The Council for the Care of Children

SUBMISSION

The Case for Change

Proposing and Enhanced Service Delivery Framework for the Child and Family Health Service Discussion Paper

17 June 2016

The Council for the CareofChildren

Government of South Australia

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SUBMISSION

The Case for Change: Proposed Enhanced Service Delivery Framework for the Child and Adolescent Family Health Service (CaFHS) Discussion Paper

Thank you for providing the Council for the Care of Children (Council) with the opportunity to provide feedback on the Discussion Paper. The Council's comments are offered in the spirit of goodwill, collaboration and with a focus on improving the outcomes of young children in South Australia. These preliminary comments are provided in anticipation of continued partnership and opportunities to comment on the actual draft Child and Family Health Service Framework.

Principles

The Discussion Paper outlines a set of five service delivery principles upon which current service delivery is based. These are *child-centred, culturally responsive, contemporary, coordinated, consistent* and they appear to be, at the heading level, well founded. It is assumed that these important principles may remain to underpin a redeveloped service delivery system.

The Council feels there is potential to re-examine the principles, possibly to include a sixth – *partnerships*, an important element in policy priorities eg the South Australia Strategic Plan, or alternatively, to replace the principle headed *coordinated* with *collaboration* or *partnerships.*

Use of the term *coordinated* emphasises a technical approach to service delivery, rather than an approach that is child and family-centred, more personalised, and focuses on the people and relationships involved in working with various agencies and families. This would signal explicit recognition of building on strengths within families, and capitalise on the skills of a range of professionals from different disciplines working together.

Reframing the explanation for some of the principles would be of benefit, especially in relation to portraying contemporary views of families and the strengths that they bring. It would again fit with the South Australia Strategic Plan including the priorities of Safe Communities, Healthy Neighbourhoods and Every Chance for Every Child.

In the interest of true partnership and continuity of care, reframing should also respectfully acknowledge the diversity of child-rearing contexts, cultures and practices in this State and the potential for strong partnerships with other agencies that do things *with* parents/carers and children rather than *doing to* or *doing for*.

The United Nations Convention on the Rights of the Child provides guidance regarding the needs, rights, wellbeing and outcomes of children, including:

Article 3 *All organisations concerned with children should work towards what is best for each child.*

Article 6 *Children have the right to live a full life. Governments should ensure that children survive and develop healthily.*

Article 18 *Both parents share responsibility for bringing up their children and should always consider what is best for each child. Governments should help parents by providing services to support them, especially if both parents work.*

Article 19 *Governments should ensure that children are properly cared for and protect them from violence, abuse and neglect by their parents or anyone else who looks after them.*

Article 24 *Children have a right to good quality health care…so that they will stay healthy.*

Article 26 *The Government should provide extra money for the children of families in need.*

Article 33 *Governments should provide ways of protecting children from dangerous drugs.' (*Unicef, www.unicef.org.au).

Equity and engagement

It is the Council's view that the current CaFHS service model that enable children and families to engage with CaFHS on a voluntary basis should be retained and that any moves to introduce statutory requirements should be resisted. Statutory powers would change the nature of CaFHS as an organisation, its relationship and its engagement with families. Most importantly, statutory powers would not encourage engagement by families who face vulnerability factors that hinder their engagement at present. However, the Case for Change initiative represents a unique opportunity to provide all babies born in South Australia with an equitable start in life, to the greatest extent possible, to improve their outcomes and to provide incentives that will encourage families to connect with services.

The Council recommends that consideration be given to the introduction of a concept similar to a 78 year old Finnish tradition in the form of a 'baby box'. In Finland, the baby box, available as a gift from the government, is a symbol of the idea of equality and of the importance of children and it encourages families to engage with services. The baby box, with its fitted mattress in the bottom, provides a safe and clean first sleeping environment for a baby The baby box contains a starter kit of bodysuits, a sleeping bag, bathing products for the baby, nappies etc. Please refer to attachment 1 for more information and photographs about the Finnish baby box.

A more recent initiative worthy of consideration is the Pēpi-Pod® Program which promotes safe sleeping and aims to reduce the risk of sudden unexpected death in Aboriginal and Torres Strait Islander babies. The Pēpi-Pod® Program has originated in New Zealand. A core element of the programme is the concept of a 'pod' (which may be similar to that of a 'coolamon'[1] traditionally used in Australia to carry water, food or babies). The Pēpi-Pod® Program is being trialled in some Australian sites as a preventive health initiative for safer sleep environments. Please refer to attachment 2 for more information and photographs about the Pēpi-Pod® Program.

