National Child & Family Hubs Network

The Hon Julia Gillard AC
Royal Commissioner
Royal Commission into Early Childhood Education and Care
GPO Box 11025
Adelaide SA 5001

Dear Commissioner Gillard AC

Submission to the South Australian Royal Commission into Early Childhood Education and Care

The National Child and Family Hubs Network (the Network) welcomes the opportunity to make a submission to the South Australian Government's Royal Commission into Early Childhood Education and Care. The Network's submission addresses the first area of inquiry, that is:

1. *The extent to which South Australian families are supported in the first 1000 days of a child's life, focused on opportunities to further leverage early childhood education and care to enable equitable and improved outcomes for South Australian children.*

Who we are - the National Child and Family Hubs Network

The National Child and Family Hubs Network (the Network) is a multidisciplinary group established in 2021 that brings together Australian Universities, research centres, medical research institutes, non-government community-based organisations, Commonwealth and State government departments. The Network's members are actively involved in conducting research, training, communication, and advocacy related to innovative (and sustainable) integrated Child and Family Hubs, to support the health and wellbeing of children and families. In addition, the philanthropic sector is a key stakeholder in the early years space and a Network partner with a critical role to play shaping investment in child and family initiatives.

An integrated Child and Family Hub provides a 'one stop shop', where families can access a range of supports that improve child development as well as child and family health and wellbeing. Integrated Child and Family Hubs have two critical roles:

- improving access to a range of health, education, and social services using a family centred approach; and
- providing opportunities to build parental capacity and for families to create social connections. [1,2]

The social function of a hub means that there is a natural and safe place for families with young children to meet and connect with other parents and children in their community.[2]

The Network's vision is that across Australia:

"families are able to walk through a Child and Family Hub's welcoming front door and receive the right care and support for the child and family at the right time, leading to improved and equitable health and development outcomes".[1]

National Child & Family Hubs Network

Recommendations:

Investing in and expanding upon the forty-seven existing South Australian Children's Centres to become integrated Child and Family Hubs should be a priority for the South Australian government. Integrated Child and Family Hubs have the potential to significantly improve outcomes for children and families, particularly those experiencing disadvantage.

Recognising that there is a role for Federal government and State government to invest in and support integrated Child and Family Hubs, this submission, by the National Child and Family Hubs Network, recommends **the South Australian Government invest in:**

1. **A systematic approach to implementing, funding and evaluating Child and Family Hubs (outside the services themselves) including:**
   - 1.1 Agreed core components and appropriate governance structures for Child and Family Hubs based on evidence.
   - 1.2 Support existing Hubs to improve integration via working with the Federal Government to fund the 'glue'. * The 'glue' is a vital component of Hubs funding that supports the integration of services and supports to reduce fragmentation.
   - 1.3 Establish new hubs, targeted to areas of significant disadvantage, including establishment infrastructure, and work with Federal government for 'glue' funding to ensure success.
   - 1.4 Build in guidance and support for ongoing quality improvement and evaluation of Hubs through a harmonised set of process and impact measures.
2. **Support the National Child and Family Hubs Network, as an existing national coordinating body, to build capacity, reduce fragmentation, and identify best practice by undertaking research, evaluation, and quality improvement to support and scale integrated Child and Family Hubs across South Australia and other jurisdictions.**

* 'Glue' funding allows greater integration of services and supports across Hubs and can be broadly grouped into funding for business oversight, staff supports, community engagement and shared information and technology systems. **Attachment A** provides more information on 'glue'.

The Network recently developed a policy submission outlining the need for investment in integrated Child and Family Hubs to the Commonwealth Government as part of the National Early Years Strategy Consultation. The suite of recommendations to the South Australian Royal Commission are closely aligned with the recommendations the Network made to the Commonwealth Government, and supporting material to explain the rationale for these recommendations can be found in the April 2023 submission (**Attachment A**).

A recent paper developed by the Network '*Child and family hubs: an important 'front door' for equitable support for families across Australia'* outlines the value of integrated Child and Family Hubs and can be found at **Attachment B.**

The recent Social Ventures Australia publication 'Happy, healthy and thriving children: Enhancing the impact of Integrated Child and Family Centres in Australia' is relevant to the South Australian context and should inform efforts to establish and strengthen place based integrated service hubs / integrated Child and Family Hubs (**Attachment C**).

National Child & Family Hubs Network

Alignment with the Royal Commission's Interim Report

Recommendation 11

That implementation of the three-year-old preschool program reflect and prioritise the role of early childhood education and care in layering supports for children and families as they need it.

That the State Government adopt a definition of three and four- year-old preschool that includes the following elements:

→ Each individual child receiving their learning entitlement (including adjustments required), from an early childhood teacher operating with support from allied health professionals as appropriate.

