the day and are followed up by phone one week following their Day Stay session to monitor their progress.

Beyond their Day Stay session, families are also offered a range of associated Day Stay activities, including phone counselling, home visiting, Circle of Security and playgroup. Behind the scenes, Day Stay staff assist by liaising with other services and professionals working with families (for example, mental health, maternal and child health, general practitioners, Child FIRST, family violence services and the Department of Health and Human Services). Day Stay staff are also involved in training and community education around issues affecting children and families (for example, infant mental health, breastfeeding and sleep settling, also hosting visiting professionals and students).

Alignment of the service model to the evidence

The evaluation found the program is broadly supported by the literature regarding effective early parenting support. The components of the Day Stay service model were examined, including parent-child interaction support and role modelling, practical parenting advice, child development information and the support offered (including referrals) for issues affecting infant/parent wellbeing. Key feedback was that developing relationships with parents is critical to the success of programs like Day Stay, as the practitioner-parent relationship is the medium through which such programs effect change. In particular the warm welcome and orientation, and parent/infant focused approach of the program were considered important elements of Day Stay, highlighting the central role of relationships to the Day Stay service model. Notwithstanding, further work is required to explicitly articulate and document how each of the Day Stay activities listed in the program logic are carried out. This would enable a more detailed review of how specific techniques used within the Day Stay activities align with the evidence and best practice, and support sustainability of the service. It would also contribute to the effectiveness of the program by ensuring that staff have a greater common understanding of key principles and practices underpinning the program.

Delivery of Day Stay

Data showed that Day Stay is generally being delivered as intended. It is clear that staff are warm and welcoming to families and offer them substantial support, information and practical help on a wide range of relevant topics. The evaluation revealed that there is some scope to make the session planning process more explicit in order to ensure this is undertaken in partnership with families, and addresses the issues that are most salient or of most interest to parents. It would also be beneficial for Day Stay staff to record when and what material aid items are given to families, referrals to other services and the number of training and education sessions delivered, to provide evidence of program outputs and ensure these aspects of the service are monitored. It is of note that the frequency at which associated activities have been delivered to families has generally declined over the period 2011/12 to 2015/16.

The impact of Day Stay

There has been substantial progress made towards achieving Day Stay's intended outcomes. There is strong evidence that all immediate (short term) outcomes are being achieved, with further evidence of progress towards the longer term outcomes articulated in the program logic. In particular, there is very strong evidence that Day Stay has improved parenting confidence and created significant positive changes for parents, children and their family units.

The contribution of Day Stay to the local community

Feedback from families and stakeholders, supported by comments made by staff, indicated that Day Stay is held in very high regard in the local community. Feedback indicated that the service is widely appreciated and is currently addressing a clear community need. It is highly valued for its extensive and practical content addressing families' early parenting needs; its high quality; its accessibility; and the active role Day Stay staff play in driving and supporting change to improve the broader service system supporting young children and their families in the region.

Considerations for future

The evaluation process uncovered many very positive findings in relation to the delivery of Day Stay, its progress towards outcomes and value to the community. It is clear that on the whole, families, stakeholders and staff view the program as functioning well, and consider that it is an essential early parenting support to many children and families in the community. The evaluation has also identified considerations for ongoing program improvement, which if implemented, would serve to further enhance and strengthen Day Stay. It has identified that the service would benefit from clearer articulation and documentation of the detail of how the service is delivered; implementing a more explicit session planning process; strengthening feedback provided to referrers into the service; and further refining ongoing program monitoring and improvement processes. Action in the areas identified for improvement will serve to strengthen this highly respected and valued service, ensuring Day Stay continues to provide a best practice response to the needs of families and young children in the local community.

1. Introduction

1.1 Program background

The FamilyCare Mother-Baby Day Stay service (Day Stay) was established in November 1995. The service was initiated as part of the organisation's broader Parent Child Program, which aims to assist local children and families with a variety of childhood, parenting and family challenges, through the provision of practical advice and support. Day Stay has been running for 21 years and currently operates for a total of five days per fortnight – three days in Shepparton and one day per fortnight on rotation in Cobram and Seymour.

Day Stay provides support to carers of newborn infants in their first year of life. Its primary activity is a one-day intervention which involves providing families with practical, flexible, individualised support and education in a seven and a half hour session. Families undergo a pre-session assessment by phone prior to attending, and are supported after their Day Stay with follow up phone calls and a variety of associated activities, including referrals to other services and activities in the community.

There are many issues faced by local families that the Day Stay service seeks to address. These range from practical parenting issues (such as feeding and sleeping), to more complex issues affecting wellbeing. The program's target group includes socially isolated families, culturally and linguistically diverse families, Aboriginal families, young parents, as well as families experiencing intellectual disability, mental health issues and family violence.

1.2 Evaluation overview

Anecdotally, feedback over many years has suggested that Day Stay is appreciated in the local community and is viewed as an effective support for the children and families it serves. However, the service has not previously been formally evaluated. In 2016, FamilyCare contracted the Centre for Community Child Health (the Centre) to undertake an evaluation of Day Stay. Broadly, the evaluation sought to clarify the Day Stay service model, its evidentiary base and consider whether it has been delivered as intended; as well as investigate program impact and the value of the service as part of the local child and family support system.

The evaluation was conceptualised into three core components. Key questions addressed by each evaluation component are summarised in Table 3.

Table 3. Key evaluation questions presented for each evaluation component

Evaluation component	Key evaluation questions
1. To analyse alignment of the service model to the evidence	• What is the service model? • How does it align to the evidence and best practice?
2. To evaluate the delivery (process) and impact of Mother-Baby Day Stay	• Was the service model delivered as intended? • Did the initiative have the immediate impact on the recipients that was expected? • Is the initiative making progress towards the longer term outcomes identified?

3. To determine the contribution of Mother-Baby Day Stay to local parent and child supports	• To what extent is Mother-Baby Day Stay valued as an important local parent and child support?

The next section of this report presents an overview of the methodology adopted for the evaluation and findings are presented in the following section. Emerging themes are then discussed, alongside considerations for the ongoing implementation of Day Stay into the future.

2. Methodology

2.1 Approach and rationale

This evaluation was underpinned by a participatory and outcomes-based approach. The development of an evaluation framework and updating the program logic were foundational tasks undertaken at the beginning of the project to guide the evaluation.

Participatory evaluations involve stakeholders in evaluation activity, with the aim of building participants' evaluation capacity (Haviland, 2004). In the context of the Day Stay evaluation, a participatory approach was adopted to enable FamilyCare staff to shape and inform the evaluation framework, enhancing skills and capacity for future monitoring and evaluation of Day Stay. This also ensured a meaningful, appropriate and feasible evaluation design was developed.

Outcomes-based approaches 'start with the end in mind', asking 'what change do we want?' and working backwards to define the strategies that are used to bring about that change. Process, impact and outcomes are key elements of an outcomes-based approach to evaluation, enabling investigation of how planned activities are delivered and what progress has been made in relation to agreed outcomes. An outcomes-based approach was a natural fit for the Day Stay evaluation given the key questions the evaluation sought to address.

2.2 Evaluation component one: Alignment of the service model to the evidence

2.2.1 Program logic development

Re-visiting a program's outcomes and clarifying a program's logic are important first steps in an outcomes-based evaluation. A program logic is intended to diagrammatically depict key components of a program and how these components lead to the intended outcomes. When undertaken in a participatory manner, this process ensures there is a shared understanding of the program to be evaluated and clarifies where evaluation focus and efforts are required.

The Centre facilitated a program logic workshop with FamilyCare staff to develop an updated Day Stay program logic (see Appendix A) in March 2016. The workshop was an exercise in the group refining the existing Day Stay program logic by clarifying service context, inputs, activities and outputs, as well as the intended short, medium and long term outcomes.

Once updated, the program logic was verified against the research evidence by the project's expert advisor. Outcomes of this verification were discussed with Day Stay staff via teleconference.

2.2.2 Evaluation framework development

An evaluation framework (see Appendix B) was developed, on the basis of the updated Day Stay program logic, to guide activities in components two and three of the evaluation. The framework detailed a series of 19 process indicators and nine impact indicators and set out relevant data sources, responsibilities for data collection and timelines.

2.3 Evaluation components two and three: process, impact and value

A range of qualitative and quantitative data was collected to address evaluation components two and three: to assess the process and impact of Day Stay, and determine the contribution of Day Stay to local parent and child supports. Data sources included administrative program data and worker notes; parent surveys and interviews; a staff focus group and stakeholder interviews. Numbers of participants involved are summarised in Table 4.

Table 4. Numbers of participants involved in data collection for evaluation components two and three

Data source	Sample size	Year of collection
Administrative data	1441 referrals	2011 to 2016
Family interviews	n=8	2016
Family service surveys • Pre-service • Mid-service • Follow up	 n=129 n=40 n=45	2015 and 2016
Family satisfaction survey	n=35	2016
Staff focus group	n=3	2016
Stakeholder interviews	n=4	2016

An overview of each source is provided below.

2.3.1 Administrative data

FamilyCare provided non-identifiable administrative program data for the period from July 2011 to June 2016 (five full financial years), based on electronic records and staff notes. Database output was provided in relation to 1441 referrals into the program across the five year period, and further records were provided in relation to discrete aspects of the process evaluation (i.e. number of visiting professionals, number of community education and training events delivered).

2.3.2 Family interviews and surveys

Family data analysed in this report included interview and survey data. Eight mothers participated in semi-structured parent interviews. Three interviews were held in-person at the Day Stay house in Shepparton in May 2016 and the five remaining interviews were conducted over the phone in June 2016. Seven of the eight mothers had attended Day Stay in the previous six months. The remaining mother attended in September 2014. Six mothers attended Day Stay in Shepparton, one attended in Cobram and the remaining mother attended in Seymour. Three mothers had attended one Day Stay session, however most mothers (n=5) reported attending Day Stay on two or more occasions. Mothers were asked a series of questions relating to their experience of Day Stay, designed to address process and impact indicators, as well as their perspective on the value of the Day Stay program in their local area (questions attached as Appendix C).

Family survey data was collected by FamilyCare as part of ongoing program monitoring and review. Data was available from two different survey processes: the family satisfaction survey and the service surveys (pre, mid and post service).

The family satisfaction survey (see Appendix D) contained nine items relating to families' experiences of Day Stay. There were 35 respondents to the survey from January to June 2016, all female, ranging in age from 16 to 55.

The service surveys are administered by Day Stay staff at the beginning of the Day Stay session (pre) and on follow up at the point of service closure (follow up) as part of normal program operations. Day Stay staff were asked to collect the survey at an additional time point (end of the Day Stay session) for one month during the evaluation. This additional time point is referred to as the 'mid-service' survey in this report. Each service survey contains the Karitane Parenting Confidence Scale (KPCS) (Črnčec, Barnett, & Matthey, 2008) for comparison of parenting confidence scores over time. The KPCS is a 15-item questionnaire designed to measure perceived parenting self-efficacy in parents of children 0-12 months. Each item is scored 0 to 3, with the sum of scores on all items producing a total score. The KPCS cut-off score is 39, indicating that parents with a total score of 39 or below may be experiencing low levels of parenting confidence. There was pre-service KPCS data for 129 families, mid-service data for 40 families and follow up service data for 45. The pre and post service surveys also contained additional items. In the pre-service survey, these related to reasons for attending and in the post service survey, these related to feelings about Day Stay. The service surveys are attached as Appendix E.

2.3.3 Staff focus group

Three Day Stay staff participated in a semi-structured staff focus group at FamilyCare in Shepparton in May 2016. Questions asked of staff are attached as Appendix F. Staff who participated in the focus group were trained in early childhood education, nursing and midwifery and perinatal and infant mental health. All three staff had been at FamilyCare for a minimum of six years at the time of the focus group, with the longest serving staff member coming up to 13 years of service. All three staff had extensive experience working with young children and their families in the local area, prior to joining FamilyCare.

2.3.4 Stakeholder interviews

FamilyCare staff identified four stakeholders involved with Day Stay as service partners and/or as part of the Day Stay referral network, to participate in telephone interviews in June 2016. These stakeholders were drawn from the Maternal and Child Health Nurse teams at Greater Shepparton City Council, Moira Shire and Strathbogie shire; and the local Best Start partnership. Questions asked of stakeholders are attached as Appendix G.

2.4 Limitations

While the methodology adopted for this evaluation had several strengths, including access to over five years of administrative program data and triangulation of data from multiple sources, using mixed methods, it important to note some limitations.

First, eight mothers and four stakeholders were consulted in qualitative interviews over the course of the evaluation. While their responses were very valuable and shed considerable light on family and

stakeholder perspectives on the program, this sample cannot be taken to be representative of all mothers or all professionals involved with Day Stay.

Second, there is a risk that there may have been a positive bias in family interview responses due to the inherent difficulty in recruiting families with negative views. It is possible that mothers who were: (1) able to be contacted and (2) who agreed to participate in an interview, may have been more likely to view the program positively, compared to those who may have been unsatisfied and/or were not contactable to participate in the review.

Third, there was likely overlap in the samples of families interviewed and surveyed. There was also likely overlap in the individuals who completed the two different surveys, but matching and mapping was not undertaken to determine the extent of this. Where interview and survey data are presented it should be noted that these are not independent samples, as families who participated in interviews were likely to have also completed surveys.

Finally, limitations must also be noted in relation to the administrative data provided. The database referral information contained some missing and inaccurate data, so does not provide a full, complete picture of all referrals into the program. For instance in some cases, case outcomes or closure reasons recorded did not match defined data entry categories and so these referrals were excluded from the analysis. However, given the large number of referrals and relatively few observed instances of missing or inaccurate data, this is not overly problematic. Inferences drawn rely on the accuracy of the data in the database.

3. Findings

3.1 What is the Day Stay service model?

The updated Day Stay program logic (Appendix A) details important components of the Day Stay service model, including program inputs, activities, outputs and associated short, medium and long term outcomes.

The primary Day Stay activity is the delivery of one seven and a half our session at the Day Stay facility (house), which involves Day Stay staff providing carer-infant dyads with practical, flexible, individualised support. Up to four families attend the same Day Stay venue at once, with two Day Stay staff working at each session. Families receive a phone call within 24 hours of referral from Child FIRST to Day Stay, in which staff conduct a pre-session assessment and arrange a time for the family to attend. Families are triaged according to presenting needs and this determines prioritisation of scheduling families into sessions.

On the day of the session, Day Stay staff use seven core strategies in delivery of Day Stay sessions, including:

- Providing families with a warm welcome and orientation to the session
- Developing an infant/parent focused care plan in partnership with the parent (addressing issues most salient to the parent) and ensure an infant/parent focused approach to the session
- Observing, eliciting and supporting parent-child interaction
- Role modelling positive parent-child interaction
- Providing practical parenting advice (feeding, settling, behaviour management, hygiene, injury prevention)

- Providing up to date information about child development (ages and stages, importance of play/stimulation)
- Offering support, information or referrals for issues affecting infant/parent wellbeing.

Families are also offered material aid to meet immediate needs that arise on the day (for example clothing, food hampers, bottles) and are followed up by phone after their Day Stay session to monitor their progress.

Beyond their Day Stay session, families are also offered a range of associated Day Stay services, including phone counselling, home visiting, Circle of Security and playgroup. Behind the scenes, Day Stay staff assist by liaising with other services and professionals working with families (for example, mental health, maternal and child health, general practitioners, Child FIRST, family violence services and the Department of Health and Human Services). Day Stay staff are also involved in training and community education around issues affecting children and families (for example, infant mental health, breastfeeding and sleep settling, also hosting visiting professionals and students).

3.2 How does the Day Stay service model align to the evidence and best practice?

The project's expert advisor reviewed the Day Stay program logic to consider how the model aligns to the evidence and best practice. This review found that the model was broadly supported by the literature regarding effective early parenting support. Components of the Day Stay service model were examined, including parent-child interaction support and role modelling, practical parenting advice, child development information and the support offered (including referrals) for issues affecting infant/parent wellbeing.

Key feedback was that developing relationships with parents is critical to the success of programs like Day Stay, as the practitioner-parent relationship is the medium through which such programs effect change. It is vital for Day Stay staff to tune into parents to ensure that the service addresses their goals and aligns with their values, and to purposefully build relationships with parents. To this end, the pre-session assessment, warm welcome and orientation, and parent/infant focused approach of the program are particularly important elements of Day Stay. Evidence suggests that taking a partnership approach with parents (Davis & Day, 2010) and making sure parents feel heard and understood are critical in order for parenting support programs to be effective. The flexibility of the Day Stay model and its ability to cater for an individual family's needs was also identified as beneficial.
The project's expert advisor offered several resources to support staff's delivery of parent-child interaction support, practical parenting advice, child development information and support and information in relation to issues affecting infant/parent wellbeing. Suggested resources are summarised in Table 5.

Table 5. Resources suggested to Day Stay staff to support program activities.

Day Stay activity	Resource
Observe, elicit and support parent-child interaction	See review of responsive parenting interventions in Moore, T.G., McDonald, M. and Sanjeevan, S. (2013). *Evidence-based service modules for a sustained home visiting program: A literature review.* Prepared for the Australian Research Alliance for Children and Youth. Parkville, Victoria: The Centre for Community Child Health at

	Murdoch Childrens Research Institute and The Royal Children's Hospital. See also: Lori A. Roggman, Lisa K. Boyce and Mark S. Innocenti (2008). *Developmental Parenting: A Guide for Early Childhood Practitioners*. Baltimore, Maryland: Paul H. Brookes.
Role model positive parent-child interaction	See: Roggman, Boyce & Innocenti (2008)
Provide practical parenting advice (feeding, settling, behaviour management, hygiene, injury prevention)	Strategies for addressing specific areas of concern around such issues were reviewed for the right@home project, see Moore, McDonald & Sanjeevan (2013)
Provide information about child development (ages and stages, importance of play/stimulation)	Victorian Maternal and Child Health materials and framework
Offer support, information or referrals for issues affecting infant/parent wellbeing	The Centre's Parent Engagement Resource (PER) provides a systematic and family-centred way of identifying issues relating to parental wellbeing and family functioning

The expert considered that further work should be undertaken at Day Stay to explicitly articulate and document how each of the activities listed in the program logic is carried out. This would enable a more detailed review of how specific techniques used within Day Stay activities align with the evidence and best practice. Undertaking this process would also have benefits for the portability and replicability of the program. It is important that staff are familiar with the relevant literature and particular approaches underlying the program (e.g. family centred, developmental parenting). Documenting these would contribute to the effectiveness of the program by ensuring that staff have a shared understanding of key principles and practices. It would also be of benefit to support the sustainability of the program, for instance in the orientation of new future staff.

3.3 Has Day Stay been delivered as intended?

To examine whether Day Stay has been delivered as intended, data was analysed against the process indicators outlined in the evaluation framework. Analysis showed that Day Stay is generally being delivered as intended. It is clear that staff are warm and welcoming to families and offer them substantial support, information and practical help on a wide range of relevant topics. The evaluation revealed that there is some scope to make the session planning process more explicit in order to ensure this is undertaken in partnership with families, and addresses the issues that are most salient or of most interest to parents. It would also be beneficial for Day Stay staff to record when and what material aid items are given to families, referrals to other services and the number of training and education sessions delivered, to provide evidence of program outputs and ensure these aspects of the service are monitored. It is of note that the frequency at which associated activities have been delivered to families has generally declined over the period 2011/12 to 2015/16.

Summary findings in relation to the process indicators are presented in Table 6. Findings are then fully elaborated by service activity in the sections that follow.

Table 6. Summary findings in relation to process indicators

Summary process findings
• 93 per cent of families referred to Day Stay participated in a pre-session assessment in the five-year period from 2011/12 to 2015/16.
• 838 families attended Day Stay in the five-year period.
• Five of eight mothers interviewed specifically recalled staff being friendly and welcoming when they first arrived, however all families commented positively on the interactions they had with staff at Day Stay during the session and on follow up.
• Staff described planning Day Stay sessions by asking families questions about their concerns and observing their interactions with their children. Families interviewed did not consider they had participated in 'planning' for their Day Stay with staff.
• Six of the eight mothers interviewed reported feeling their Day Stay session was designed around their family's needs. 94 per cent of respondents to the satisfaction survey agreed that staff listened to them. In interviews, all families indicated they appreciated staff observing, eliciting and supporting parent-child interaction.
• All staff indicated it was common practice for them to role model positive parenting behaviour during Day Stay sessions.
• All families interviewed indicated that Day Stay staff provided them with practical parenting help by role modelling and demonstrating new techniques. All 45 respondents to the follow up parent survey agreed that Day Stay staff were knowledgeable about parenting and babies. Five of the eight mothers interviewed reported Day Stay staff had provided them with support in relation to broader issues.
• FamilyCare receives donations of baby clothes, toys and other items which staff distribute as required. No data on number and type of items distributed is currently recorded. Transport assistance can be provided if families cannot get to Day Stay.
• Staff reported that all families receive follow up phone calls one week after Day Stay. Families commented that their experience of Day Stay follow up was exceptional. Analysis of administrative data revealed that between two to seven per cent of families had participated in different associated activities over five years.
• Day Stay hosted a total of 82 visiting professionals and students over five years. No data on number of training and education sessions delivered is currently recorded.

3.3.1 Pre-session assessment

In the period from July 2011 to June 2016, 1059 families were referred to Day Stay. Some 841 families were referred to Day Stay on a single occasion, while the remaining 218 families were referred to Day Stay multiple times over the five-year period (median of two referrals, with a maximum of 11 referrals for one family over the five years). In total, Day Stay received 1441 referrals from 2011/12 to 2015/16, as summarised in Table 7.

Table 7. Referrals to Day Stay by region in the period 2011/12 to 2015/16.

Region	2011/12	2012/13	2013/14	2014/15	2015/16	Total
Benalla	1	1	-	-	1	3
Campaspe	-	1	3	4	18	26
Greater Shepparton	154	138	150	143	176	761
Loddon	-	-	-	-	1	1

Mitchell	64	66	29	22	55	236
Moira	87	67	51	42	69	316
Murrundindi	10	2	2	8	3	25
New South Wales	3	5	-	1	5	14
Queensland	-	-	-	-	1	1
Strathbogie	11	10	9	14	13	57
Whittlesea	-	1	-	-	-	1
Total	**330**	**291**	**244**	**234**	**342**	**1441**

Day Stay referral data captured service closure reasons for 1372 (95 per cent) of the total 1441 referrals into the program. Of those 1372 referrals with a recorded closure reason, only 95 (7 per cent) were closed without Day Stay staff having made initial contact with the family to undertake a pre-session assessment and coordinate an appointment time. It can therefore be inferred that 1277 referrals to Day Stay (93 per cent) progressed to a pre-session assessment. Numbers of referrals closed without a pre-session assessment from 2011/12 to 2015/16 are summarised in Table 8.

Table 8. Number and percentage of Day Stay referrals closed without a pre-session assessment having taken place from 2011/12 to 2015/16.

Financial year	Number	Percentage
2011/12	15	5%
2012/13	16	6%
2013/14	16	7%
2014/15	21	9%
2015/16	27	9%
Total	**95**	**7%**

Day Stay Case Statistics reports provided an indication of the response time (in calendar days) families waited between referral to Day Stay and their first phone call from Day Stay staff in the same period. Across the five year period, most families received a phone call on the same day as the referral was received by Day Stay staff, as summarised in Figure 1.

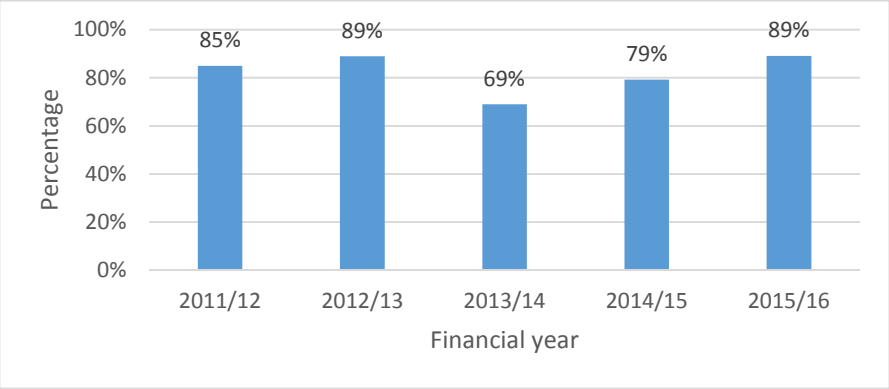

Figure 1. Proportions of families who received an initial pre-session assessment phone call on the same day their referral was received by Day Stay in the period 2011/12 to 2015/16.

3.3.2 Day Stay session activities

Number of families attending Day Stay

A total of 1089 individual Day Stay sessions were delivered to families over the period 2011/12 to 2015/16.[1] Analysis revealed that a total of 838 different families attended these sessions (79 per cent of the total 1059 families referred to Day Stay). Number of Day Stays delivered and families participating in Day Stay over the period 2011/12 to 2015/16 are summarised in Figure 2.

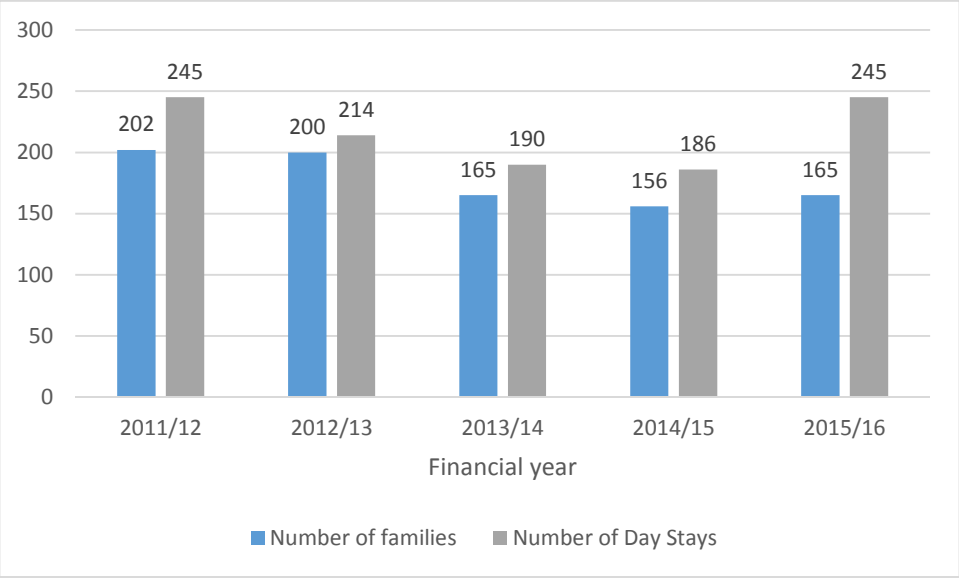

Figure 2. Number of individual Day Stay sessions delivered to families over the period 2011/12 to 2015/16.

Note: higher number of Day Stays delivered per year than number of families per year in Figure 2 is indicative of multiple attendances at Day Stay by some families.

A sub-set of 57 families referred to Day Stay during the period 2011/12 to 2015/16 were referred as part of the Parent Assessment and Skills Development Service (PASDS).[2] Analysis revealed that 48 of the 57 families (84 per cent) attended Day Stay in the relevant period.[3] A breakdown of the number of PASDS families attending Day Stay each year is provided in Figure 3. Note: one family attended in two years and so have been included in Figure 3 for both of those years.

[1] To determine how many of the total 1441 referrals to Day Stay translated into attendance at Day Stay, referral data was filtered by closure reason and case outcome. Due to some missing data and data entry errors, outcome data was available for 1371 referrals and as reported above, exit closure reasons were available for 1372 referrals. Referrals with missing or erroneous data (codes outside set closure and outcome categories) were removed, along with those where the recorded outcome was 'not applicable' (closed at assessment or prior to) and those where the family did not engage with the service. The resulting filtering identified a total of 1089 referrals, indicating that at least 1089 sessions had taken place

[2] FamilyCare is one of nine agencies delivering PASDS in Victoria. The Victorian Department of Health and Human Services website describes PASDS as a targeted service provided to children who are notified to child protection from birth to two years of age. PASDS includes an assessment of children's overall wellbeing and the parent's capacity to care for and protect the child. These assessments are then used by child protection and the Children's Court to inform decision making and ensure appropriate supports are provided to vulnerable children and their families. These services also include an intensive education and skill development component for parents.

[3] Using the same filtering process as described in footnote 1.