[1] A coolamon is a shallow, canoe-shaped dish measuring up to 70 cm, usually made out of wood.

Question 1

What do you see as the main strengths of the draft framework?

The Discussion Paper uses the 'Five by Five' framework as a key reference point and makes a strong case for the provision of parenting support to 'families', screening, and ante-natal engagement. This is supported as a foundation for CaFHS' future work because of its sound research base and the opportunity to gain a consistent understanding of children's development in this State. The strong evidence based foundation of the document is a key strength. It might be worth considering again the Strategic Plan for S.A. and the role of Data SA as part of this evidence base.

The economic benefits and social obligation of society to focus on the early years of life and the emphasis on the strong history of South Australia in focusing on early childhood development are acknowledged.

In setting out the context, the Discussion Paper flags the focus of the framework in building strong foundations for children's long-term health and wellbeing. However there is little acknowledgement that robust and accessible health services delivered in concert with a range of other early childhood and family services also provide a foundation for educational outcomes.

The Discussion Paper recognises that parents are key to supporting successful child outcomes and that parents have diverse needs requiring different support strategies. This is commendable. However, a strong focus on families can be at the expense of a focus on children, including their best interests and outcomes, and the Council recommends that this matter be given careful consideration to ensure the focus is indeed one of child-centredness.

Although children frequently live in the context of families and communities, especially in Aboriginal families and communities, this is not always the case. Regardless, their separate needs, rights, wellbeing and outcomes must be identified and recognised alongside those of 'families' (especially as the term 'families' can be applied to a household or group of two or more adults where no children are present).

The Discussion Paper is to be commended for its recognition that children in South Australia are not developing equitably, and that environment or context play a significant role in affecting development. However, there appears to be an implicit 'deficit' rather than 'strengths based' orientation in the document.

Question 2

In you experience, does the draft framework as described meet the needs of all families? If not, which families are not represented and how could they better be supported?

The very first service delivery principle of the draft framework is *child-centred* and the Council strongly supports this emphasis. However, the focus of the draft framework does not reflect a child-centred approach. The Council recommends that careful consideration be given to what is intended by the term 'child-centred approach' to ensure that the focus of any subsequent papers and the service model is indeed child-centred.

The main access point to services in the Discussion Paper appears to be the universal contact visit (UCV). This may also imply that the framework is directed at first time parents, particularly those who give birth in hospitals, and lacks flexibility in terms of entry points. In the absence of multiple entry points, it would appear that the parent(s) of children who have not been identified may include those parents who:

- do not have contact with a general practitioner
- live in rural and remote areas
- are homeless
- avoid contact with services and/or refuse the UCV
- live with disability including cognitive impairment
- are under the care and protection of the Minister
- have premature babies or babies with disability and/or serious health concerns that have a long stay in medical facilities after birth.

Ways to proactively reach out to parents to ensure they can comfortably access an appropriate level of services and support at any time should be considered.

The Discussion Paper does not adequately acknowledge the role of fathers and other partners in child-rearing. As such greater acknowledgement could be made of the real diversity of family forms with accompanying sets of diverse needs. The framework implies a response only to the traditional role of biological mothers, with service responses such as ‘eMum’ being seen as explicitly exclusive. There is silence on understanding diverse child-rearing practices of newly arrived families. This would be seen as a significant gap in any service delivery model.

The matter of economic hardship facing many families does not appear to be explicitly identified as an issue although it could be claimed that it is implicit in many of the ‘entry points’ for services. The Discussion Paper could benefit from a more explicit recognition of the issues of unemployment (chronic and inter-generational in many instances). The related matter of social dislocation, and its impact on the wellbeing of the young and the most vulnerable, needs be identified. To meet the needs of all families consideration could be given to more explicitly identifying this element particularly as it impacts on the health of very young children as evidenced by a raft of national and international research.

Section, 5.4.2 on page 23 gives the impression that there is only one context for Aboriginal people rather than many contexts and cultural practices, although this is more accurately stated in the *Recognising the Strength of Culture Discussion paper* (Culture Paper). The Discussion Paper does not acknowledge the strengths that these parents bring to child-rearing and the need to build on that. Furthermore, there is no recognition of how other services (eg childcare, children’s centres, Learning Together or playgroups may be players in the enhanced service delivery system which is the focus of the Culture Paper.