→ Early identification of a child's developmental needs on site (e.g., by child development checks) and organised pathways to interventions, including providing those on site as appropriate.

→ Organised pathways to broader parental and community supports, including those provided on site as appropriate.

The Network notes that providing children and families with tiered supports and pathways to broader parental and community support is enabled when there is adequate investment in 'glue' for service coordination and integration within Children's Centres.

Recommendation 18

That universal three-year-old preschool be delivered through the following mix of provision. Three-year-olds already in long day care or non-government preschool receive their preschool through that long day care or non-government preschool setting.

→ Additional capacity in government preschools be offered on a priority basis to three-year-olds that are not already engaging in early childhood education care.

→ In areas of high developmental vulnerability, there be place- based commissioning of integrated service hubs

→ In other areas, unmet demand be met by managed market response, matching parent demand with cost efficient increases in supply. This should be facilitated by locally based implementation team working on behalf of State Government. Following the completion of the roll out, consideration could be given to making this function ongoing, to provide ongoing stewardship across the early childhood education and care sector.

The Network supports the principle of commissioning place-based integrated service hubs in areas of high developmental vulnerability. The recommendations in this submission provide guidance on how the South Australian Government can invest in Children's Centres.

Evidence on integrated Child and Family Hubs in early years settings

In early years settings, the evidence demonstrates that integrated care and supports are associated with improved school readiness, parental knowledge, and confidence.[3,4,5,6] When comparing non-integrated models of care and support with co-located and integrated models of care in early years and primary school settings there is a trend toward improved child academic outcomes in the latter settings.[7] An evaluation of NSW Aboriginal Child and Family Centres demonstrated improvements in

health checks and immunisation rates among children as well as first time engagement with early childhood education and care services for 'hard to reach' families. [8] In addition, a three-year evaluation of South Australian Children's Centres for Early Childhood Development and Parenting found that:

- Children's Centres met the service needs of families with well-informed support and referrals, with opportunities to expand parental engagement,
- When compared with referral processes and pathways in the community, Children's Centres were found to
    - achieve earlier identification of vulnerable children and families
    - provide new knowledge or skills for team members
    - improve the capacity to reach more children and families
    - provide a clearer pathway for families to the supports and services
    - improve access to specialist services and preschool programs.
- Children using the universal services in Children's Centres tended to live in areas characterised as experiencing disadvantage, come from an Aboriginal or Torres Strait Islander background, and live in remote areas. However, targeted supports were found to be more heavily utilised by families living in areas characterised as more socially and economically advantaged.
- Overall, parents using Children's Centre's reported experiencing high levels of wellbeing, social connectedness and positive parenting practices [9] (**Attachment D**).

These findings suggest that the following elements of integrated Child and Family Hubs could be strengthened in the South Australian context: co-design with families, access to services for families experiencing socio-economic disadvantage, broadening supports within Hubs to include social services, and support for staff to establish and maintain integrated services.

Self-determination and cultural competency are critical for Aboriginal and Torres Strait Islander families.

The Network recognises the unique position of Aboriginal and Torres Strait Islander families and supports the provision of integrated child and family services primarily through Aboriginal Community Controlled Organisations (ACCOs). To further support this approach, the Network acknowledges the submission made by SNAICC – National Voice for Our Children to the Royal Commission into Early Childhood Education and Care and supports the submission in principle.

National Child & Family Hubs Network

Consultation

This submission has been informed by consultation with members of the National Child and Family Hubs Network (Network). Membership comprises:

- Centre for Community Child Health, at Murdoch Children's Research Institute
- University of New South Wales/ Population Child Health Research Group
- Children's Health Queensland
- ARC Centre of Excellence for Children and Families Across the Life Course and the Telethon Kids Institute
- Social Ventures Australia
- Karitane
- Our Place
- National Children's Commissioner, Human Rights Australia
- University of New South Wales/ Early Life Determinants of Health, Sydney Partnership for Health, Education, Research and Enterprise
- University of Sydney / Sydney Health Partners Child and Adolescent Clinical Academic Group
- University of Tasmania, Menzies Institute for Medical Research
- Australian Research Alliance for Children and Youth (ARACY)
- Thriving Queensland Kids Partnerships

The Network commends the work of the Royal Commission in working to improve outcomes for children and families experiencing disadvantage.

I would be pleased to provide additional information to support the recommendations made in this submission and can be contacted at [redacted]

Yours sincerely

[redacted]

Professor Sharon Goldfeld

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Director, Centre for Community Child Health, Royal Children's Hospital
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[redacted]

National Child & Family Hubs Network

Attachments

Attachment A – National Child and Family Hubs Network – Submission to the National Early Years Strategy consultation.

