Inner West Sydney

Healthy Homes and Neighbourhoods

Conference
Posters, 2019

Healthy Homes
and neighbourhoods

An interagency collaboration
for children, young people
and their families

Auspiced by Sydney Local Health District

NSW GOVERNMENT Health
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Reduced Hospitalisation

Big Data Evaluation of an Integrated Care Initiative for Vulnerable Families

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Healthy Homes and neighbourhoods

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Introduction

In March 2014, the New South Wales (NSW) State Government of Australia Integrated Care Strategy established an integrated care initiative for vulnerable families called Healthy Homes and Neighbourhoods (HHAN). It was designed as a:

"population-based, family-centered, care-coordination network that functioned across agencies to assist vulnerable families to navigate the health and social-care system, to keep themselves and their children safe, and in doing so, promote social cohesiveness."

There were nine key components:

1. Identification of vulnerable families
2. Healthy Homes care coordination
3. Evidence-informed interventions
4. General Practice engagement, linkage and support
5. Family health improvement
6. Healthy Neighbourhoods place-based support
7. Interagency system change and planning
8. Monitoring of individual and family outcomes
9. Evaluation – Mixed Method Realist

Methods

The HHAN mixed-method evaluation framework included the monitoring of unplanned and potentially preventable or avoidable admissions to hospital.

Minimum data on patients accessing the Integrated Care (IC) services was linked to:

- records of the Admitted Patient Data Collection (public hospitals) and NSW Private Hospital Inpatient Statistics Collection, from 1 January 2010 onwards
- records of the Emergency Department Data Collection, from 1 January 2010 onwards.

Results

Preliminary results demonstrated a reduction in probable preventable hospitalisation, emergency department visits, admissions and length of stay for members of HHAN families. The impact was evident for both child and adult members of families. The reductions (statistically significant, based on individual patient referential year-on-year difference analysis) were greater in the second year after enrolment with HHAN Integrated Care Program.

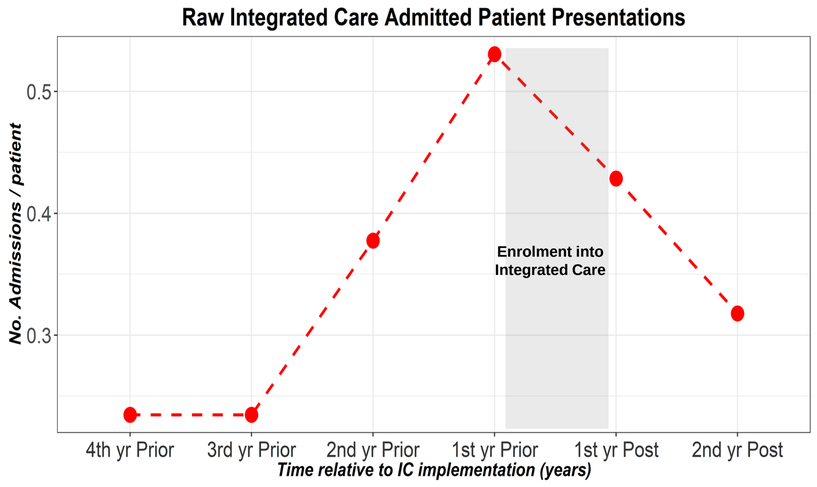

Figure 1: Average admissions per patient.

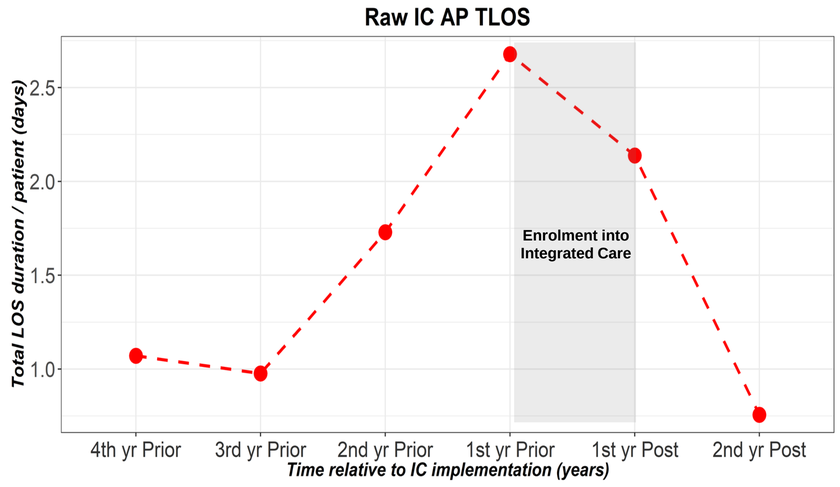

Figure 2: Total Length of Stay per episode of care.

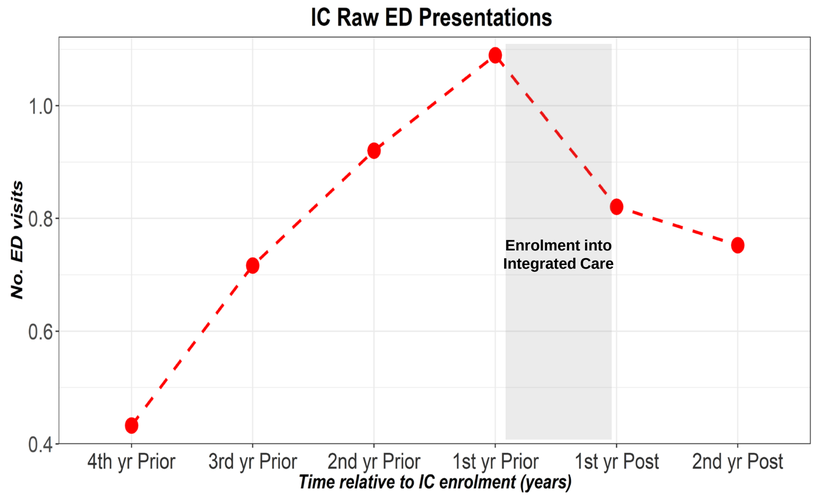

Figure 3: Average ED visits per patient.

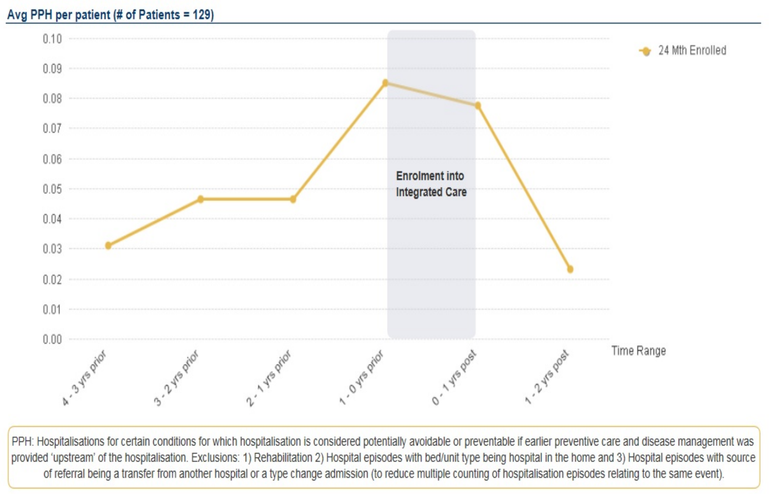

Figure 4: Average Potentially Preventable Hospitalisation

Discussion

The preliminary hospital related outcome evaluation findings suggest that HHAN is having a positive impact on avoiding hospital presentation. In order to directly measure the impact of IC on outcomes for patients, a reliable estimate of the counterfactual would ideally be obtained. Given that a randomised control trial is not feasible for IC, Propensity Score Matching (PSM) techniques will be employed to retrospectively construct a plausible comparison group.

Lessons Learned

Intensive whole-of-family wrap-around care coordination of vulnerable families may reduce avoidable hospital presentations and admissions.

Future Research

The HHAN intervention model should be studied with other "high risk" patient groups including those adults who do not have children.

Conclusions

The HHAN Initiative was designed to assist vulnerable families to navigate the health and social-care system, to keep themselves and their children safe. The initiative was originally conceived as a "twin generation" child protection intervention with outcome objectives related to child development, housing and family safety. The reduction in avoidable hospital presentations and admissions was unexpected. The findings suggest that targeted "whole-of-family" interventions may be beneficial more generally.

Building healthy strong communities: Integrating health and social care through system transformation

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Introduction

We describe here the development of a person-centred integrated care policy framework for central and inner-west Sydney, Australia.

The purpose was to provide an overarching policy framework for the system transformation initiatives being undertaken in Sydney Local Health District (SLHD).

Policy Context

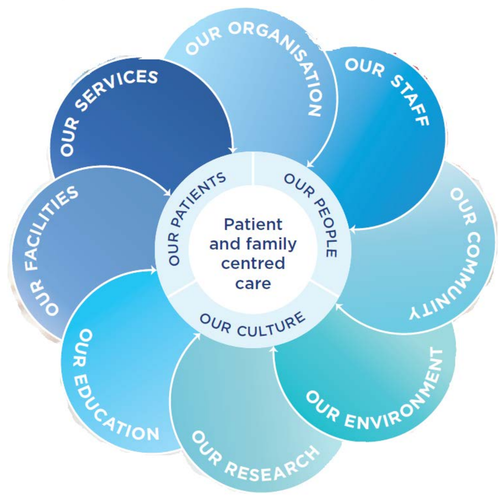
In March 2014, the New South Wales (NSW) State Government of Australia announced the NSW Integrated Care Strategy and two integrated care initiatives were commenced in SLHD. In 2015 the NSW Social Policy Cabinet Committee approved the testing of different service delivery and governance models in four districts including SLHD.