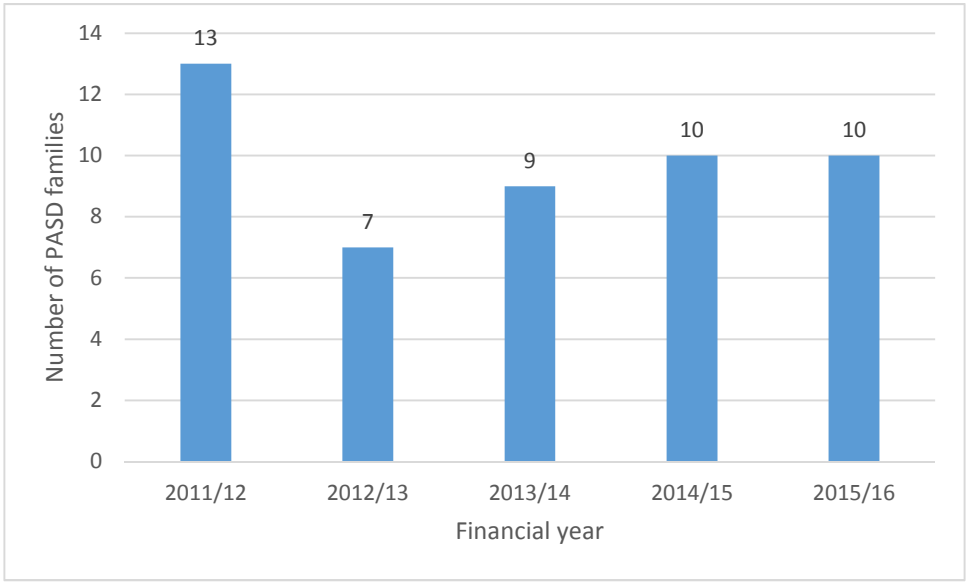

Figure 3. Number of PASDS families attending Day Stay in the period 2011/12 to 2015/16.

Warm welcome and orientation

A key focus of Day Stay is ensuring families feel welcome when they first arrive. Both Day Care staff and families reflected on how this took place.

In the staff focus group, Day Stay workers described actively trying to make families feel welcome at the beginning of sessions by introducing themselves and others, orientating families to where things are at the Day Stay house (toilets, where to put bottles, etc) and talking to them about the day. Staff considered it important that families feel at home for the day from the very beginning, but also emphasised that it was important to be responsive to each family as they walk through the door:

> *"We had a client the other week and she was extremely anxious, and the baby was due to sleep, so the baby went into her room… and she was up the front [of the house] for her to have a rest because she was just exhausted, and we thought 'hey, this mum is really struggling'. I went down and spoke to her and talked about how difficult it can be when you come here and your baby needs to be put to sleep straight away and you haven't got used to us, and trust us when you don't know us. She really warmed to that idea, and she said 'yes, look this is what I'm struggling with', and we were able to talk with her and we got a good outcome on the day. But it could have gone the opposite way – it was the teamwork of [one worker saying] 'I'm here settling the baby, can you go and sort mum out?', otherwise that mum could have walked back out." (Day Stay staff member)*

Staff reported that mothers often feel anxious when they arrive at Day Stay, but that by lunchtime, most feel comfortable to leave their babies with Day Stay staff while they go out and get some lunch. They commented that it was a major step for many mothers to separate from their babies and, that doing so, demonstrated the level of trust staff and families develop during Day Stay sessions. One worker described a difficult situation where a mother was very confrontational on arrival and how she managed to diffuse the situation:

"I had a mum one day when I was here on my own come in with her back up against the wall and she basically dressed me down as soon as we met and that was a really difficult situation. So I basically sat her down to calm her down, made her a cup of tea, she was in tears, very apologetic that I just happened to be the scapegoat of the day. It's just a matter of working through whatever you get, but by the end of the day she was fine." (Day Stay staff member)

Staff commented that it could be particularly challenging for families referred to Day Stay from Child Protection. They noted that these families can be quite suspicious and defensive, and described how explaining to them that Day Stay is there to help sort out what interventions and supports they need, those families tended to relax. Staff added that some of the families who had been mandated to attend Day Stay through Child Protection in the past had asked to come back for subsequent sessions, voluntarily, to learn more about how to parent their children:

"We've got two at the moment, one of them said they've never had their children for this long, they don't know what to do, they want to come back in. And initially they were made to come, so I think that is a positive." (Day Stay staff member)

When families were asked to comment on their experience with the Day Stay staff in interviews, five of the eight mothers specifically recalled the staff being friendly and welcoming when they first arrived at Day Stay. All mothers commented positively on the interactions they had with staff during the session. They reported that the Day Stay staff made them feel comfortable and supported, and many mentioned that they appreciated the calm, non-judgmental environment that staff created during their session(s):

"They made me feel really comfortable, which is important because it can be a bit daunting. Sometimes I get judged being a younger mum but I didn't feel judged for being a younger mum. They asked me things and didn't judge me for it, they suggested other ways I could do it. They were very welcoming." (Day Stay mother)

Two mothers mentioned that they had been nervous about attending a program like Day Stay, but commented that they soon felt at ease once they arrived at the session:

"When you first walk through the door of something like this, you feel kind of like oh, God, everyone's going to think I'm a failure, having to come to things like this. But you soon realise that the environment's not like that. The Mums are here for the same reason and the staff have had their own kids and they've been through it themselves. It's comfortable." (Day Stay mother)

"When I first arrived, I have to admit that I felt really anxious, a bit uptight because I didn't know what I was walking into. I thought I'd get grief if I was doing something wrong. After I walked in and they spoke to me, I have to admit that I actually felt better. …The first time I went, I was stressed, all the other times I've been fine, because I know. …I was just thinking that two weeks ago, I was so excited because I was going to go [to Day Stay] to learn something new." (Day Stay mother)

In the satisfaction survey, families were asked to rate how often they felt staff listened to them during their involvement with Day Stay. Of 35 respondents, 29 (83 per cent) responded 'always', four (11 per cent) responded 'most of the time' and two responded 'sometimes.' While most families provided positive comments about their experience with the workers, mirroring feedback of families in interviews, one respondent raised a negative experience with the service:

"To be honest, I felt I was not listened to when it came to my needs or just was not understood. I also felt judged and felt the worker always 'forgot' what we talked about the prior visit." (Day Stay mother)

Of the 45 respondents to the family follow up service survey, 44 (98 per cent) agreed that they felt they could talk to Day Stay staff about their concerns. The remaining family responded 'neutral' to this question.

Overall, family feedback indicated that staff strategies have been effective in making families feel welcome at Day Stay, to normalise their experience of accessing an early parenting service and to help them to feel comfortable in the service environment.

Session planning and adopting an infant/parent focused approach

Staff and families were asked to reflect on how Day Stay session planning has occurred and to what extent Day Stay is delivered using an infant/parent focused approach.

Staff described Day Stay sessions in terms of a combination of standard activities undertaken with each family and flexible incidental teaching in relation to things that come up on the day. They indicated that Day Stay always involves covering feeding, sleeping and identifying tired signs, but that any other issues that emerge can be addressed through individualising the session. They indicated that they plan for the session by asking each family what has brought them to Day Stay, what their issues, needs and most pressing problems are. Staff reported that in general the morning involves role modelling and in the afternoon families implement the new techniques demonstrated with support from Day Stay staff. However, they noted that this is flexible as older children (e.g. eight months) and very young babies may not respond to the workers so the support for each family is customised to suit these needs.

Staff described the need to pay close attention to the families to respond to their needs – both needs that families articulate and those that staff uncover through observations and interactions on the day:

"Once they start to settle in you'll start to work things out, like depression, family violence." (Day Stay staff member)

"[One Mum] didn't identify that [her child] didn't eat solids very well, so we did a lot of role modelling on how to do that in a positive way." (Day Stay staff member)

"It's very diverse, very flexible, we are thinking all the time – that's why you are so exhausted. No two families are ever the same. And you're watching the mums the whole time." (Day Stay staff member)

Staff talked about how imperative teamwork was in their planning and support provided to families:

"If [one staff member] is struggling with something you'll say 'I've done this and this, do you want to look at this for me, what do you reckon', so we often bounce ideas around." (Day Stay staff member)

Staff reflected that they worked well together as a team to determine and meet families' needs. They considered that this benefited families because it meant that all staff were on the same page and could offer backup support throughout the day. They spoke of how their work has evolved over time, and that

they don't necessarily get together and decide on the most effective ways of doing things in terms of formal planning, they prefer to work together to adapt their practice for the needs of each family. Staff provided a particular example of how this adaptive practice works in the team:

> *"I used my attachment theory stuff because this mum hasn't separated from her baby at all, so the first thing I've got to do is get the baby to lay in the cot beside mum for the day, that was our goal. We have done it with two mums now. This was the first time, and I said to [the other Day Stay worker], 'how am I going to get this cot out of here?' And we wheeled it out into the common area, and sat mum down. Six to eight weeks later, we got baby sleeping and mum managing. Well, the other day I had this baby's cousin turn up and he is 8 months old and he has never slept in his cot. So I put him in the other room and as soon as I started to look, he started to cry and I looked at mum and I said right. [The other worker] saw me with the cot, and she knew exactly what I was doing and she said 'you've got another one', I didn't have to say 'this is what I need you to do', she knew what the problem was." (Day Stay staff member)*

In addition to conversations at the pre-assessment and initial welcome, families are asked to complete the Day Stay pre-service questionnaire when they first arrive for their Day Stay session. The first question asks families to provide an indication of their main reasons for attending the service. The survey presents a list of eight early parenting topics, including 'other' where families can specify additional issues. Answers to the pre-service survey is another means by which staff are guided by families in terms of what to cover during Day Stay sessions. Pre-service survey responses to this question (n=129) are summarised in Figure 4.

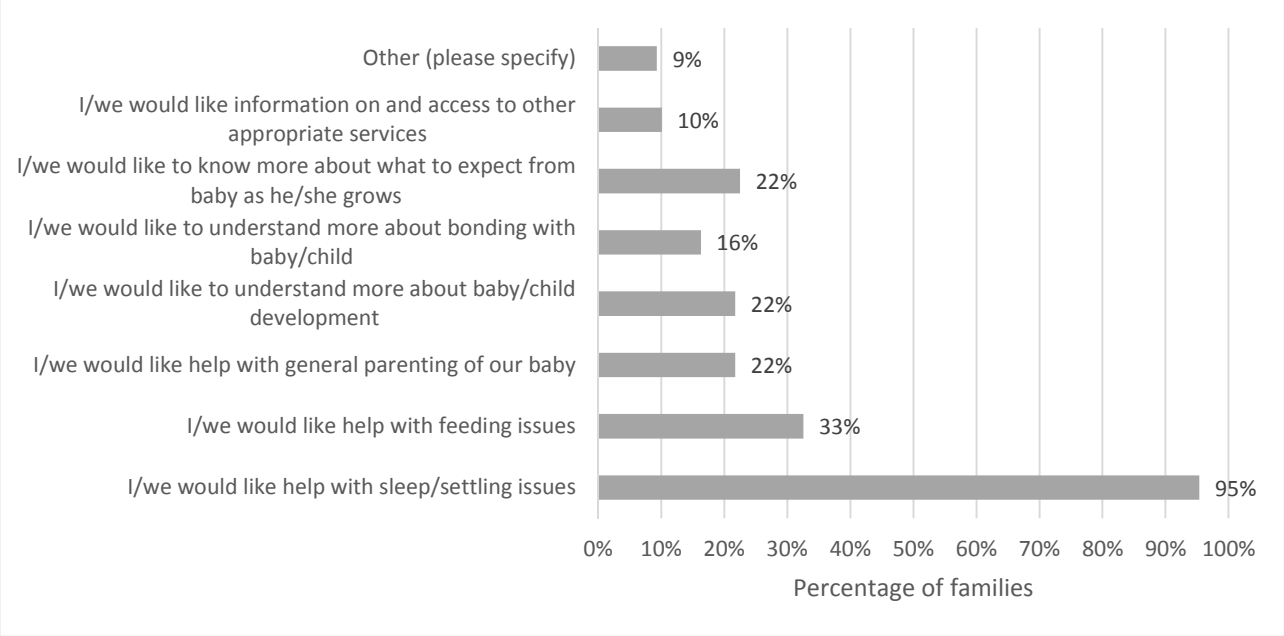

Figure 4. Percentage of families indicating they would like help with specific topics listed in the Day Stay pre-service survey.

As shown in Figure 4, nearly all respondents to the pre-service survey (95 per cent) indicated they were interested assistance with sleep and settling issues during their Day Stay session. One third wanted help with feeding issues and just under one quarter wanted information about what to expect as their baby grows; help to understand more about baby/child development; and help with general parenting of

their baby. Nine per cent of families wanted 'other' assistance, including addressing anger and frustration with the baby; returning to work; post-natal depression support; parenting groups; substance abuse; and dealing with separation anxiety.

On the whole, families who were interviewed did not consider that they had participated in 'planning' for their Day Stay session with the staff. However, six of the eight mothers reported that they felt the session was designed around their needs and their child's needs (i.e. that the session was parent and infant focused), indicating that session content had been responsive to individual parent-child dyads:

> *"[Staff were] interested in everything I was interested in. If it was a problem they took it on" (Day Stay mother)*

> *"We don't necessarily plan anything, but it's more taking it how it happens. There's no real activity behind it, it's just rolling with the punches… They work to what you need. Everyone who comes in is here for one reason or another, like bubs isn't settling during the day or night or whatever, it might be because that baby's got reflux, or something else with that baby, so even though we're all in one group, they're still individually assessing what your needs are." (Day Stay mother)*

Reflecting on session planning and the staff's focus on parent and child needs, the two remaining mothers commented that they thought Day Stay was only about babies' sleep and settling. While one of these mothers was only interested this type of help, the other indicated that it would have been good to learn about a wider variety of topics on the day. She commented that she did not bring these up with staff at the time, but reflected that if she had have asked during the session, she was sure staff would have addressed these things with her:

> *"We just chatted more than anything. …[It would have been good for them to] teach me how to play with her or something, but they covered more just sleeping. I would have known how to stimulate her more. I probably could have asked…I felt like I could have learnt more about feeding, maybe a conversation about it, I didn't think to bring that up either. I'm sure if I bought it up they would have addressed it." (Day Stay mother)*

In their focus group, Day Stay staff commented that while sleep and settling is an important part of the Day Stay service, they do not provide a 'sleep school'. They reiterated that it is important that families, professionals and the community view and perceive the program in the holistic manner that it is intended.

Reflections from the family interviews were supported by data from the Day Stay satisfaction survey, administered from January to June 2016. Of 35 respondents, 33 (94 per cent) agreed that staff listened to them most of the time (n=4) or always (n=29). Twenty eight respondents (80 per cent) indicated that they either knew how to raise concerns with Day Stay staff, or were confident they would be able to find out how to do so.

Taken together, responses from families and staff indicate that while staff are responsive to the needs of mothers and children as they present, families are generally not aware they are involved in 'session planning' for their Day Stay and this may be a more implicit process undertaken by staff. This appears to have been effective for many families, however there may be some value in making session planning

a more explicitly joint process that staff undertake with families, to ensure that all families get the most out of their Day Stay session. The existing FamilyCare Parent Child Program Care Plan document could be used for this purpose.

Practical parenting support, advice and child development information

Both staff and families described the practical parenting support, advice and child development information Day Stay offers to families, and how this occurs throughout sessions. Survey data indicated that families have confidence in the staff's knowledge and reflected families' views that Day Stay had taught them new skills.

Staff described that their approach to providing parenting support, advice and child development information is largely dependent on the child's age and how the mother is feeling on the day. They commented that if the mother is showing signs of not coping well, it is hard to get parent-child interaction started, so instead the focus turns to trying to get more supports around her first. Staff noted that they mainly use role modelling as a core strategy to provide parenting support. They also described observing the quality of parent-child attachment and listening to what the mother says about her relationship with her child. Staff described the need to explain infant behaviour to families, to unravel assumptions about their children's behaviour and what they should or should not be doing at any particular age:

> *"Sometimes when parents come in with babies at a similar age they think, my baby is doing that or it's not. And then you get a chance to talk about what the expectations are. There is a lot of learning involved." (Day Stay staff member)*

> *"One mum said the baby doesn't like her… If the baby is exhausted he's not going to like anyone. It's not so much that he doesn't like mum, [but] she's personalising and internalising it. So you've got to be worried about where she is with that infant." (Day Stay staff member)*

Staff also mentioned using families' phones to take pictures of tired signs and video interactions between mothers and their babies:

> *"We are going to do more of that because seeing is believing. It will shift their thinking. …that little boy was looking for mum the other day but she didn't notice, so we can show her that 'hey, someone really loves you, he's looking for you', but she was so caught up." (Day Stay staff member)*

Staff reported providing Day Stay booklets to families, depending on their needs. They described the booklet as largely visual, to cater for families with low literacy and/or intellectual disability. They also reported providing information from the Raising Children Network and pamphlets from the FamilyCare office (i.e. family violence). Staff mentioned that they talk through families' Maternal and Child Health 'green books' (My Health Learning and Development Record) when families bring them along to the session. All families are asked to bring their child's green book along to Day Stay and staff are endeavour to record session outcomes in the book. This information then forms part of the child's health, learning and development record. Staff commented on the need to vary their approach to providing information and support to families, according to the needs and circumstances of each family:

"Giving them a variety of sources to access because some don't get on the internet, others use their phone, it just depends. Our book is done just visual as well in case clients have no literacy or IDs, visual pictorial things too." (Day Stay staff member)

"The mums we had here today would soak it up like a sponge, but maybe our child protection clients would dismiss it. So again it's dependent on your audience. The child protection clients, even though you know they're not taking it on board, you keep honing in on it hoping that they eventually understand where the baby is coming from. They have such unrealistic expectations on what their baby should be doing. You find yourself advocating for the baby. You say developmentally your baby is only up to that." (Day Stay staff member)

Staff reported that they had access to good professional development, felt well supported and had good access to resources in performing their roles. However, they did raise a concern about their ability to continue to provide the service within current staffing arrangements. They indicated that their work with families is intensive and demanding, and that it would be good to expand the team to relieve pressure on the three current workers. Staff indicated that maintaining current staffing arrangements may lead to worker burn out. They also considered that having an additional staff member would enable all staff to do more in-home support and follow up with families, to the great benefit of families.

All families interviewed indicated that Day Stay staff provided them with practical parenting help by observing, eliciting and supporting parent-child interactions and providing parenting advice. Mothers reported that staff role modelled and demonstrated new and different techniques to try with their babies, and gave them hints and tips on various topics of interest. Five of the eight mothers (63 per cent) also reported receiving information about child development more generally during their Day Stay via conversations and pamphlets/flyers. Issues mothers reported receiving support, advice and information about included: settling, sleep, feeding, how to wrap a baby, baby massage, changing babies, tantrums (for older children) and oral health.

Mothers made the following comments about the support, advice and information they received at Day Stay:

"[The Day Stay worker] was very good at teaching me what I should be looking for, but she was there in a practical sense to implement it and show it as well. Rather than just hearing from her what you should do, she was showing me step by step what you should be doing and what you should be looking for. Which I really needed. …A pamphlet came home, which talked about the early tired signs. What I should be looking for, which I did refer to, because on the day there was a lot of information. So when I got home, I did refer to the information when I was trying to implement it. It talked about tired signs and a few things about settling." (Day Stay mother)

"They'd explain to me why bubs was doing it and what I should do in that situation. How to bath the baby, how to massage the baby, change the baby, which I needed. I'd been shown a little bit in the hospital, but you don't get much time. Because I had caesars, I didn't really get out of bed to do much at the time. I had no family, I didn't have anyone around to show me, or anyone that I'd watched growing up, because I was the youngest. So, I found the Day Stay really helpful." (Day Stay mother)

One of the mothers reported that the way Day Stay staff took the time to explain the 'why' of what they were teaching was very beneficial, and in her view, was a point of difference between Day Stay and other early parenting services:

> *"A family I was speaking to on the weekend said they felt like they were being dictated to [at a service in Melbourne]. [Nurses at that service] said 'Just let the baby cry'. Here, [the worker] said 'Do you hear that cry? It's escalating, let it go a bit longer, if it gets too high in pitch, you need to go in'. So, it's explaining to you as to why you're leaving the baby crying. And how to gauge what's an ok cry, getting upset, and frantic – you need to go and soothe them. That's the difference." (Day Stay mother)*

All 45 respondents to the follow up Day Stay service survey agreed that Day Stay staff were knowledgeable about parenting and babies. Forty two of 45 respondents (93 per cent) felt they had learned new skills after attending Day Stay (two responded neutral and one response was missing).

Support, information and referrals on broader issues

Staff and families also spoke about how Day Stay provides families with support, information and referrals on broader issues related to family wellbeing.

Staff mentioned providing families with a range of information, including access to FamilyCare resources (i.e. pamphlets on family violence) and other services (i.e. the Goulburn Valley Health Breastfeeding Support Service). They mentioned contacting services on behalf of families, for example calling doctors' clinics to advocate for appointment times or contacting pharmacists for advice. Staff spoke about feeling lucky that the Day Stay program is nested within FamilyCare, as this means the program has good connections with other supports and services, including Child Protection:

> *"We are lucky. If we are stuck we know there is someone for us to go, we are not isolated. We've got a good network and know where to go." (Day Stay staff member)*

> *"The GPs know us and we write letters. We have even escorted a client on the day stay session to the GP. This is the beauty of how this works – we have that flexibility, if you are really concerned, you are able. If we were all busy we can call a duty worker to come over and help us." (Day Stay staff member)*

Staff described asking mothers to represent their support network on a pie chart as part of the pre-service survey at the beginning of the Day Stay session. They described using this as a springboard to learn more about the family's situation and determine what extra support and links into the community might be appropriate:

> *"And one lady drew herself outside the circle and nothing in the circle, so we said right, let's get her into a mothers group and link in to what's available in the community." (Day Stay staff member)*

> *"…And it's powerful [to see] who gets what proportion [of the pie chart]. So if the partner is not getting much, there maybe something going on there. That's the beauty of having seven hours, you don't have to address it then and there, as the day progresses you can go back to it." (Day Stay staff member)*

Five of the eight mothers interviewed reported that Day Stay staff had provided them with support in relation to broader issues (beyond parenting). One of these mothers spoke about how Day Stay staff had assisted her by writing a letter to the family's doctor about her child's health. The remaining four mothers reported that Day Stay staff had been actively interested in their own wellbeing:

> *"The worker was really great with just calling me a week later to see how I was going. Also making sure the situation wasn't getting on top of me. She said 'Have you recently done one of those postnatal depression tests?' and I said 'Yes, the maternal health nurse has been onto that'. My husband and I are really good at communicating, but it was just reassuring that with the bigger picture stuff as well, when you are going through a bit of a crappy time, they're not just there to see that your child is feeding and sleeping, but that you're coping with the situation. That was really helpful." (Day Stay mother)*

> *"I'm able to talk to them. I've got a background problem from my past. There was one specific lady who worked with FamilyCare that I absolutely loved because I could open up to her and talk to her. She puts me in the right direction and tells me what I should do and what she recommends I do, but I don't have to do it, it's totally up to me. I love seeing her because she advises me on my own problems and what I can do about them. And I've actually started doing it." (Day Stay mother)*

> *"I know it's focused on sleep/settle, but I think it has much more benefit… you can really pick up other things that might be going on…The support and knowledge. You can't get it from a book. It doesn't hand you tissues when you're crying your eyes out, or laugh at you when you're doing something silly." (Day Stay mother)*

Two of the remaining three mothers did not think they needed additional support on broader issues. The final mother was only interested in help with settling and her child's sleep.

3.3.3 Follow up phone calls

Day Stay staff reported that all families receive follow up progress calls one week after their Day Stay session, however no systematic data was provided in relation to the frequency or timing of these calls. This information is currently collected in the IRIS database, but was unable to be easily extracted for analysis. Families are asked to report on progress and may receive ongoing weekly contact until they are satisfied with their progress. Day Stay staff described the amount of phone contact as being determined by families' satisfaction and or success, as well as their ongoing needs.

Families who were interviewed were not asked to comment specifically about whether or not they received follow up phone calls after their Day Stay sessions. Notwithstanding, four of the eight mothers interviewed spontaneously commented on how much they appreciated Day Stay staff following up with them over the phone subsequent to their Day Stay session:

> *"The follow up was exceptional. [My Day Stay worker] was calling me every week to see how I was going. She recommended, that since I was still having some challenges, to go back a second time. By that stage I'd put a lot of things into practice and they helped me fine tune it, so that was exceptional." (Day Stay mother)*

"The fact that they follow up, with phone calls. That makes you feel like they actually care. They'd ring regularly to ask how things were going. If things were going good, they'd not ring that often, but if they knew that you were struggling, they'd ring and check in or give advice, or tell you to come in and do another Day Stay." (Day Stay mother)

3.3.4 Associated Day Stay support activities

Numbers of families involved in associated Day Stay support activities across the period 2011/12 to 2015/16 are summarised in Figure 5 and Figure 6.

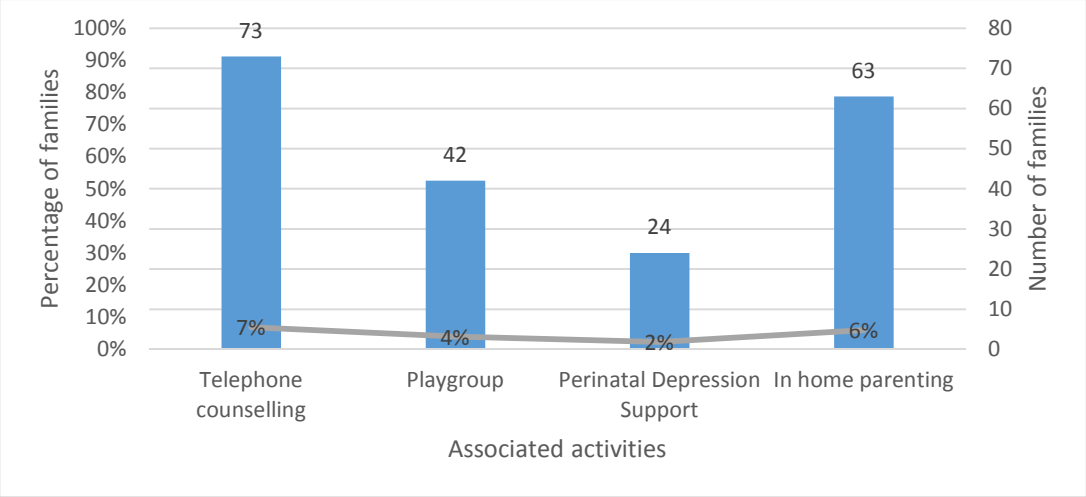

Figure 5. Numbers and percentages of Day Stay families referred to associated activities across the period 2011/12 to 2015/16 (total).

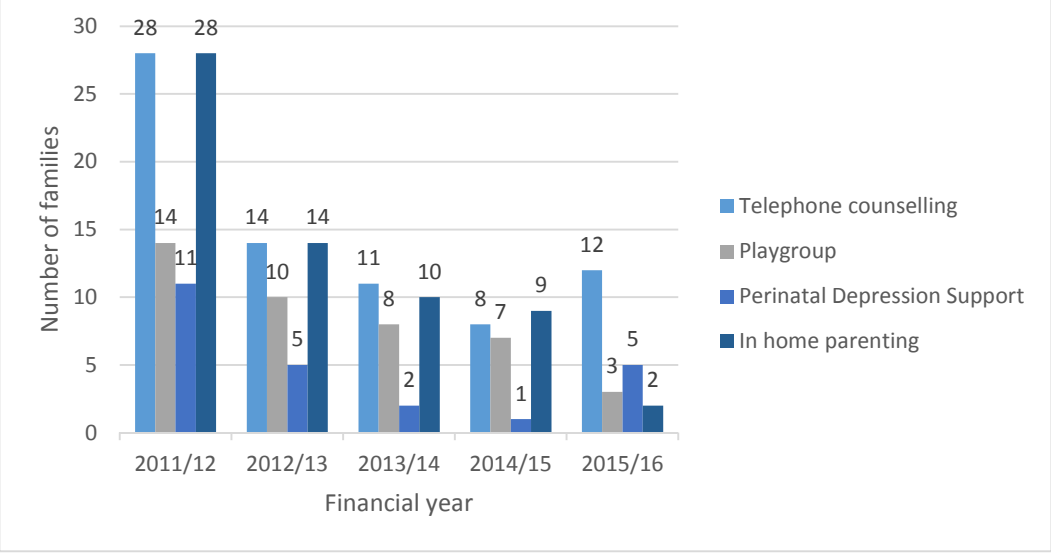

Figure 6. Numbers of Day Stay families referred to associated activities by year.