Attachment B – National Child and Family Hubs Network - Child and family hubs: an important 'front door' for equitable support for families across Australia

Attachment C – Social Ventures Australia - Happy, healthy and thriving: enhancing the impact on our integrated Child and Family Centres in Australia

Attachment D – Children's Centre Evaluation, Evaluation Report: a report on the measurement of process and impacts

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[1] Honisett S, Cahill R, Callard N, Eapen V, Eastwood J, Goodhue R, Graham C, Heery, Hiscock H, Hodgins M, Hollonds A, Jose K, Newcomb D, O'Loughlin G, Ostojic K, Sydenham E, Tayton S, Woolfenden S. and Goldfeld S. (2023). Child and family hubs: an important 'front door' for equitable support for families across Australia. National Child and Family Hubs Network. Available from: https://doi.org/10.25374/MCRI.22031951

[2] Moore TG. (2021b). Developing holistic integrated early learning services for young children and families experiencing socio-economic vulnerability [brief]. Prepared for Social Ventures Australia. Parkville, Victoria: Centre for Community Child Health, Murdoch Children's Research Institute, The Royal Children's Hospital.

[3] Cattan S, Conti G, Farquharson C, Ginja R, Pecher M. (2021). The Health Impacts of Sure Start. Available from: https://ifs.org.uk/uploads/BN332-The-health-impacts-ofsure-start-1.pdf

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[6] Taylor C, Jose K, van de Lageweg WI, Christensen D. (2017). Tasmania's child and family centres: a place-based early childhood services model for families and children from pregnancy to age five. Early Child Dev Care. 2017; 187(10):1496-510.

[7] Newman S, McLoughlin J, Skouteris H, Blewitt C, Melhuish E, Bailey C. (2020). Does an integrated, wrap-around school and community service model in an early learning setting improve academic outcomes for children from low socioeconomic backgrounds? Early Child Development and Care. Available from: https://doi.org/10.1080/03004430.2020.1803298

[8] Social Ventures Australia (SVA) & Centre for Community Child Health (CCCH). (2023). Exploring the need and funding for integrated child and family centres. [unpublished]. 21 March 2023.

[9] Fraser Mustard Centre (2018). Children's Centre Evaluation – Evaluation Report: a report on the measurement of process and impacts, South Australia. Available at: www.education.sa.gov.au/docs/early-years/childrens-centre-evaluation-report.pdf

National Child & Family Hubs Network

Integrated Child and Family Hubs – A Plan for Australia

Who we are - the National Child and Family Hubs Network:

The National Child and Family Hubs Network (the Network) is a multidisciplinary group established in 2021 that brings together Australian universities, research centres, medical research institutes, non-government community-based organisations, Commonwealth, and state government departments. The Network's members are actively involved in conducting research, training, communication, and advocacy related to innovative (and sustainable) integrated Child and Family Hubs, to support the health and wellbeing of children and families. Importantly, the philanthropic sector is a key stakeholder in the early years space and a Network partner with a critical role to play shaping investment in child and family initiatives.

An integrated Child and Family Hub provides a 'one stop shop', where families can access a range of supports that improve child development as well as child and family health and wellbeing. Integrated Child and Family Hubs have two critical roles:

- improving access to a range of health, education, and social services using a family centred approach; and
- providing opportunities to build parental capacity and for families to create social connections.[1,2]

The social function of a hub means that there is a natural and safe place for families with young children to meet and connect with other parents and children in their community.[2]

The Network's vision is that across Australia:
"families are able to walk through a Child and Family Hub's welcoming front door and receive the right care and support for the child and family at the right time, leading to improved and equitable health and development outcomes".[1]

National Child & Family Hubs Network

Recommendations:

Investing in integrated Child and Family Hubs across Australia should be a priority area for policy reform within the Early Years Strategy. They have the potential to significantly improve outcomes for children and families, particularly those experiencing disadvantage. This submission, by the National Child and Family Hubs Network, recommends:

The Commonwealth Government should invest in integrated Child and Family Hubs nationally as a priority area, with specific financial investment to include:

1. **A national approach to implementing, funding, and evaluating Hubs (outside the services themselves) including:**
   - 1.1. Agreed core components and appropriate governance structures for Child and Family Hubs based on evidence.
   - 1.2. Support existing Hubs to improve integration via funding for the 'glue'[*]. The 'glue' is a vital component of Hubs funding that supports the integration of services and supports to reduce fragmentation.
   - 1.3. Establish new Hubs, targeted to areas of significant disadvantage, including establishment, infrastructure, and 'glue' funding to ensure success.
   - 1.4. Build in guidance and support for ongoing quality improvement and evaluation of Hubs through a harmonised set of process and impact measures.