A Healthy Strong Communities Consortium was established within Sydney Local Health District and a number of integrated care initiatives were commenced or strengthened. Collaborative interagency consultation was undertaken to develop interagency plans for children, families, and young people. There remained a need to develop an overarching integrated care policy framework to support on-going whole-of-system transformation.

Policy Development

The policy development drew on extensive community consultation undertaken as part of the District planning process, place-based community needs assessments, and both person-centred and partner agency-centred evaluation studies.

The consumer consultation projects included: interviews with patients experiencing long hospital stay, care-givers of vulnerable children, and focus groups in socially high need communities. Partner consultation included: interviews and surveys of primary care and hospital providers; consultation forums; and Delphi and mixed-method social network studies.



Figures 1: SLHD Patient and Family Centred Care

System Approach

A whole of system approach was taken underpinned by the policy direction provided by the: WHO framework on integrated people-centred health services; The Alma Ata Declaration of Primary Health Care, NSW Social Policy Committee service delivery reform initiative; and the NSW Integrated Care Strategy.

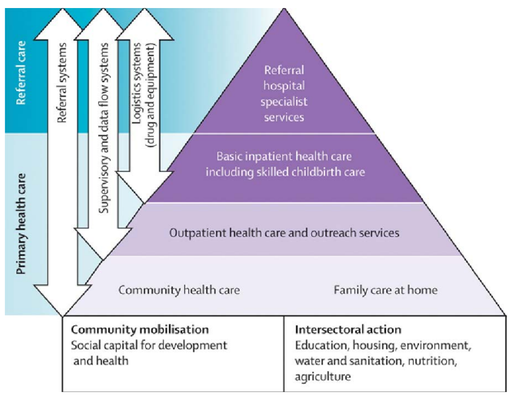


Figure 2: Alma Ata Declaration of Primary Health Care

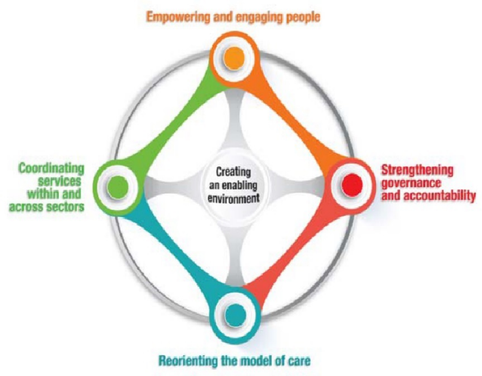


Figure 3: WHO Framework on integrated people centred health services

Health and Social Action Approach

The integration of health and social care is a particular innovation and focus of the policy framework.

Transferability

The framework is transferable as it is consistent with the WHO framework on integrated people-centred health services and utilises foundational integrated care approaches found in the: Alma Ata Declaration; Quadruple Aim; population stratification (Kaiser Permanente); and the Rainbow Model of Integrated Care proposed by Valentijn (2015).

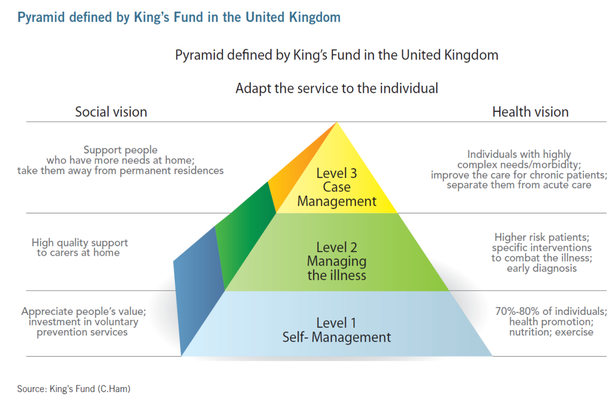


Figure 4: Population Stratification as per Kaiser Permanente and adapted by Kings Fund

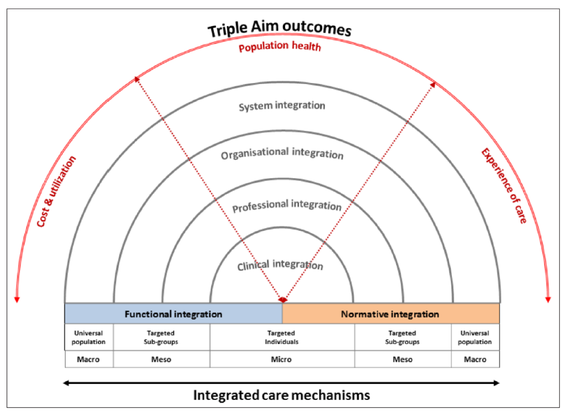


Figure 5: Rainbow Model of Integrated Care proposed by Valentijn (2015).

Six inter-dependent priority areas were identified with a focus on integrating care and system transformation.

- Leadership and governance
- Creating supportive systems and enabling environments
- Collaboration and coordination – working together
- People and communities first – empowering and engaging
- Innovative models of care
- Evaluation and Research.

The draft framework was mapped to seven SLHD strategic focus areas.

Our Communities, Partnerships and Environment	Our Patients, Families, Carers and Consumers	Our Services and Systems	Our Facilities	Our Staff	Our Research	Our Education
Population Risk Stratification	Health Literacy	Whole of Health and Integrated Care	Community Whole of System "Hubs"	Confident and Empathic Workforce	The Sydney Institute for Women, Children and their Families	An Integrated Care Education Curriculum
Health and Wellbeing Zones	Co-design of care pathways	Wrap Around Service Models	Mobile workforce and outreach clinics	Employee Support	An Urban Integrated Care Health and Social Wellbeing Research Collaboration	An E-Learning Platform
Social Inclusion	Patient and Carer Reported Measures	Prevention in Practice	Hospital based primary health care clinics	General Practice Support	Integrated Care Data Analytic Capability	Integrated Care Special Interest Group
Child Youth and Family Health and Social Wellbeing		Care in the Community and Patient Flow	Whole of System Performance Metrics		Integrated Care Research Methodology	The Multidisciplinary Team
Equitable Care for Aboriginal Peoples		Health Pathways and System Redesign	Joined up information systems	Community and Lay Workers		
Health and Social Care Neighbour-hoods		A Health and Social Care Alliance				

Conclusion

The process of developing the framework has enabled the engagement of hospital, community and consumer partners in discussions regarding integrating care and transforming the current system. It has also enabled initiation of new projects in relation to health literacy, consumer engagement, workforce capacity building and systems integration.

Health and social care influences on long hospital length of stay: a critical realist study in a large metropolitan hospital

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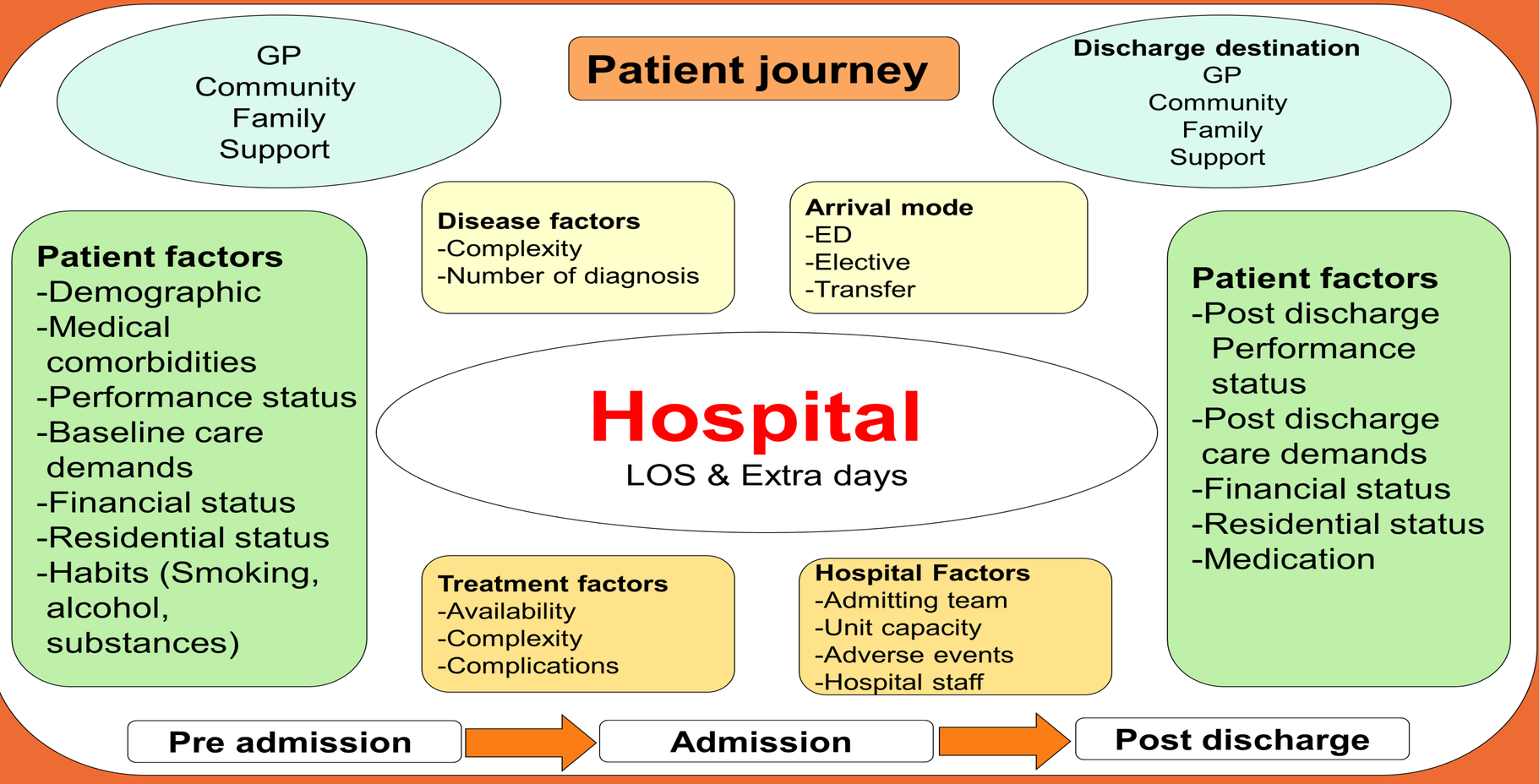
Healthy Homes and neighbourhoods

NSW GOVERNMENT Health Sydney Local Health District

Background

To assess the success of integrated care interventions pre-existing system performance needs to be assessed. Hospital Length of Stay (LOS) is one of the most important indicators of hospital performance and healthcare delivery. LOS not only sheds light on bed management and the efficiency of internal hospital systems but also the performance of pre-admission and post-discharge community-based health and social care systems.