Of all associated activities, telephone counselling was the most commonly offered support to Day Stay families in the relevant five year period (offered to 7 per cent of families). As shown in Figure 4,

numbers of families referred to post Day Stay activities declined from 2011/12 to 2015/16. This reflects staff report of decreasing capacity of these additional services over the years due to funding.

No systematic administrative data was available to indicate how many families had been linked with other services by Day Stay or how many families had participated in Circle of Security.

Training and community education sessions
While a record of the number of training and community education sessions delivered by Day Stay staff was not available, Day Stay records indicated that between six to 13 families participated in these events each year in the period 2011/12 to 2015/16. Day Stay staff reported that on average, each session would be attended by around five to 10 families and some professionals, with at least one Maternal and Child Health Nursing (MCHN) student present at each session.

Day Stay records indicated that a total of 82 professionals and students had visited the program over the last five years from 2011/12 to 2015/16. A breakdown of numbers per year and visitor type is provided in Table 9.

Table 9. Number of visiting professionals and students hosted at Day Stay in the period 2011/12 to 2015/16.

Financial year	Total number	Visitor type
2011/12	18	18 MCHN students
2012/13	14	12 MCHN students, 2 graduate midwives
2013/14	18	3 student midwives, 12 medical students, 3 MCHN students
2014/15	13	1 graduate midwife, 3 MCHN students, 5 medical students, 4 social work students
2015/16	19	3 graduate midwives, 3 MCHN nurses, 8 medical students, 5 social work students
Total	**82**	

3.4 What impact has Day Stay had?

To assess the impact of Day Stay on parents, children, families and the community, the following questions were examined:

- Did Day Stay have the immediate expected impact?
- Was progress made towards longer term outcomes?

Analysis of the data presented in this section clearly shows that there has been significant progress made towards achieving Day Stay's intended impacts. There is strong evidence that all immediate (short term) outcomes are being achieved, with further evidence of progress towards the longer term outcomes articulated in the program logic. In addition, given the strength of the progress towards achieving short term outcomes, it can be implied through the program's logic that achievement of longer term outcomes will follow over time.

A summary of findings in relation to the evaluation impact indicators is presented in Table 10. Findings are elaborated fully by outcome area (parent, child, family and community) in the sections that follow.

Table 10. Summary findings in relation to impact indicators

Summary impact findings

• Six of the eight families interviewed stated they felt more confident in parenting after Day Stay. Analysis of pre and follow up service surveys showed substantial improvements in parenting confidence over the length of involvement in Day Stay.
• Seven of the eight families interviewed spoke about the things they learned about their children's needs and how to respond to them. 93 per cent of respondents to the service follow up survey agreed that they had learnt new skills after attending Day Stay and 89 per cent agreed they had been able to put into place what they learnt.
• Families found information provided about children's ages and stages of development useful. They appreciated the opportunity to attend Day Stay with other families as this provided an opportunity to observe children of different ages and learn more from other families and staff.
• Families interviewed commented that the main benefits of Day Stay for themselves had been increased support and confidence, and therefore capacity to enjoy parenting. One family made a broad comment indicating that Day Stay had improved their overall experience of their child.
• Seven of the eight families interviewed reported their child was more settled after attending Day Stay. Respondents to the service follow up survey also reported their children to be more settled following Day Stay.
• Two of the eight families interviewed stated that Day Stay had positive impacts on their family environments.
• All families interviewed reported trusting Day Stay staff and feeling supported by them. 98 percent of respondents to the service follow up survey agreed that they could speak with Day Stay staff about their concerns; 83 per cent agreed staff always listened to them and 71 per cent felt that support was always available to them when needed.
• Three families interviewed mentioned improvements in their knowledge of support services through Day Stay. Other families said they had not needed further supports. 91 per cent of respondents to the satisfaction survey agreed that Day Stay had provided them with adequate information about supports.

3.4.1 Parent outcomes

Parenting confidence

Karitane Parenting Confidence Scale (KPCS) (Črnčec, Barnett, & Matthey, 2008) data available for analysis included:

- 129 responses to the **pre-service** questionnaire (on arrival at Day Stay)
- 40 responses to the **mid-service** (end of first Day Stay session)
- 45 responses to the **follow up** (service close) questionnaire.

Matched pre and follow up surveys were available for 29 families who attended Day Stay between December 2015 and March 2016.[4] Of the 29 families with matched pre-service and follow up KPCS scores, 23 (79 per cent) scored below the cut off on their first KPCS, indicating low levels of parenting confidence. At follow up, the number of families with low levels of parenting confidence reduced to 13 (10 per cent of matched families). The average KPCS score increased from 35 pre-service (four points below the cut off) to 41 post service (two points above the cut off).

Analysis of all non-matched scores revealed the same trends applied for the full set of data at the pre-service and follow up time points. There was a middling improvement at the mid-service time point, as summarised in Table 11. The consistent trend of improvement of total KPCS scores from start of service to end of service provides strong evidence of Day Stay's positive impact on parenting confidence.

[4] Only two families had matched pre-service, mid-service and follow-up scores available for analysis, so comparisons for matched families focus on the pre-service and follow up data.

Table 11. Average KPCS scores across time, comparing matched families and all families.

	Pre-service	Mid-service	Follow up
Matched families	35 (n=29)	n/a	41 (n=29)
All families	35 (n=129)	38 (n=40)	41 (n=45)

Figure 7 provides a summary of the change in matched families' (n=29) responses to individual KPCS items receiving a score from 0 (no, hardly ever) to 3 (yes, most of the time) (see Appendix E for the individual KPCS items). Before Day Stay, larger proportions of parents answered 'no, not very often' and 'yes, some of the time' on individual KPCS items. By contrast, at service closure, 70 per cent of responses to individual items on the scale were 'yes, most of the time'.

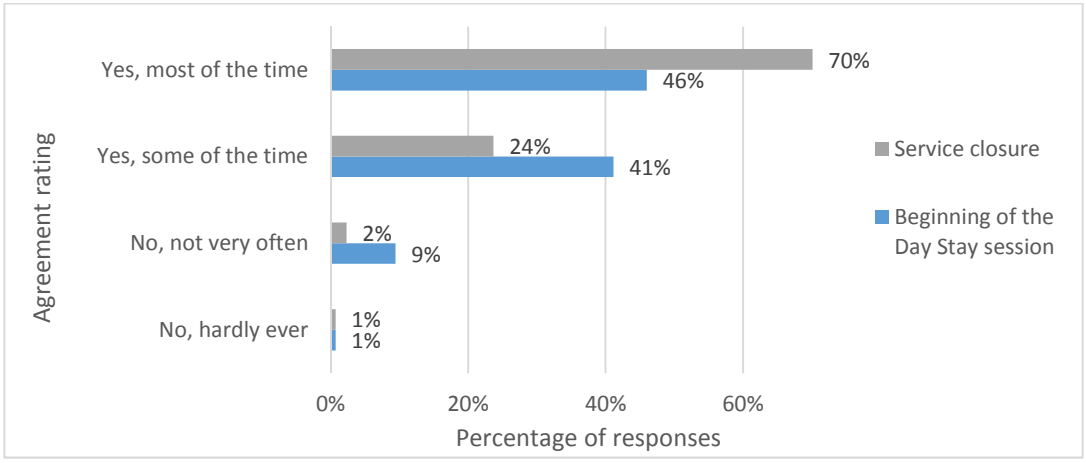

Figure 7. Percentages of responses on individual KPCS items for matched families (n=29) pre-service and at end of service.

Similarly, six of the eight families who participated in interviews stated that they felt more confident in parenting after having attended Day Stay. Families mentioned that it was the availability of expert feedback and reassurance that made them feel more confident in their parenting after Day Stay:

> *"It was absolutely fantastic in terms of providing me and my husband some support and helping us get our confidence back. It was our third child and we though we knew it all, but apparently we didn't! …It was a very calm and comfortable place to be… It was that reassurance and helping us with our confidence." (Day Stay mother)*

> *"I didn't have the confidence I was doing everything right. [My baby] would pick up on my vibes. I didn't feel like what I was doing was wrong [but] they gave me permission that what I was doing was right." (Day Stay mother)*

> *"…now I feel like I'm in control now, whereas before I wasn't." (Day Stay mother)*

Only one parent who was interviewed stated that she did not feel more confident after attending Day Stay. This was because the techniques she learned did not work for her child. The remaining parent did not comment on any change in parenting confidence.

Finally, of 45 family respondents to the follow up service questionnaire, 40 (89 per cent) agreed that they had more confidence in their parenting after attending Day Stay (four responded 'neural' and one response was missing). Families were also asked to identify any significant change that had occurred for them as a result of attending Day Stay. Thirty nine families (87 per cent) identified significant changes. Of those, around one third (n=11) listed improved parenting confidence as their significant change:

> *"I am now able to more confidently identify my baby's tired signs and act on them. My confidence as a mum to my baby has improved and I feel more relaxed." (Day Stay mother)*

> *"I had more confidence with settling my babies I also learnt little signs and signals that my babies were telling me. All mothers should do this."*

Learning about and responding to children's needs and developmental stages

In interviews, seven of the eight families spoke about things they had learned about their children's needs, the changing ages and stages in child development, and how to manage and respond to these. Five families mentioned learning about and managing sleep, including recognising tired signs and routines. Three mentioned feeding, two spoke of reflux and general settling, and one described learning to be more responsive through play:

> *"It's been four years between my kids, things change, when you start solids and all that sort of stuff, it's all changed…I've learned so much. I've learned more the second time round. The tired signs was something that made a huge difference for me. I needed some kind of factual thing. They have handouts and pictures up, all that sort of stuff. Sleep routine… With PND for myself, I had trouble engaging, so they actually taught me how to play with bubs. Naturally, I'm a very playful person, but in that moment, I wasn't. So they'd say to me: 'look, [your baby's] smiling at you, try and use this rattle and get her to roll over' things like that. So, it kept you engaged with your child." (Day Stay mother)*

> *"I learnt about wrapping my baby… I've got five, but I've wrapped them all differently. I found out this time that there was a much better way and he can't get out, so I was really happy with that…I also learnt other stuff, like parenting at home. The advice was fantastic and I was really happy with that. When he's crying at home, what I can do to settle him, because all the signs are different. Whether he's hungry, or tired, or whether he just wanted a hug. They showed me all that and helped me with it. …Sleeping, understanding him more, whereas before, when I first came home with him, he was a bit all over the shop. I didn't quite understand him. I've had kids in the past, but it was different this time. When I went there, I realised, every baby's different. …[Day Stay] helps us parents on how to look after our children. Knowing the signs that they're giving us, like when they're tired, hungry, even when they want to play. I've seen a lot of mothers out here that don't pick up on it, and I think that's only because I've been to Day Stay." (Day Stay mother)*

Families commented that information provided about children's ages and stages of development at Day Stay had been useful. They also considered it helpful to attend Day Stay with other families who have children at different developmental stages as this provided an opportunity to observe the changing ages and stages and ask questions of staff and other families about what to expect and how to manage it. Families said that they learned from listening to staff explain different aspects of child development to other families and asking questions related to future developmental milestones:

> *"It's the fact that you can ask a wide variety of questions. Even though my bubs is four months, I can ask questions about what's going to be happening at six months and they're happy to answer questions. …The conversations we have with other Mums is because of that, because we're at different points or dealing with different things. Staff would suggest try this… or try that… and I'll be sitting there asking 'why would you do that?' …People who have had previous kids have different experiences. Lots of advice and you choose what you need out of it." (Day Stay mother)*

> *"I refer back to the little flyer they gave us that said depending on your age, a rough idea of how much they should sleep and feed and how many times a day, which was really reassuring. So, that education and the flyers they gave were good and very helpful." (Day Stay mother)*

Likewise, of 45 family respondents to the post Day Stay service survey, 42 (93 per cent) agreed that they had learnt new skills after attending Day Stay (two responded neutral and one response was missing) and 40 (89 per cent) agreed that they had been able to put into place what they learnt at Day Stay (four responded neutral and one response was missing). Forty two families (93 per cent) also agreed that the strategies they learnt at Day Stay would help them in future (two responded neutral and one response was missing).

Taken together, findings presented in this section suggest that parents have learned about their children's needs and development (short term outcomes), as well as how to respond to these needs and differing developmental stages (medium term) through Day Stay. With reference to the program logic, these findings infer that progress is also therefore being made towards the long term outcome that Day Stay parents are able to support their child's transition through developmental stages.

Parents' enjoyment in parenting

In interviews, families commented on the benefits of Day Stay for parents and carers. The most prominent benefit, mentioned by five families, related to feeling supported and more confident in their parenting role. Families emphasised that the support at Day Stay provided them with a break and that this was highly beneficial when they had been struggling with the demands of parenting.

> *"Support and having someone there to talk to if I needed. At a certain point in the day, they let you just lay down and rest. After they've taught you the techniques, they just give you a bit of a break." (Day Stay mother)*

> *"Definitely the support. I was struggling a lot. And the knowledge of someone else. I think that the support and knowledge comes from someone outside of your family and your friends. You always have people telling you you're not feeding them enough, you're not doing this, you need to do this, but everyone's got their own input. Coming from someone who is an expert in the field, who has done it on a daily basis with how many other babies, was really useful to me. I*

was getting a bit jack of everyone telling me what I should and shouldn't be doing. I knew this was coming from a really knowledgeable place." (Day Stay mother)

One family made broad comments about how their experience of Day Stay had improved their overall experience of their child:

> *"I feel like had I not gone, our experience would have been completely different with our baby. I think it taught us so much about her, what her needs were, what our needs were and how to help her with sleeping. Now we have the perfect little baby in terms of sleeping and none of it has been a stress. So we've got to that point in a really calm, productive way. There's a fear about sleep programs that they cry it out, but it's never been like that, it's never been stressful or anything. It's a lot more calm and everyone's a lot happier for it. …It was so beneficial. It basically changed our experience with our baby." (Day Stay mother)*

Together, these observations suggest that Day Stay is having a positive impact on parent wellbeing and parent-child relationships, and therefore, parents' capacity to enjoy parenting. As a result, and in accordance with the program logic (and the evidence that relevant short and medium term outcomes are being achieved), it can be inferred that progress is being made towards Day Stay's long term parent outcome of increasing parents' enjoyment of parenting.

3.4.2 Child outcomes

Children are settled, healthy, happy and thriving

Seven of the eight families interviewed reported that their children were more settled after attending Day Stay. Seven families reported that children were sleeping better and two reported children were feeding better, were happier and healthier. One family reported their children had responded positively to a more consistent routine and one said their child was exhibiting improved development.

Families' comments on the benefits they observed Day Stay had for their children included:

> *"Ever since that second stay, I implemented a few more things, and my child has been sleeping. It's been amazing. …Obviously sleep is necessary, but the flow on effects from him sleeping properly are that he is much, much happier. He's not whingeing around after me all the time, he's shown a lot more development after he'd been to the Day Stay. He started doing things that he wasn't doing before. I think it was because he was not tired all the time, so he had the energy to do new things. …We were trying to get him to feed himself with fingerfood, but he just wouldn't do it. He'd just sit there with his arms by his side, waiting for you to feed him. He really got cranky about it when we tried to get him to feed himself. Once he'd been to Day Stay and he was sleeping, he just started feeding himself quite happily. I think it was because he was not so tired, whereas before he didn't want to do anything extra because he was tired all the time." (Day Stay mother)*

> *"[My child] went from never sleeping during the day to sleeping on her own. The medication was what we needed, but nowhere else could we get the right advice. …She was much happier once she started sleeping better, it was a cycle. Once we calmed down, she calmed down. I feel like all the pieces of the puzzle just fell into place." (Day Stay mother)*

"Better consistency with how to settle him. We're pretty strict with what we do and when we pop him down, following what they encouraged us to do. He benefits from that because he knows what to expect when we're putting him to bed. And advice on the feeding side of things. Obviously a benefit is that now we have the correct people and professionals helping us and I have a child who can feed and sleep and grow now, so it's worked out well for everyone." (Day Stay mother)

The remaining family responded that there had been no benefits for their baby. This mother noted that none of the Day Stay strategies had worked for her child, but this may have been because he was 'too old' for the intervention (at eight months old), and it may have been more successful if they had have attended earlier.

Children's needs are responded to appropriately

Comparison of responses to several individual items on the KPCS at pre-service and at follow up provide an indication of the impact of Day Stay on parents' own perceived abilities to respond to their child's needs, and thus a proxy bearing on whether children's needs are being responded to appropriately. Percentages of matched families (n=29) providing the maximum response to several relevant items on the KPCS pre and post Day Stay, are summarised in Figure 8 (see Appendix E for the full list of KPCS items). Increases in the percentage of maximum KPCS responses ('Yes, most of the time') from pre-service to follow up (end of service) provides proxy evidence of improvements in parents' responses to children's needs.

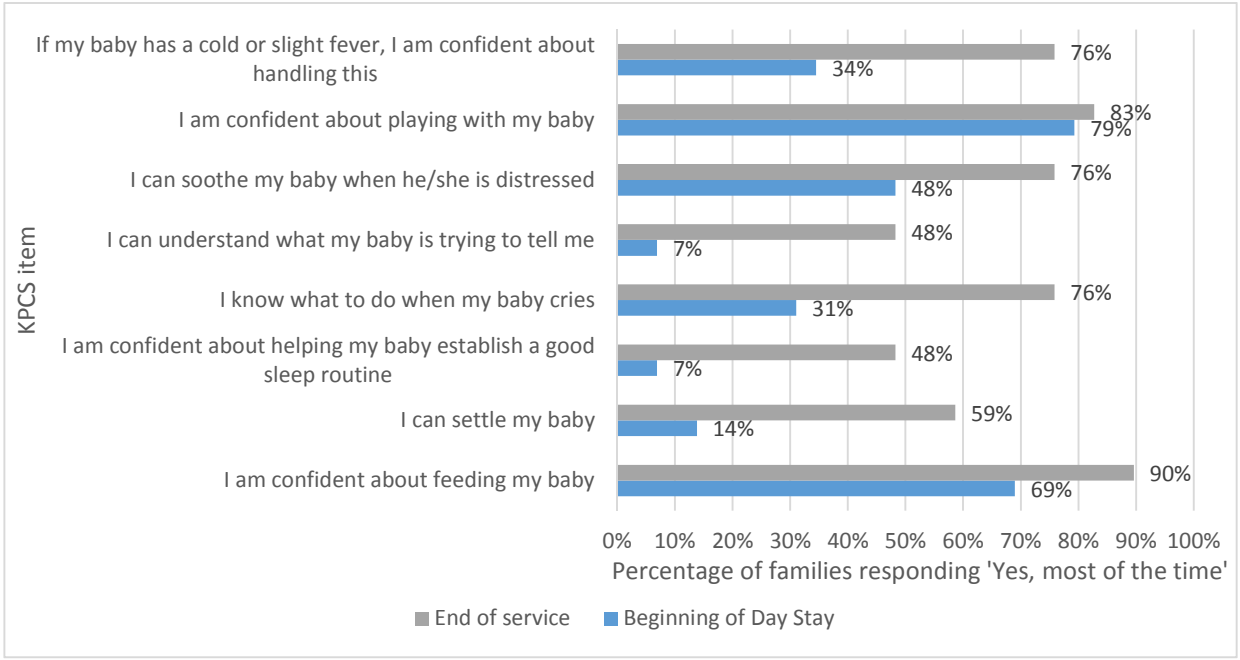

Figure 8. Percentage of families responding 'Yes, most of the time' to KPCS items relating to responding to children's needs pre and post Day Stay.

Figure 8 shows large percentage increases in the proportion of parents providing the maximum response in multiple areas, indicating improved confidence in feeding, settling, establishing good sleep routines, knowing what to do when the child cries, understanding the child's signals, soothing and

dealing with illness. Most families (79 per cent) were already confident about playing with their baby, but even in relation to this there was an increase in the proportion of families choosing the maximum response (83 per cent).

That 89 per cent of respondents to the follow up service survey reported being able to put into place what they learned at Day Stay provides further evidence of the program's impact on improving the way that children's needs are responded to. Families' general comments on the survey provided further insight into the impact of the program for children:

> *"I have had extreme improvements in my baby's sleep behaviour since attending day stay on two occasions. He was previously waking every one and half hours and would not sleep during the day. He now sleeps through the night and has solid day time naps. I am extremely happy that I was referred to this service, it has been a lifesaver." (Day Stay mother)*

> *"[Day Stay staff] were very helpful and gave great advice on how to help [my daughter] with her reflux e.g. ways to hold [her] that would give comfort to her tummy and also expressing that [she] could need more medication, which was correct." (Day Stay mother)*

> *"I have learnt to read my baby better which has helped me put her to sleep and she is sleeping better and longer as a result." (Day Stay family)*

3.4.3 Family outcomes

Family environments are positive and family relationships are strong

Two of the eight families interviewed commented directly about the positive impact attending Day Stay had on their family environments. For both families, the support and advice offered at Day Stay enabled parents and infants to function better together and they reflected that this had wider impacts for the rest of the family:

> *"It was just helping her be able to get more rest so that she could be happier. And then that helped the family because I was able to put her to bed with minimum fuss. Then I could concentrate on the other children or whatever else I had to do. And just feeling more relaxed, which benefited the whole family. The more tense you are, the more prone you can be to snapping at responses or less patient. Just general tiredness. If she sleeps better, I sleep better." (Day Stay mother)*

A respondent to the satisfaction survey also commented on the broader impact of Day Stay on their family:

> *"My baby and family unit are doing much better. It was so nice to hear we were doing all we could for our baby and this built confidence in all of us." (Day Stay family)*

As outlined earlier, one family commented that learning about their child and how to manage their child through Day Stay had changed their whole experience of the child, positively impacting parent-child and overall family relationships.

3.4.4 Community outcomes

Parents trust practitioners and feel supported

In interviews, families provided strong feedback that they trusted Day Stay staff and felt supported by them, as outlined in earlier sections of this report. Forty four (98 per cent) of the 45 respondents to the post service survey agreed that they could speak with Day Stay staff about their concerns. Of the 35 respondents to the client satisfaction survey, 29 (83 per cent) agreed that staff always listened to them, while four (11 per cent) indicated this happened most of the time and two (six per cent) agreed that this occurred sometimes. Twenty five respondents (71 percent) indicated that support was always available when needed (seven responded most of the time and three responded sometimes).

Parents remain engaged with Day Stay staff, seek support, and families are connected to the community

Families who were interviewed overwhelmingly appreciated Day Stay's comprehensive phone follow up and also expressed that after their experience of Day Stay, they were comfortable about contacting Day Stay staff if any future problems arose:

> *"I really appreciate this service and that it was available to me as soon as I needed it. Thank you so much girls for such amazing one-on-one help and advice. It's wonderful I can call you both if I need to, that is great to know as well." (Day Stay family)*

Three of the families interviewed mentioned improvements in their knowledge of family support services through Day Stay, including support for post-natal depression, more intensive sleep programs and other resources in the community. Of 35 respondents to the satisfaction survey, 32 (91 per cent) agreed that Day Stay had provided them with adequate information about supports (one disagreed and the remaining two were unsure).

The strong relationships Day Stay staff develop with families during their involvement with the service appears to facilitate ongoing engagement with Day Stay via phone and repeat visits. This fosters families' abilities and confidence to reach out for support when needed, providing positive experiences of service support. Observations about how families have interacted with and maintained engagement with Day Stay staff indicate that the program is making progress towards the long term outcome that parents seek support from services and families are connected to the community.

3.5 To what extent is Day Stay valued as an important local parent and child support?

Feedback from families and stakeholders, supported by comments made by staff, indicated that Day Stay is held in very high regard in the local community. Feedback suggested that the service is widely appreciated and is currently addressing a clear community need. It is highly valued for its extensive and practical content which addresses families' early parenting needs; its high quality; its accessibility; and the active role Day Stay staff play in driving and supporting change to improve the broader service system supporting young children and their families in the region.

3.5.1 Stakeholders

All four stakeholders who participated in interviews for the evaluation valued the Day Stay service very highly. Their perceptions of the value of the service as an important local parent and child support in the

community can be broadly conceptualised in four broad themes: meeting families' needs; quality of the program; access to the program; and role in the service system.

Meeting families' needs

All four stakeholders viewed Day Stay as an essential service in the region. This was largely due to the opportunity it provides for parents to access direct, practical help from early childhood professionals who provide parenting assistance during the critical adjustment to a new child. They considered a strength of the program was the availability of a full day of in-person support, which is flexible enough to meet families' diverse needs, from feeding and settling, to safety and the parent's emotional wellbeing. To this end, one stakeholder described Day Stay as a "very comprehensive service" and all four stakeholders valued the program as an important preventative intervention, to address a wide range of difficulties that otherwise may progress to become significant issues for families:

> *"I think broadly, that type of service is really, really valuable to families and goes a long way towards both preventing more significant issues in terms of adjustment to parenthood and emotional wellbeing and support of parents, their infants and children. It's addressing something that is a really significant issue for parents of infants and young children. Things like sleep and support for their parenting and support for their emotional and mental wellbeing. I think those things are hugely important at a time when they're going through a really major life adjustment. …it's addressing things that parents see as really important." (Stakeholder)*

> *"[Day Stay is] absolutely critical. We're in a situation where we've lost our perinatal emotional health and wellbeing program at Goulburn Valley Health…Day Stay is vital, it's an essential service… [it provides] the opportunity to come in and spend some time in a trusted, secure environment for the mother or father, parent and child and be able to go through the cycle of day to day care and observe what the issues are for the mother. That ability to observe, to coach, to encourage, to just have a space in the actual Day Stay where parents can come in and be supported and be able to talk honestly about what's happening and gain the support they need." (Stakeholder)*

One stakeholder mentioned that some families had found the service's routine fairly rigid and others had reported finding it distressing to persist with techniques when their child was upset. This stakeholder commented that these observations were balanced by a large amount of feedback indicating that families were happy with the service, and reflected:

> *"I guess, to a degree, I think you're always going to get that. I think that's where it's really important that the parents are involved in the process, what's going to happen and what the parameters are." (Stakeholder)*

Quality

Stakeholders viewed the quality of the Day Stay service as high. They commented that the high calibre of the staff, their passion and their extensive experience was critical to the success of Day Stay and a core reason why it is well-respected by professionals and families alike:

"They're highly experienced in managing sleep issues. Highly experienced in managing issues with feeding. Vast experience of topics that are relevant to families attending Day Stay." (Stakeholder)

"I find the staff are good to work with. In terms of colleagues working in the same space, who are passionate about trying to improve outcomes for children in our community, I don't think you'd get more passionate or committed staff who work really hard in what they do. That's obviously a real strength." (Stakeholder)

Other quality aspects of the service stakeholders valued included Day Stay's thorough follow up processes (with both families and professionals), and the comfortable service environment:

"The follow up the team has with the clients who pass through their doors, even if they're not seen physically again... We're often aware that they stay in contact with the family and call them back." (Stakeholder)

"They follow up their clients, they liaise with local MCH staff. It's a high ratio of staff to clients. I've been there on several occasions when the program's been running and it's a very supportive environment." (Stakeholder)

"It's a really lovely environment there, their home-style environment. It's housed in a 50s style brick house in the centre of town. It's very accessible to our clients. It has a very encompassing feel to it." (Stakeholder)

One stakeholder, however, did express a view that Day Stay's follow up with referring services could be improved:

"…I think [Day Stay staff] need to write a short letter. I've had a couple of phone calls recently, which was really good…Even a few lines, just to say what happened and how [the families] were. They would have to get permission from the participant. I just think it would be really helpful for nurses if we did get some kind of feedback…A worker rang me about a mum she was really concerned about her mental health. And she'd referred her. That was really helpful. But normally, nothing." (Stakeholder)

Stakeholders reflected that the fact that families use and like the service is a good indication of its quality:

"I see the strengths as being I think it's highly regarded by families in the area. They're happy to go there. That's not something that we can always easily say." (Stakeholder)

"There would be very few clients over the course of my experience with Day Stay who have reported dissatisfaction. Most of them, the responses would be: I wish I'd gone earlier." (Stakeholder)

Access

In terms of access, stakeholders commented that proximity of the service to families in their local area was key. All four stakeholders described a lack of other services for infants and parents in their region,

and valued the fact that Day Stay is free and is often quick and easy for families to get into and physically travel to. Stakeholders emphasised the need for local early parenting services, as travel was often a significant barrier for young families, and more so for those who are socially isolated, vulnerable or otherwise hesitant to access services located further away, outside of their comfort zone (i.e. in Melbourne):

> *"For people here, it's particularly important because whilst a lot of us living somewhere like Shepparton may easily access services in Melbourne, for some people, travelling to Melbourne to access a service like that is really problematic. It's a real barrier. I can't tell you the number of times that I've talked to families about similar services in Melbourne that they could access, but they just don't. I think it's a little bit like when they have a mood disorder and because of their situation, they're just not in the headspace where they can do what they need to do…. If you've got parents who are not coping and they're sleep deprived, the idea of giving them something that when they're well and coping well, would be difficult to do, in that situation, it's just almost impossible. I think we do need services that are local that families can access, particularly for us, given that we've recently lost funding for the perinatal emotional health program that families found hugely supportive. I think we need a suite of services that we can offer to families and this is one of those services." (Stakeholder)*

> *"I had a child the other day who should have gone down to the Children's Hospital for a birthmark, but the parents have never driven in Melbourne and weren't prepared to take her. If you say you've got to go to Melbourne or Albury to do something like this, they just won't even consider it. If you can say 'you can go down to Seymour or Shepparton'…they're used to going there to do their shopping and they're happy to go there…We have very few services around [in Strathbogie]. It is one of the few services that we do have. So it's very important for Strathbogie …there's no services located in the Shire except for GPs and [MCH]." (Stakeholder)*

> *"There's less services, so the ones you have are more important. If you lived in Melbourne, you might be able to drive across suburbs to another service if the one that you were with was full or you didn't particularly like the way it was operated. Whereas for here, the Day Stay program is the only one, so it's essential. And I know people travel from a wide radius to come and attend it. That shows how vital it is, and the fact that you can attend multiple times if you need to. There's open contact, you can ring in if you need to. They've got a telephone counselling aspect to it. I believe in the past there was a home visiting component to it." (Stakeholder)*

Stakeholders also commented that families being able to access Day Stay held further value for the local service system by taking some burden away from local Maternal and Child Health services:

> *"To be able to access something like Day Stay pretty quickly is good. It's good for us [MCH nurses] because we're not having to see these families a couple of times per week." (Stakeholder)*

Role in the service system

Two stakeholders spoke about the valuable contributions Day Stay staff make to the broader service system. They indicated that Day Stay staff are highly engaged in broader service development and take an active role on local working groups, with a strong presence various initiatives including the Shepparton Best Start partnership and working groups (e.g. breastfeeding working group),

Communities for Children, The Bridge adolescent antenatal program, a postnatal depression project and the local early years reference group. These stakeholders described Day Stay staff as "very engaged" in service development conferences and consultations, and noted FamilyCare's driving advocacy role in relation to the establishment of a local Mother-Baby unit.