Question 3

Are there any issues that this draft framework doesn't address (bear in mind that operational details will follow)?

Given that *Five by Five* appears to be the benchmark for the draft framework, it would be appropriate to identify broad outcomes for children for each of the five levels. This would be helpful in terms of evaluation and reporting on effectiveness and in terms of children moving between levels, depending upon need and circumstances, and also exiting from the levels.

It might also be helpful to have case studies in either the framework or in accompanying documentation with examples of children from birth to five years entering the model, moving between levels and exiting the model.

The draft framework appears to extend the reach of CaFHS to children from birth to five years. In the absence of modelling of demand, capacity, staffing and other resources, and training requirements, it is not apparent how this will be achieved at an operational level. However, the Discussion Paper does not indicate if an analysis of CaFHS' strengths and weaknesses has identified that it already has the expertise, resources and capacity to extend service provision and support to children from one to five years, and if not, how this will be achieved. It would be of great concern if already-stretched services for children under 12 months and their parents are stretched further.

Greater emphasis should be given to the development of a culture-friendly workforce which is an imperative in a multi-cultural society such as that in South Australia. The workforce strategy should include clearly articulated goals for recruitment and retention. In doing so, specific attention should be given to increasing the numbers of Aboriginal and Torres Strait Islander staff by providing training, supervision and support (eg through coaching or mentoring and 'buddy' schemes). It is not sufficient to recruit well, as staff must also be trained initially and ongoingly and be supervised and supported appropriately and adequately.

While acknowledgement of Aboriginal people is paramount there is no recognition of the diversity of cultures in South Australia and how responses will be made to that diversity.

The framework certainly touches upon the matter of mental health but links with national frameworks eg the Roadmap for Mental Health Reform 2012-22 could be more directly linked with the South Australian scene. Again, there is an implicit 'deficit' focus in the writing, and the document could benefit from a stronger strengths-based focus taking into account wellbeing ie the document might benefit from a stronger focus on enhancing and promoting wellbeing and health.

Consideration is given to emerging technology in the delivery of health care but it really only receives a sentence or two and any forward thinking framework simply cannot overlook the role of technology in the delivery of services. It is strongly suggested that much greater and more careful consideration is given to this aspect of the proposal. This aspect has significant implications for rural and remote families and their young children.

Question 4

Are there any risks associated with this draft framework?

Consistency in data collection and reporting is crucial. It is important to address harmonisation of evidence-based indicators across all Australian jurisdictions in the interest of gathering consistent evidence longitudinally for comparison purposes and to inform population based strategies and future funding allocation. How this fits with the focus of Data SA, the South Australian Government Data Directory, is not clear.

The 'bubbles' model on page 22 of the framework is of concern in terms of the proportions that have been identified for levels I to V. It is not clear on what basis it has been determined that only 2% (n=400) of children will require the highest level of support (level V).

If the framework is intended for all children from birth to five years, keeping in mind that a child's parent(s) may experience complexities, risk and chaos and fluctuating capacity when the child is three or four years old, the overall numbers and proportions might be different.

The framework assigns levels of service delivery on the basis of a cluster of parental indicators. It can be argued that the indicators of *levels of psychosocial distress* and *ability for reflective functioning* do not always coincide as described in each level.

The framework is very linear in its structure, fitting parents into a given level and appearing to assume that parents will pass through levels. This does not reflect how families, and parents/carers in particular, work. Rather, factors affecting the care of children are fluid and demand multiple, dynamic and congruent responses.

In addition to the implied linear progression for parents, there is an assumption that children progress from one service to another, rather than using a multiplicity of services concurrently. For example, the mention of *Learning Together* as a program into which children will progress from CaFHS services indicates a facile understanding of the program, its intention and its capacity.

There is sparse mention of services for children, other than those offered by CaFHS (eg Children's Centres). This foreshadows a possible risk that CaFHS may not succeed in collaborating with a range of other service providers and therefore miss opportunities to deliver a well-coordinated and efficient service in concert with others.

It may not be identified as a 'risk' as such but the document reads as a very 'urban' or metropolitan focused document. It is strongly suggested that the matter of remote and rural families and the particular issues they face in accessing and receiving services needs significantly greater consideration.

Question 5

Supporting families with a range of parenting barriers is complex and will require a joined-up, multi-agency approach. Are there any opportunities that you are aware of to increase our partnership work?