Aim

This study aims to determine the underlying internal and external health and social care factors that impact on long length of stay in RPA hospital.

Methods

A Critical Realism (CR) design was used for this study. CR seeks to understand the underlying mechanisms and structures that are generating the observed phenomenon with the assumption that there are multiple structural layers which influence the observable reality.

Mixed method (Quantitative and Qualitative) studies are used to combine the strengths of, and to compensate for, the limitations of quantitative and qualitative methods.

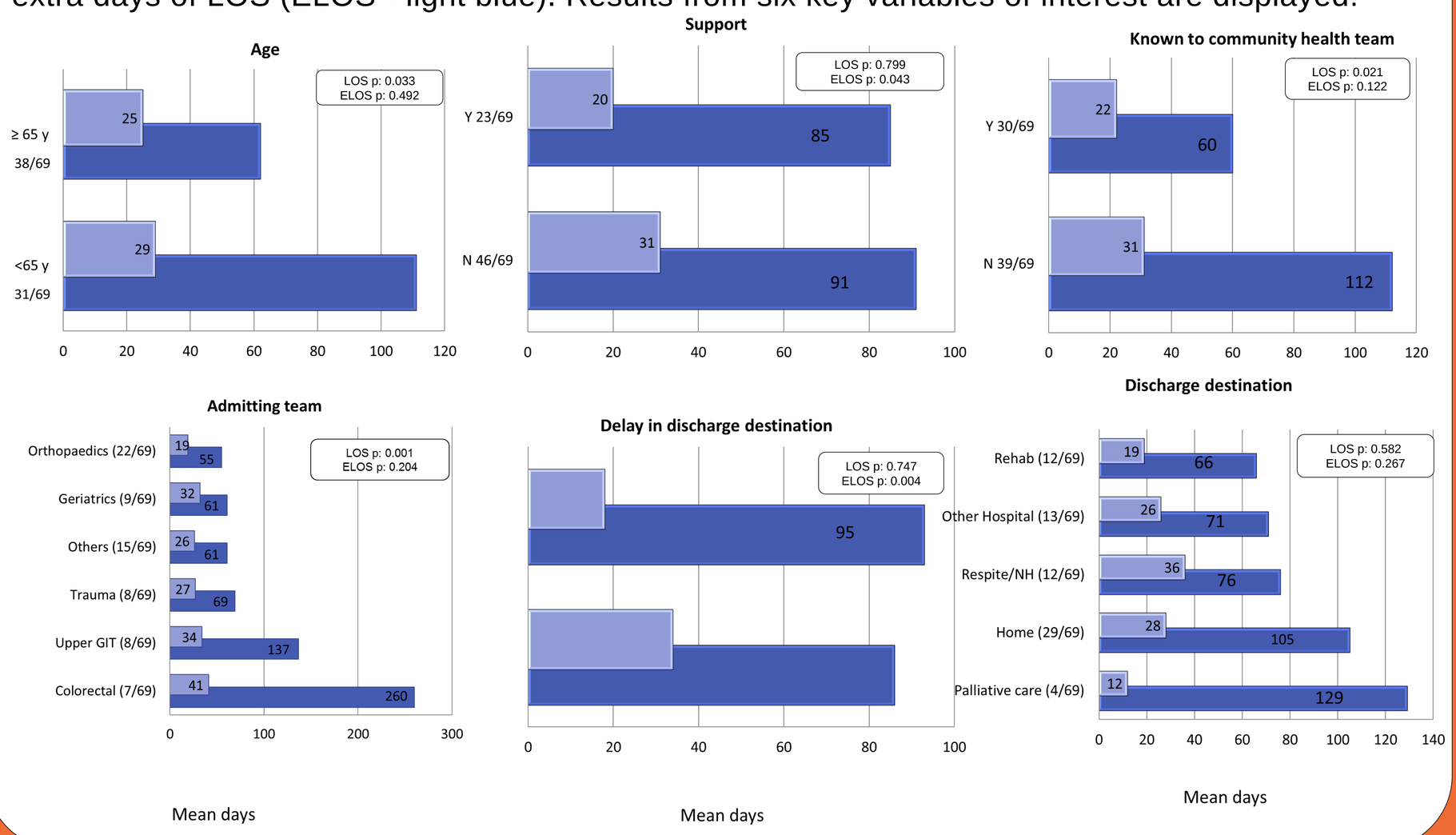
Quantitative component
- Audit based
- Jan 2017- June 2018
- 69 patients

Qualitative component
- Interviewing patients
- Interviewing hospital staff
- 16 to 24 patients & staff

Critical realism (CR)
-Mechanism
-Context
-Outcome

Key quantitative results

A range of independent variables descriptive of the patient and their disease, arrival, treatment and discharge (above), were explored against two key dependent variables: LOS (dark blue) & extra days of LOS (ELOS - light blue). Results from six key variables of interest are displayed:



Conclusion

Some variables were found to have a measurable association with LOS & ELOS, however both LOS & ELOS were driven by varying constellations of factors. Classic determinants of ELOS were not independently predictive of extra days utilised. We now plan to explore the circumstances surrounding selected long stay cases using qualitative methods.

Top 4 items for action:

Review and consolidate resources for patients under 65y
- ✓Integrated Care
- ✓Community support

Pre admission clinic
- ✓Risk assessments
- ✓Identifying high risk patients

Rehabilitation services
- ✓Outpatient services
- ✓Review referral pathway and capacity
- ✓Barriers to transfer to Rehab facility

Collaboration with Primary Health Network/ Community Health
- ✓GPs and Community Health services referrals- Pre and post admission
- ✓Nursing Home placement officer

Inter-organisational social network analysis of service providers in a new integrated care initiative

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1: Australian Institute of Health Innovation, Macquarie University, Australia; 2: Sydney Local Health District, NSW, Australia

Introduction

Healthy Homes and Neighbourhoods (HHAN) is a care initiative that seeks to facilitate integration of multiple agencies serving vulnerable families in Sydney Australia. As part of a broader evaluation, we examined the types and quality of interagency relationships involved in HHAN, and perceptions of advantages, disadvantages and levels of support for collaboration.

Methods

A purposive sample was drawn from 29 senior managers of agencies affiliated with HHAN who provided responses on behalf of their agency. The term agency indicates work units that may be stand alone or part of a larger organisation.

Responses were collected between October 2017 and February 2018 through an online survey, administered at the end of a semi-structured interview that formed part of the larger research project.

Respondents reported on relationships between member agencies selecting from: “we send referrals to them”, “we receive referrals from them”, “we share information about clients”, “we work together in other ways”. The quality of each of these relationships were rated on a three-point scale: (1) somewhat trusted; (2) trusted; and, (3) highly trusted.

Advantages and disadvantages were presented as statements and respondents were asked to select those that had already happened, were expected to happen, or were not expected to happen. Respondents were also asked about their agencies’ motivations for collaboration with other organisations.

Results

Interactions were explored between selected agencies involved in HHAN by representatives of 20 agencies. Twenty-six additional agencies were nominated as collaborative partners by respondents (N=46). The General Collaboration network (pooling all types of relationship) was centred around key community health agencies.

Most common form of collaboration was “works with in other ways.” Most partner relationships were rated as highly trusted. Sociogram of the trust network is shown in Figure 1; referral network in Figure 2.

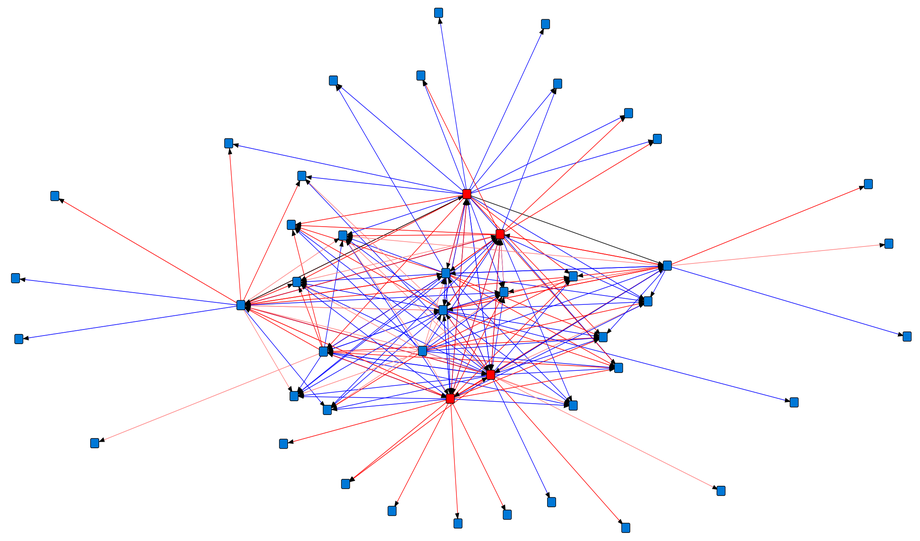


Figure 1: Perceptions of interorganisational trust. Colour represents the quality of the link: Red = highly trusted, blue = trusted and orange = somewhat trusted.