2. **Build on the National Child and Family Hubs Network, as an existing national coordinating body, to build capacity, reduce fragmentation, and identify best practice by undertaking research, evaluation, and quality improvement to support and scale integrated Child and Family Hubs across Australia.**

The recommendations of the National Child and Family Hubs Network support the National Early Years Strategy intention to reduce silos and create an integrated approach to the early years, subsequently increasing the accountability for the wellbeing, education, health (including mental health), safety and development of Australia's children.

[*] 'Glue' funding allows greater integration of services and supports across Hubs and can be broadly grouped into funding for business oversight, staff supports, community engagement and shared information and technology systems.

By the time children start school, research has demonstrated two clear issues: high rates of preventable health and developmental problems[3] and clear inequities already evident.[4] **Child and Family Hubs** are one solution to this problem, outlined in the Early Years Discussion Paper and presented in Appendix 1. Hubs are increasingly recognised around the world as a means of building connections between existing services and supports to meet the diverse needs of families.[5] This approach is gaining momentum around Australia with models being developed that aim to integrate variations of health, education, social care (including legal and financial), disability support, and social support within co-located and integrated child and family focused Hubs.[1]

Integrated Child and Family Hubs provide a non-stigmatising 'front door' for families to access a range of integrated and co-located services, supports and social connections. These hubs are located in early childhood services, primary schools, primary health care, non-government organisations, Aboriginal Community Controlled Health Organisations (ACCHOs) and, or available virtually. Each of these settings provides a potential equitable platform to engage a wide population of children and their families, particularly those living with adversities. Critically, Child and Family Hubs have dual roles - acting as a social hub, providing a local place where families can go to build social networks; and they can act as a service hub for the delivery of a wide range of integrated child and family services. These Hubs have the capacity to:

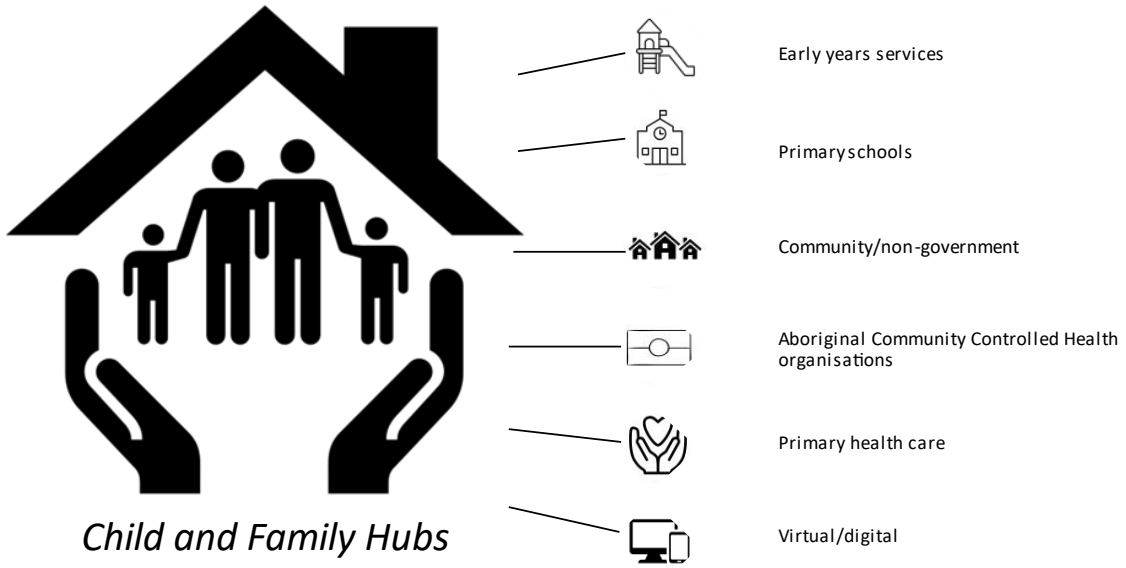
- Identify and support a child's learning and development needs.
- Engage families early and provide access to prevention and early intervention supports.
- Identify broader issues that may be affecting a child's wellbeing, such as poverty, family violence and marginalisation.
- Assist families to navigate support, via referrals and appropriate service pathways.
- Engage families and children in the co-design and ongoing implementation and governance of the Hub to improve self-determination; and
- Provide a safe and convenient space for families to build social connections.

There are a number of Australian state and federal policies that support the need to implement and evaluate integrated, or collaborative, models of care such as Child and Family Hubs (see Appendix 2).

Recommendation 1: Develop a national approach to implementing, funding, and evaluating Hubs.