Article 24 of the United Nations Declaration on the Rights of Indigenous Peoples provides that Aboriginal people have the right to access health care and social services without discrimination. This is mentioned in connection with the 'Recognising the Strength of Culture' Discussion Paper which identifies the proposed enhanced service delivery framework as an opportunity to fully integrate services for Aboriginal children (and families) and the Council supports this notion.

Nevertheless, it is the view of the Council that, by core principles and elements not *also* being embedded comprehensively in the primary Discussion Paper (in addition to the separate paper), it loses weight. Not being integral may affect proper implementation and detract from a strategic opportunity to change organisational culture and to ensure that Aboriginal children and families are at the core of any future service model.

There doesn't appear to be a strong focus on integrated, holistic services eg for children who are involved with Families SA or the National Disability Insurance Scheme (NDIS).

The emergency of the NDIS needs serious consideration in the framework with particular consideration for groups who are especially vulnerable eg in remote and rural areas. It is also not apparent from the Discussion Paper how referrals will occur.

Generally, given that it is widely accepted that children's earliest development includes health and wellbeing and learning from birth, it is crucial that partnerships with a range of providers are developed. It will be important to design partnerships with potential partners from the outset if the intention is to establish complementary provisions.

Question 6

Are there any further comments you'd like to make regarding this framework?

Once again, thank you for providing the Council with the opportunity to comment on the draft framework and the Council is available to continue to work with CaFHS in the development of the new framework.

There appears to be some inconsistency in the use of definitions around early childhood in the Discussion Paper. For example, it seems that the 'early years' may generally be referring to the phase of life from birth – to five years (b-5) based on the Five by Five framework.

Section 4.3 of the Discussion Paper implies that the early years may refer to a segment of the b-5 phase in stating '*It supports families with children from birth up to five years of age with a focus on the early years.'* Given that international definitions often identify the early years as birth to eight years it would be useful to include a definition in subsequent papers to avoid unnecessary confusion.

The Discussion Paper sets out its purpose early in seeking to develop an 'enhanced' service delivery framework. It is not clearly expressed whether the enhancement applies to the delivery of the current activities or a wider intention for more significant change, possibly including the fundamental principles and orientations underpinning program delivery. Later, in introducing the framework, it

is clarified that the ‘enhancements’ apply to the components of existing service delivery rather than a fresh look at the underpinning principles.

The Discussion Paper is very statement oriented, and whilst noting that operational detail will follow, it is not readily apparent what is going to change.

There is no apparent specification of how this framework advances new knowledge and understanding of the delivery of health services for the youngest and some of the most vulnerable members of our communities.

The framework reads as a rather ‘reactive’ document lacking a ‘future’ orientation that anticipates the significant changes and challenges that families with young children will face in relation to emerging technologies and the delivery of health care.

The section on consultation identifies a large number of consumers have been involved in various consultations about specific issue to date. It is not clear however, how consumers have been or will be involved in consultation.

About the Council for the Care of Children

The Government of South Australia established the Council for the Care of Children in 2006 under the *Children's Protection Act 1993* and the Council's functions and responsibilities extend to all children and young people in SA from birth up to 18 years of age.

In looking out for children and young people across all communities and sectors in South Australia ('SA'), the Council advises government and others, and works collaboratively with state and national stakeholders, with the aim of ensuring children and young people in SA are cherished, nurtured and respected.

Broadly speaking, the Council's role in SA can be summarised as:

- advocating for and supporting the active participation of children and young people as valued citizens
- improving outcomes for children and young people by providing expert advice to government on their rights, needs and interests and the implications for policy, practice, and research
- raising awareness of issues impacting on children and young people
- monitoring the wellbeing of children and young people from birth to 18 years of age
- promoting the wellbeing, safe care and development of vulnerable children and young people (especially those with disability and/or under the guardianship of the Minister and/or who are Aboriginal or Torres Strait Islander).

One of the South Australian Government's seven key priorities is priority no 4, *Every chance for every child* which refers to all children and young people in SA up to 18 years of age. *Every chance for every child* aims to provide children and young people with the best possible start in life and to assist families to provide the best possible support for their children.

The Council supports *Every chance for every child*. This strategic direction is well-aligned with the Council's legislative mandate in SA and with the principles of the international human rights instruments which Australia upholds including the:

- United Nations Convention on the Rights of the Child
- United Nations Convention on the Rights of Persons with Disability
- United Nations Declaration on the Rights of Indigenous Peoples.