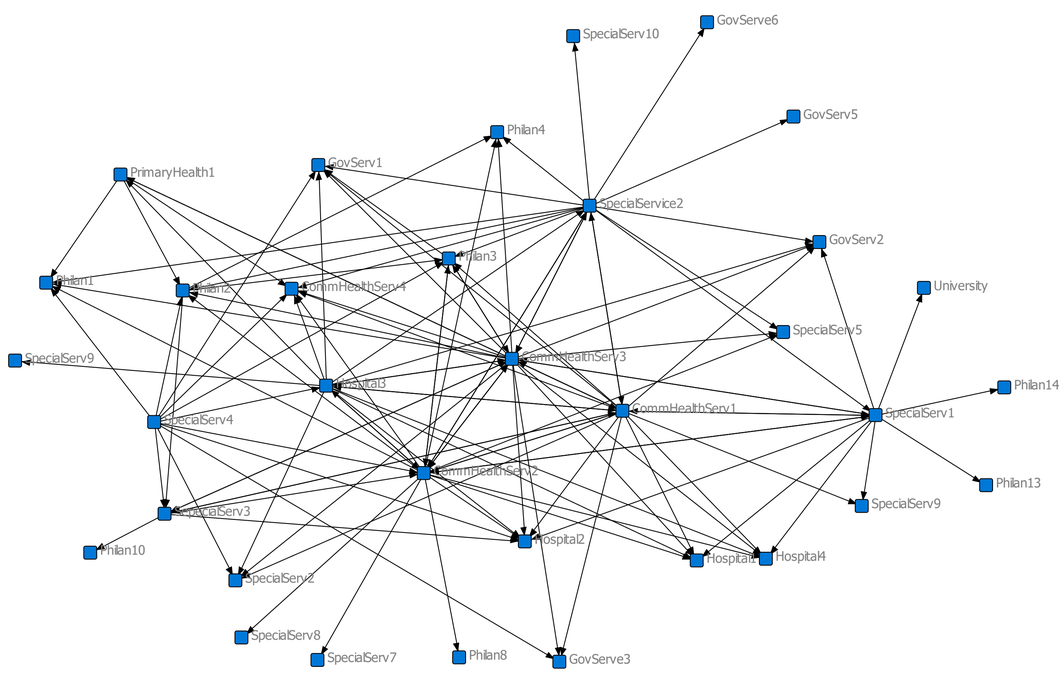


Figure 2: Referral network: “which organisations do you refer to?” (CommHealth = community health services, SpecialServ=specialist services (e.g., mental health, dental), Philan=philanthropic, GovServ=government services (e.g., police, education)

Executive support for collaboration with other services ranged from medium to very strong indicating a positive perception of top down support. Respondents’ perceptions of support for collaboration from staff with direct client interaction was slightly lower. Motivations for interagency collaboration are shown in Figure 3.

“Ability to serve our clients better” and “pooling of information across agencies” was reported by all respondents as a current benefit of interagency collaboration. The benefit with the most frequent report of not being expected to happen was “acquisition of additional funding or other resources.” Respondents had more varied experience of disadvantages of collaboration. The most common disadvantages selected were: “unreliable partners”, “service and time restraints,” which had been experienced by around 50% of respondents.

Discussion

Interagency collaboration was perceived as clearly benefitting families and increasing understanding of population needs by pooling research. However there was also an awareness of barriers and costs involved in working together that required careful management.

Conclusions

Enhanced understanding of community and population needs through research and pooling of information across the network of organisations was a clear and valued vision of most respondents.

Lessons Learned

While these and other benefits to collaboration were clear, the costs were also apparent. Executive staff should use a strategic approach to collaboration, ensuring goals are articulated and aligned.

Limitations

Our sample was drawn from a group already working towards greater integration of services. This may have skewed results in favour of collaboration. Self-reported ties in the social network component of the study were not verified.

Suggestion for future research

A greater number of respondents, including agencies from outside HHAN would enhance understanding.

Figure 3: Wordle© graphic of free text responses to “What is the main motivation for your service to collaborate with other services?”

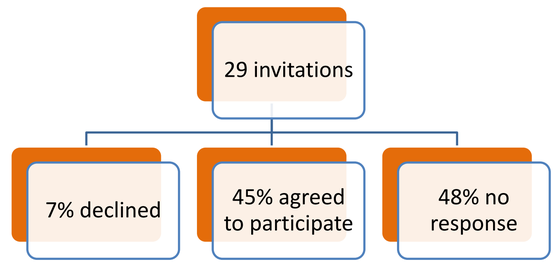
Qualitative exploration of enablers and barriers to interagency collaboration from the perspectives of senior managers and executive staff including social network analysis

Costantino, K[1], Hansen S[1], Miller E[1], Long JC[2], Eastwood J[1,3-5]

1: Sydney Local Heath District, 2: Macquarie University NSW, 3: University of NSW, 4: University of Sydney, 5: Griffith University

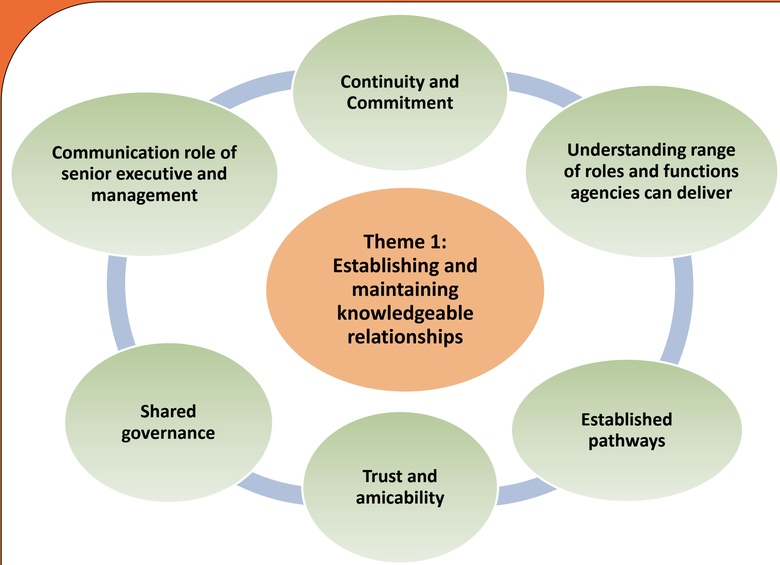
Introduction

The Healthy Homes and Neighbourhoods (HHAN) integrated care program, which started in 2014, was developed to address the complex health and social care needs of vulnerable families, which well exceeds the capacity of the public healthcare system alone.
Semi-structured, qualitative interviews took place with senior managers and executive staff from agencies which HHAN considers partners or potential partners. An agency for the purpose of this study could be within a broader organisation. The aim was to determine participant's definition of interagency collaboration and explore enablers and barriers as viewed by them.

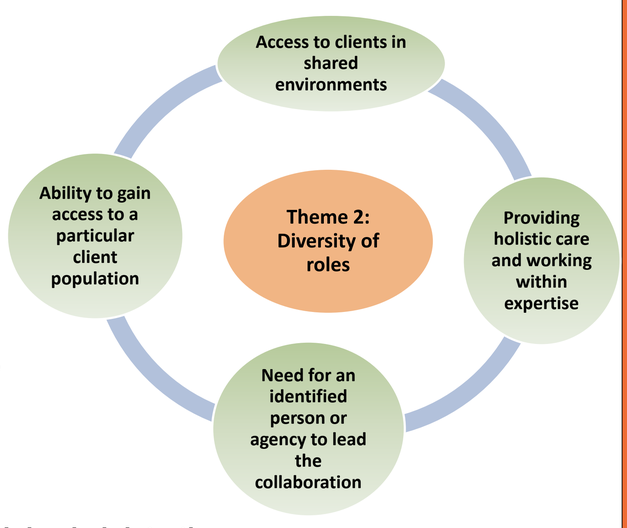


Recruitment took place by purposive sampling. Twenty-nine invitations to participate were sent by email to participants from 11 organisations. In total, 13 interviews took place, representing 11 agencies from 6 different organisations across health and non-health in the government, non-government and charity sectors.

Using a grounded theory method, questions in subsequent interviews were guided by discussions had in prior interviews though strict coherence to the methodology was not achieved nor was saturation of themes. A single coder thematic analysis of interview transcripts using NVIVO software occurred.