One stakeholder considered that Day Stay could do more to 'sell' the service out in the community by taking more opportunities to publicise the service at local events and conferences, providing handouts of information to new staff at other agencies, and providing more information about the service model, what they do and what techniques they use on the FamilyCare website.

3.5.2 Families

In interviews, families echoed similar themes to stakeholders in terms of the value of Day Stay. They spoke at length about the importance of being able to access high quality, hands-on early parenting services, particularly in their local area:

> *"I think the biggest challenge that lots of Mums face is that we are raising children really isolated. Although we've got all the social media and advice around, when it comes to the day to day stuff, so many women, in particular if they're staying home, are really isolated and there's no such thing as a village anymore. So if you can't do something that's a bit tricky, you feel like you have to slog it out. …I think FamilyCare provide that new village to mothers and fathers when they're at a point or at a crossroads where they say 'I don't know what to do, how to help my baby sleep or feed or whatever the problem may be….' …There are so many people in Echuca/Moama who are using the service over in Shepparton because there's nothing here for families. I tell people about it and I know a lot of women around me, friends or friends of friends and they've used it, or they're using it now, or they're booked in the future. There's a definite need. People don't know what to do or where to go, or they're not finding the Maternal and Child Health resources enough. They're fantastic, but when it comes to the day to day, you've actually got to live this experience." (Day Stay mother)*

> *"I think it's super important for mothers' mental health, which I think is a huge issue. Post-natal depression: I think it is definitely a step that could stop people going down that path if they were struggling. I think that's really important to address that issue in the community before it gets out of hand. Something as simple as a Day Stay where people help you, can make a massive impact on that…Also from a baby's development – it's crucial that they're sleeping…I think it's a really almost dangerous predicament to new mums to not have a service like that in the community and one that's easily accessible. It's extremely important and you can't underestimate how much services like this are needed for new mums, and that they feel that its easily accessible and they feel that it's something they can get information about and they know about." (Day Stay mother)*

One mother commented about how she had been referred to Day Stay and a service in Melbourne at the same time. At the time of her interview (six months post-referral) she had successfully completed her involvement with Day Stay, but was still yet to even hear from the service in Melbourne:

> *"Being in a remote area…I have to travel, the only other alternative is Melbourne and there's a massive, massive waiting list for some of those places at the sleep and settle school. And a lot of them aren't in the public health system, so it's a massive cost for anyone. That's why I didn't*

utilise those. I didn't have the time to take a newborn baby to Melbourne. At the same time I think a referral went to the Mercy Hospital at the same time as the referral to the Day Stay and I still haven't heard back from the Mercy. We're talking six month wait. I'd possibly still be sitting here with a child who wouldn't feed. I think it's very important to save on that travel time. A lot of people prefer to stick local and have that local support. It's definitely worth it. I think it's something that a lot of people use." (Day Stay mother)

Another mother suggested that although Day Stay was highly valued in the community, there was a considerable gap in the availability of extended overnight early parenting services in the region:

"It's a massive gap. These guys do as much as they can with sleep/settle, but it would be lovely to have a place where you can stay overnight. It would be lovely to have a mother-baby unit in Shep. All those sort of things. This is it. This is what we've got. We're lucky to have such a great set-up, plus experienced staff." (Day Stay mother)

Families' responses to the Day Stay satisfaction survey also shed light on the value of the service as perceived by families. Of 35 respondents to survey between January and June 2016, 33 (94 per cent) were either satisfied or very satisfied with Day Stay; agreed that Day Stay had made a difference; and rated the service quality as good or very good. Thirty-two families (91 per cent) indicated that Day Stay had met most to all of their needs. Families' responses to these questions from the Day Stay satisfaction survey are summarised in Table 12.

Table 12. Day Stay satisfaction survey responses

Survey question	Rating				
Did the service meet your needs?	*None*	*Few*	*Most*	*Almost all*	*All needs met*
	3%	6%	3%	26%	63%
Did the service make a difference?	*No, worse*	*No*	*Yes, slightly*	*Yes moderately*	*Yes a great deal*
	0%	6%	3%	40%	51%
Service quality rating	*Very poor*	*Poor*	*Fair*	*Good*	*Very Good*
	0%	3%	3%	11%	83%
Overall satisfaction	*Very dissatisfied*	*Dissatisfied*	*Indifferent*	*Satisfied*	*Very Satisfied*
	0%	3%	3%	23%	71%

Many families made positive comments in the survey, praising the workers and the service:

"Day Stay was a service I was desperately in need of with a baby who would not sleep. The advice, help and support from staff including follow up was exceptional. I believe this service is integral in helping mothers and preventing postnatal depression by giving parents practical assistance. I believe I would have struggled greatly without this service." (Day Stay family)

"[The workers] from the Day Stay program were very kind, supportive, friendly and understanding. I would recommend the program and staff to other mums - which I already have! A big thank you to these two amazing, lovely women!!" (Day Stay family)

In answering the survey, three families commented that they would have preferred to get into the service earlier, with a shorter wait time. The one family who responded that they were 'dissatisfied' with the service overall and considered the service quality as 'poor' commented that they did not feel listened to or understood, and that they felt judged. They were also disappointed that the worker had forgotten what was spoken about at prior visits to Day Stay.

Some families provided suggestions of how Day Stay could have helped them more. Suggestions included: linking with other support groups, home visits and availability of extended stay options (longer than one day).

Families also praised the quality of the program and the workers in the post Day Stay service survey. One family commented that her particular worker was an asset to the local community:

> *"[My worker] at FamilyCare Day Stay was so knowledgeable and such a great help she really is gifted and such an asset to our community." (Day Stay family)*

Another emphasised the need for programs like Day Stay in rural areas:

> *"I felt so lucky to have this service available to me in Cobram. I have heard from many friends who also had positive experiences. Such an important resource available to families." (Day Stay family)*

3.5.3 Staff

Staff similarly noted that the value of Day Stay to the community is that there is no other service available for parents of young children that currently offers hands-on early parenting support in the local area. They cited the broad reach of the program, for example families traveling from Swan Hill and Echuca, as evidence of its value to the community. They spoke about the long wait lists for early parenting services in Melbourne and the fact that two to three months is a very long time in the life of a young family, for example, it could mean the difference between breast and bottle feeding.

Reflecting on the value of the service to the local community, staff also spoke about support the service received when the continuation of Day Stay was in jeopardy. They reflected on how professionals and families had rallied around Day Stay, with a petition of 1,000 signatures to keep the service open. Staff mentioned that although they are not usually privy to families' feedback forms, from what they have heard, Day Stay has received highly complementary feedback.

4. Discussion

The evaluation process has uncovered many very positive findings in relation to the delivery of Day Stay, its progress towards outcomes and value to the community. It is clear that on the whole, families, stakeholders and staff view the program as functioning well, and consider that it is a vital early parenting support to children and families in the community. The evaluation has also raised some considerations for ongoing program improvement, which if implemented, would serve to further enhance and strengthen Day Stay. It has identified that the service would benefit from clearer articulation and documentation of the detail of the program; implementing a more explicit session planning process; strengthening feedback provided to referrers into the service; and further refining

ongoing program monitoring and improvement processes. These considerations are raised in the sections below, with summary actions presented at the end of each area for improvement.

4.1 Articulating and documenting program detail

The exercise of re-defining the program's logic as part of this evaluation was helpful for staff and service leadership to consider the key elements of Day Stay by re-defining its inputs, activities, outputs and expected outcomes. This helped staff to unpack their way of working and give considered thought to the different aspects of Day Stay. However, it was not possible to delve into the next level of detail in terms of the specifics of what particular parenting techniques are implemented by staff and how, as it was necessary to focus on clarifying the service model at a higher level first. Updating the existing staff manual to contain the detail of exactly what staff do within each activity area would be a useful next step in the process of defining the Day Stay service model. Assembling this information would enable more comprehensive assessment of the alignment of the service with the evidence and best practice.

Evaluation findings indicate that the current Day Stay staff team are a highly skilled, high functioning unit, who work well together to implement the service. Although the service is functioning well with the current team of staff, sustainability of the program beyond this team is an additional reason why the specifics of Day Stay's operations should be documented in more detail. Updating the program manual to contain detail of the techniques and theoretical approaches used as part of Day Stay activities would enable replication of the program by other staff and/or organisations, ensuring the program could be implemented with fidelity by other teams and/or in other locations. It is important that staff involved in delivery of parenting programs are familiar with the relevant literature and particular approaches underlying the program they are involved with (e.g. family centred, developmental parenting). Documenting these in relation to Day Stay would ensure a common, shared understanding of the program is able to endure, independent of which individuals are involved with the program at any one time.

In addition to an updated program manual, consideration should be given to further developing the Day Stay program logic. Through the evaluation process, it became clear that additional inputs contribute to the service model, including program guidance materials, and staff supervision, professional development and support arrangements. These foundational inputs underlie the ongoing sustainability of the service and so should be captured by the program logic. In addition, once the details of program activities are further defined, or as a guide for the process of defining this detail, the short term outcomes that refer to 'children's needs' in a broad sense could be further specified to focus in on the specific needs the service seeks to address. Recognising that flexibility is an asset of the current Day Stay service model, it is also important for the program to have a clear focus in relation to the core needs it seeks to address. Revisiting the list of associated activities would also be of benefit to clarify the scope of the program, particularly in relation to whether or not there is an intention to reinvigorate associated activities that have declined in frequency over the years (i.e. playgroup and home visiting) and to clarify the relationship between Day Stay and activities that are delivered outside of the program, i.e. Circle of Security. Tightening these aspects of the program logic will assist to focus the delivery of the service, facilitate its implementation by new or future staff and to provide a strong basis for future evaluation.

Updating program documentation would also provide an opportunity to review and record processes for staff supervision, professional development and support arrangements. Although staff reported that current support they receive to deliver the program was good, concerns raised about the potential for

burn out and need for additional staff indicate that attention to these areas is important to maintain the high standard of service delivered by the current team.

Summary of suggested actions:

- *Document the particular techniques workers use in each activity area*
- *Document underlying theoretical approaches behind techniques implemented*
- *Review and document processes for staff supervision, professional development and support*
- *Re-visit program logic to:*
    - *Update inputs (include program manual, staff supervision, PD and support)*
    - *Update activities with additional detail of techniques*
    - *Clarify scope of program re: associated activities*
        - *Is there an intention to re-instate regular home visiting and playgroup as part of the program? If not, remove*
        - *Should Circle of Security be listed under referrals to other services, given it sits outside of the Day Stay program?*
    - *Make short term outcomes re: 'child needs' more specific*

4.2 Session planning

Feedback indicated that most families were satisfied with the topics covered in their Day Stay session, suggesting that existing planning processes are generally acceptable to families. However, the process evaluation found that at the moment, session planning is not necessarily an explicit process that families are aware they are engaging in with staff. Undertaking an explicit, documented planning process in partnership with families at the beginning of their Day Stay session would ensure that Day Stay care plans address all issues most salient to parents. This goes some way to eliminate the risk that unarticulated interests or thoughts are not addressed, empowering parents to contribute their voice into the structure of the session. The existing FamilyCare Parent Child Program Care Plan document can be used for this purpose. Taking a partnership approach to planning will build on the family centred strengths of the Day Stay service, ensuring that families feel heard and understood, a key factor necessary to promote families' successful service engagement.

Summary of suggested action:

- *Ensure FamilyCare Parent Child Program Care Plan form is completed jointly by family and practitioner at the start of the session and parents understand that they have active input into the session plan*

4.3 Feedback to referrers

While the evaluation found that Day Stay staff are active in connecting with other services and professionals in the community to advocate for and source information for families, some stakeholders suggested there may be scope for improvement in the feedback provided to referrers about families who have attended Day Stay. Stakeholders indicated that on the occasions where feedback has been received, this has been highly valuable to the referring service. FamilyCare could consider implementing a standard referrer feedback process where, with families' consent, referrers are notified of families' attendance at Day Stay, the topics covered, a brief reflection on status of the family by the end of the session and any information about Day Stay's ongoing work and follow up with the family. Establishing and using a template to guide this process may assist to standardise information exchange between Day Stay and referring services. It may also assist the local service system to provide more coordinated and efficient support to those families.

Summary of suggested actions:

- *Create a template for standard feedback to referrers of families who attend Day Stay (to be provided to referrers with families' consent)*
- *Could contain:*
  - *When the family attended Day Stay*
  - *Topics covered*
  - *Reflection on status at end of Day Stay*
  - *Projected ongoing work and follow up*
- *Provide completed feedback form to all referrers once families have attended Day Stay*

4.4 Ongoing program monitoring and improvement

FamilyCare and the Day Stay team should be commended on their commitment to collecting extensive data on the Day Stay service over many years. There was a wealth of administrative data available for analysis in this evaluation, which provided important insights into the program's operations over the relevant five-year period. The process of collating and organising the data so that it could be subjected to analysis was a learning process for all involved. It highlighted some issues in relation to the complexity of consulting multiple databases and sources, and helped to develop staff's understanding of how and what information is currently recorded; what that information means for practice; and how it can be used to inform service reflection and planning. There are some aspects of the program where data is currently not being collected. Consideration should be given to collecting this data in relation to material aid, links with other services and the number of community training and education events conducted, to ensure these aspects of the program are actively monitored. While data is currently recorded in relation to timing and frequency of follow up phone calls on the IRIS system, this was not able to be extracted for the evaluation. Thought should be given to how this data can be best captured to ensure that it is regularly consulted and reflected upon.

It is vital that community organisations are able to use the data that is collected to inform program reflection and planning (including staffing and resourcing) easily and efficiently. Now that the Day Stay leadership has a better understanding of the administrative data that is collected, workers and leadership should be encouraged to regularly consult the data to monitor the service and observe relevant trends i.e. in relation to closure reasons and outcomes. To this end, it would be useful for the program manual to be updated to include definitions for each of the closure reasons and outcome codes. The current closure reasons and outcome code categories are broad and can be ambiguous in terms of their practical meaning in individual case circumstances. Establishing and documenting a consistent understanding of what circumstances these codes encompass will ensure that closure and outcome data is entered consistently, improving the reliability and useability of this data into the future.

The Day Stay family surveys currently administered are very comprehensive. It is of note that the surveys include the KPCS, a validated measure of parenting confidence, which is administered pre-service, mid-service and at follow up, to track improvements in parenting confidence over the course of the program. Given the stable improvements in KPCS scores over time that have been reported here, it may be sufficient to measure this only at the pre-service and follow up stage, excluding the mid-service time point. The KPCS questions in the mid-service survey could be replaced with alternative questions gathering participants' thoughts on the service and how the day was for them, for example, whether they felt heard and understood? And any other comments/feedback that would be valuable to capture in relation to families' immediate experiences on the day. Finally, consideration might be given to eliminating a small number of overlapping questions between the satisfaction survey and the follow up survey.

Overall, Day Stay's commitment to gathering families' feedback on the service is highly admirable. All feedback, the positives and any negatives, should be regularly shared with staff involved in delivery of the service to ensure a culture of reflective practice and ongoing improvement.

Summary of suggested actions:

- *Continue to access and discuss program data regularly to inform program planning and development*
- *Record data in relation to the following additional details by family (/referral number):*
  - *Number and type of material aid items given out*
  - *Number of referrals made to other services (specifying what services)*
  - *Number of training and education events attended*
- *Consider how best to record telephone contacts so that their timing and frequency can easily be reported on and monitored*
- *Maintain a record of the number of training and education events run*
- *Clarify and document what circumstances each of the case outcome and closure reasons codes cover*
- *Replace mid-service (end of day) survey Karitane questions with questions about families' immediate thoughts on the service and how the day was, i.e.:*
  - *What did you think of the service?*
  - *Did you feel heard and understood by staff?*
  - *Is there anything you would like more information about?*
  - *What could we have done better?*
  - *Consider seeking a rating out of 10 and reasons for that rating*
- *Consider overlap between satisfaction and follow up service survey – minimise number of questions asked*

5. Conclusion

This evaluation has provided the opportunity to:

- clarify and document the Day Stay service model;
- consider how the service model aligns to the evidence and best practice;
- determine to what extent the program has been delivered as intended;
- consider to what extent progress has been made towards shorter and longer term outcomes; and
- explore the value of the service in the local community.

Findings indicate that the Day Stay service model is broadly supported by the literature regarding effective early parenting support. Developing relationships with parents is critical to the success of programs like Day Stay, as the practitioner-parent relationship is the medium through which such programs effect change. To this end, the warm welcome and orientation and parent/infant focused approach of the program are particularly important elements of Day Stay. Notwithstanding, further work is required to explicitly articulate and document how each of the Day Stay activities listed in the program logic are carried out. This would enable a more detailed review of how specific techniques used within the Day Stay activities align with the evidence and best practice.

The evaluation found that Day Stay has generally been delivered as intended. It is clear that staff are warm and welcoming to families and offer them substantial support, information and practical help on a wide range of topics relevant to their parenting capacity. There may be some scope to improve Day Stay session planning by making the planning process more explicit, ensuring planning is undertaken in partnership with families. This will ensure that the service addresses all issues that are most salient or of most interest to parents. It would also be beneficial for Day Stay staff to record additional

administrative data to ensure all aspects of the program are monitored (material aid, linkages to other services and the number of community training and education sessions conducted).

Analysis of data related to program impact clearly showed that there has been great progress made towards achieving Day Stay's intended outcomes. There is strong evidence that all immediate (short term) outcomes are being achieved, with further evidence of progress towards the longer term outcomes articulated in the program logic. In particular, there is very strong evidence that Day Stay has been effective to improve parenting confidence and has created significant changes for parents, children and their family units.

Feedback from families and stakeholders, supported by comments made by staff, indicated that Day Stay is held in very high regard in the local community. The service is appreciated for its extensive and practical content which addresses families' early parenting needs; its high quality; its accessibility; and the active role Day Stay staff play in driving and supporting change to improve the broader service system supporting young children and their families.

While the evaluation uncovered many positive findings about Day Stay, it has also raised some considerations for ongoing program improvement. These include clearer articulation and documentation of program detail; implementing a more explicit session planning process; strengthening feedback provided to referrers into the service; and further refining ongoing program monitoring and improvement processes. Action in the areas identified for improvement will serve to strengthen this highly respected and valued program, ensuring Day Stay continues to provide a best practice response to the needs of families and young children in the local community.

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7. Appendices

Appendix A: Updated Day Stay program logic

Appendix B: Day Stay evaluation framework

Appendix C: Family interview questions

Appendix D: Family satisfaction survey

Appendix E: Family service surveys

Appendix F: Staff focus group questions

Appendix G: Stakeholder interview questions

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Attachment B

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Goulburn Valley Health

Scoping Project: Development of a Residential Parenting/Mother/Baby Unit in Shepparton

Prepared for Goulburn Valley Health
by Lesley Yates, RADNO Pty Ltd.
June 2012

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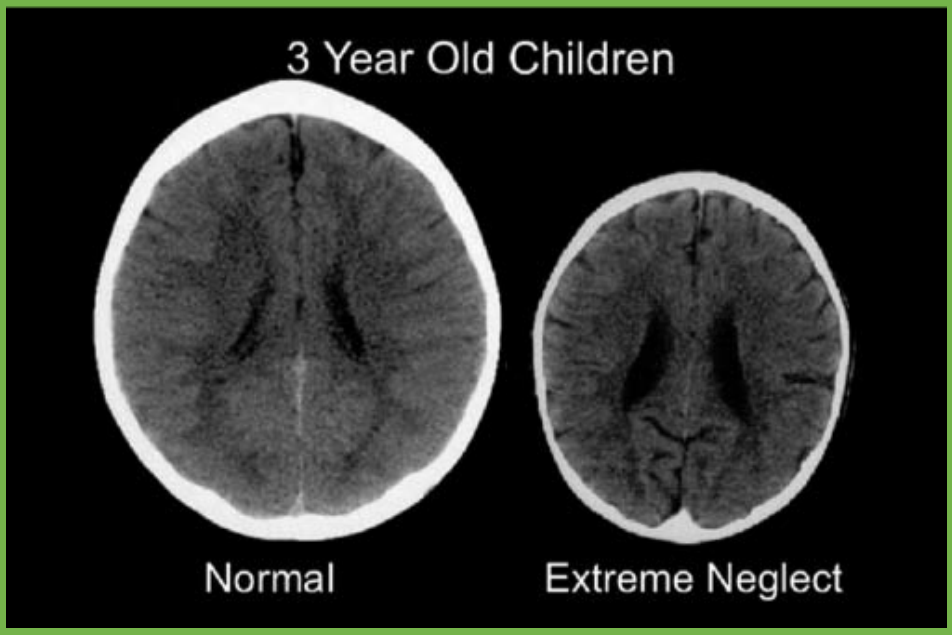
Scoping Project:

Development of a Residential Parenting/ Mother/Baby Unit in Shepparton

Contents



This image illustrates the negative impact of neglect on the developing brain. The CT scan on the left is from a healthy 3-year-old child with an average head size (50th percentile). The image on the right is from a series of three 3-year-old children following severe sensory-deprivation neglect in early childhood. The child's brain is significantly smaller than average and has abnormal development of cortex (cortical atrophy) and other abnormalities suggesting abnormal development of the brain.

From studies conducted by researchers from the Child Trauma Academy (www.childtrauma.org) led by Bruce D Perry, MD, PhD.

Executive Summary

In April 2012, Goulburn Valley Health in partnership with FamilyCare from Shepparton and Tweddle Child & Family Health Service from Melbourne commissioned a **Mother Baby Unit Scoping Project** to assess need and service options.

What is now known that was unknown or not articulated at the commencement of the project? What was achieved as a result of this project? The answer is the Steering Committee has now articulated an assessment of need, an understanding of the service continuum and service gaps, an understanding of the consequences of the lack of intensive services and a recommended service configuration.

Assessment of Need:

1. The Greater Shepparton and Hume regions have a concentration of vulnerable parents and vulnerable children within identified catchment areas located in the region.
2. Vulnerability indicators (poverty, transient populations, social economic status, family violence) are considerably higher in some catchment areas within the region.

Meeting These Needs: Current Services

3. The service mapping determined that mental health and parenting services are available at the universal and secondary end of the service continuum.
4. The consultation process determined that there is a high level of service integration and cooperation between agencies despite differing funding streams and differing professional paradigms.
5. The only intensive supervised intervention available for vulnerable families and mothers with a mental illness is home visiting or inpatient psychiatric interventions for women without their infants.
6. Home visiting parenting services available under the Parenting Assessment and Skills Development program or delivered as intensive in home support is effective for families. However, there will always be a percentage of vulnerable families for whom home visiting is not effective, not appropriate or not a safe environment for home visiting staff.
7. There is an absence of programs for dads in the region and there are no intensive services available for sole parent fathers.
8. Indigenous families are not generally not attending Melbourne based services despite professional referrals to Tweddle and QEC.
9. Intensive preventative residential services that are designed to prevent child protection intervention for complex family needs are available in residential (non-PASDS) programs in Metropolitan Melbourne and are not available in regional areas of Victoria.

Consequences of Current Service Configuration

10. Perinatal professionals confirm that the absence of tertiary or intensive pyscho-educational parenting services results in ‘work arounds’ that harm infant and parent mental health.
11. The ‘work-arounds’ include infants placed in the paediatric ward for periods of up to five days whilst professionals determine the actions in the best interest of the child.
12. **Services are delayed, interventions are delayed, and critical infant brain development time is wasted as infants ‘wait’ for professional parenting assessment before stable parenting or care arrangements can commence.**
13. Service time is wasted as professionals attempt to deliver home visiting services to families that are unwilling to receive home visiting or are absent from the home when professionals visit.
14. Many families are not participating in required intervention services due to the requirement to attend a Melbourne based service and the wait lists for these services. A further professional intervention is then required to assess if

separation will occur due to the risk of infant harm.

15. Separations of infant from parents occur without the ethical and necessary component of parenting assessment and skill development in an intensive residential supervised setting.
16. When parents do attend a Melbourne based service there can be delays in communication with regional services preventing a seamless wrap around delivery that ensures that parents and infants are not subject to gaps in supervision and care.
17. Mothers with a mental illness requiring inpatient care have two choices: inpatient care in the local community, separated from their infants, or inpatient care in Melbourne with their infant and separated from the love and support of their families and friends.

Recommended Service Configuration

18. The human need to be met is to ensure infant well being and optimal development of the infant within a safe parenting environment, current services are only able to meet human needs at a non-intensive intervention level.
19. The recommended model is for a combined Mother Baby Unit/Residential Early Parenting Service.
20. The view of the research and the perinatal health and welfare professionals consulted in this project is that the Shepparton based solution should be broader than the service profile of a traditional Mother Baby Unit. Their view and the key finding of this report, is that there are clear benefits and synergies that can be achieved with a combined Mother Baby Unit and a Residential Early Parenting Service.
21. It is the strong view of the individuals consulted in this project that a submission for a Mother Baby Unit would be a wasted opportunity to address the issues that arise from the high prevalence of vulnerable families in the region and the probability of infant harm within these families.
22. **This scoping project outlines a case for a highly innovative service that combines the MBU and EPC service models to meet human and community needs.**

What remains unknown?