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Attachment 1

Why Finnish babies sleep in cardboard boxes

By Helena Lee BBC News 4 June 2013; http://www.bbc.com/news/magazine-22751415

For 75 years, Finland's expectant mothers have been given a box by the state. It's like a starter kit of clothes, sheets and toys that can even be used as a bed. And some say it helped Finland achieve one of the world's lowest infant mortality rates.

It's a tradition that dates back to the 1930s and it's designed to give all children in Finland, no matter what background they're from, an equal start in life.

The maternity package - a gift from the government - is available to all expectant mothers.

It contains bodysuits, a sleeping bag, outdoor gear, bathing products for the baby, as well as nappies, bedding and a small mattress.

With the mattress in the bottom, the box becomes a baby's first bed. Many children, from all social backgrounds, have their first naps within the safety of the box's four cardboard walls.

Mothers have a choice between taking the box, or a cash grant, currently set at 140 euros, but 95% opt for the box as it's worth much more.

The tradition dates back to 1938. To begin with, the scheme was only available to families on low incomes, but that changed in 1949.

"Not only was it offered to all mothers-to-be but new legislation meant in order to get the grant, or maternity box, they had to visit a doctor or municipal pre-natal clinic before their fourth month of pregnancy," says Heidi Liesivesi, who works at Kela - the Social Insurance Institution of Finland.

So the box provided mothers with what they needed to look after their baby, but it also helped steer pregnant women into the arms of the doctors and nurses of Finland's nascent welfare state.

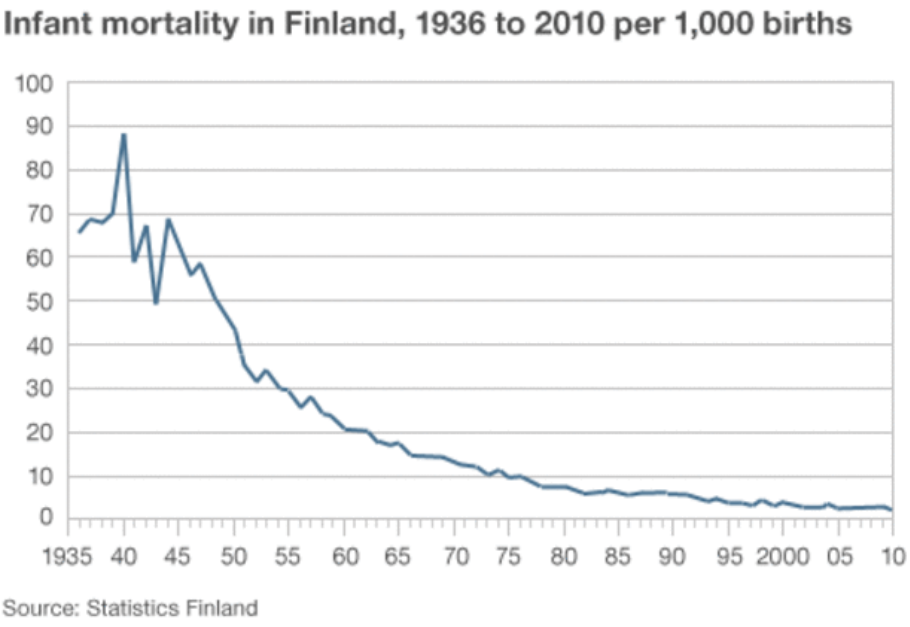
In the 1930s Finland was a poor country and infant mortality was high - 65 out of 1,000 babies died. But the figures improved rapidly in the decades that followed.

Mika Gissler, a professor at the National Institute for Health and Welfare in Helsinki, gives several reasons for this - the maternity box and pre-natal care for all women in the 1940s, followed in the 60s by a national health insurance system and the central hospital network.

CONTENTS OF THE BOX

- Mattress, mattress cover, undersheet, duvet cover, blanket, sleeping bag/quilt
- Box itself doubles as a crib
- Snowsuit, hat, insluated mittens and booties
- Light hooded suit and knitted overalls
- Socks and mittens, knitted hat and balaclava
- Bodysuits, romper suits and leggings in unisex colours and patterns
- Hooded bath towel, nail scissors, hairbrush, toothbrush, bath thermometer, nappy cream, washcloth
- Cloth nappy set and muslin squares
- Picture book and teething toy
- Bra pads, condoms

At 75 years old, the box is now an established part of the Finnish rite of passage towards motherhood, uniting generations of women.