There are approximately 460 Hubs operating across Australia. These Hubs provide a local and welcoming 'front door' for families within their community, with these 'front doors' situated across early years centres, primary schools, community/non-government organisation, Aboriginal Community Controlled Health Organisations, primary health care, and virtual/digital settings (Figure 1.). See Appendix 3 for a list of Australian Hubs.[6]

Figure 1. Child and Family Hubs provide a 'front' door for families across a variety of settings.



Although this existing capacity provides significant potential to support child health and wellbeing, these Hubs have developed mainly independently and are variably robust in their implementation and evaluation. In addition, there is often insufficient funding for these Hubs to support the integration of services and supports to best promote the health and wellbeing of families and their children. Creating a coordinated national approach by embedding evidence-based core components, ensuring appropriate and sufficient funding and robust quality improvement and evaluation would utilise and amplify this existing capacity, reducing the siloed effort across Australia and create a coordinated and joined up approach in the post-COVID re-set of services. [7]

A national approach for integrated Child and Family Hubs should link with the National Centre for Place-Based Collaboration (Nexus Centre), presenting an opportunity to address the wide range of social determinants that affect the health and wellbeing of children and their families locally.

"A siloed approach risks duplicating functions, unnecessary competing for resources and missing opportunities to work collaboratively to improve outcomes". (National Early Years Discussion Paper)

Recommendation 1.1 – A national approach to implementing, funding, and evaluating Hubs, including agreed core components and appropriate governance structures for Child and Family Hubs based on evidence.

Agreed core components:

There are a number of core components of integrated Child and Family Hubs, identified through research[2,8] and stakeholder consultation[1] that are likely to lead to effective engagement and equitable outcomes for children and families shown in Figure 2.

Figure 2. Core components of Child and Family Hubs

Community level:
- A welcoming and safe space for families
- Participatory approaches to service design and implementation
- Ongoing family/community input and involvement in governance*
- Strong links with community services outside of the Hub

Individual/family level:
- Outreach services to connect high need families
- Culturally safe policies and practices
- Support to build parenting capacity

Service level:
- High quality services with quality frameworks and standards
- Relational practice/family centre care
- Workforce development and ongoing support*
- Local leadership and administration to support integration*
- Coordination/Navigation/Link staff*
- A focus on social determinants of health
- A multi-disciplinary approach*
- Mapped referral processes

* Indicates element of 'glue' that promote and support integration

Further research will be required to comprehensively understand how these core components are implemented and adapted, such as for rural or regional areas of Australia, multicultural or Aboriginal communities, or when focussed on a specific health or development issues, such as mental health.

Settings in which integrated Child and Family Hubs operate and current evidence.

Integrated Child and Family Hubs operate across a range of settings. Core components of integrated Child and Family Hubs are essential to all variations and settings and there is promising evidence on the effect of these integrated care and support models within a range of settings. [1] For example:

- In the ***early years setting***, the evidence demonstrates that integrated care and supports are associated with improved school readiness, parental knowledge, and confidence. [9,10,11,12] When comparing non-integrated models of care and support with co-located and integrated models of care in early years and primary school settings there is a trend toward improved child academic outcomes in the latter settings. [13] An evaluation of NSW Aboriginal Child and Family Centres demonstrated improvements in health checks and immunisation rates among children as well as first time engagement with early childhood education and care services for 'hard to reach' families. [14]

- In the ***primary school setting***, Hubs draw otherwise disparate early learning, child health, playgroup, and community services into one place where they are more easily accessed by families requiring them and can result in improved health and educational outcomes.[15] They provide a place for families to forge connections that have the potential to endure throughout their child's primary schooling and beyond. The focus is "on engaging families with early childhood development needs, contributing to a home environment in which young children can thrive, and providing a supported transition into schooling and subsequent sustained participation". [16]
- In integrated community-based Hubs established by ***non-government organisations***, the evidence suggests association with improved identification of developmental vulnerability and increased access to care for families that might not otherwise engage with services. [17,18,19,20]
- Integrated care delivered by ***Aboriginal Community Controlled Health Organisations (ACCHOs)*** address health inequity experienced by Aboriginal and Torres Strait Islander communities by delivering integrated, holistic, comprehensive and culturally appropriate primary health care. ACCHOs attract and retain Aboriginal clients significantly more than mainstream providers [21] and are more effective than mainstream health services at improving Indigenous health. [22]
- In ***primary health care settings***, integrated care is associated with improved family engagement,[23] coordinated supports across health, social and educational systems, [24] improved child health outcomes [25] and reduced care costs. [26]
- ***Digital/virtual Hubs*** are currently in development as a model of support for families. Digital solutions can provide high reach, low stigma mechanisms to provide information, programs and services[27], which can be tailored to a family's need. This rapidly deployable approach will capitalise on the existing high level of digital penetration in the community.[25] Digital solutions can overlay physical Hubs and provide a comprehensive hybrid model of support to families.