1. The exact size of the facility i.e. how many families per annum. Numbers are provided in this scoping report but further work is required to test the hypothesis of the number of mothers, fathers and families that require this level of intervention. The number of parents and infants that would receive services is a difficult interplay of need and service delivery models, ensuring critical mass and optimum asset utilisation requires a little more work.
2. Service model – the Steering Committee is of the view that the intensive residential component can be of a reduced duration with wrap around services such as day-stay, outpatient care, home visiting and group work. Home visiting services exist currently but a group work component would require design and development. How many residential days, supplemented and supported by how many non-residential days requires further deliberation.
3. The non-residential component can include or cooperate with other services such as existing 24 hour phone support and the integration of existing services – just how these services work together is a necessary first step before the finalisation of the optimum leadership and governance model.
4. How large does the facility need to be and can the unit include a private bed? It would be inappropriate to rule out a private component, but the perinatal professionals are divided on the feasibility of a private option in the suggested MBU/EPC unit.
5. Staffing issues require further discussion – the Steering Committee is of the view that staffing configuration does not need to be based on the traditional MBU unit approach and would prefer to model the staffing profile on the EPC multidisciplinary team approach.
6. What is to be co-located? The Steering Committee is of the strong opinion that this service should fill the critical gap of intensive services for complex families and not duplicate any existing service that is meeting human need. How do these services work together and do these services need to exist in the same physical space.

7. And finally, ‘last but by no means least’, who funds? It’s a hybrid model crossing two government entities – Mental Health and Child Protection. Articulating the number of families that can be accommodated in each category should be completed and necessary and critical final step is to negotiate and gain a government views/decisions on recurrent and capital funding.
8. Any capital-funding grant is likely to require a co-contribution from the local community, and the availability and preparedness to contribute to the capital cost is yet to be established.

The Steering Committee recommends to Goulburn Valley Health that the principles and directions in this report are adopted and a Stage 2 process is funded to undertake the assessment and resolution of the remaining feasibility issues.

1. Background

1.1 Introduction

In 2010, the then Victorian Liberal Opposition announced a commitment to the development of Regional Mother Baby Units (MBU). Since the election of a Coalition Government in 2010 the Government has announced three 5 bed Mother Baby Units requiring a government commitment of $3 million per unit. During the announcement for new MBUs in Ballarat, Bendigo and Gippsland the Minister the Hon Ms Wooldridge said:

"Mothers dealing with severe post-natal depression in regional areas are faced with options that include traveling to Melbourne for treatment or staying without their children in an adult acute mental health facility. (Regionally based) mother-baby mental health units allow mothers to continue developing parenting skills and attachment to their babies while at the same time receiving treatment for mental illness, closer to home."

As a result of the pre-election commitment Goulburn Valley Health in partnership with FamilyCare from Shepparton and Tweddle Child & Family Health Service from Melbourne, commissioned a scoping project to assess need and service options as a first step to defining the project before commencing formal discussions with government. A scoping project was required to assess the human need and the optimum service profile. There has been a very long history (some 14 – 16 years) of professional advocacy for a residential parenting service in the region. A residential parenting service has a different emphasis than a Mother Baby Unit.

It should be stated at the outset that this is a report on the scoping project for a Mother Baby Unit (MBU) **plus** a residential Early Parenting Service (EPC). The view of the professionals consulted in this project is that the Shepparton based solution should be broader than the service profile of a traditional Mother Baby Unit. Their view and the key finding of this report, is that there are clear benefits and synergies that can be achieved with a combined Mother Baby Unit and a Residential Early Parenting Service. It is the strong view of the individuals consulted in this project that a submission for a Mother Baby Unit would be a wasted opportunity to address the issues that arise from the high prevalence of vulnerable families in the region, the probability of infant harm within these families and taking the opportunity of providing intensive early intervention and prevention services. **This scoping project outlines a case for a highly innovative service that combines the MBU and EPC service models to meet human and community needs.**

Goulburn Valley Health, in partnership with FamilyCare from Shepparton and Tweddle Child & Family Health Service engaged independent consults (RADNO) to undertake a scoping project on the development of a residential Mother Baby Unit (MBU) / Early Parenting Centre (EPC) in Shepparton. The following report outlines the scope of the optimum service configuration based on interviews with regionally based professionals, government departments and a review of the relevant government policy, research and reports.

This report could not have been completed without the commitment and generosity of the local service providers, community leaders and professionals. Many individuals gave freely of their time and their expertise and the contents of this report are informed by their commitment, their wisdom and their experience. A full list of these participants can be located in Appendix Two.

1.2 Project Partners

GVHealth is the lead agency for this project. GVHealth is the Regional Public Health Service for the western sector of the Hume Region with the main acute and mental health services located in Shepparton. GVHealth provides a range of acute services including Paediatric Services – Inpatient and Home Care, Maternity Services including a Level 2 Neonatal Unit and an Emergency Department. There is also a Child and Youth Mental Health Service (CYMHS) and a Paediatric Outpatient Service.

In the 2010/11 financial year, there were a total of 3,220 Paediatric and Neonatal Inpatient separations, made up of 1974 separations for Paediatrics and 1246 Neonatal separations.

FamilyCare has been one of the main providers of Child and Family Services in the Goulburn Valley since 1984. FamilyCare also provides a current day-stay mother/baby service in Shepparton, Cobram and Seymour. Over the last two-three years FamilyCare has received an average of 460 total referrals for the Parent/Child Program and an average of 318 clients using the Day Stay Program in Shepparton, Cobram and Seymour.

Tweddle Child & Family Health Service is located in Footscray and offers a range of specialist programs to families who are experiencing challenges with parenting their children up to the age of 4 years. Programs include residential, day stay and sessional groups delivered at Tweddle or in local communities, collaboratively with local government, community organisations or health services. Residential services currently operate 12 days per fortnight, 24 hours per day with stays of 10, 4 days and 3 days depending on the nature and complexity of parenting issues. Over 2000 clients access the residential and day stay programs each year. An audit of the clients accessing Tweddle services in 2009/2010 identified approximately 200 families from the Goulburn Valley region of Victoria. This does not include those families from the area that contacted the service requesting help who did not take up the offer of admission or who failed to attend the program after meeting the criteria for admission.

2. Early Intervention

The classic public health definition of 'primary prevention' refers to interventions that ward off the initial onset of a disorder, i.e. intervening before damage takes place in a way that avoids the later costs in both human and financial terms of handling the consequences of that damage.

The early years are far and away the greatest period of growth in the human brain. It has been estimated that the connections or synapses in a baby's brain grow 20-fold, from having perhaps 10 trillion at birth to 200 trillion at age 3. For a baby, this is an explosive process of learning from the environment. The early years are a very sensitive period when it is much easier to help the developing social and emotional structure of the infant brain, and after which the basic architecture is formed for life. Whilst it is not impossible for the brain to develop later, it becomes significantly harder, particularly in terms of emotional capabilities, which are largely set in the first 18 months of life.

The intended outcomes for a Mother Baby Unit and an Early Parenting Centre are for optimal development of the infant based on sound evidence of the quality of mother-infant attachment. These services share a philosophy of strength-based early intervention: building upon the skills that are in evidence to provide a parenting environment that will result in sound mental health for the infant and the mother. Both services undertake parenting assessment. Whilst the foundation of the MBU model is to address the mother's mental health whilst minimising harm to the infant and encouraging attachment and bonding, parenting assessment is occurring whilst these services are delivered in the MBU. The intent may not be overt and there is some deliberation about whether this is the intent of a MBU. However, psychiatric professionals in Mother Baby Units do assess the mother's ability to parent and child protection reports and mother baby separations occur based on this assessment.

Mother Baby Units are intended for women with a mental illness that is of a severity that requires inpatient services. MBUs are located in a hospital setting with individual rooms and common areas for interaction and parenting assessment and support. These Units are located within the hospital grounds often located near an adult psychiatric unit.

Early Parenting Centres (EPCs) offer residential services to assist parents who are experiencing difficulties in caring for their infants. Women are referred to EPCs by a health or allied health care professional. These residential early parenting services are not designated psychiatric services. The Tweddle residential program, for example, admits up to nine families with children up to 4 years old for three or four night stays. The service cares for approximately 600 families per year. Each family is accommodated together in a two-room suite with a bathroom. Shared living and eating spaces provide opportunities for social interaction amongst families. Fathers are encouraged to attend and participate in the program. The program focuses on both infant and parent needs. On admission, individualised care plans are devised based on a comprehensive admission assessment. The residential program is staffed by a team of maternal and child health nurses and early childhood professionals. The program provides support, education and role modelling in individual and group contexts. Parents work towards achieving their goals through one-to-one interaction with staff, group education sessions, self-directed learning and supported practice. Group psycho-educational sessions foster understanding of infant development, including needs for sleep and play, strategies for soothing and comforting and promoting sustainable sleep

habits. Facilitated discussion encourages reflection on adjustment to parenthood and includes active promotion of the important role of fathers or other supportive adults in healthy infant development and family functioning. Residential staff work individually with parents to build confidence by observing and providing feedback and encouragement to assist skills development. Discharge planning includes arrangements for appropriate primary and specialist follow-up care.

The Tweddle residential service has two different intake streams and program content:

1. 4-5 day residential parenting program for families with complex needs referred by a health or allied health professional or by early intervention services such as Child FIRST[1]. The residential program is delivered to families for whom a short-term intensive intervention away from home is deemed to be warranted and more effective than sporadic interventions over a longer period of time.

2. A 10 day residential parenting assessment and skill development program (PASDS) delivered to families with high needs, high complexity and an identified infant risk factor. Department of Human Services Child Protection refers these families to the service. During the 10-day residential program, parents are permitted to leave the centre for periods of time, however the infant is subject to protection orders and is required to remain in the care of the Early Parenting Centre for the duration of the program. Parents may not leave the centre with the infant without supervision or permission from the EPC.

Both services provide parenting assessment, both services provide strength-based skill development; both services are founded on attachment theory. Differences in service provision can be seen in the following; Mother Baby Units serve mothers that have a diagnosed mental illness. Fathers are in attendance in a MBU for sessional and weekend (overnight) stays. Early Parenting Centres admit both the father and the mother and neither will be admitted if there is a requirement for acute care of a diagnosed mental illness[2]. These services are not the same service with different funding streams and different names. A Mother Baby Unit is interested in the mother and her mental health, and whilst other parents may be admitted, this is the exception rather than the rule. Mother Baby Unit professionals are interested in observing/caring for the mother; Early Parenting Centres are interested in observing, supporting and caring for the parents and the family relationships. Whilst the two services are not interchangeable, the synergies are clear.

[1] Child FIRST (Child and Family Information, Referral and Support Teams). Child FIRST (Child and Family Information, Referral and Support Teams) is the Central Intake (entry point) to Family Services Programs for families with children under the age of 18 years (this can include an unborn child). This service is a State Government early intervention initiative to support and strengthen families and reduce their involvement with Child Protection. There are 24 Child FIRST programs across Victoria, organised by "catchments' or groupings of Local Government Areas (LGA's).

[2] Mental illness is prevalent in the Parents receiving residential services from Tweddle and QEC. EPC Nursing staff are clearly qualified to administer and supervise medication – the distinction here is not about whether patients have a mental illness: parenting centres are providers of mental health services and are classified as psychosocial or psycho-education interventions. The distinction is the level of acute care required and the primary presenting condition.

3. Demand

Goulburn Valley Health, FamilyCare, Tweddle and locally based health professionals have identified a need for a Residential Mother/Baby Unit + Residential Early Parenting Centre in Shepparton, based on:

1. The demographic, socio-economic and health indicators for the region;
2. Higher proportions of low income households generally and in greater concentration than larger metropolitan populations;
3. An increased potential for isolation in many forms;
4. The demand for the existing maternal mental health and parenting services in the region;
5. Gaps in the service continuum, specifically an absence of intensive residential services in the region:
6. The consequences of parents not seeking solutions and not attending Melbourne based services.

3.1 Demographics

The population of greater Shepparton is approximately 65,000, predicted to rise to 70,000 by 2018. Shepparton is the major centre for a region from Deniliquin (NSW) in the north, Benalla in the east, and Kyneton in the south-west. This region, including Shepparton, has a population of approximately 175,000. Annual births in this region are approximately 4,500. If Albury-Wodonga and Wangaratta to the northeast are also included – there are strong links to Shepparton – the catchment increases by a further 120,000 and the annual birth rate increases to **6,287 per annum.**

Shepparton and the Goulburn Valley region is an area of considerable economic and social disadvantage, as rated by a range of indicators. The unemployment rate in 2010 was 7.9% (national 5.1%), with a relatively high proportion of the population born overseas (15.8%) and a large Indigenous population (10%). The region has the largest Indigenous population in Victoria outside metropolitan Melbourne. School leavers are less likely to be engaged in work or study – 55.4% compared to Victorian figure of 71.9%. Crime rates are higher than the Victorian average – in 2010-11 there were 1157 crimes against the person per 100,000 population (Victoria 875) and 5653 crimes against property (Victoria 4551). (All figures are for the Greater Shepparton area.)

3.2 Prevalence

Vulnerable Children

Greater Shepparton has a large Indigenous population; this has particular significance in relation to child health and welfare. The number of low birth weight babies is 50% higher than Shepparton's non-Indigenous population, the number of babies born to teenagers 15-19 is nearly four times higher than the non-Indigenous population, child protection orders are five times higher, and there is a large gap in life expectancy – at the 2006 Census only 12% of the Indigenous population was over 50, compared to 32% of the whole population. A residential parenting centre in Shepparton is particularly needed for the Indigenous community as families typically lack the resources to go to Melbourne, young mothers with their babies are at added risk due to travel, and family support is not available when the mother and baby are in Melbourne.

The Victorian Government has recommended an expansion of early parenting centres to assist vulnerable families and children and to improve access for families in outer Melbourne, regional and rural areas (Department of Premier and

Cabinet, *Protecting Victoria's Vulnerable Children*, 2012 – Rec 12).

Recommendation 12
The Government should fund the expansion of early parenting centres to provide services to a greater range of vulnerable families and to improve access to families living in outer Melbourne, regional and rural areas.

Department of Premier and Cabinet, 2012.
Protecting Victoria's Vulnerable Children Inquiry

Submissions to the 2012 Protecting Victoria's Vulnerable Children Inquiry demonstrated the devastating personal costs of abuse and neglect. Estimates prepared for the Inquiry show that the total lifetime financial costs of child abuse and neglect for all abused and neglected children that occurred in Victoria for the first time in 2009-10 is between $1.6 and $1.9 billion. The Inquiry noted that vulnerability and the risk factors associated with child abuse and neglect are concentrated in certain areas of Victoria and there is a correlation with social and economic disadvantage. This suggests the most effective focus of government activity is to address vulnerability of children and their families through locally based initiatives and services. It is our submission that the Greater Shepparton and the Hume region is an area where vulnerability and risk factors associated with child abuse and neglect are concentrated, and that the region has a clearly demonstrated need for such a service and is well placed to provide it to the surrounding region.

Perinatal Mental Health

Social workers and clinicians in the region report post natal depression as a significant issue. While it is estimated that 15% of new mothers will experience some form or level of postnatal depression, a much smaller percentage seek help and require admission to hospital. Based on the number of births in the Greater Shepparton region, approximately 25 mothers could require hospital treatment each year, but it is believed a higher number of cases are unreported and untreated.

There is a range of mental health issues affecting mothers before and after the birth of their babies, from mild to severe. Some of these disorders may have been pre-existing, some may be exacerbated by pregnancy and birth, and some may only become apparent after birth.

It is clear that some mild disorders are best monitored and treated in the home, whereas others should be treated in a supportive mother baby residential facility, either because of the nature of the illness or because the home is not supportive for a range of reasons.

It has been found in a UK study that psychiatric disorder, and suicide in particular, is the leading cause of maternal death. Suicide accounted for 28% of the maternal deaths. None of the women who died had been admitted to a mother baby unit or had had adequate (intensive) care.[3]

It has been long recognised that some women develop severe mental illness, or puerperal psychosis, in the days and weeks following childbirth. The incidence of this condition has remained constant at two per thousand deliveries, and it has a tendency to recur after future childbirths. While this psychosis is rare, it does occur and in a population of four to five thousand births annually, could well be expected in some cases.

What is more common is postnatal depression, or PND, which affects 10 to 13% of new mothers to a greater or lesser extent. It is estimated that 3 to 5% of women suffer from a moderate to severe depressive illness following childbirth. Women with pre-existing mental illnesses are at greater risk of recurrence following delivery. While for some women PND is unpredictable, for those with a previous history of mental illness, pregnancy gives 9 months warning and ample time for detection of risk and putting in place a management plan, possibly though a mother baby unit of the kind proposed.

[3] Oates. M. (2003) Perinatal psychiatric disorders: a leading cause of maternal morbidity and mortality. British Medical Bulletin, 67 (1): 219-229.

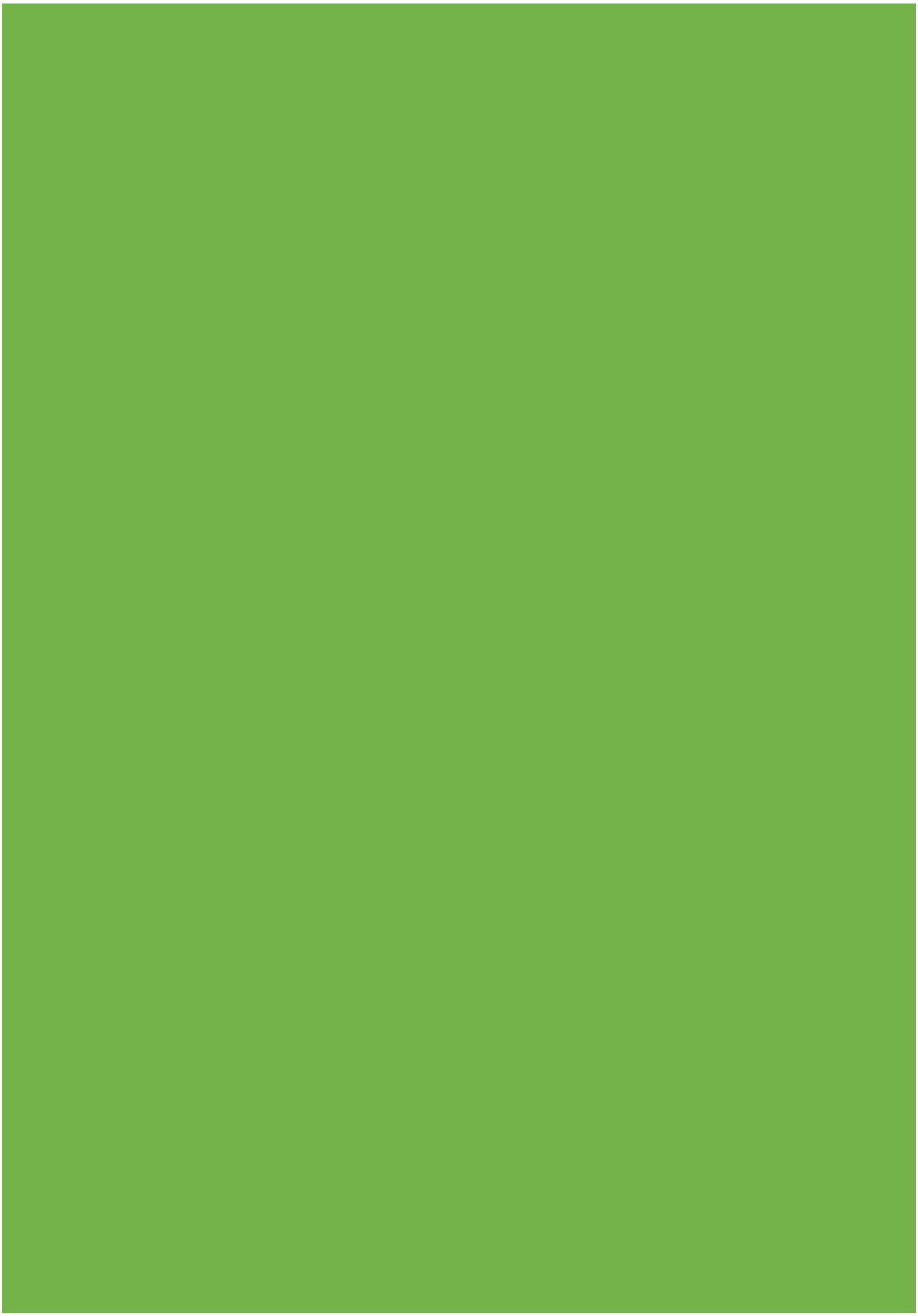
It is not necessary here to consider the various types of mental illness as they affect pregnant women and new mothers, but it should be noted that their effect on the mother, the child, and other family members is serious. It should also be noted that a mother may be reluctant to seek help for a mental illness or depressive condition for fear that their baby may be taken away. Studies have shown that maternal depression may be associated with infant cognitive delay, together with emotional and behavioural difficulties in young children. In more extreme cases, maternal schizophrenia is associated with significant parenting difficulties, with a high proportion of women losing care of their child and poor outcomes for the mental health of the child. Mental illness also brings with it in many cases social isolation and poverty, which will have deleterious effects on the child's mental and physical health. All of these factors point to the importance of appropriate treatment of women during pregnancy and the mother and baby in the postnatal period.

Self-Reported Health: was measured in the 2007 Community Indicators Victoria Survey. Respondents were asked to rate their health as excellent, very good, good, fair or poor. 51.6% of persons living within Greater Shepparton reported that their health was either excellent or very good as compared to the Victorian State average of 54.3%.

Social Support was measured in the Department of Planning and Community Development Community Strength Survey in 2008. Respondents were asked if they could get help from friends, family or neighbours when they needed it, definitely, sometimes or not at all. 88.6% of persons living within Greater Shepparton reported that they could definitely get help from friends, family or neighbours when they needed it, as compared to the Victorian State Average of 91.7%.

Victoria Police produces crime statistics annually. Summaries of offences are reported per 100,000 population to enable comparisons across different areas. In Greater Shepparton, there were 1157 recorded crimes against the person per 100,000 population in 2010-11 compared to the Victorian State average of 875. In Greater Shepparton, there were 5635 recorded crimes against property per 100,000 population in 2010-11, compared to the Victorian State average of 4551.

Destination of School leavers: Engaged or Disengaged: In Greater Shepparton, 55.4% of 15-19 year-old school leavers were fully engaged in work or non-school study, compared to the Victorian State average of 71.9%. Furthermore, 24.6% were disengaged, compared to the Victorian State average of 15.4%.



4. Service Catchment

We will discuss the specific families with specific needs, but for the moment it is appropriate to ask about the size of the catchment and therefore, the number of families and births that are relevant to scope of the project. The families that will be within the service catchment reside in the area outlined in illustration one.

The Region consists of a triangle, with Deniliquin as its Northern point, Benalla as it' Eastern point, then following through Seymour to its Western point in Kyneton. The City of Greater Shepparton is located at the confluence of the Goulburn and Broken Rivers in northern Victoria, about 180 kilometres north of Melbourne. Shepparton is the major urban centre of this region.

The City is the commercial, manufacturing and transport capital of the Goulburn Valley. As the major regional centre for the Goulburn Valley, Shepparton is relatively self-contained in employment terms and indeed many people travel to parts of the City from the neighbouring Shires for work, education and services. Shepparton Central and Shepparton North Central tend to attract young adults due to their centrality of location and their proximity to services and available rental accommodation. Areas such as Mooroopna, Shepparton North-West and Shepparton South-East tend to attract young couples and families, with affordable home owning opportunities. Future changes to population will be mainly associated with employment growth or decreases in local industries as well as further development of tourism. Migration gain to Greater Shepparton tends to be based on families from overseas as well as young adults from neighbouring Shires.

This region covers more than just Greater Shepparton; it covers the whole of the Local Government areas of Deniliquin, Greater Shepparton and Strathbogie, and covers parts of Mitchell Shire, Macedon Ranges, Greater Bendigo, Mount Alexander, Campaspe, Moira and Benalla. However, if this is the only residential intensive intervention available, the catchment could be as far east as Wodonga. Many of the individuals consulted stated: *if you build it they will come*. If there is a service available, it will be used widely.

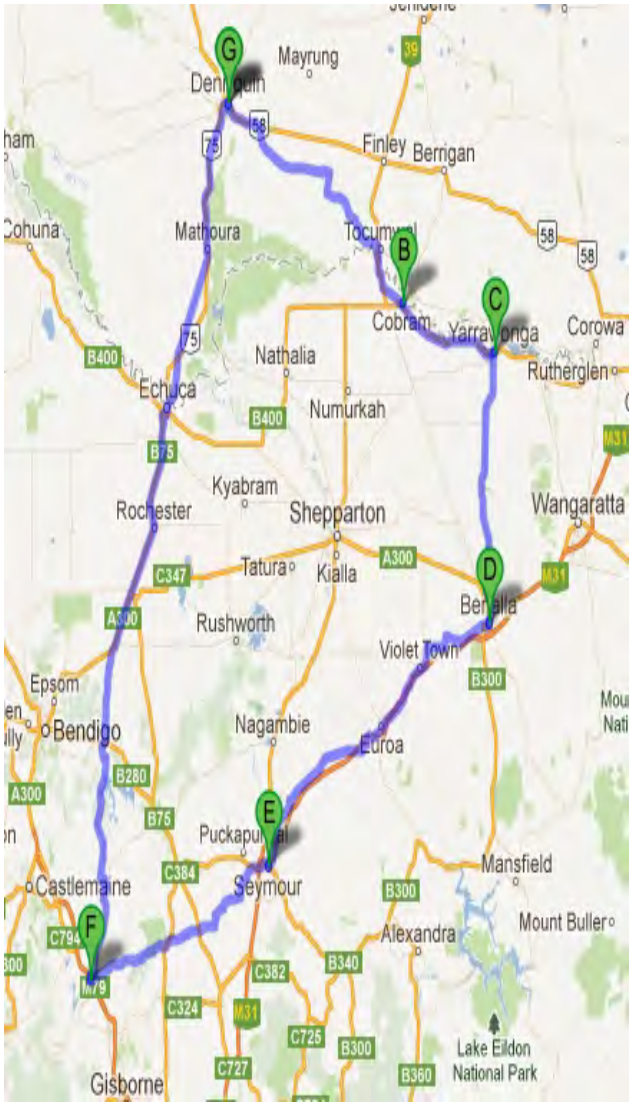


Figure 1: Service Catchment.

Population of Region:	**Population in other areas serviced by GVH:**
Strathbogie – 9,974 Greater Shepparton – 62, 368 Campaspe – 38,790 Moira – 29,127 Deniliquin Council – 7,693 Kyneton – 5,908 Seymour – 7,000 Benalla Council – 14,208	Albury - 53,507 Wodonga - 38,452 Wangaratta - 28 117
Total population of Region = 175,140 people	**Total – 120,076 people**
Births in Region:	**Births in Albury/Wodonga & Wangaratta *2007**
Moira - 351 Greater Shepparton - 1200 Campaspe - 475 Strathbogie - 78 Benalla Rural City Council - 152 Greater Bendigo - 1330 Mitchell Shire - 452 Macedon Ranges - 426 Deniliquin – 108	Albury - 644 Wodonga - 522 Wangaratta – 349
Total - 4772	**Total – 1,515**
Population of Region + Albury/Wodonga and Wangaratta = 295,216 People	**Births of Region + Albury/Wodonga and Wangaratta** **= 6,287**

Future Forecasts: Greater Shepparton: From 2012 – 2018 Population will rise from 64,735 to 69,708. An extra 5,000 people. The rate of births will rise from 4,473 in the 2007-2011 period to 4,757 per year in the 2012-2016 period[4].

[4] Source: http://forecast2.id.com.au/Default.aspx?id=272&pg=5000

5. Human Need

The configuration and content of services that should be incorporated into the scope of the service must be guided by human need: the answer to the questions: what results for which recipients should inform the solution. Whist it would be easier to simply take a Melbourne Metropolitan model and provide a satellite version in Shepparton, this would be a transplanted model and not a model built on an assessment of human need. Rather than take an existing service and scale it for the region, this project examined the unique requirements of a regional service and then sought to articulate the model that best serves this need. As a result of extensive discussions with professionals in direct service provision to families the following list represents the immediate human needs to be met within any proposed service model:

5.1 Intended Recipients

Vulnerable families/vulnerable children

Parents of infants 0-12 months of age.