During the 30s and 40s, it contained fabric because mothers were accustomed to making the baby's clothes.

But during World War II, flannel and plain-weave cotton were needed by the Defence Ministry, so some of the material was replaced by paper bed sheets and swaddling cloth.

The 50s saw an increase in the number of ready-made clothes, and in the 60s and 70s these began to be made from new stretchy fabrics.

In 1968 a sleeping bag appeared, and the following year disposable nappies featured for the first time.

Not for long. At the turn of the century, the cloth nappies were back in and the disposable variety were out, having fallen out of favour on environmental grounds.

Encouraging good parenting has been part of the maternity box policy all along.

"Babies used to sleep in the same bed as their parents and it was recommended that they stop," says Panu Pulma, professor in Finnish and Nordic History at the University of Helsinki. "Including the box as a bed meant people started to let their babies sleep separately from them."

At a certain point, baby bottles and dummies were removed to promote breastfeeding.

"One of the main goals of the whole system was to get women to breastfeed more," Pulma says. And, he adds, "It's happened."

He also thinks including a picture book has had a positive effect, encouraging children to handle books, and, one day, to read.

And in addition to all this, Pulma says, the box is a symbol. A symbol of the idea of equality, and of the importance of children.

THE STORY OF THE MATERNITY PACK

- 1938: Finnish Maternity Grants Act introduced - two-thirds of women giving birth that year eligible for cash grant, maternity pack or mixture of the two
- Pack could be used as a cot as poorest homes didn't always have a clean place for baby to sleep
- 1940s: Despite wartime shortages, scheme continued as many Finns lost homes in bombings and evacuations
- 1942-6: Paper replaced fabric for items such as swaddling wraps and mother's bedsheet
- 1949: Income testing removed, pack offered to all mothers in Finland - if they had prenatal health checks (1953 pack pictured above)
- 1957: Fabrics and sewing materials completely replaced with ready-made garments
- 1969: Disposable nappies added to the pack
- 1970s: With more women in work, easy-to-wash stretch cotton and colourful patterns replace white non-stretch garments
- 2006: Cloth nappies reintroduced, bottle left out to encourage breastfeeding.

Attachment 2

The Pēpi-Pod® Program

http://www.usc.edu.au/media/15595923/pepi-pod-materials_2015_australia_finalsept.pdf

http://www.usc.edu.au/connect/research-and-innovation/medical-and-health-science/nurture/research-projects/the-pepi-pod-program

Co-sleeping is a culturally valued practice by many Indigenous families, however is associated with sudden unexpected death in infancy (SUDI) in hazardous

circumstances. This study aimed to evaluate a safe sleep strategy in collaboration with Aboriginal and Torres Strait Islander families with high risk for SUDI.

A project team from USC have collaborated with Change for our Children Limited in New Zealand for the first trial of a safe sleep enabler in Australia. The Pēpi-Pod Safe Sleep Program was initiated in New Zealand by *Change for our Children* in 2011 as a public health response for babies at a higher risk of SUDI.

Methods

The Pēpi-Pod® Program, comprising a safe sleep enabler, safe sleeping parent education and safety briefing; and family commitment to share safe sleeping messages in social networks, was delivered to Aboriginal and Torres Strait Islander families with identified SUDI risks, recruited through Queensland maternal and child health services (n=10 services, 25 communities) across metropolitan, regional and rural/remote areas.

Results

Program acceptability and feasibility was established and raised awareness of safe sleeping in communities. Families reported benefits including safety, convenience and portability. Partnering health services reported that the program was feasible, flexible, sustainable, and built local workforce capacity with integration into current service models.

Awards

This project was recognised with two national awards in 2014:

- Winner, HESTA Australian Nursing Awards - Team Innovation
- National Winner, National Lead Clinicians Group Award for Excellence in Innovative Implementation of Clinical Practice (Indigenous Health Category).

Conclusion

This is the first evaluation of a safe sleep enabler in Australia. Evaluating innovative and culturally respectful strategies to reduce SUDI risk through enabling safe sleep environments, which support community ownership, develop multidisciplinary team skills, and reorient services from safe sleep advice to safe sleep action, will better inform the evidence-base used by educators, clinicians, researchers and policy makers in supporting parents and reducing infant deaths.