> *"Integrated Child and Family Centres (ICFS) have the potential to play an important part in meeting the needs of children and their families. They provide a local place where children and families can go, build social networks, and get support from other parents and young children. ICFS can also provide a safe and positive relational environment where the child is protected from abuse or neglect. They can support children in building secure attachments and in the development of self-regulation and other skills."* [2]

See Appendix 4 for case studies presenting parents' perspectives on the value of Child and Family Hubs.

Appropriate governance structures:

Clear governance structures for Child and Family Hubs will assist in the development of Hubs locally to ensure efficient, effective, and sustainable practice. Co-design and participatory approaches to service design and implementation are critical and governance structures should include local community and family members to ensure they participate in decisions that affect their lives.

Recommendation 1.2: Future investment required to support existing Hubs to improve integration via funding for the 'glue'. The 'glue' is a vital component of Hubs funding that supports the integration of services and supports to reduce fragmentation.

Despite many services being funded to co-locate, we know this is not sufficient to deliver a high quality, effective integrated Hub that can support the needs of children and their families. It's clear that delivering the core components of ANY Hub requires **funding for 'glue'**† and this funding is particularly relevant to the existing 460 Child and Family Hubs currently in operation across Australia**.** Stakeholder consultation, research[10] and Network members all converge around the need for 'glue' funding for success - this vital ingredient provides the perfect contribution by the Commonwealth for the success of these Hubs. 'Glue' funding can be broadly grouped into business oversight, staff supports, community engagement and shared information and technology systems:

Business oversight:

- A clear governance framework incorporating all partners and family representatives.
- Contracting with a single lead agency who is accountable for all performance measures and sub-contracts any partnership-related work.
- Dedicated funding for social care to avoid further fragmentation of services.

Staff Supports:

- Coordinator position to lead collaboration/integration within the hub and a 'navigator' role to establish and support networks and referrals with other relevant services.
- A workforce which includes staff with either lived experience and/or cultural background that is shared with the families the Hub services and supports.
- Funding time for each Hub practitioner to support workforce development and ongoing learning, professional supervision and allow collaboration across disciplines.
- Funding time for each Hub practitioner to support ongoing Hub quality improvement and development.
- Other business and operational supports that staff need to perform their jobs properly.

Community engagement:

- Funding to support co-design with the local community, families, children, and Hub staff, which is then continuously improved upon with ongoing community, family and child involvement and guidance.
- Resources required to support families to attend a Hub or to be able to participate in a broader range of supports offered. This includes resources such as, the use of artworks to humanise, enliven and engage families with the Hub, additional staff, vehicles and brokerage of client supports such as emergency housing.

Shared information and technology systems:

- The necessary hardware, software, and capability that a Hub needs, including a data capture system, data sharing capability between services and supports to build data collection and analysis capabilities.

† 'Glue' funding allows greater integration of services and supports across Hubs and can be broadly grouped into funding for business oversight, staff supports, community engagement and shared information and technology systems.

- Dedicated funding and support for harmonised impact measurement data for monitoring and evaluation.

Without funding for 'glue', undue administrative complexity, ongoing fragmentation rather than integration, and eventual unsustainability of Hubs occurs. This type of funding is essential for sustainability and requires flexibility to account for the maturity of a Hub and to meet the community's unique needs. This funding could come from any level of government and is outlined in Table 1 below.

Prioritisation of geographical areas and existing Hubs to receive glue funding will be addressed in the next recommendation (1.3).

Table 1. Cost drivers and estimates for Child and Family Hubs

Hub component	***Description***	***Key cost drivers and considerations***	***Cost components for a medium-sized Hub***
Upfront costs			
Establishment process	Participatory processes to plan for, design and establish a Hub	• Size and demographic complexity of community • Size of centre • Length of process	• 1-2 EFT social and community services staff. • Operational costs. *Assuming a one-year process*
Infrastructure – upfront	Establishment of the Hubs capital (buildings and equipment), this may be a new building or redesign of an existing building.	• Size and demographic complexity of community • Size of centre	• New building/s and equipment OR refurbishment of an existing building/equipment. • Inclusion of budget allocation for co-design and artwork integration costs, with an emphasis on community needs and cultural safety
Ongoing costs			
Infrastructure – ongoing	Maintenance of the Hub capital (buildings and equipment)	• Size of community and centre	• Operational costs -maintenance and other 'glue' operations outside of staffing (25% of ongoing costs)