1. Mothers with a diagnosed mental illness require inpatient services with their babies to minimise harm that can occur to the mother baby attachment and bond.
2. Mothers with a diagnosed mental illness require parenting assessment and skill development.
3. Infants require optimum attachment and bonding in order to develop cognitive capacity and emotional stability.
4. Parents require a parenting assessment and skill development service that cannot occur in the home due to home circumstances, challenges to employee safety or distance.
5. Parents require a secure parenting assessment and skill development service that is more intensive and short term than home visiting can provide.
6. The Government, specifically the Department of Human Services require a reliable and professional assessment in order to make a decision regarding child placement in the child's best interest.
7. The community of Shepparton, Hume and Victoria require that all that can be done should be done to either support a parent to love and care for their child or make the decision that separation is to occur because the infant harm risk is unacceptable.
8. The community of Shepparton, Hume and Victoria require that if a separation of parent from the baby is to occur, it should be based on sound evidence and professional assessment and it should be made without delay.
9. The child and maternal health professionals require a service that is a 'step up' from what is currently available. An opportunity to refer to an intensive service when the current services are not working, not intensive enough or not sufficient to meet the human needs.
10. GV Health professionals require a service option that does not see infants 'waiting' in paediatrics or maternity nurseries because the best interest decision requires a parenting assessment necessitating a Melbourne referral.

It is reasonable to ask: if these are the human needs, how are these currently met? The current service options include:

1. Referral to a Melbourne based Mother Baby Unit.

2. Inpatient care in an adult facility without the infant.
3. Referral to a Melbourne based Early Parenting Centre.
4. Intensive home-visiting services, that may or may not be effective or safe for employees.

5.2 Mother Baby Units

Women who need inpatient care for a mental disorder within 12 months of childbirth should normally be admitted to a specialist mother and baby unit, unless there are specific reasons for not doing so. The Australia wide estimate states 15% of parents will at some stage experience some form of post-natal-depression, but not actually seek help and be admitted to a service or a hospital. The estimated Incidence rate of PND for those who seek help and are admitted - in comparison to births is 0.6%

Depression and anxiety in the postnatal period can have a serious impact on a woman's ability to cope with day-to-day life, including looking after her infant and other children in the family. Even sub threshold symptoms can affect a woman's general functioning and the development of her infant. Treating sub threshold symptoms may prevent escalation of symptoms into a diagnosis of depression or anxiety, and also improve a woman's ability to cope.

Local Government Area	Births	State % of Births	PND (15%)	PND Admittance Ratio (0.6%)
Moira	351	0.5	52.65	2.106
Greater Shepparton	855	1.2	128.25	5.13
Campaspe	475	0.6	71.25	2.85
Strathbogie	78	0.1	11.7	0.468
Benalla Rural City Council	152	0.2	22.8	0.912
Greater Bendigo	1330	1.8	199.5	7.98
Mitchell Shire	452	0.6	67.8	2.712
Macedon Ranges	426	0.6	63.9	2.556
Deniliquin	108		16.2	0.648
TOTAL	**4227**	**5.6**	***634.05**	**25.362**

Source: DHS, IRIS Date *Data available only until 31 March 2010. Data for 2009-2010 covers the 12-month period from April 2009 to March 2010. Note that there appears to be some under-reporting for the March quarter of 2010 that will affect the 2009 – 10 financial.[1]

5.3 Parenting Services

Referrals to Melbourne based services are problematic. It's not simply a case of the 2-hour travel being inconvenient for most families. In many instances, families fail to attend. If a family is referred to a Melbourne based service and they fail to attend, there is a delay in service provision because regional staff may be of the view that the family is in Melbourne receiving treatment, when this is not the case. If the family does attend a Melbourne facility there can be a delay in notifying regional staff of their admission and their discharge. We listened to a number of case studies of Maternal and Child Health Nurses visiting homes, where the family was not home because they were referred to Melbourne, and we heard stories of delays in receiving information following discharge. Providing a sound 'step down' service from the intensive residential service, requires good communication between Melbourne based services and regionally based health and welfare services.

In all interviews and consultations this question was asked: what do you do now with high needs/ high probability of infant harm? A reasonable summary of the answers given is – *we work around what we have and we know that families are missed, or that families fall through a gap*. Maternity staff commonly use the phrase ***"we send them home, and we hold our breath".***

Currently in the region there is a Parent/Child Program and a Day Stay mother/baby facility provided by FamilyCare in Shepparton, Cobram and Seymour. While this service does good work, there is a lack of regional services for referral where the day stay or home visiting program are not able to meet high needs or highly complex vulnerable family needs. Over the past three years FamilyCare has received an average of 460 referrals per year to the Parent/Child Program and 318 clients using the Day Stay Program.

At present residential programs are only provided at the Early Parenting Centres in Metropolitan Melbourne. Tweddle is a member of the Steering Committee and hence data regarding regional attendees was made available for use in this project. Tweddle is located in Footscray in metropolitan Melbourne. Over 2000 clients access Tweddle's residential and day stay programs each year, and an audit of services in 2009-10 showed

that 70 of these client families came from the Shepparton/Goulburn Valley region. However, the need to travel to Melbourne for this service is costly, inconvenient and disruptive to family life. While it is unknown how many families from the Goulburn Valley who needed the service did not even consider it, or did not take up an offer of admission (failure to attend). During interviews, social workers and medical professionals in the region stated that they have contact and are aware of many families who would benefit from a residential service if provided closer to home.

Since the commencement of 2012, the Rumbalara Aboriginal Cooperative has referred five families to Tweddle, and none of these families attended, indicating that a need clearly identified by health and social work professionals is not being met.

What are the family characteristics and needs of families that are encouraged or required to attend residential parenting services? The Early Parenting Centres have recently adopted common data collection and it is too early to use their intake figures to ascertain or extrapolate common factors. A useful data set is available on the evaluation of the Child First framework. Since the introduction of the Child and Family Service reforms, children and families receiving support from Child FIRST and Integrated Family Services are substantially more likely to be demonstrating characteristics, which are indicative of increasing complexity. This includes greater likelihood of involvement with Child Protection, mental health issues, substance abuse, family violence, and intellectual disability. As illustrated in the Table below, of substantive cases in the 12 months to March 2010:

- 21 per cent had Child Protection involvement, compared to 14 per cent in 2005-06
- 28 per cent involved family violence, compared to 26 per cent in 2005-06
- 14 per cent involved substance abuse, compared to 10 per cent in 2005-06
- 31 per cent involved mental health issues, compared to 28 per cent in 2005-06
- 9 per cent involved intellectual disability compared to seven per cent in 2005-06

There is a high degree of variation in case complexity when considering individual catchments. In the Upper Hume, Wellington, Central Hume and Greater Grampians, over 80 per cent of substantive cases had one or more complex issues in the year to March 2010 – well above the state average of 65 per cent.

Table: Proportion of substantive cases by complex issue category, by financial year (Jan 2004 to Mar 2010)

	2004 – 05		2005 – 06		2006 – 07		2007 – 08		2008 – 09		2009 – 10*	
Issue category	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Child Protection Involvement	1,409	12	1,896	14	2,137	16	2,722	19	2,918	19	2,814	21
Disability – Intellectual	719	6	786	6	787	6	921	6	1,023	7	980	7
Disability – Physical	371	3	342	3	276	2	353	2	353	2	297	2
Family violence	2,969	25	3,500	26	3,389	25	3,898	27	3,916	26	3,786	28
Juvenile Justice Involvement	79	1	75	1	70	1	117	1	103	1	68	1
Mental Health	3,406	29	3,830	28	3,688	27	4,542	31	4,521	30	4,098	31
Sexual Assault	587	5	558	4	537	4	624	4	608	4	524	4
Substance abuse	1,045	9	1,306	10	1,383	10	1,870	13	1,982	13	1,812	14

Region Based Services:

Maternal & Child Health (Greater Shepparton City Council)

- Course & seminars
- Enhanced Maternal and Child Health

GV Health

- Paediatric Services
- Perinatal & Emotional Health Program
- Maternity
- CAMHS

Rumbalara

- Integrated Family Services
- Aboriginal in home Support Program
- Early Intervention and Parenting

FamilyCare

- Integrated family services
  - Child First
  - Family services (Day stay)
  - Parent Child Program
  - Perinatal Depression support Group

General Practitioners

The Bridge Youth Service

- Partnering FamilyCare to deliver "Cradle to Kinder" Service

Regional Parenting Services

Regional Parenting Services provide group education, information and intervention programs to parents. Regional Parenting Services provide families with the opportunity to participate in local, effective and relevant parenting programs that focus on key transition points in the lives of children and families. Services are targeted to neighbourhoods of social and economic disadvantage. One service is located in each of the Department of Education and Early Childhood Development regions across the State.

Primary Care Connect Community Health Service

Hume Region Parent Education Service

Hume Region Parent Education Service is a preventative service, providing parent education, information and support to parents and carers of children 0 to 18 years of age.

- Group parenting programs and workshops
- Up to four one to one parenting consultations with parents or carers of one hour duration
- Written information relating to parenting
- Access to Telephone Education Service
- Resource Library providing books, videos and audio tapes

6. Service Mapping

It is not appropriate to simply document the parenting services that are available within the Region. A critical element is the service **continuum** – that is the evidence that services span the range of human needs and that these services are integrated and work together in family centred practice. Within the early parenting sector there is a paradigm of a three levels of service delivery: universal, secondary and tertiary.

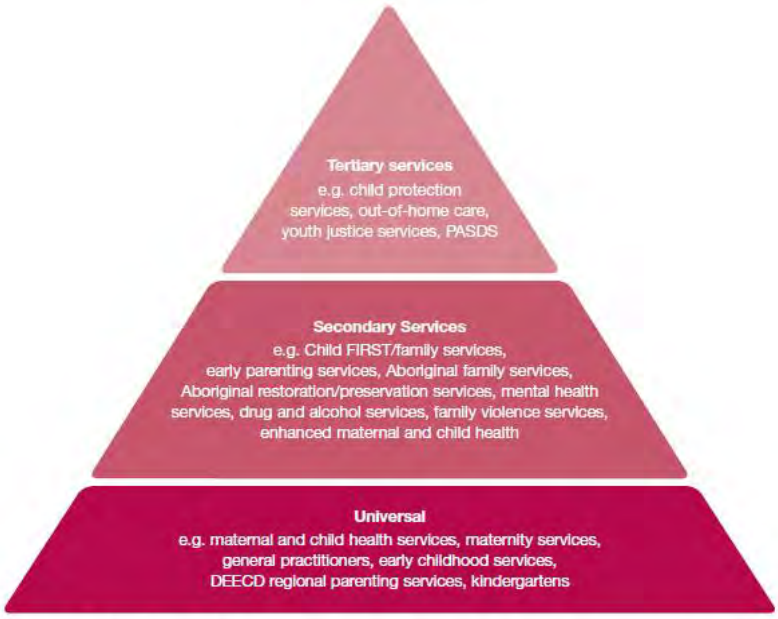


Diagram 1. Public Health Model for Protecting Children (adapted from the Australian Research Alliance for Children and Youth (ARACY) 2009)

Translating the parenting service mapping into the three service levels for the region demonstrates the gap identified by the professionals consulted in this project. There are sound universal and secondary services **with a clear gap in regionally based intensive services** – as indicated in the following:

Universal services — The goal of universal services is to support the wellbeing of all children and families before problems arise. These services are available to all families and act as a platform for preventing neglect and abuse.

Secondary services —The goal of secondary services is to provide specialised services to address specific risk factors that compromise parenting in vulnerable families and that cannot be provided by universal services. These services are provided with the family's consent and aim to intervene earlier to support families to promote the safety, stability and development of children, before they reach the point of requiring further specialist services or tertiary interventions.

Tertiary services —Tertiary services are for the protection of children who have experienced child abuse and neglect and seek to ensure that the problems do not continue. These services tend to be statutory interventions requiring a court order that ensures the participation of the child and family in the service.

Universal Level Services	Secondary (additional needs) Level Services	Tertiary Level / High Intensity Services Shepparton/Hume Region	Tertiary / High Intensity Intervention (Melbourne)
Maternal + Child Health Visits			Mercy Mental Health Mother Baby Unit (Werribee)
	Enhanced Maternal + Child Health		
Maternal + Child Health Seminars			Monash Medical Centre
Maternal + Child Health - Toddlers			Austin Health Mother Baby Unit
	Rumbalara in-home Support Program	PASDS Home Visiting (FamilyCare)	
Goulburn Valley CHS			Masada Private Hospital - Mother Baby Unit
	Rumbalara Early Intervention and Parenting		
General Practitioners/ Paediatricians			Mitcham Private Hospital - Mother Baby Unit
	Rumbalara Integrated Family Services		
General Medical Practitioners (GP'S)			Albert Road Clinic - Mother Baby Unit
	FamilyCare - Child First		North-Park Private Hospital - Mother Baby Unit
Primary Care Connect Community Health Service - Hume Region Parent Education Service	FamilyCare - Day Stay		
	FamilyCare - Parent Child Program		EPC multi-day-stay PASDS (Tweddle)
	FamilyCare - Perinatal Depression Support Group		EPC 120-hours home-based PASDS (QEC)
Websites (e.g. www.raisingchildren.net.au)			EPC 9-night residential PASDS (QEC, Tweddle)
	The Bridge Youth Service - Cradle to Kinder		Families First
			Take Two
	Hospital Based Services		
	- Paediatric Services		
	- Perinatal & Emotional Health Program		
	- CYMHS		
	- Neonatal		

7. Shepparton Mother/Baby Unit and Residential Early Parenting Service

The preferred model combines the functions of a Mother Baby Unit with the functions of the residential programs of the Early Parenting Centres: Intensive early intervention and prevention: Residential Parenting and Child Protection Parenting Assessment and Skills Development Service (PASDS). This model builds upon the universal and secondary services provided in the region and is therefore a model of integrated care and service delivery. A guiding principle for this project was the requirement not to duplicate what is currently available within the community. This service is designed to be a tertiary end, high intensity service. Universal and secondary level services will be integrated into this model but not replaced by this service.

The following diagrams and tables provide an outline of the service characteristics: size, duration and service content and funding sources. The service is built from human need forwards, not from a preferred model backwards.

It is a solution to human need and as such it is a complicated funding model spanning health and welfare government funding and programs. However, if there is a shared commitment to an integrated solution at the regional level, this may lead to a high probability of the two separate government funding agencies cooperating to produce a viable recurrent funding outcome.

7.1 Capacity

The size of the unit is problematic. The demographic and prevalence data do not provide a level of accuracy sufficient to estimate the ideal size. The current arrangements are a work around: families do not attend Melbourne facilities; there are delays in attendance, wait-lists and a lack of communication regarding the families that do attend. How large should this centre be? How many families and what length of residential stay is required? The data is useful as a starting point, but there can be no doubt that as the only residential early parenting facility in a regional setting, the service will be well used and will grow. The final decision regarding the facility should take into account that the facility should be designed to accommodate growth with minimal capital outlay.

Without the data how is the final size to be determined? The interviews focussed specifically on providing solutions to human need – and in every interview, the respondents were asked – 'how many families will need this service'. The final size therefore is based on respondents' professional judgement and experience and on an assessment of the economies of scale and viability.

The service should be large enough to account for economies of scale (based on staff /family ratios), have room to expand and be of a modest size that would encourage government recurrent funding.

7.2 Capital Cost

The capital cost of the facility should also be considered in this scoping project. There are a number of Commonwealth programs that are appropriate for this project, however each of these programs require a contribution from the project protagonists.

There is also a requirement for State Government contribution and support for Federal Government funding. The size and configuration of the facility will depend upon the outcomes of intense advocacy to the relevant state government departments and it recommended that the Department of Mental Health and the Department of Human Services are engaged to discuss the capital after the deliberations have been made concerning the level and the sources of recurrent funding. It is likely however, that a level of local capital funding will be required and our early estimate is that the facility is likely to require 30 –

50% local capital raising or contribution from FamilyCare or GV Health. The full cost of the capital will be dependent upon the location selected and if the facility is to be purpose built or if an existing building can be modified to be fit-for-purpose. Individuals consulted during this project were asked questions regarding the optimal configuration and capital attributes and these attributes were strongly endorsed by the majority of respondents. The residential services should combine private family space and public spaces, allowing for private interventions with families (for example, feeding and settling the baby) and shared interventions, such as play sessions, peer discussions and formal and informal information giving.

Desired attributes of a potential Shepparton based Mother Baby Unit/Early Parenting Centre:
Located close to the centre of Shepparton.

- Walking distance:
  - Playground
  - Shops/Restaurants
  - Gym
- Transport / Public transport
- Consulting rooms
- Day stay workshop room
- Group Facility
- Parenting bedrooms require ensuite bathrooms
- Baby rooms – separate small room attached to parent's room.
- Security access
- Parking
- Video taping facilities
- Outdoor area
  - Green Areas
  - Group Seating

8. Service Configuration

Early in this report it was noted that a scaled down version of the Melbourne metropolitan service models is not necessarily the best regional option. The Steering Committee has been advised that innovative and hybrid models are of interest if they can provide good service outcomes (meet human need) and do so cost efficiently.

8.1 Mother Baby Unit

The previous Government announcements regarding new regional MBUs (Ballarat, Bendigo and Gippsland) have each outlined a 5-bed facility. Residential service provision is expensive due to the intensity of the intervention and 24-hour, 7-day care. Early stage assessment would indicate that if there is a core service it is possible to add supplementary services that may reduce stay and may reduce the need to return to care. It is recommended that the Steering Committee consider a model that would care for 5 mothers and their babies in a 3 + 2 model: i.e. 3 residential service beds (2 public + one private) and outpatient services for a further two families per fortnight. The average length of stay in a MBU is 2 weeks. If this length of stay is reduced to a 10 day cycle the savings that can be made on the final weekend could be directed to outpatient services: either through a Mother Baby Clinic Day Stay program or group programs.

Shepparton: Mother Baby Unit Component	
10 day inpatient services: 3 beds mothers and babies	78 mothers per year
2 mothers and babies outpatient services: Home visiting/group therapy	50 mothers per year
Total number of families:	**128 families per year**

8.2 Early Parenting Service: Residential Parenting & PASDS

Residential parenting services provide support to families experiencing difficulties with parenting. There are publicly funded agencies that provide residential parenting services and residential PASDS in the metropolitan area. These are the Queen Elizabeth Centre (QEC), O'Connell Family Services and Tweddle Child and Family Health Service. Two of these metropolitan centres (Tweddle and QEC) provide residential PASDS: The focus of the residential PASDS is **to provide an assessment of parenting capacity**. Skills development occurs as part of identifying the ability of parent/s to learn and maintain parenting skills.

Tweddle and QEC residential PASDS is delivered across ten continuous days. All three Centres offer (non-PASDS/non child protection) intensive residential parenting over a five-day period, Monday to Friday.

There is a precedent for residential parenting to be delivered via a public hospital provision: A regionally specific residential program has been developed by Barwon PASDS based at the City of Greater Geelong and the Geelong Hospital. The City of Greater Geelong feeds most of its residential PASDS through a unit within the Geelong Hospital and stays at the unit usually last between five to ten days. The Barwon PASDS coordinator works with local paediatricians to gain access to a bed within a special parent-child unit at the hospital. This residential facility is used only when the work involves a newborn infant and there is need for 24-hour supervision.

The QEC and Tweddle residential models are similar. They include 24-hour stay across a minimum of five days and maximum of ten days.

Most clients, unless they leave the program, receive a ten-day program.

The ten-day program is provided to PASDS clients and provides the time necessary to carefully observe parenting practice, assess areas of strength and greatest need, implement a small scale skills development plan and assess the progress of the parenting practices of the families. The Department of Human Services is provided with a comprehensive assessment report within 21 days of the client receiving the service.

At Tweddle the ratio of PASDS clients to other families is 20–25 per cent. This ratio provides the opportunity for a normalised experience for PASDS clients whilst in the program, encouraging them to interact with other families, rather than isolating them.

PASDS families usually receive a higher level of one to-one care from the staff, and efforts are made to ensure that each family has continuous relationships with particular staff to facilitate the development of trust, to focus the transmission of learning, and to provide reliable and systematic observation for assessment purposes. PASDS families are encouraged to participate in some of the group activities undertaken with other parents. While residential settings simulate the home and allow for intensive observation and skills, families are relieved of many everyday home care responsibilities in order to focus on the parent-infant interaction. Tweddle requires participants to be drug and alcohol free during the period of residency. Some families may be in methadone programs.

The optimum size for the Shepparton based facility is based on consultations with Tweddle, local practitioner professional judgement and an estimate of demand from Child Protection, Child First and Home Visiting PASDS (FamilyCare).

Shepparton: Residential Parenting Program	
PASDS (8 day residential program plus 2 Day Stay/group therapy) 2 cycles per month 2 families *Child Protection Referral*	48 families per year
Residential Intensive Parenting (5 day program) 2 cycles per month 2 families *Child FIRST/health care professional Referral*	48 families per year
Total number of families:	**96 families per year**

Outcome Study at Tweddle:

The Outcome Study assessed eligible mothers and infants during admission to the Tweddle Residential Program and at one month and six months after discharge. Some of the main findings were:

- Mothers and infants admitted to the residential programs at Tweddle generally have very complex social circumstances and poor mental and physical health.
- Many mothers are inadequately supported by their families and have very little leisure time.
- Relationships with partners are often problematic, including inability to confide, little involvement of fathers in infant care or household chores. In extreme cases there can be fear of intimidation or actual violence.
- Some have a past personal or family history of psychiatric illness.
- Reproductive life had often been difficult, including previous pregnancy loss, assisted conception and obstetric complications.
- Many women have persistent health problems and most have severe fatigue.
- Infants brought to Tweddle are usually unsettled, with poor sleep patterns, frequent overnight waking, prolonged and inconsolable crying, resistance to soothing, and feeding difficulties.
- More than a third of mothers have depressive symptoms and are anxious.
- The mother's mood and infant behaviour improve significantly one month after completion of the program, and these improvements were sustained at six months.

Key Centre for Women's Health in Society Early Parenting Study, Melbourne University. Associate Professor Jane Fisher, Dr Heather Rowe and Dr Sonia Young. Tweddle Child and Family Service, Masada Private Hospital's Mother Baby Unit.

Shepparton Mother Baby Unit + Early Parenting Centre

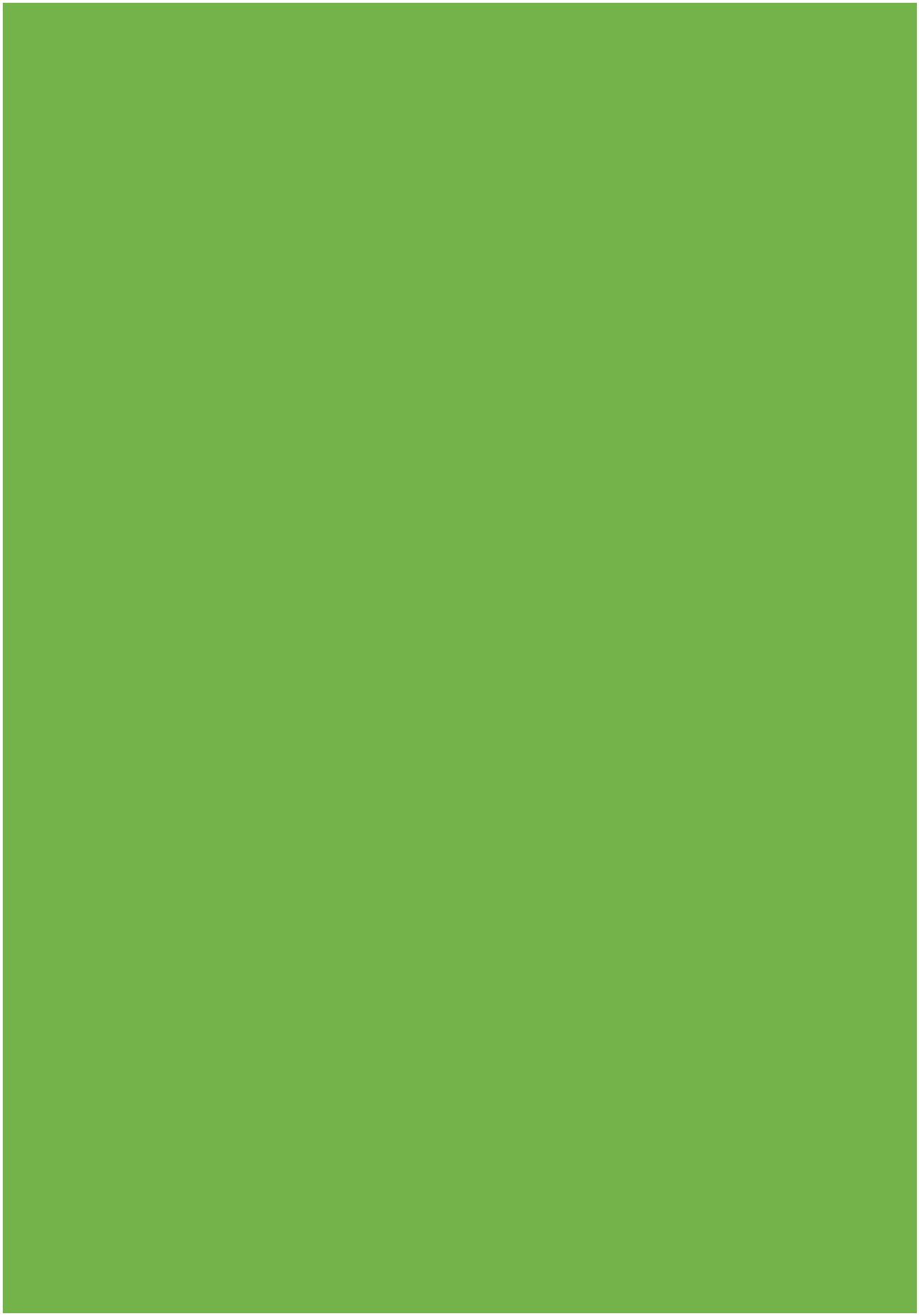
Category One: Core Services (MBU+PASDS/ Residential Parenting)
Two core services: Mother Baby Unit (2 public and 1 private bed) and the Residential Parenting and Residential PASDS

Service	Service Description	Recipients	Funding	Referral Process	Service staffing
PASDS Parenting Assessment and Skills Development 2 beds	To provide an assessment of parenting capacity. Skills development occurs as part of identifying the ability of parent/s to learn and maintain knowledge regarding parenting skills. Length of Stay 8 days	Parents with a child up to 18 months that have been identified by Child Protection staff as at risk of infant physical or mental harm.	Department of Human Services	Child Protection	1 Registered nurse 1 Early childhood Development staff member
Residential Parenting 2 beds	Parenting assessment and skills development for high needs families for whom home visiting is inappropriate and child protection reports are a high likelihood without early intervention.	Parents with a child up to 18 months that have been identified as requiring additional assessment or support with no previous child protection reports – appropriate for young women, women with intellectual disabilities – some mothers to arrive directly from GV Health Maternity or Neonatal unit.		Child First GV Health Maternity/Vulnerable Families Ctte Enhanced Maternal and Child Health	
Mental Health MBU (Public) 2 beds **Mental Health MBU (Private) 1 bed**	**Mother Baby Unit: Inpatient Program** A for mothers with their babies up to 12 mths for conditions such as : Postnatal depression/distress, Maternal anxiety, Adjustment difficulties etc. Inpatient programs are both structured and flexible to meet individual need. Personal treatment plans are developed on admission. Individualised treatment to best meet the needs of mother and infants as individuals and as a dyad. The average length of stay is 2 weeks. **The Unit will offer both inpatient & day programs**	Mothers with a mental illness, who have a baby up to 12 months. Able to be managed in an open ward and no activity risk to baby.	Department of Mental Health: Mother Baby Unit Self funding	Medical Practitioner (GP, psychiatrist, paediatrician) Medical Practitioner (GP, psychiatrist, paediatrician)	MBU Staffing = one psychiatric nurse (3 shifts – 24 hours)

Category Two: Examples of Additional Services that can enhance the core services / reduce the length of stay / have synergy with the core services and do not duplicate existing community based services.