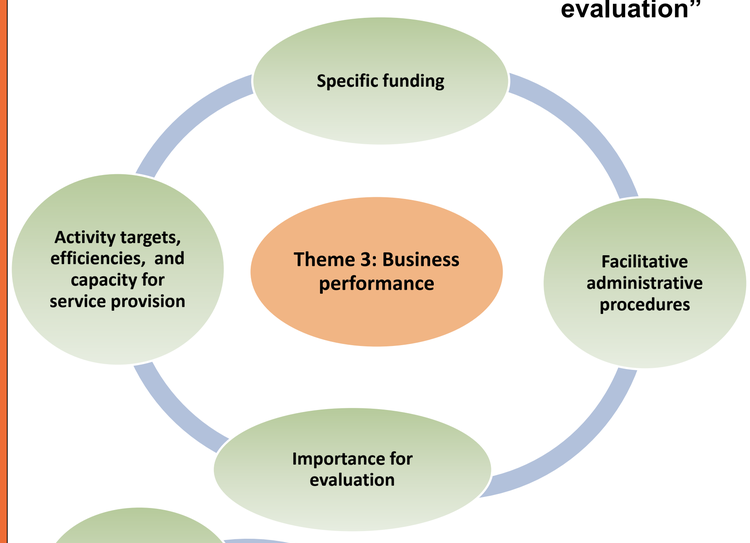


"You wouldn't choose to [collaborate] unless there was some value [to be added] … maybe bringing research skills or they may be bringing access to a particular population or cultural expertise or you know a myriad of things that we can't do alone"



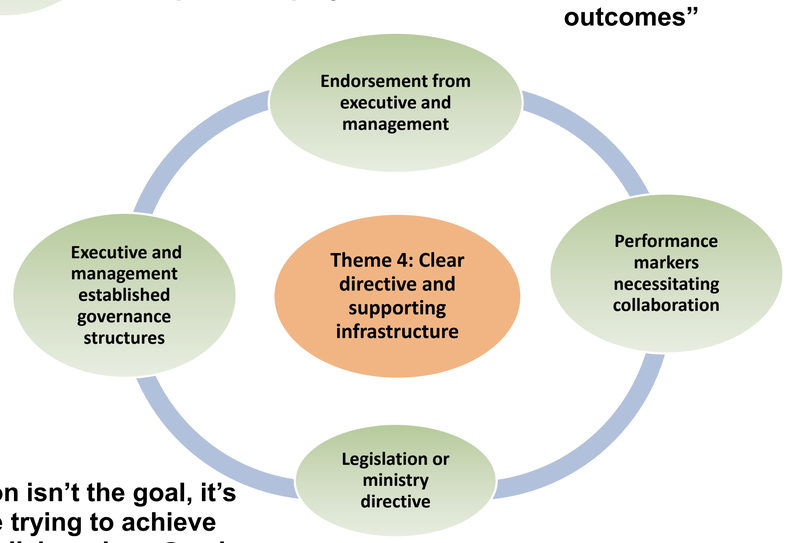
"The first step is to get the right policies in place and the right approach"

"One of the reasons why service partnerships start to dwindle, is when an evaluation is not clearly part of the process…It is not quite as easy as it seems, the evaluation"



"I think administrative process and, and administrative efficiency is incredibly important and matching the degree of paperwork to the scope of the project"

"It means more efficient, more effective collaboration. It means achieving better outcomes"



"Collaboration isn't the goal, it's what you're trying to achieve through the collaboration. Set the goal and if collaboration helps then [collaborate]"

Discussion

Two key pieces of work helped to guide analysis. One is "The Collective Impact Model" by Kania and Kramer[2]. There was notable alignment between the Collective Impact Model and the data collected in interview. Whether this study provides supporting evidence to the work by Kania and Kramer or if it is a reflection of familiarity of their work is not clear, with the model being spontaneously referred to in only one of the interviews. The second is "Working together: inter-sectoral action for health" by Harris, Wise et al[3], their work is widely known and influential within the HHAN network.

The findings from this research were consistent with extant literature.[4] The study confirmed that knowledge within the partner network pre-existed in relation to what is required for effective collaboration, but possibly missing was a level of formality. The frameworks by Kania and Kramer and Harris et al both propose the formal acknowledgement of collaboration - not an organically developed informal process, at least not in a mature collaborative arrangement.

From a health service delivery point of view, this raised the question as to how best to implement a program. Does one organically develop informal arrangements and then overtime formalise the details? Or does one attempt to formalise arrangements from the beginning in an attempt to increase success rates while potentially limiting innovation or getting a program off the ground? Which will achieve the greatest good in the short term and which will achieve the greatest good in the long term?

Results

Thirteen semi-structured, qualitative interviews by a single interviewer occurred followed by a single-coder thematic analysis, in consultation with the research team.
The majority of participants expressed a continuum on which they viewed interagency collaborations to be able to occur, depending on what was trying to be achieved. Achieving efficient, knowledgeable referrals (with single client focus) between agencies, whether government or non-government, was the most basic and common type of collaboration being aspired to. Collaboration could also include working together on shared projects and strategic planning to advance population health initiatives.

Reviewing enablers and barriers, it became apparent that whether something was being characterised as an enabler or as a barrier was dependent on how the idea was being framed. Therefore, the five themes of enablers which emerged from the data have been presented above, noting responses were often framed from the opposite perspective, in that the negative may be a barrier to collaboration. While features of a grounded theory approach were used, strict adherence to the methodology did not take place nor did complete saturation of themes.

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Ngaramadhi Space

Santuri Rungan[1], Patrick Faucher[2], Susan Gardner[1], Lauren Kilroy[2] and John Eastwood[1]

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2: Green Square School for Specific Purposes, Waterloo, NSW, Australia

Artwork by William J, Student, Green Square School, Waterloo, NSW, Australia

Introduction

Historically, education and health work separately when trying to manage children with emotional and behavioural issues. The UK NICE Conduct Disorder guidelines recommend an integrated approach to care. A school-based interagency and community partnership was established at Green Square School (GSS an inner-city school in Sydney, Australia), to strengthen service delivery for students experiencing challenges with their mental health.

Short description of practice change implemented

'Ngaramadhi Space', was established in consultation with the local Aboriginal and school communities. 'Ngaramadhi' means 'active listening' in the Dharawal language and was gifted by the local Aboriginal community. A person-centred interagency multidisciplinary approach is used to address the physical health, learning, psychological and social issues experienced by students and their families while developing innovative and integrating teaching practices. Agreed principles of neuroscience underpin the entire process, clinic to classroom. Students learn about these principles in class so that they can understand the process they and their families are engaged with.

This approach was conceptualised in 2015 via the GSS and allied health translational network, with NSW Health joining to see students and families on 26 July 2016.

Aim and theory of change

- Supplement the educational opportunities by providing access to health and social support services
- Undertake interagency multidisciplinary planning, review and implementation of personalised learning and development plans
- Connect teachers with health practitioners to build their health literacy and universal therapeutic techniques
- Enabling teachers to transfer skills to mainstream classrooms
- Provide an educational opportunity for families, integrating once siloed specialists into coordinated set of interventions.
- Students learn about the neuroscience principals underpinning this coordinated approach, developing literacy around how their brains, nervous system and environment impact their social and academic skills.

Targeted population and stakeholders

Targeted Population: Students and families referred from regional public schools due to significant behavioural concerns.

Stakeholders: Aboriginal Land Council, schools, principals, teachers, private therapists, social services, non-government agencies, local government, mental health, drug health, youth health and community paediatrics

Highlights (innovation, impact and outcomes)

- Students predominantly male. Around 34% of students had open case with child welfare agencies (Family and Community Services). Failure to attend rate was 34%, considered low for this high-risk group.
- Trauma-informed practice is translated to mainstream schools. Translational network and cross-sectoral clinical tools improved impact of whole of system resources.
- Overwhelmingly positive teacher feedback from four local mainstream schools who participated in targeted professional learning resulted in Ngaramadhi Space trauma-informed workshops being incorporated into beginning teacher and Aboriginal teacher conferences across the education network.
- Surveyed students have commented that the neuroscience lessons in class are amongst their favourite and are requesting for the same lessons to be provided at their referring schools for all students.

Discussion

The Ngaramadhi Space has been successful in improving access to health and education for students and families experiencing significant behavioural concerns. The partnership between health and education has led to a more holistic and coordinated approach to the student's needs on a long-term basis. This initiative is an example of whole of system collaboration with knowledge translation.

Comments on sustainability

The clinic continues to be sustainable based on the commitment by health and education to provide staffing for the Ngaramadhi Space and teachers willing to take additional students to make available an entire classroom for health/allied health practitioners to operate.

Comments on transferability

We are now working towards including another school into the local program and the development of a similar initiative in another region.

Lessons learned

A collaborative approach between health and education requires communication and development of a shared vocabulary.

Health is able to build on the trust and security created by the school environment to improve access to health services in hard to reach groups.

Reference

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A realist synthesis of literature informing programme theories for Well-Child Care in primary health systems of developed economies

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Introduction

Well-child Care is the provision of preventative health care services for children. However, the approaches to provide these services universally are contentious.

Theory and Methods

We undertook a realist synthesis for developing theoretical mechanisms affecting provision of Well-Child Care.

Results

Well-Child Care is re-conceptualised as an integrated program delivered in continuum during pregnancy, infancy and early childhood period. Several embedded theoretical mechanisms affect the adaptation and evolution of programs in developed economies.