"Glue" - Foundations of integration	Leadership and administration required to operationalise the Hub, including a Navigator/Link worker.	• Size of community and centre • Service need and complexity • Number of staff required • Salaries/wages of staff	Two to four full-time equivalent staff e.g.: • 1 EFT to lead collaboration/integration within the Hub, and with external supporting organisations and a workforce which includes staff with either lived experience and/or cultural background that is shared with the families the Hub serves. • 1 EFT to support the collection and use of data for ongoing monitoring, evaluation, and improvements - this would ideally be someone with change management experience who could conduct Plan-Do-Study-Act cycles, use data to bring about change, and ideally move towards a learning health/social care system model. • 1 EFT of dedicated funding for social care to avoid further fragmentation of services - e.g., a social prescriber/ care navigator/link worker. (Approximately 75% of ongoing costs)
Flexible bucket for community designated services	Funding for services outside of core services	• Ability to leverage existing funding streams • Whether services are community-driven or appointment-based • Relationship to core services • Complexity and magnitude of services	• Assumed to be funded through existing funding streams. • Potential for Paediatric support as a clinic lead for the Hubs to support child health and wellbeing and training across other Hubs staff. •
Core services	Early learning programs, Maternal Child Health, family services and allied health services	• Ability to leverage existing funding streams • Complexity and magnitude of services	• Assumed to be mostly funded through existing funding streams. • Funding needed to support the national approach to Hubs and work through unlocking the barriers higher than just at the local Hub level (Systems governance)

Source: Deloitte Access Economics (2023). Adapted to reflect advice of the National Child and Family Hubs Network.

Note: These cost estimates are illustrative only. They do not reflect the exact costs of any existing centre or model, but a triangulation of different estimates from consultation. We recommend the Commonwealth Government work with us to define appropriate funding formulas for different sized new and existing Hubs.

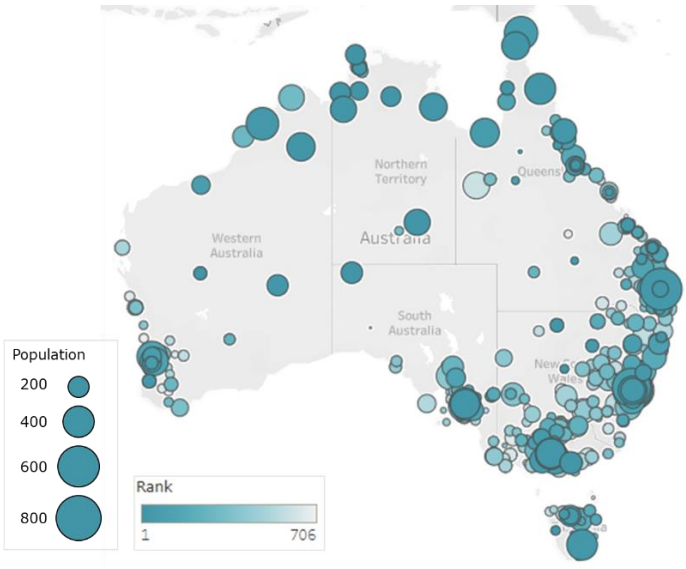
Recommendation 1.3: Future investment required to establish new Hubs, targeted to areas of significant disadvantage, including establishment, infrastructure, and 'glue' funding to ensure success.

Although integrated Child and Family Hubs provide a universal platform that can benefit all children and families, the evidence on the impact of disadvantage on children's development and wellbeing suggests prioritisation should go to areas experiencing greatest disadvantage. However, it will be important to understand areas of highest need across Australia to ensure that Child and Family Hubs are best placed to equitably support the children and families who need it the most.

A recent needs analysis undertaken by Deloitte Access Economics[10] provides an initial indication of the communities across Australia that would benefit from either the development of new (either via a new build or a refurbishment of an existing building) or improvement of existing Hubs through the provision of 'glue' funding, if not already present. This needs analysis focused two key assessments to inform future Hub work:

1. Assessment of need: Mapping geographic locations across Australia with high levels of socioeconomic disadvantage and vulnerability of children (0-6 years) and families (based on Australian Early development Consensus and Socio-economic Index for Area).
2. Assessment of Population: Map population levels of children aged birth to six in the shortlisted areas of need (identified above) that meet criteria for disadvantage (e.g., children with parents who are unemployed, have low income, or live in social housing).

Figure 3. below shows the map of current need against population.



Areas of highest need demonstrate the most significant share of children aged birth to six in need or experiencing disadvantage/vulnerabilities. This needs analysis undertaken by Deloitte Access economics is an initial insight into potential future funding for Hubs across Australia.

Need versus current provision.