Service	Service Description	Recipients	Funding	Referral Process	Service staffing
Mental Health Early Intervention	**Early Intervention Postnatal Depression** A 12 week group therapy program Women receive 8, 1 hour, sessions of individual cognitive-behavioural therapy with a psychologist. Designed to improve maternal mood. Women learn coping strategies to help manage their moods.	**Mothers and partners:** Needing strategies to understand and manage their moods and their expectations of parenting. Previous Maternal PND/depression/anxiety. Overwhelmed and unable to cope (depressed, anxious)	Department of Mental Health	**Medical Practitioner** (GP, psychiatrist, paediatrician) **Self-Referral**	Sessional staff
Maternal Mental Health Intensive Parenting support – step down and an adjunct to PASDS and residential parenting	**Adjusting to Parenthood** **Play Steps** Focuses on the mother and baby together and the interaction between them **Playgroup** A specialised playgroup focusing on interaction between mother and baby **Intuitive Mothering: Dance Therapy Program** Using Dance, movement and play to address difficulties in the mother infant relationship.	**Mothers who need:** Assistance to become more fully engaged and attuned to their infant following treatment for PND **Mothers with an infant 1-18 mths:** Experiencing some adjustment difficulties since birth of baby. An EPDS score 16 or above **For mothers needing to:** Further develop their intuitive interaction with their infant through a program of dance, natural movement and imaginative play	Department of Mental Health	**Residential parents and inpatients of the Shepparton MBU + EPC would be eligible to attend following the discharge from residential services**	Sessional staff
Post diagnosis Mild/Moderate Intervention	**Overcoming Depression** 6 week program, community treatment for depression involves GP, MCHN and psychologist working together.	**Any mother with an infant who:** Feels overwhelmed and unable to cope or is struggling to manage their moods (sad, depressed, anxious, panicky)	Department of Mental Health	**Medical Practitioner** (GP, psychiatrist, paediatrician) **Self-Referral**	Sessional staff

GV Health Mental Health	**Mother Baby Unit: Day program** A Mother Baby 12 week program for individuals who require treatment without hospitalisation or those who may require transitional care following an inpatient stay. Specialist day programs for women experiencing postnatal difficulties.	**Any mother with an infant who:** Feels overwhelmed and unable to cope or is struggling to manage their moods (sad, depressed, anxious, panicky)	Confirm level & type of health cover. Self-funding	**Medical Practitioner**(GP, psychiatrist or paediatrician) Allied health provider **MCHN**	
In Home	**Outreach Team** Provides home care for families when hospitalisation is not an option or as an interim measure while waiting admission to the Mother Baby unit.	**For families:** Where the mother is experiencing symptoms of post-natal depression or other adjustment symptoms,	Department of Mental Health	**Medical Practitioner**(GP, psychiatrist or paediatrician) Allied health provider **MCHN**	Sessional staff



9. Infrastructure

9.1 Funding

This Scoping Project was concerned with the assessment of human need and the optimum model for meeting these human needs. Effectively we can see from the regional data, the service mapping and the professional experience of family need that there is a requirement for an intensive intervention. An effective funding model is to 'pair' this intensive (residential) care with day stay or group interventions that can occur after the intensive intervention. If the day and group programs are co-located there is likely to be an improvement in attendance and parent and infant outcomes. The early advice from this study is that incorporating structured day programs that occur in the same facility can reduce the length of stay in the residential component. There is also a view that the staffing profile should be examined for innovative and effective practice. The Steering Committee was advised that the staffing ratios and qualifications should be fit for purpose and not based on a scaled down Melbourne model. The focus for the scoping component was to ascertain the need, the ideal location and the constituent components.

It is proposed as a next step is to undertake a Feasibility Study in which the model is further developed i.e. to seek final agreement on the number of care rotations, staffing requirements, days of opening and number of families. When the model of staffing and operating is resolved, it is a logical to then to cost the model and commence an advocacy and seek funding.

There will be a number of other areas that require attention in a Stage 2 Feasibility Study. These issues include the Governance of the entity – which is now likely to be titled a 'Parent Infant Unit'. This project did complete the first stages of these discussions and these are noted here in this Scoping Study to allow Stage 2 to build upon work that has been completed.

The individuals consulted in the course of the Scoping Study have identified the characteristics of the capital facility. There is not an existing facility that has the location or the physical characteristics suitable to house the Parent Infant Unit. We do have some idea of the size, the location and the configuration from the consultative process and we can therefore speculate on the likely capital cost. There are funding streams available for capital but as mentioned early in this report there will be a requirement for a local contribution that can be matched by State or Federal funding. In Stage 2 the actual location and square meters required can be assessed and the likely capital cost can be firmed into a dollar figure. The assumption that many have used for the capital cost is $800,000 - $1,000,000. Early stage assessment of local real estate and the cost of modification would indicate that this is likely to be the appropriate capital expenditure range. When the final numbers have been agreed, the capital cost can be accurately estimated.

9.2 Governance

It has been assumed that Goulburn Valley Health as the accountable entity will govern the facility. However, it is likely that this facility/suite of services will span the health/welfare divide and the funding for the welfare component would be appropriately placed with FamilyCare/Tweddle.

There is an assumption within the Steering Committee and the community practitioners that the Mother Baby Unit component is funded by the Department of Mental Health (Department of Health) and the Department of Human Services

funds the Early Parenting component. It's a complicated funding option because this project worked from a genuine assessment of human need. Whilst the authors were mindful of government policy, strategy and previous funded services, the project was not designed to manipulate the outcome to ensure that the solution could fit neatly within an existing funding regime. There was no attempt to try to fit the solution into the current funding guidelines of either department. During the project we were also informed that Mother Baby Unit specifications were under review and these funding guidelines may change in the short to medium term. Clearly Stage 2 will require direct discussion with both government departments regarding how such a service could work and whether the funding would come in two separate streams or be integrated into the funding of Goulburn Valley Health.

It is a generalisation that the governance structure normally follows the funding – the body that receives the funds is accountable for the use of these funds and the quality of the service. However, without a clear funding model it is not possible to document the specific arrangements for the Shepparton Parent Infant Unit and Stage 2 should see a firmer recommendation regarding the governance and oversight of the unit/service/programs that come together in the **Parent Infant Unit**.

Tweddle is governed by a board appointed by the Minister for Health and has accreditation for governance in a health and welfare setting. We considered a role for Tweddle in the governance of this unit and we are of the view that this would be sound option if the local community service providers were of the view that this would be beneficial. There will also be a requirement for the clinical governance and training of the residential early parenting component of the service and Tweddle has indicated a willingness to provide a role in delivering the residential parenting services and providing:

1. Accredited Residential Parenting program content.
2. Staff recruitment and training
3. In service training
4. Policies and Procedures

Depending upon the nature of the government funding and approval, and the timeline for implementation, it may be sensible for FamilyCare/Tweddle to receive the funding for the Early Parenting Service. In a small proportion of families, there will be a requirement to refer to Tweddle's Footscray facility. Some personal circumstances require a Melbourne stay in order to break a cycle of drug use or violence. Maintaining close links between Melbourne and regionally based services can lead to better communication and improved 'step up' and 'step down' service provision.

9.3 Local Capabilities

The regional expertise in parenting, paediatrics and psychiatry is considerable. A reasonable assessment of the current infrastructure indicates that the region is well placed to host and operate a hybrid residential parenting service. The region is a leader in collaboration between services and well known for excellence in the provision of infant mental health, adolescent mental health, adult mental health, paediatrics and parenting support programs.

9.4 Indigenous Families

The human needs assessment of this report provided data on the demographics of the indigenous community in this region. If this community is seen to be integral to the need for a residential service, then all efforts should be explored to ensure that the service is accessible for families with demonstrated high needs for services and support. During discussions with the indigenous community it is clear that there is a high level of 'no show' to mainstream services that are not tailored to need and not staffed by indigenous professional staff. The configuration of this service is a chance to get this right and there are options for improving the service's ability to attract indigenous families:

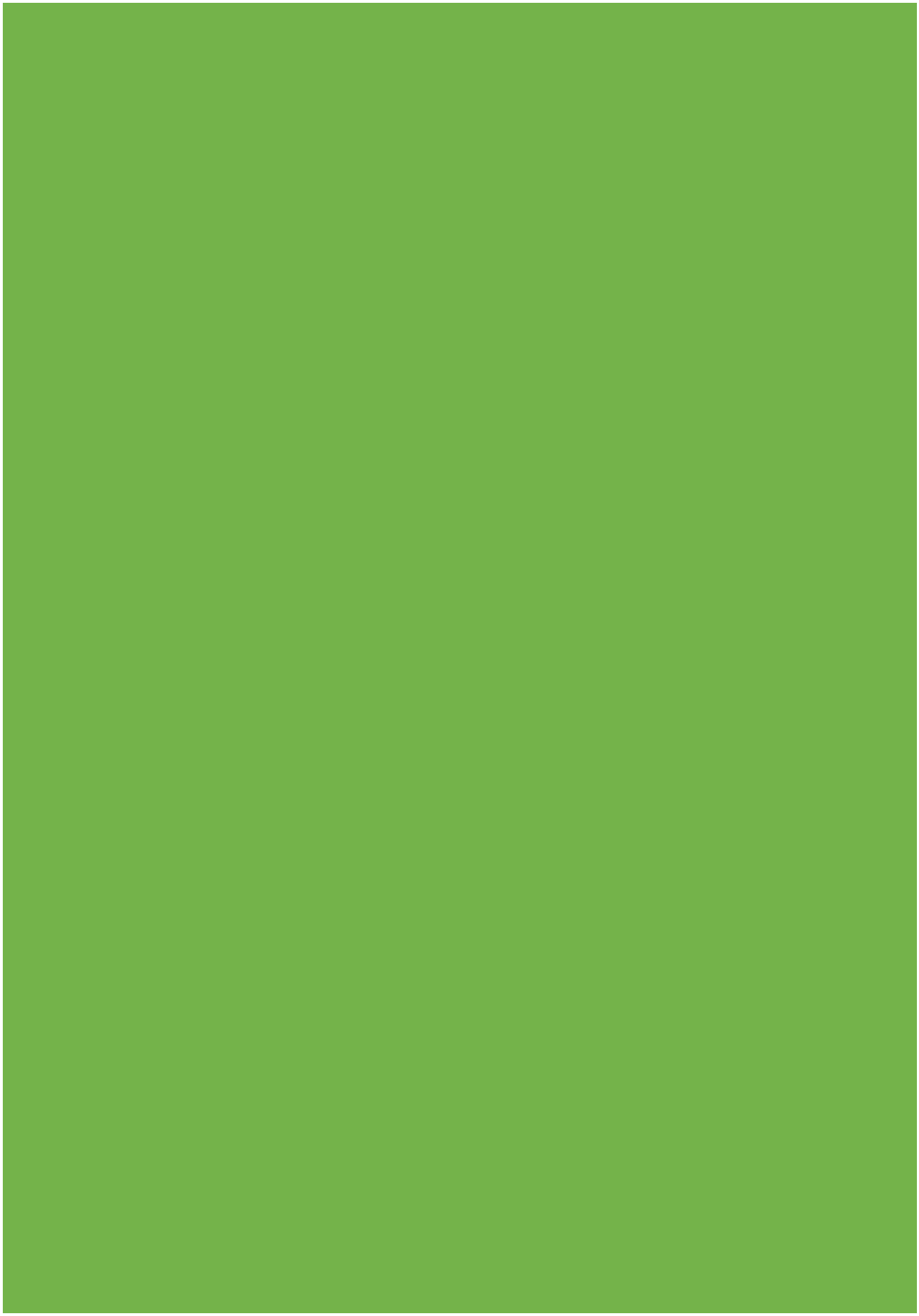
1. Intake of families into residential parenting services occurs in a cycle – all families are admitted together on day one, and barring early discharge, all families complete the 8 or 5 night stay together. It would be a valuable exercise to design a cycle that has 100% to 50% indigenous families for that particular intake cycle.

2. For services to be taken up and be effective, Indigenous families need to see other indigenous faces and the training of professionals to work in the services is a valuable medium term option. In the short-term, however it would be feasible for the proposed service to contract-in a Rumbalara parenting professional to work along side the staff for the full cycle and discharge plan.

3. Close ties with Rumbalara are required: there are natural synergies with the intensive parenting services that are offered by Rumbalara (Appendix Three) and Rumbalara parenting professionals are supportive of a residential service. These ties can be formalised by incorporating Rumbalara into the referral and intake process and by working with Rumbalara staff during the discharge process.

9.5 Research

Any proposed project to be provided to government for potential funding should also include a component of evaluation and research. Tweddle has an established research capacity and has published research findings and analysis on day stay and residential parenting programs. Goulburn Valley Health has an on site relationship with the University of Melbourne providing the service with robust options for collaborative research and evaluation. Should the Government agree to fund an innovative hybrid model that can be both an effective service for human needs and a cost effective method of delivering these service outcomes, research on the evidence for this model will be critical.



Appendix One

Steering Committee Members

Ms Vivienne Amery CEO Tweddle
Mr Bill Brown Executive Director Mental Health, GV Health
Dr Peter Eastaugh Paediatrician, Clinical Director, GV Health
Ms Wendy Lewis Chief Nursing and Midwifery Officer, GV Health
Mr David Tennant CEO FamilyCare
Ms Rebecca Woolstencroft Consumer

Appendix Two

Individuals and Organisations Consulted

Greater Shepparton Best Start Early Years Committee	Greater Shepparton Council
Dr Dan Garrick	Paediatrician
A/Prof Ravi Bhat	Divisional Director MHS GV Health
Ms Linda Riddell	NUM Paediatrics
Dr Anthony Gallagher	Psychiatrist, Clinical Director, GV CYMHS
Ms Kaye Gall	Divisional Operations Director
Ms Jillian Michalski	Manager GV CYMHS
Dr Vasu Iyengar	Divisional Clinical Director, Women's & Children's Health
Ms Virginia Keller	Chief Social Worker, GV Health, Maternal & Child Health
Ms Cherie McPherson	Social Worker, GVH
Ms Jacqueline Roberts	Social Worker, GVH
Ms Andrea Griffin	Child Protection, DHS
Mrs Christine Widdicombe	Greater Shepparton City Council, MCH Team Leader
Ms Cathy Dooling	Manager, Health Information Service
Ms Ange Armstrong Wright	Service Director, FamilyCare
Ms Di O'Bree	CaFS Manager, FamilyCare
Ms Rosemary Rutledge	Parent Child Program Leader, FamilyCare
Ms Bernadette Wardle	Maternity Services Manager
Mr Bill MacDonald	A/Manager Service Improvement Mental Health Drugs & Regions Division
Ms Tara Tracey	Manager Neonatal Nursery
Ms Cheryl Burke	RUMBALARA Aboriginal Family Services

Appendix Three

Rumbalara

Rumbalara Aboriginal Cooperative is recognised today as a key stakeholder in Aboriginal health. Maintaining a high profile within the public and private sectors in areas such as research, consultancy, policy development, and partnerships, Rumbalara operates in a culturally appropriate and sensitive community controlled environment that maintains a holistic approach to service provision and emphasises the importance of family and community.

Relevant Services:

- Medical Clinic
    - General Practitioner and Community Health Nurse Services
    - Visiting Specialist Programs
    - Diabetes Program: Diabetes Management & Education
    - Women & Children's Heath: Antenatal and Postnatal care for women
    - Women's Business information and referral
    - Aboriginal Health Workers: Assist Health Service programs and services

- Integrated Family Services
    - The aim of our Integrated Family Service program is provide culturally appropriate supports to vulnerable families, in an attempt to reduce reports and re reports to child protection.
- Aboriginal In Home Support Program
    - The In Home Support Program is available to all Aboriginal families and individuals with an Aboriginal child aged 0-3 years. Essentially the program provides one on one support to increase parenting knowledge and skills. It provides:
        - Support for mothers to breastfeed and linking them to expert advice if they experience difficulty
        - Role modelling of developmentally appropriate play in the home
          Positive parenting techniques
        - Assistance for families with appointments and attendance at key milestone events such as Maternal Child Health visits; immunisation sessions; child and adult health checks.

- Aboriginal Family Preservation Program

Assists Aboriginal families to remain together by providing intensive, time limited, in home support to families where a child is 'at risk' of being placed in extended care because of safety concerns.

Rumbalara's role is to empower parents to prevent out of home placements by working through issues and linking families to appropriate services. There is a limited caseload within the preservation program allowing for intensive supports to be provided to families. All referrals to this program are via the Department of Human Services.

Appendix Four

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Attachment C

Goulburn Valley Parent Child Unit

RADNO
it's about growth

RADNO Pty Ltd
February 2013


tweddle
child + family health service
GOULBURN VALLEY
HEALTH
Caring for your Community
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Executive Summary

There is a clear and identified gap in intensive parenting services in Goulburn Valley. Specifically, there is no appropriate local residential service; families with complex needs must travel to Melbourne for support. The report outlines and advocates for the funding and development of a proposed Goulburn Valley Parent Child Unit to address this gap and to support hard to reach families with complex needs, whose needs could not be met by primary prevention and universal services.

The purpose of the Goulburn Valley Parent Child Unit (GVPCU) will be to address an extensive service gap for intensive family intervention and parenting support in Northern Victoria, a State Government priority area for investment in rural services and its Vulnerable Children's Strategy.

"Mothers dealing with severe post-natal depression in regional areas are faced with options that include traveling to Melbourne for treatment or staying without their children in an adult acute mental health facility. [Regionally based] mother-baby mental health units allow mothers to continue developing parenting skills and attachment to their babies while at the same time receiving treatment for mental illness, closer to home."

The Hon Ms Mary Wooldridge
Minister for Mental Health, Women's Affairs and Community Services

Recommendation 12 of the Department of Premier and Cabinet's **Protecting Victoria's Vulnerable Children Inquiry** states that; *"The Government should fund the expansion of early parenting centres to provide services to a greater range of vulnerable families and to improve access to families living in outer Melbourne, regional and rural areas."* The GVPCU directly addresses this call, providing a **hub that incorporates the most urgently needed aspects of parenting assistance.**

At the moment, a lack of cohesive, dedicated resources means that services and interventions are delayed or don't occur and the number of risk assessments that are completed are limited.

In mid-2012, Goulburn Valley Health and partner agencies FamilyCare and Tweddle, in association with RADNO, completed a scoping exercise for a Residential Mother/Baby Unit located in Shepparton. The extensive investigation and consultation process clearly outlined the need for a facility in the area.

The initial scoping exercise identified the need for an intensive parenting intervention service. This report builds on the initial assessment of need by providing details of a proposed new intensive parenting hybrid model. An innovative unit has been designed that incorporates the solutions offered by both the residential Early Parenting Centres and Mother Baby Units. This report provides an outline of what the new unit will contain in order to meet the needs of the community, including details on model and structure, program content, number of beds, Indigenous and community considerations, staffing, costing and implementation.

This second report is intended to be used by Goulburn Valley Health, Tweddle, FamilyCare and wider Goulburn Valley community in advocating to government and other stakeholders to seek support for the model and the funding to bring this much needed facility to a reality.

Background

In April 2012, Goulburn Valley Health in partnership with FamilyCare from Shepparton and Tweddle Child & Family Health Service from Melbourne commissioned a **Mother Baby Unit Scoping Project** to assess need and service options.

During the process of research and consultation, the Project Steering Committee articulated the assessment of need, the service continuum and service gaps, an assessment of the consequences of the lack of intensive services and a recommended service configuration for a new **Parent Child Unit to be located in Shepparton**.

Assessment of Need

Extensive consultation with community and health service providers and family/health professionals, and service mapping resulted in a finding that the Greater Shepparton and Hume regions have a concentration of vulnerable parents and vulnerable children within identified catchment areas located in the region. Vulnerability indicators (poverty, transient populations, social economic status, family violence) are considerably higher in some catchment areas within the region.

The service mapping determined that mental health and parenting services are available at the universal and secondary end of the service continuum. The consultation process determined that there is a high level of service integration and cooperation between agencies despite differing funding streams and differing professional paradigms. However, the only intensive supervised intervention available for vulnerable families and mothers with a mental illness is home visiting or inpatient psychiatric interventions for women without their infants.

Existing regionally based home visiting parenting services available under the Parenting Assessment and Skills Development program or delivered as intensive in home support is effective for families. However, there will always be a percentage of vulnerable families for whom home visiting is not effective, not appropriate or not a safe environment for home visiting staff.

There is an absence of programs for dads in the region and there are no intensive services available for fathers who are primary carers or sole parents. Indigenous families are not always attending Melbourne based services despite professional referrals to Tweddle and other EPCs. Intensive preventative residential services that are designed to prevent child protection intervention for complex family needs are available in residential (non-PASDS) programs in Metropolitan Melbourne and are not available in regional areas of Victoria.

Consequences of the Current Service Configuration

Perinatal professionals confirm that the absence of tertiary therapeutic or intensive pyscho-educational parenting services results in ‘work arounds’ that potentially harm infant and parent mental health and damage attachment. The ‘work-arounds’ include infants placed in the paediatric ward for periods of up to five days whilst professionals determine the actions in the best interest of the child. **Services are delayed,**

interventions are delayed, and critical infant brain development time is wasted as infants 'wait' for professional parenting assessment before stable parenting or care arrangements can commence. Service time is wasted as professionals attempt to deliver home visiting services to families that are unwilling to receive home visiting or are absent from the home when professionals visit.

Many families are not participating in required intervention services due to the requirement to attend a Melbourne based service and the wait lists for these services. A further professional intervention is then required to assess if removal of a child to care will occur due to the risk of infant harm. Separations of infant from parents may occur without real evidence – the ethical and necessary component of parenting assessment and skill development in an intensive residential supervised setting. When parents do attend a Melbourne based service there can be delays in communication with regional services preventing a seamless wrap around original long-term case management that ensures that parents and infants are not subject to gaps in supervision and care.

Mothers with a mental illness requiring inpatient care have two choices: inpatient care in the local community, separated from their infants, or inpatient care in Melbourne with their infant and separated from the love and support of their families and friends.

The human need that is not met by the current service landscape in this region is ensuring infant well being and optimal development of the infant within a safe parenting environment. Current services are only able to meet human needs at a non-intensive intervention level.

As a result of the Stage One research and consultation, the Steering Committee adopted a position that the recommended model for this region is a combined Mother Baby Unit/Residential Early Parenting Service.

The view of perinatal health and welfare professionals consulted is that the Shepparton based solution will be broader than the service profile of a traditional Mother Baby Unit. Their view and the key finding of this report, is that there are clear benefits and synergies that can be achieved with a combined Mother Baby Unit and a Residential Early Parenting Service.

It is the strong view of the individuals consulted in this project that a submission for a Mother Baby Unit would be a wasted opportunity to address the issues that arise from the high prevalence of vulnerable families in the region and the probability of infant harm within these families.

This scoping project outlines a case for a highly innovative service that combines the MBU and EPC service models to meet human and community needs.

This report seeks to outline the answers to the questions that were generated in phase one of the project:

1. The exact size of the facility i.e. how many families per annum. The number of parents and infants that would receive services is a difficult interplay of need and service delivery models, ensuring critical mass and optimum asset utilisation.
2. Service model – the Steering Committee is of the view that the intensive residential component can be of a reduced duration with wrap around services such as day-stay,
3. outpatient care, home visiting and group work. Home visiting services exist currently but a group work component would require design and development – a suite of service to meet the needs of a diverse community.
4. The non-residential component can include or cooperate with other services such as existing 24 hour phone support, Aboriginal health and family services and the integration of existing services.
5. Staffing issues – the Steering Committee is of the view that staffing configuration does not need to be based on the traditional MBU unit approach and would prefer to model the staffing profile on the EPC multidisciplinary team approach.
6. What is to be co-located and/or integrated? The Steering Committee is of the strong opinion that this service will fill the critical gap of intensive services for complex families and not duplicate any existing service that is meeting human need. How do these services work together and do these services need to exist in the same physical space.

Model: An Integrated Hub

The Goulburn Valley Parent Child Unit is intended to be a unique and innovative centre operating under an integrated model of care.

The diagram at Appendix One shows how the GVPCU Pathways Model works with a range of referring agencies, supports residents through intake into the early parenting service and helps them transition into other modes of care which can be placed in an adjoining hub. This unique model encompasses the whole journey of early parenting services – starting from preganancy through birth, before clients take residence, and continuing long after they go home. Existing Goulburn Valley Health psychiatry, maternity and paediatric services would work with ChildFIRST or Child Protection to refer families into the service. Community based client management will support families in the community and in their homes after residence.

Innovation

The proposed GVPCU model is unique because it integrates a number of existing services in a completely new way. The GV Parent Child Unit is not merely an Early Parenting Centre or a Mother Baby Unit; it is both. An integrated, innovative, hybrid model working from a model of human need – where the family is central.

The key to the model is to provide a flexible, integrated, child centred and family focused approach so each child, parent or primary caregiver will have a custom-built pathway in, through and out of the service. It will be flexible enough so that parents don't have to stay in longer than they need to because of funding cycles, will accommodate work commitments so that more partners can be involved, and will ensure wrap-around services are in place after their departure.

It will provide the residential service that the community so desperately needs and link families into a range of community and in-home services. It will be responsive to the range of different family and community needs. It will not stand alone, rather it will integrate with other supports a family may need. Supports will be readily accessed.

All GVPCU staff will have the qualifications, experience and skills necessary to make informed decisions regarding risk, bonding and attachment between parent and infant. Staff will be trained in evidence-based programs like the NCAST Teaching Scale to rate parent-child interactions throughout their journey. Recorded interviews and observations will provide a formal evidence base to confirm recommendations made by the GVPCU staff.

The development of a brand-new facility is not only an opportunity to deliver an integrated residential Parent Child Unit service, but also to use the site to co-locate relevant external wrap-around services. Ideally, the GVPCU will be seen as the parenting hub of Shepparton and the greater Goulburn Valley area – a place where all parents come for maternal and early childhood services – not just those in the residential unit. A children's toy library, paediatric consulting suites and family support services could all be available at the GV Parenting Hub, which could be built alongside the more intensive Parent Child Unit. Though initially funding is only being sourced for the residential component, with further advocacy to and support from the local community and council, the dream of a universal parenting hub may become a reality.

The Goulburn Valley Parent Child Unit will give the community better results and save money through more efficient use of resources. Social and family workers and medical professionals will have what they've told us they need to do their jobs better. This service will not simply replicate the services available in metropolitan Melbourne; its innovative model will ensure that families are better supported and receive prompt, local and integrated access to the help that they need.

Admission Criteria

The criteria for admission into the GVPCU will be robust and rigorous with thorough triage. This is not a service for the 'worried well'. The service will focus only on the most vulnerable in our community, with the essential criteria being that without an appropriate assessment a child is at immediate or imminent risk or beyond the Child Protection threshold.

The eligible ages of the children are birth (potential pregnancy) to four years of age with a focus and priority from birth to two. Flexibility will be demonstrated regarding age for children with a learning, intellectual and/or physical disability.

Summary of inclusion criteria:

- 0 – 4 years of age. The facility's primary focus will be on parents with children aged 0-2, however where circumstances necessitate an assessment children 2-4 will be included;
- Known to either Child Protection, Child FIRST, Enhanced MCHN or Intensive Psychiatric Services;
- Child is at immediate or imminent risk without intervention;
- Not appropriate for intensive in home services due to risk;
- An intensive holistic family assessment is required including by the courts to determine what is in the best interests of the child, removal, reunification, intensive in home supports;
- Vulnerability of the primary carer, age (children having children), intellectual and emotional capacity, family violence, social inclusion.

Summary of exclusion criteria:

- The perpetrator of significant (medical attention required) family violence;
- Individuals with a significant criminal record regarding assault of police or other professions;
- Individuals with specialist mental health needs; e.g. serious psychosis, significant self-harm, serious and non-conforming addiction and substance abuse.

Referrals

Referrals will be accepted from Enhanced Maternal and Child Health Nurse Team Leaders (or equivalent), Child FIRST Team Leaders, Child Protection Unit Managers (High Risk Infant Unit Manager or the new model equivalent) or the Psychiatric Triage Manager (Goulburn Valley Health).

Referrals can come from outside of the catchment area, but must be admitted through a Department of Human Services or Department of Health funding process e.g. Department of Community Services from NSW.

Consultation between the GVPCU Advisory Committee and the department of Human Services will determine the prioritisation of referrals based on risk and potential outcomes.

Intake

The intake process will be holistic, factoring in all members of the family, and will assess, physical, mental and emotional health. In particular it will focus on the age, stage and development of each child, ensuring that they receive the services and support they need to address any issues or delays. Different intake services will be required for those from different referral sources, with detailed referrals providing the essential information required for the family's pathway through the service. Upon arrival, every child will have a paediatric assessment – demonstrating their position regarding developmental milestones. This will identify any delays or concerns that can then be addressed immediately, and will ensure that parents are provided with a plan and pathway.