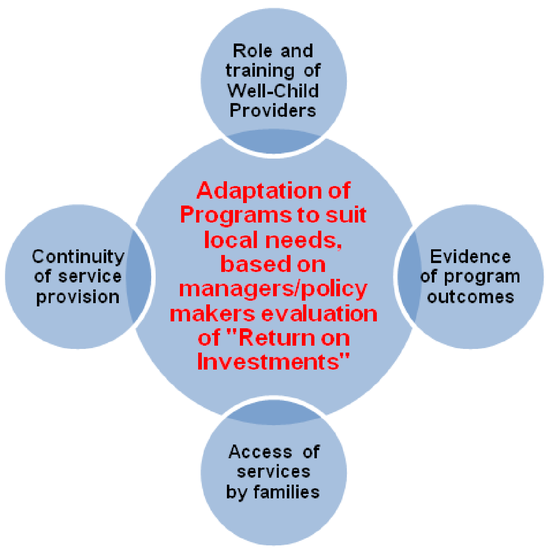

Fig. 1. Theoretical mechanisms affecting of Well Child Care

The programs of Well-Child Care adapt in local contexts based on:

-**Health system factors** – role, training of health providers and continuity

-**Characteristics of population**, such as diversity, accessibility of services

-Investment in programs based on administrators interpretation and perceptions of outcomes of programs

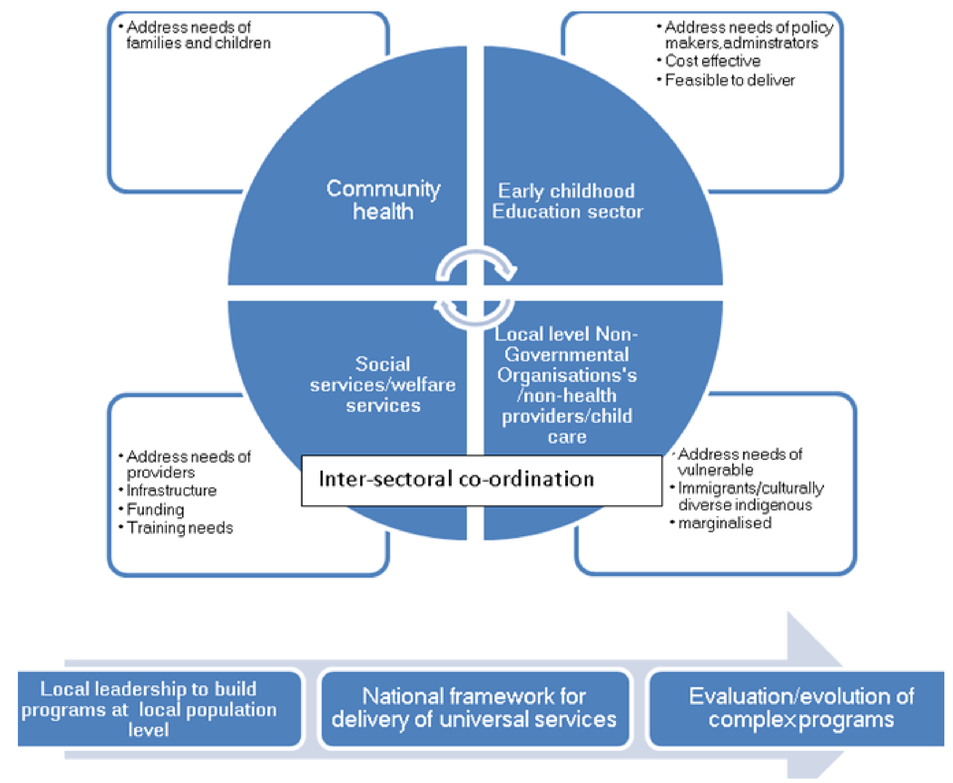

Fig. 2. Integrated program of Well Child Care

The term Well-Child Care is often used in literature only in the context of a structured systematic delivery of anticipatory guidance; developmental screening and surveillance activities during either scheduled or unscheduled health visits.

The outcomes of Well-Child Care are better when delivered in partnerships and collaboration with health, social and education sectors. A cross country comparison of national outcome indicators reflect the commitment and policies promoting early childhood development.

Discussion

The outcomes of a single based program of Well Child Care delivered at doctors' practices is often not going to include the roles of other agencies and sectors who come in contact with families and thereby provide Well-Child Care and potentially impact the social determinants of child health outcomes.

Conclusions

Well-Child Care has to be delivered in an integrated framework, using clinical governance structures at a local government and/or organisational level.

Supporting primary health care providers is only one aspect of the program.

Lessons Learned

Several mechanisms continue to impact development of Well-Child Care. A realist evaluation of Well-Child Care programs will provide more robust evidence of success of programs rather than empirical studies alone.

Limitations

Majority of the empirical studies on Well-Child Care frequently lack the acknowledgement of underlying program mechanisms and contexts.

Suggestions for future research

A realist methodology for program development and evaluation provides a satisfactory research method for ascertaining success and development of outcome indicators of Well Child programs in "real world".

Table 1. National level indicators of Well-Child Care

Proportion of children exclusively breastfed up to 6 months
Proportion of mothers identified with postpartum depression
Proportion of preschool children identified as overweight and obese
Proportion of children with developmental vulnerabilities in at least one domain at school entry
Proportion of babies immunised fully at 2 years of age
Continuity of provider for Well-Child Care (usual source of primary health care provider)
Proportion of children with Autism spectrum Disorder SD (2-17 years), most recent estimates
Proportion of children watching TV more than 1 hour and less than 4 hrs (1- 17 years)
Proportion of children who had developmental screening completed (10 months to 5 years)
Proportion of families involved in home visitation programs
Proportion of children less than 5 years visiting dental worker
Proportion of 4 year children enrolled in an early education program
Annual number of deaths and injuries 1-14 years per 100000
Child maltreatment deaths per 100000 children (up to 15 years)

Health professional perceptions regarding screening tools for developmental surveillance for children in a multicultural part of Sydney, Australia

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Introduction

Early identification of developmental difficulties is a priority. However, the use of these tools has remained sub-optimal.

A longitudinal prospective birth cohort "Watch Me Grow" study was carried out in the South Western Sydney region to ascertain the uptake as well as the strategies and the resources required to maximise surveillance program.

We examined the attitudes, enablers and barriers to the current developmental surveillance practices, with reference to screening tools, amongst health professionals.

Theory and Methods:

Qualitative data, using in-depth interviews and focus groups, was audio recorded and transcribed from 37 primary health care providers in a region of relative disadvantage in Sydney. Data was analysed using thematic synthesis using NVivo qualitative software.

Results

Qualitative analysis highlighted two broad themes of -"Limitations" and "Usefulness" of surveillance tools.

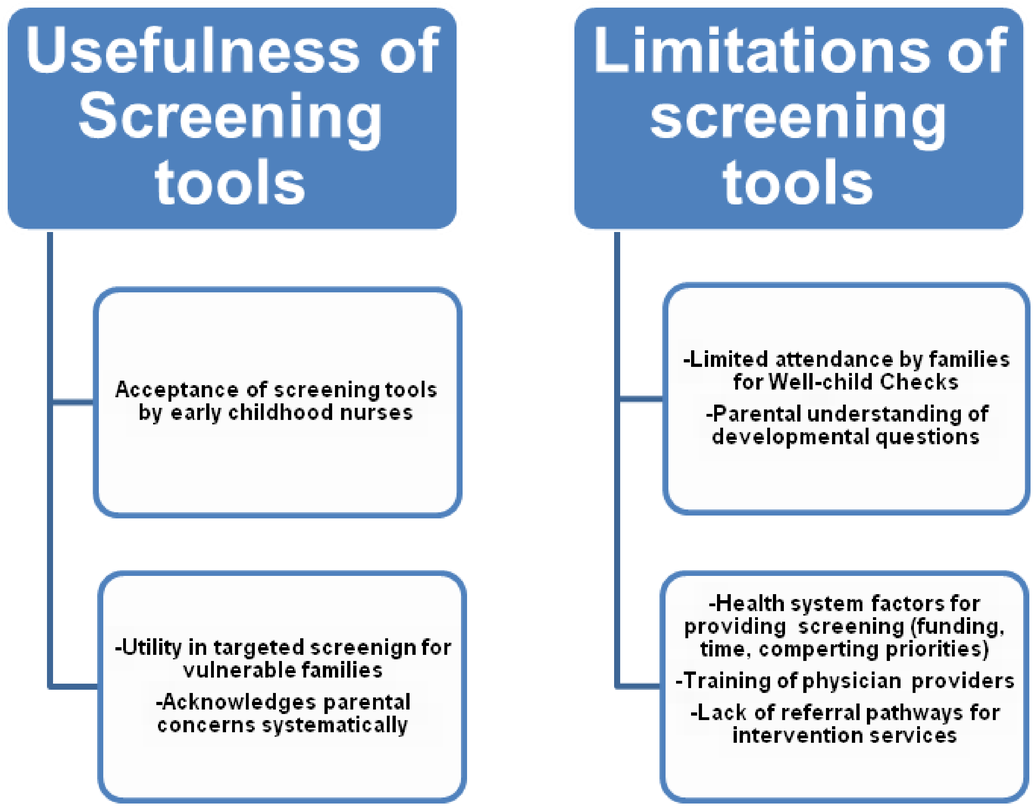

Fig 2. Main categories and themes –according to the importance attributed to each theme by the participants

Conclusions

The results highlight the practical challenges and limited knowledge and uptake of the use of recommended developmental screening tools.

An integrated model of care involved shared data mechanisms using IT services and co-located models is needed in Australia.

Lessons learned

The developmental screening tools as part of a surveillance process for identifying children with neuro-developmental problems are not used consistently particularly by physician providers.

Limitations

The transferability of the data is limited to the setting of screening activities for vulnerable populations

Suggestions for future research

There is a need for large population based surveys on the use of screening tools by nurses and physician providers in Australia.

Data collection procedure	Number (n)	Median Years (IQR)	Median Years of experience (IQR)	Gender	Roles
Individual Interviews	25	53 (44-58)	20 (14- 28)	Females - 16 Males -9	Nurses- 10 Allied Health – 1 Paediatricians – 8 GPs -6
Focus Group 1	8	38 (32-43)	7 (0.5- 18)	All females	All nurses
Focus Group 2	4	49 (41-54)	15 (12- 21)	All females	All nurses

Fig 1. Demographic characteristics of participants

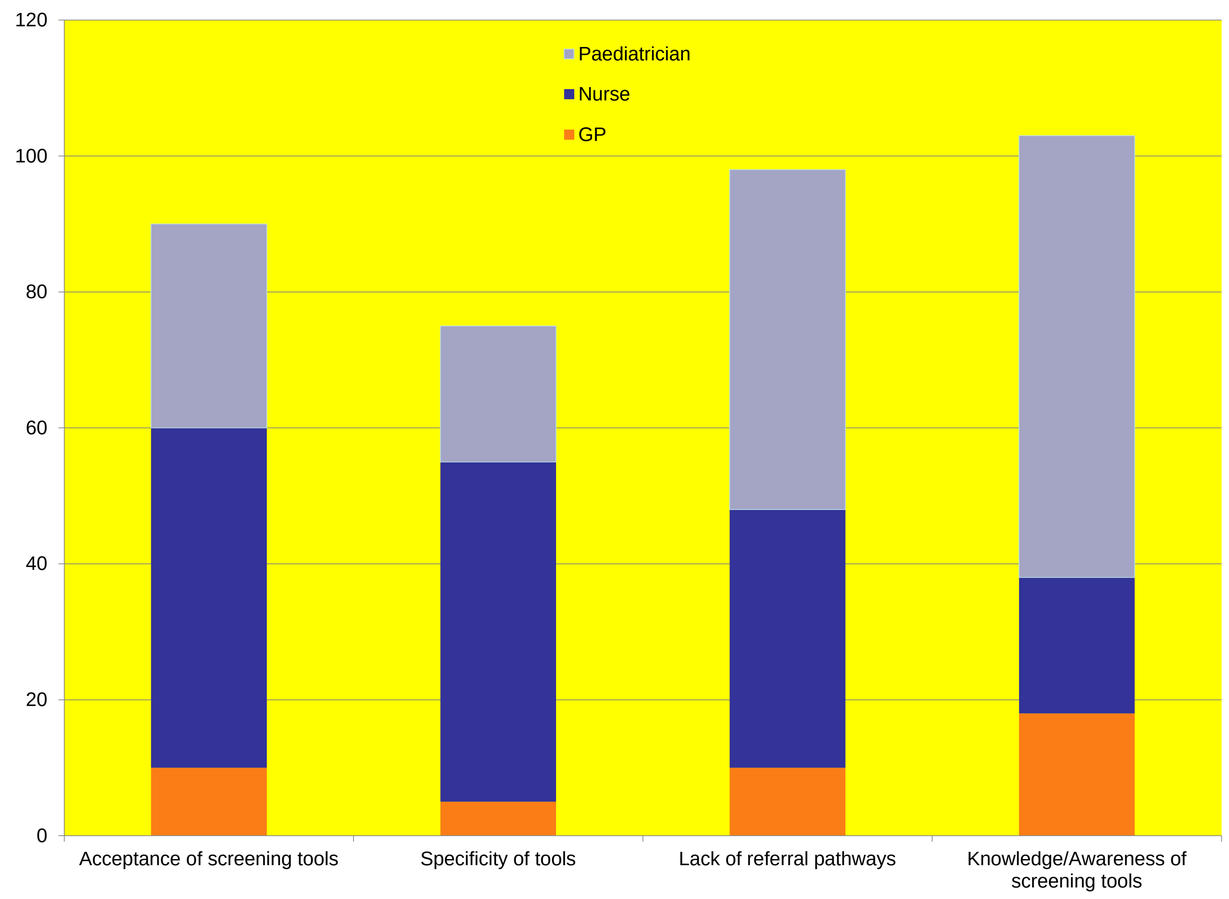

Fig 3. Main themes highlighted by providers according to their profession

Discussion

Barriers to use of developmental screening tools have been identified in many prior studies from North America. This is a first study from Australia that has systematically explored health professionals' perceptions inn using these tools based on the context of their practices.

***The authors acknowledge the "Watch Me Grow" study group .**

A qualitative study into the health and social care needs and barriers to service access for Sudanese women living in a socioeconomically disadvantaged area of Sydney, Australia

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Sydney Local Heath District

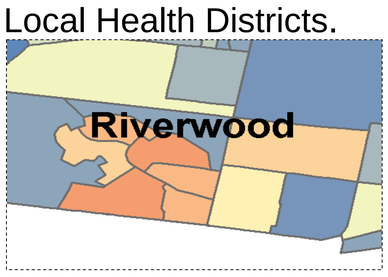
Aims

This research is a part of a broader community consultation aimed to identify barriers and enablers to care for all families in a disadvantaged area in Sydney. Language barriers prevented participation in the community consult for key CALD groups and research design was to access these through targeted focus groups.

Background

Healthy Homes and Neighbourhoods (HHAN) is an Integrated Care Initiative A core goal of the HHAN program is sector-capacity building, engagement and identification of the needs of the communities served.

Spatial epidemiology identified **"hot spots"** of extreme family disadvantage – one of which is located in Riverwood/Narwee. This area was specifically targeted by HHAN. Riverwood lies in central Sydney, on the south west border of the Sydney Local Health District and two neighbouring Local Health Districts.



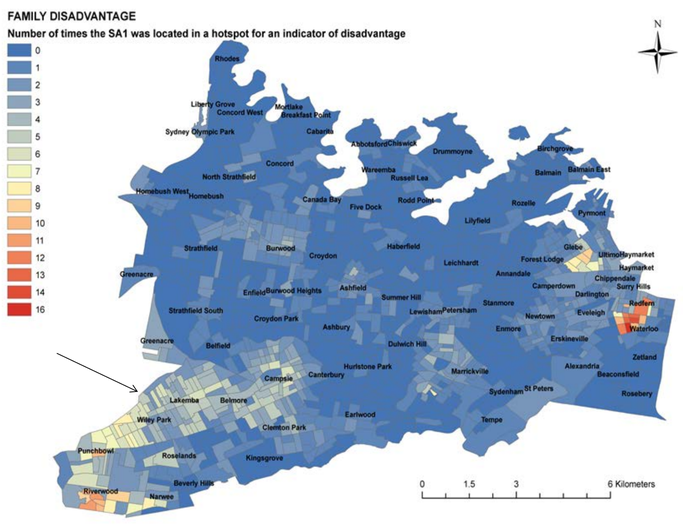


Figure 1: Number of times an indicator of family stress was located in a small statistical area(SA1)

Methods

Service Provider Consultation

Service provider interviews were undertaken in 2015-2016.

Community Consultation

A community forum was held in 2017 to investigate barriers and enablers to accessing health and social care, from the perspective of families. The consultation was conducted predominantly in English.

Sudanese Focus Group Consultation

A key community leader was identified and involved in shared planning and goal development.

In 2018 participants were recruited via multi-modal direct and indirect community engagement strategies

Invitation to participate in a community consultation group specifically for Sudanese women living in the area of interest.

A session was conducted in English with Arabic interpretation.

A set of five questions was used, as used in English community consultation.

Emerging key themes were recorded on paper by scribes, later summarised and analysed.

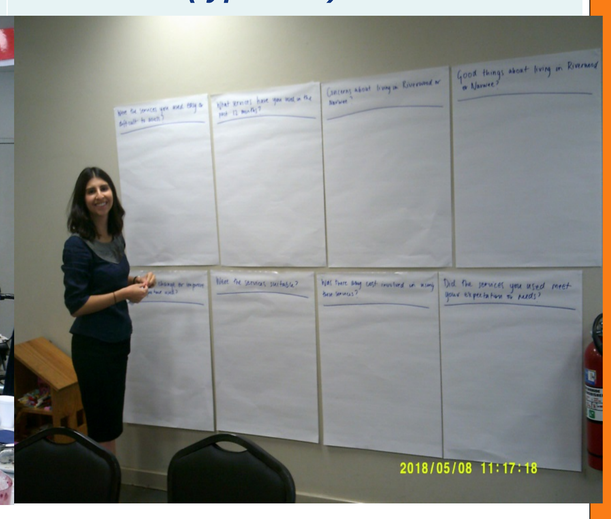
Results

15 women attended – 13 ethnically Sudanese.

Mean age: 40 years, mean number of children in each family 3

14 of the participants had caring responsibilities for at least 1 child

Enablers **in accessing health and social care services**	***Barriers*** **to accessing health and social care services**
Job-readiness programs through Macquarie College	Inaccessibility of culturally appropriate primary care physicians
Programs for engagement at the Riverwood Community Centre + strong Sudanese community support	Cost of physical therapies post rebate (and care plans)
Cost of physical therapies post rebate (and care plans)	Perinatal, childbirth and primary care services unprepared for Female Genital Mutilation (FGM) ***NB *FGM is the practice of deliberately cutting or injuring female genitalia without medical indication (types 1-4)***



Exploration revealed Sudanese women felt:

- Feelings of alienation during pregnancy and childbirth interventions
- Unexpected or poorly communicated care and post-birth complications
- Shame to seek follow-up for women's health issues

Future Directions

Issues to be addressed by Health sector

- Need for better coordination of acute and community-based services
- More effectively advertised and culturally targeted services
- Need for improved training of birth attendants and of General

Practitioners in the effects of FGM on pregnancy, birthing and sexual health

Suggestions for future research

Future research will focus on gaining individual in depth information on the cultural, moral and social acceptability of FGM and the breadth of experiences of women exposed to FGM generationally and across the lifespan. The research undertaken was limited as exploration of sensitive issues was determined by the consult methodology and varying levels of English comprehension.