Cultural and disability awareness will be ensured through the intake process. All clients will be asked about access requirements, language or interpreting needs, and if they are interested in finding out more about Indigenous and other community services upon arrival. Each pathway that is created is unique, regardless of cultural or other diverse factors, custom made for the individual to meet their needs.

Service Utilisation

Every family entering the GVPCU will do so through a referral agency and will be funded according to either Mother Baby Unit funding guidelines or the Victorian Department of Human Services Child Protection and Child First parenting programs. Early estimates developed through the consultation process and ratified by the Steering Committee would suggest that the GVPCU has capacity to support over 370 families each year.

Whilst our calculations provide for full government funding for each bed based on the assessment of need for intensive intervention there is an additional funding source: private health insurance. As entry into the GVPCU will be based on human need and best interests of each child, it would not be appropriate for a family with private health insurance cover to receive higher priority than a family without insurance. Therefore, design recommendations include seven public bedrooms and one private health bedroom. This bed will be available for parents that are referred by their private practitioner, who will oversee their care and visit the service as a consultant, in the same way they would in a private hospital.

For further information on bed utilisation and the impacts of a private bed in the facility, refer to Appendix Two.

Indigenous Community

Greater Shepparton has a large Indigenous population; this has particular significance in relation to child health and welfare. The number of low birth weight babies is 50% higher than Shepparton's non-Indigenous population, the number of babies born to teenagers 15-19 is nearly four times higher than the non-Indigenous population, child protection orders are five times higher, and there is a large gap in life expectancy – at the 2006 Census only 12% of the Indigenous population was over 50, compared to 32% of the whole population. A residential parenting centre in Shepparton is particularly needed for the Indigenous community as families typically lack the resources to go to Melbourne, young mothers with their babies are at added risk due to travel, and family support is not available

Goulburn Valley Health, 2012
Scoping Project: Development of a Residential Parenting Unit in Shepparton

Local Indigenous service providers and community members have expressed a genuine interest and offer of being involved in the planning and delivery of the proposed new service. Community consultation was undertaken in the development of this report in order to ensure the needs and views of Goulburn Valley's Indigenous community were appropriately represented. Goulburn Valley Health welcomes the participation of Rumbalara Aboriginal Co-Operative in planning for the GVPCU.

In order for the GVPCU to be a success, to be ratified by and to start to meet the needs of local communities (identified as being one of its largest potential user groups), the project will need genuine and strategic Indigenous representation at all services and in all parts of the service decision making. This ranges from taking a leadership role on the newly established Advisory Committee and contributing to the naming and design process, to ensuring Indigenous staff members are included within the GVPCU team, as well as supporting the intake process and program delivery. The knowledge and skills of the GVH and Rumbalara Aboriginal Taskforce will be utilised in determining the process for this level of community involvement.

Cultural competency is essential to the design and delivery of the service and its program. Everyone will be treated as an individual regardless of cultural background – this begins from the intake process and continues throughout the pathway. It is anticipated that the GVPCU team will include Aboriginal health professionals working collaboratively with agencies, especially Rumbalara.

Indigenous families will be integrated into ongoing service programs, rather than through specific cycles. Architectural consultations will ensure the GVPCU is a culturally appropriate, with welcoming spaces and rooms will be designed to ensure that extended families can visit or stay.

Broader health initiatives such as 'Closing the Gap' will be built into the program framework, e.g. through addressing substance abuse issues and financial planning workshops. The steering committee has agreed the next step in the journey will be to ensure Indigenous representation on the Advisory Committee.

Design

A number of design recommendations have been prepared as the start of an architect's brief for construction of the GVPCU. These can be found at Appendix Three.

The design will be as pragmatic as it is flexible. It will be both secure and welcoming, offer assistance without feeling like an institution, and create a supported, home-like environment.

Construction of the PCU will address more than the physical building itself. The facility will also be integrated into the community and positioned as a place of healing, help and support. Privacy and natural light are both important considerations for bedroom spaces, and the facility will include communal dining, play and outdoor spaces. The facility itself will be centrally located nearby to places to eat, shop and play.

Community participation in the development of the centre will be encouraged both through consultation and through the projects such as a community garden or children's artwork competition.

Staff

Residents will be cared for by an **experienced team of professionals,** made up of GVPCU staff and external sessional experts, as well as receiving support from wrap-around services and case managers. A Psychiatric Nurse and Early Childhood Professional will be in the building at all times to ensure the safety and wellbeing of all clients and staff.

The Parent Child Unit will be a division of Goulburn Valley Health with expertise from other external agencies subcontracted into the centre, ensuring clients' needs are met by appropriately-skilled health professionals.

The range of expert practitioners available will create economies of scale with a pool of nurses and other professionals available in a central location. The service will work with staff from existing providers like Rumbalara to ensure the GVPCU team is as diverse as the families it looks after. There will be a Rumbalara staff member working inside the GVPCU facility. Funding will be sought for a scholarship fund to support Psychiatric Nursing training for Indigenous and other CALD groups like the local Afghan and Sudanese communities, a recognised need in the area.

Programs

The GVPCU programs will not only assist in engagement, developing life skills and healthy support networks but will also provide assessment opportunities for practitioners and provide children with a safe, supported and nurturing environment.

Three sessions each day will be designed to establish a routine that families will be able to transfer upon discharge into their family home. The focus of the programs is on parenting skills, therapy, demonstrating the importance of play, bonding and attachment and how this delivers routine and appropriate boundaries. For an example of program rotation, see Appendix Four.

Each of the programs will have an operational component but will be underpinned by the importance of bonding, attachment and therapeutic practices. For example, Primary Care programs will look beyond the operational basics of parenting skills by seeing the action of bathing a child as an opportunity to develop the parent-child bond as well as a therapeutic experience for both parent and child.

Many GVPCU parents have themselves had traumatic childhoods and have not learned or experienced the importance of routine and positive attachments until they witness the impact that it can have on their child.

The GVPCU will model the types of behaviours and interactions that it wants parents to implement in the family home. Through demonstrations by expert staff, even reluctant families will be shown the benefits of such practices as increased routine and boundaries, improved behaviours and settling and creating a calm and relaxing experience for all.

It will not be possible or practical to deal fully with complex and ingrained problems during periods of residence. The programs and activities undertaken whilst in residence will explore the relationships between issues such as financial stress, substance abuse and family violence, and will provide simple examples, demonstrations and participatory exercises to address these. In planning for discharge, family support plans will be developed designed to meet any skill and support gaps that are identified.

In order to provide continuity and to build on existing relationships of trust, the case worker allocated to a family prior to referral to the GVPCU will continue to be engaged in family's support post-discharge.

Transition

The GVPCU is the body that links up the entire client journey. It is not merely a centre which starts at 'intake' and finishes at 'discharge'. Individual pathways ensure clients are transitioned out of the residential component of the journey and into other external services that meet their ongoing needs, which may be located within the parenting hub.

Consultation with current service providers identified a need for continuing 'mentoring' as a key component of this transition process. Clients may be engaged with during pregnancy and after admission to a GVPCU services, and will be followed-up and monitored to ensure continual growth and development in accordance with the goals and objectives identified in their pathways plan. Mentors and other support staff will be engaged to assist clients in their identified areas of need, enabling them to lead self-sustained lives while still receiving adequate support.

Governance

The Goulburn Valley Parent Child Unit is to be owned and operated by Goulburn Valley Health. The operations of the GVPCU will therefore be the responsibility of GVH and the entity will become an operating unit of the hospital and will be subject to the governance by-laws of the hospital. There will be no requirement for a separate governing board. However, as a multidisciplinary unit, the entity would benefit from the establishment of a GVPCU Advisory Committee that is ultimately accountable to the GVH Board of Directors. Draft Terms of Reference for the Advisory Committee can be found at Appendix Five

The GVPCU Advisory Committee will be comprised of the project partners and will allow for key stakeholders to bring their sector expertise to advise how the service can best deliver for both clients and funding bodies, as well as facilitating shared clinical governance arrangements through a Memorandum of Understanding between the agencies. While smaller services may be incorporated into the Parenting Hub, it is recommended that the Advisory Committee be comprised of the four major service agencies:

- Tweddle Child & Family Health Service
- FamilyCare
- Goulburn Valley Health
- Rumbalara Aboriginal Co-Operative

It is important to note that this group will be overseeing the operations of the GVPCU – particularly the use of the facility, the client mix and the fulfilment of funding conditions. There is an active Goulburn Valley Best Start/Early Years Partnership committee that considers broader issues including the cooperation between services, and the changing demographics of the region. This committee enjoys a remarkable level of goodwill and cooperation, and it is important that the GVPCU Advisory Committee does not inhibit the value of, or duplicate, the work of this committee.

Costing

Capital Costing

These approximate establishment costs are a minimum number for what is required for the GVPCU. Not included are fit-out costs, utilities and architectural expenses. A more formal and complete capital costing will be conducted in consultation with an architect, once the specifications and design are agreed upon – these figures are educated estimates that have been developed in consultation with local real estate agents and the Master Builders Association.

Initial capital costing for the GVPCU addresses two key components; land purchase and building costs. The approximate funding requirement for land and buildings is calculated at $924,740, subject to fluctuations in formal land and construction costs. These costs have been estimated by real estate and property professionals in the region.

There is a need to obtain funds for the fit out of the facility including outdoor landscaping and equipment, approximated at $500,000. It is proposed that the Advisory Committee engages in a dialogue with government regarding a shared funding agreement for such costs.

Item	Specs	m2	Number	Cost
Block of Land	Minimum 2 Acres, Close proximity to town centre & public transport	8093.71	1	350000
Construction				
Bedroom	3.6 x 2.9 m	10.44	8	125280.0
Baby Space	3.6 x 1.7 m	6.12	8	73440.0
Ensuite	2.2 x 1.9 m	4.18	8	50160.0
Communal Laundry/Nurses Statio	4.8 x 4.2 m	20.16	2	60480.0
Consultation Suite	3.6 x 2.9 m	10.44	3	46980.0
Observation Room	3.6 x 4.6 m	16.56	2	49680.0
Communal Kitchen/Dining Space	5.2 x 12.6 m	65.52	1	98280.0
Entrance/ Administrative Area	3.6 x 4.2 m	15.12	2	45360.0
Bathroom/ Toilet	2.2 x 1.9 m	4.18	4	25080.0
	Sub-Total			574740.0
Total				**924740.0**

Recurrent Costing

The recurrent costing assumptions have been formulated from a demand as opposed to a supply position. Rather than calculating the individual cost of the numerous components that make up the GVPCU, we have assessed the potential funding that can be delivered to achieve human outcomes and looked to work within that framework.

While at present funding is delivered on a rate per program or daily rate of stay, the GVPCU's innovative pathways model proposes that government contracts the centre for human outcomes and funds for these results as opposed to a fixed cycle. However, in order to project a proposed recurrent figure, we had to utilise current funding schemes to obtain a basis for calculations.

- MBU funding guidelines: Efforts to attain a 'general' price or funding indication for patients admitted to acute programs through Goulburn Valley Health and funded under DRG or WIES proved problematic as there is great difficulty in attaining a consistent amount when clients often enter through different streams with various diagnoses.

- EPC funding guidelines: Estimates from Tweddle's finance department arrived at funding approximations of $13,000 per 10 day PASDS program and $1150 per day for the Early Parenting program.

Based on these figures as well as our own utilisation assumptions found earlier in this report, we would anticipate a funding figure of approximately **$2,663,400 per annum**. This figure, when extrapolated to factor in added psychiatric and paediatric costs, indicates a band from **$2.8million to $3.2million.** A recurrent funding figure of this amount equates well with other services such as those offered by Tweddle and GVH; delivering an innovative service, achieving human outcomes, at an improved rate.

We are recommending a recurrent expenditure bid that would see the GVPCU receive an amount per family based on EPC/MBU funding guidelines; this funding structure is financially viable and beneficial. The PCU will be able to work within the existing per head funding model for Mother Baby Units and Early Parenting Centres because:

- The GVPCU presents a flexible model which can switch between EPC/MBU clients on a needs basis, ensuring optimum utilisation rates
- Funding for the EPC is based on an assumed length of stay. PASDS funding assumes a 10-day stay, EPC residential assumes a 4-5 day stay.
- All of these days may not be utilised as residential service delivery, but the full schedule funding will be accepted. The GVPCU model would see the same human outcomes achieved with a '2+6+2' mode; 2 days assessment/support + 6 days residential and 2 days group work or day stay. This is representative of the flexibility of the individual pathways model.
- Economies of Scale can be achieved through back office support from Goulburn Valley Health and the availability of paediatricians, psychiatrists, hospital management, kitchen staff, cleaners and access to the GVH bank of nurses.

The innovation of the GVPCU model is that it is not a fixed service regardless of the family needs or presenting issues. The PCU addresses the need for a flexible service system that accommodates families, but also works within the framework of the needs and requirements of funding bodies. If a family is referred in for a PASDS (a typical 8 – 10 day service) but after a 2-day assessment that identifies minimal risks and no need for an intensive residential service; then they will be discharged. This will allow another family to access the service, meeting both their individual need as well as community demand - increasing the service utilisation as well as providing a more comfortable journey for the family who are able to continue with in home support services. Similarly we know from consultations in the sector that professionals know within a 48 hour period if the residential intervention will be effective in keeping a family together. Where there is evidence that a further 6 to 8 days will not improve the situation i.e. will not reduce the risk to the child, it is within the design of the PCU to discuss early discharge and separation of the child with DHS.

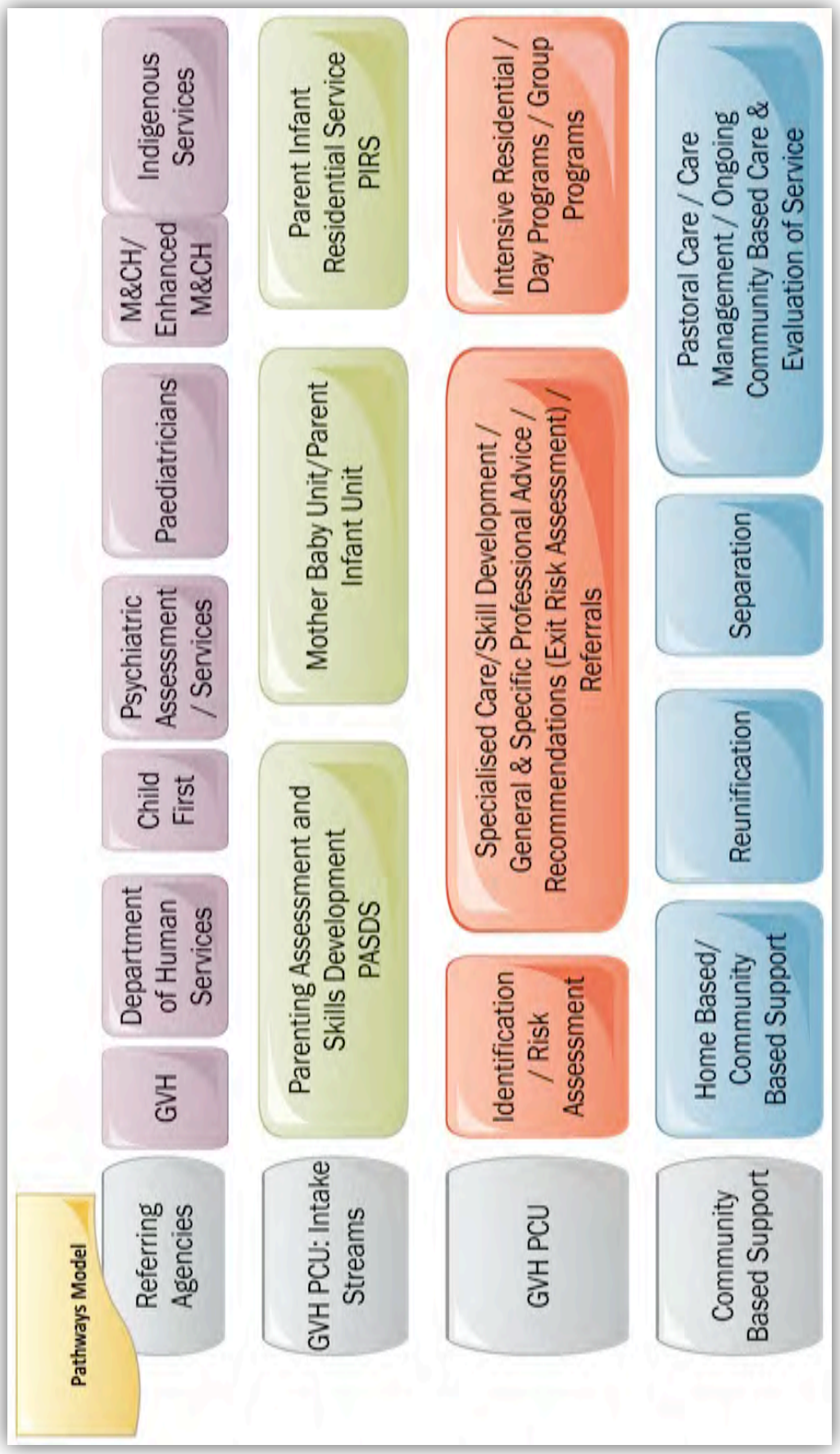
It is not a good use of funds to require every family to undertake 10 days of residential stay where the outcomes are not likely to be improved by a further 8 days of intensive support. Where the traditional model delivers 10 days for every family referred into the PASDS program, the PCU will have a 2 + 6 + 2 as a working model that will be adapted to the needs of each family. We are able therefore to discharge the family after 2 days, to discharge after 8 or, if necessary, to dischagre after 10. The program will be designed to enable this flexible model, and for the PASDS clients, DHS staff will be involved in dialogue before and during admission regarding optimum length of stay.

Discussions around percentages of funding obtained for outcomes as above, which are delivered short of standard program delivery cycles and their implications, will have to be discussed further and negotiated with the department - but this flexible service model is in the best interests of all parties.

It is essential that in order for the GVPCU project to proceed, each partner agency must take on an active role in advocating for the service. Goulburn Valley Health, FamilyCare, Tweddle and Rumbalara must finalise the model and the organisational aspects of what the service will look like.

Once these elements are in place, the GVH Board of Directors must drive the process. A number of prominent advocates for the service may be identified, and these advocates can ensure that stakeholder sign-on is achieved from government, notably the Greater Shepparton City Council, Department of Health and Department of Human Services. Finally, lobbying of individual members of Parliament at a state and federal level will ensure this project has the backing required to proceed.

Appendix One: Pathways Model



Appendix Two: Service Utilisation

These numbers are not perfect – they are figures estimated by a variety of sector and region experts and have been based on the unit being a 7-bed facility. Provision for an 8th private bed has not been considered in these calculations.

	Number	Days	Total
Beds	7	365	2555
	Families	Avg Stay (Days)	Total
Parent Infant Residential Service	234	4	936
Mother Baby Unit / Parent Infant Unit	46	14	644
Parent Assessment and Skill Development Service	92	8	736
TOTAL			2316
Target Service Utilisation		2316/2555	90%

There will be a variation in the number of family members admitted; the facility will allow for adjoining rooms to be utilised by one family and this will affect the utilisation rate. At this stage the number of times this is likely to occur is unknown.

The Parent Infant Residential Service will operate in a manner similar to PASDS however does not include an assessment phase. This service will be referred through family services and not through Child Protection.

It is not anticipated that there will be high demand for a private service, however this funding source will not be ignored and the facility can be designed in an innovative manner to ensure that space is not wasted on a bed that is not to be occupied with same high utilisation rate that is expected for the public bed. The private bed will be a flexible space that is utilised for other purposes when it is not utilised by a private patient: There is an expectation that the standard bed arrangement may be insufficient for large extended families. In some instances it would be appropriate to admit more family members that the two parents plus the infant. The private bed can be established with a partition wall to allow this room to be utilised for an extended public bed when it is not used for a private patient. The public programs will support seven families and there will be flexibility to use the eighth room as an extended family room or to be seperate for the private patient.

Appendix Three: Design Considerations

The House

- 8 bedrooms, so that each resident has their own private space, ensuite, natural light, and room for other infants, partners or family members.
- Two different bedroom designs (one with a separate nursery and one without) will allow residents to replicate their home sleeping environments. Adjoining rooms will have secure, sound-proofed internal doors or retractable walls to allow families with multiple children to occupy one space.
- Room sizes have been estimated at a minimum: 3.6 x 2.9 for Parents' Space, 3.6 x 1.7 for Baby Space and 2.2 x 1.9 for ensuites.
- All bedrooms will contain a cot, drawers and robe, change table, nursing chair and queen size bed.
- 4 rooms will be made fully secure and separate to cater for families in different situations.
- Suggested layout with rooms structured in a circular design, with high use of glass in common areas and a central area for staff to increase visibility.
- Enviornmentally smart, using he best available technology to minimise the facility's environmental footprint.
- An open green-space area to include seating, dining and play spaces and a vegetable garden.
- Video conferencing and recording facilities to ensure innovative, robust and evidence based practice.
- One or two larger multi-purpose rooms that can be used for programs, education, quiet-spaces or visits from larger family groups.
- Staff and common areas will be included as well as stations for nurses working long shifts.
- Two consultation suites for meetings and clinical services to come on-site. These rooms will have a separate entrance so visitors are not required to enter the main facility. Residents will be ensured privacy and respect by placing consultation suites away from common area, giving them confidentiality and discretion as would be granted in their own home.
- Opportunities for formal assessment using observation rooms with two-way mirrors and informal supervision in more naturalistic settings.
- Communal kitchen and dining areas so residents have the choice to self cater and so staff can monitor the families' safety and diet. Residents will also have the ability to attend basic cooking or nutrition classes.
- Communal laundry facilities will also be available so residents can start building capacity around daily routines for after they leave.
- Fully secure entrance with perimeter safety and ability to lockdown if necessary.
- Back entrance for ambulance and emergency access.
- Secure staff and storage areas.

Positioning

- A minimum land size of 2 acres is required to properly house the GVPCU. A space of this size will adequately accommodate all the required specifications and facilities while allowing room for potential growth.
- A location that is walking distance to playgrounds, shops, places to eat and play, and public transport.
- A site and a design that can accommodate the residential centre as well as a new parenting hub, and that can grow up or out if demand increases.
- Plans based on the principle of universal design, so that all of the shared and work areas are fully accessible and at least one of the family suites has additional access supports permanently built in to provide for either parents or children with disability.
- Consideration of the ecological footprint and how the building can be as self-sustaining as possible, building solar panels and water tanks into the architectural plans.
- Inviting the local community to take ownership of the service and giving them opportunities to get involved during construction, such as through a children's artwork competition or organic vegetable garden project.
- Involving the local Indigenous community in architectural conversations to make sure all of the spaces are welcoming and culturally appropriate, and to find a name for the service in language that can inspire the rest of the design. Local elders will also be asked to conduct a Welcome to Country and smoking ceremony at a public launch.

Appendix Four: GVPCU Weekly Program Example/Sample

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Morning							
Afternoon							
Evening							

Play Group (physical, musical, art)
Relaxation Group (music, reading)
Importance of Routine (how to establish a routine)
Primary Care (changing a nappy, preparing a bottle, bathing a child)
Importance of Play (how to engage a child in play)
Importance of Self-Care

Appendix Five: Recommended Terms of Reference for the GVPCU Advisory Committee

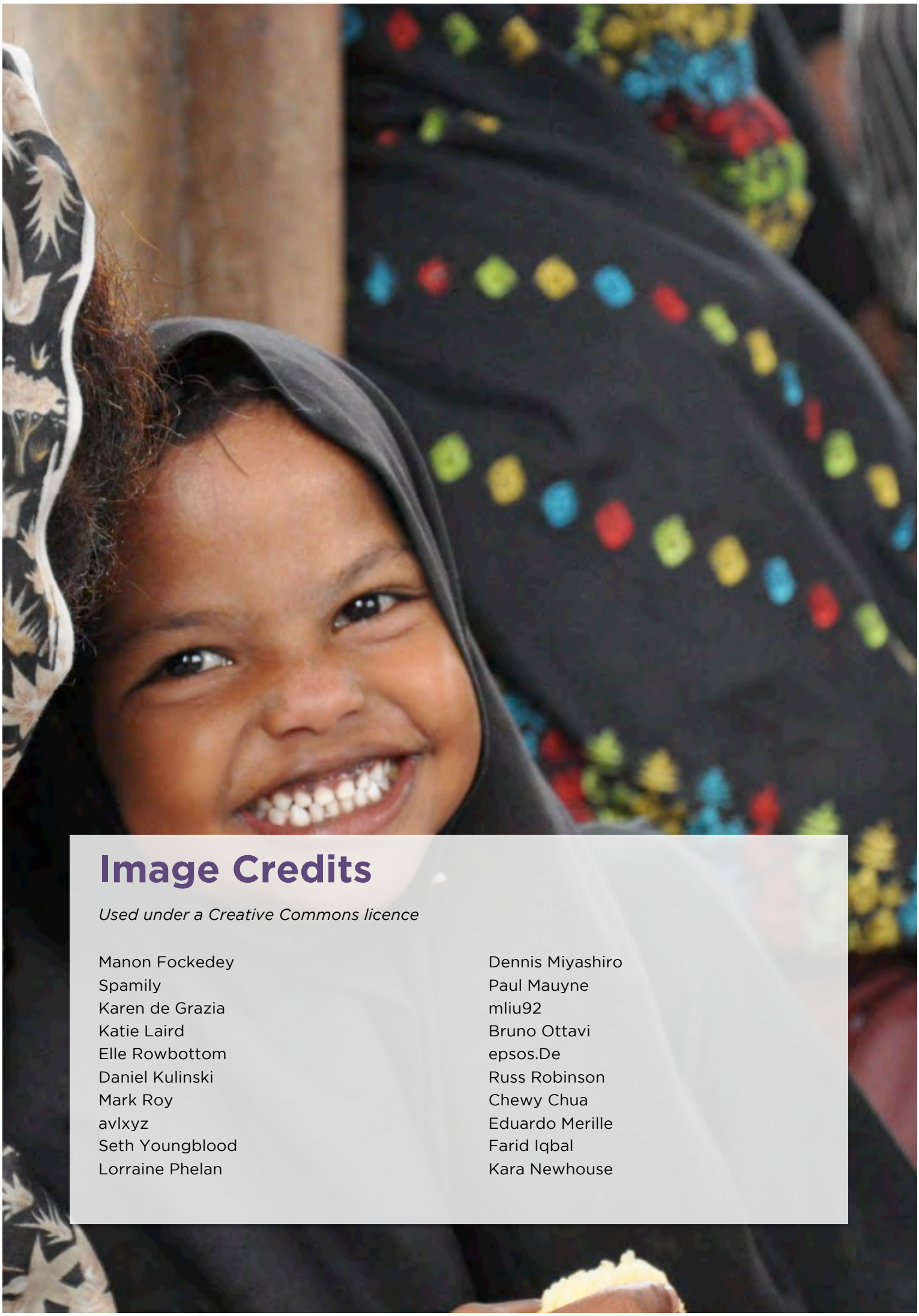
The GVPCU Advisory Committee shall meet bi-monthly to provide oversight to the work of the Parent Child Unit.

The Advisory Committee will receive regular reports on the activities of the GVPCU and monitor the degree to which the service is meeting the requirements of funding guidelines.

The Advisory Committee will also monitor and evaluate issues such as:

- Referral pathways
- The client mix: program mix and demographics
- The catchment – the geography of the client base, where are these clients drawn from?
- The effectiveness of the service: monitoring regular evaluation of client outcomes and seeking research partnerships to evaluate the effectiveness of the services
- The level of cooperation between the service providers and the degree to which the GVPCU facilitates integrated service provision
- The GVPCU Advisory Committee will develop a three year strategic plan to allow for future development and expansion of the service that would enhance the ability of the GVPCU to support families in the region.
- The GVPCU Advisory Committee will be responsible for managing Memorandums of Understanding with partner agencies that feed into the GVPCU.
- Providing annual reports to the GVH Board of Directors and reporting the outcomes of the facility to the public.

The issue of clinical governance will be complex for the GVPCU. The expertise for clinical governance and supervision will rest with the partner agencies on the Advisory Committee. Questions of responsibility and supervision must be considered by the Advisory Committee in order to ensure the effective and successful operation of the facility.



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