Developing a model of care for Substance Use in Pregnancy and Parenting Services in Sydney, Australia

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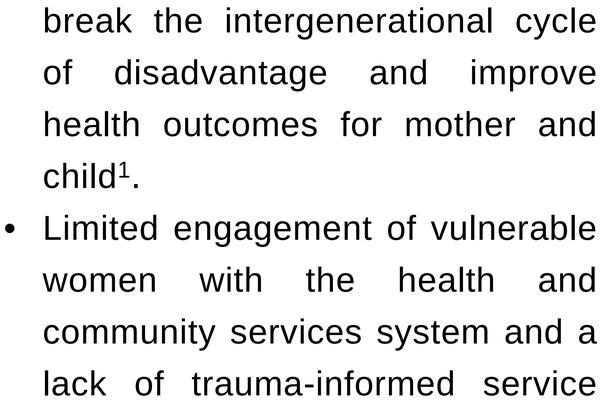
[2]Community Paediatrics, SLHD, [3]University of Sydney, Australia

Introduction

- Substance Use in Pregnancy and Parenting Services (SUPPS) in Sydney Local Health District (SLHD) aim to provide pregnant women and mothers with substance use disorders with support and care throughout their transition into parenthood until the child reaches two years of age.
- SUPPS take an integrated care approach, involving a care pathway of multi-disciplinary service delivery from antenatal to post-natal care, from hospital to community.
- The provision of drug and alcohol treatment and other interventions for women with substance use problems has the potential to break the intergenerational cycle of disadvantage and improve health outcomes for mother and child[1].
- Limited engagement of vulnerable women with the health and community services system and a lack of trauma-informed service models remain significant barriers to women accessing the support they need[2].
- This project aimed to develop an evidence-based SUPPS model of care that enhances continuity-of-care, delivers effective integrated care and informs policies, planning and clinical practices across hospital and community domains to meet the needs of vulnerable women in SLHD.



References

[1] Niccols et al. (2012) *Integrated programs for mothers with substance abuse issues: A systematic review of studies reporting on parenting outcomes*.

[2] Goode (2000). *Sociological Research Online*.

Theory/Methods

- A systematic literature review.
- Semi-structured interviews with 38 service providers linked with SUPPs were undertaken.

Results

- Findings highlighted that the way staff engage with women was a key component of good health outcomes and continuity of care.
- Participants reported that engagement with clients was facilitated by adopting a harm reduction approach, focusing on providing holistic, compassionate care, client-centredness and involvement of staff with particular personal qualities and experience. Additionally, appropriate referrals to and involvement of community services were key to good outcomes.
- Barriers to engagement and continuity of care included lack of consensus regarding scopes of practice among staff, siloing of services, a hospital-centric approach to service delivery, and disparate institutional priorities, policies and practices.
- Role clarity, team governance, negotiated case management, adequate staff resources and opportunities to reflect on team practices, were important factors influencing collaboration across disciplines and agencies.

Discussion

- Integration of diverse health services is critical to the SUPPS model of care in SLHD. However, significant challenges exist in integrating services provided by multiple staff across sectors, in inpatient, outpatient and community settings to meet the varied needs of both women and children.

Conclusions

- Effective integrated care for pregnant women with substance use disorders requires dedicated organisational structures, goals, policies and staff resources.
- Enhancing integrated care in practice will depend on endorsement of the model by all stakeholders and implementation of policies and practices related to collaboration.

Lessons learned

- A range of strategies are needed to support integrated care across community and hospital services: formal agreements and shared policies; enhanced processes for information sharing, community follow-up and referral pathways.
- These should be incorporated into an evaluation framework for monitoring the effectiveness of SUPPS.

Limitations

- Data was drawn from service providers who were willing to participate in interviews and may not be representative of the views of all service providers involved in SUPPs in SLHD.
- Perspectives of consumers are yet to be included, so findings related to women's needs are based on service providers' views.

Suggestions for future research

- The voices of women with substance use disorders need to be included.
- Throughout the process of implementation of the model of care, barriers and enablers of uptake should be assessed, including fidelity to model adherence.

Acknowledgements: Research funding by Drug Health Services, Sydney Local Health District.

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Amending integrated perinatal care policy to respond to women in distress in pregnancy using a risk stratification model

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[1]Sydney Local Heath District, [2]University of Newcastle, [3]University of New South Wales,
[4]University of Sydney, [5]Western Sydney University

Healthy Homes and neighbourhoods

NSW GOVERNMENT Health Sydney Local Health District

Background and aim

The Edinburgh Perinatal Depression Scale (EPDS) is the most widely used depression screening tool in the perinatal period with a score of 13 or more chosen as the threshold for further assessment and intervention. However, an increasing body of literature suggests subthreshold scores of 10 to 12 indicate clinically relevant distress. Stress in the perinatal period affects a range of persistent adverse outcomes for mother and child. The design of the New South Wales (NSW) SafeStart guidelines was intended to facilitate psychosocial assessment (including depression screening) within an integrated perinatal care framework. Despite advocacy for attention to be paid to women who are distressed, though subthreshold for intervention during pregnancy and after birth, the 2017 Australian clinical practice guidelines uphold an EPDS threshold of 13 or more.

A focus for integrated perinatal care programs has been the identification and support of families experiencing stress, anxiety and depression during the perinatal period. A program of research has been undertaken to better inform models of risk identification and evidence-based interventions.

Methods

A narrative literature review and policy analysis was undertaken to map psychosocial assessment roll-out in NSW. A critical analysis of randomised controlled trials examining interventions designed to prevent postnatal depression was also conducted.

Results

We conceptualise the EPDS as a risk stratification tool. Women currently scoring ≥13 on EPDS screening are offered further assessment and intervention.

Currently, women scoring 10 to 12 undergo reapplication of EPDS screening, however we recommend offering interventions with a focus on therapeutic interaction and prevention. Finally, women scoring ≤9 are targeted by expanded health promotion strategies.

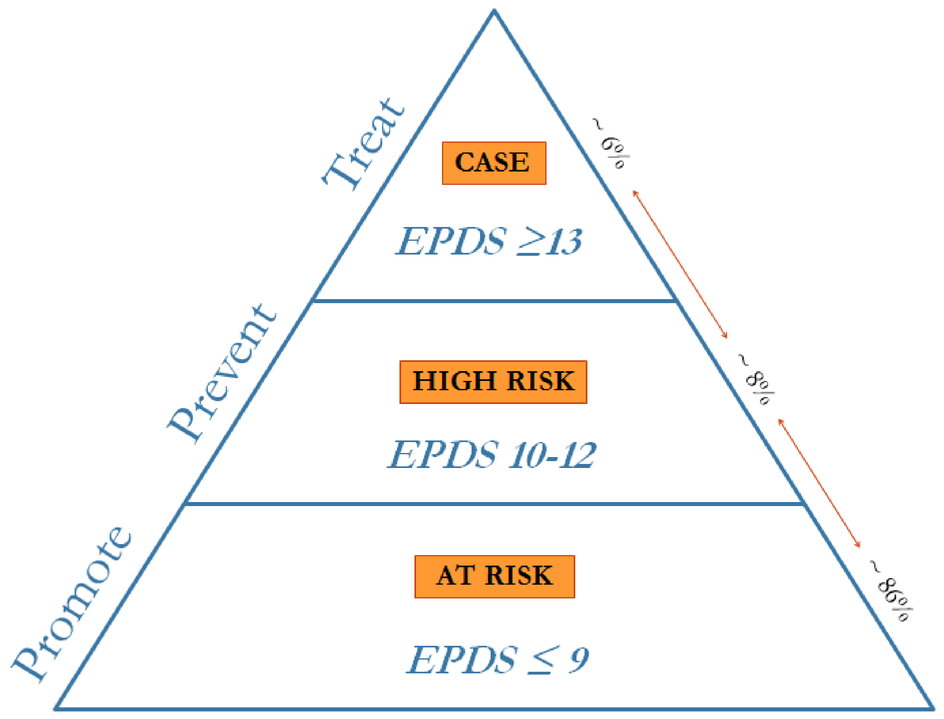

Figure 1: EPDS risk stratification model, based on the 'Kaiser' triangle. Prevalence figures based on a local cohort analysis.

Table 1: Suite of evidence-based interventions offered according to a risk stratification model

EPDS ≤ 9	• Health promotion messaging • Universal maternity and child family health services, continuity of care • Phone applications (e.g. Mind the Bump).
EPDS 10-12	• Locally delivered antenatal and postnatal parenting groups • Lay-person telephone support • Couple-based psychoeducational groups • Interpersonal and cognitive behavioural psychotherapies.
EPDS ≥ 13	• Specialised assessment and monitoring • Psychotherapy • Psychotropic medication • Social intervention/support (sustained nurse home visitation, family group conferencing).

Discussion

We propose an amendment to the current NSW SafeStart policy, underpinned by a proportionate universalism philosophy. Given the wide application of the EPDS in the perinatal space, results indicative of distress should not be dismissed. Suggested interventions are population-derived and offered according to risk-stratification. Potential policy instruments such as existing mental health access funding models could be utilised.

Healthy Homes
and neighbourhoods

AUDIO VISUAL SERVICES 80952