The existing 460 Child and Family Hubs across the Australia were subsequently mapped against need, based on level of disadvantage, and population levels of children experiencing disadvantage (identified above). Further work will be required to ensure that significant areas of disadvantage/vulnerability are captured through this process e.g., areas of significant migrant or Aboriginal and Torres Strait Islander communities and that communities are engaged to ensure that a Child and Family Hubs are appropriate for the needs of that community.

Funding for new, or newly refurbished, Child and Family Hubs should be based on the upfront and ongoing funding costs outlined in Table 1. These costs are based on stakeholder interviews and desk-top research undertaken by Deloitte Access Economics [10] and represent a starting point to determine levels of funding.

Recommendation 1.4 Future investment to build in guidance and support for ongoing quality improvement and evaluation of Hubs through a harmonised set of process and impact measures.

The national approach to integrated Child and Family Hubs should include guidance for the ongoing quality improvement and evaluation of Hubs, including the identification of harmonised impact measures, to ensure the collective impact of investment in integrated Child and Family Hubs can be evaluated. In addition, a broader economic analysis on cost-benefit and social return on investment should be undertaken.

Recommendation 2: Build on the National Child and Family Hubs Network, as an existing national coordinating body, to build capacity, reduce fragmentation, and identify best practice by undertaking research, evaluation, and quality improvement to support and scale integrated Child and Family Hubs across Australia.

With increasing interest in Child and Family Hubs across most Australian jurisdictions up until now there has been no coordinating group of organisations implementing and evaluating integrated community-based Hubs. The National Child and Family Hubs Network fills that gap and has been designed to leverage this interest and create an opportunity for collaborative learning and sustainable and effective practice. The Network is a multidisciplinary group that brings together Australian universities, research centres, medical research institutes, non-government community-based organisations, Commonwealth, and state government departments. The Network is guided by 20 state and national organisations on the Steering Committee, and includes a growing membership base, all actively involved in conducting research, training, communication, and advocacy related to innovative (and sustainable) integrated community-based Hubs, to support the health and wellbeing of children and families. Over the coming three years the Network aims to:

- build collective capacity by linking Hubs across Australia to support a shared language, networking, and collective learning,
- define child and family Hubs and develop a common approach across Australia based on evidence informed core components,

- develop an implementation and outcomes framework for Hubs, and
- develop and advocate for sustainable funding models to ensure optimal investment of Australia's public dollar.

This established Network provides an ideal existing platform to continue supporting Hubs, and recently received seed funding from the Ian Potter Foundation to provide a concise range of capacity and capability building activities to support Hubs nationally. However, to engage in all the activities required and to significantly accelerate this work additional funding will be required.

It is recommended that the National Child and Family Hubs Network be funded recurrently as an existing national coordinating body, to build capacity, reduce fragmentation, and identify best practice by undertaking research and evaluation to support integrated Child and Family Hubs across Australia. There is also the potential for the Network to develop a rolling national program of hub future infrastructure in well considered locations and play a commissioning role in funding of these Hubs.

A 10-year plan to scale.

Significant community input and decision-making are required prior to establishing a Hub to ensure it reflects community needs. The needs of the community and the existing services and supports available are often diverse, therefore, this relationship-based work to establish a Hub – building relationships between and with community - takes time.

Even with investment interests and support coming from both government and philanthropy, it's likely that initially, there could be about 10-15 communities 'at the ready' – i.e., with the prerequisite community readiness in place for Hub implementation. Like a 'flywheel', the momentum, knowledge, communities of practice, and community capacity building will amplify rapidly within the 10-year period, eventually creating a higher number of 'at the ready' communities in any one year. The initial rollout over 10-15 communities, supported by evaluation, also serves to support the framework for wider-scale and faster rollout. This initial scaled wave will also provide the opportunity to sort through the policy and investment coordination reforms that are needed to support the integrated delivery. So, the plan to scale needs to acknowledge both community need and readiness, as well as providing the insights and scoping the funding policy reforms necessary for larger-scale implementation.

- Tranches based on community need and readiness to identify priority locations and 'at the ready' communities.
- Using the first tranche of 10-15 communities 'at the ready' to identify, incorporate and trial the supporting enabling policy/funding reforms (such as flexing of funding of existing programs).
- Identifying a forward pipeline of communities likely to be ready to incorporate Hubs, considering issues such as population growth and workforce availability.

Sequencing the local implementation of initiatives to be expanded at a faster pace of scale, based on the scoping, trialling and timeliness of enabling policy reforms identified in the first tranche.

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- University of New South Wales/ Population Child Health Research Group (Dr Katarina Ostojic, Michael Hodgins)
- University of Sydney / Sydney Health Partners Child and Adolescent Clinical Academic Group (Prof. Sue Woolfenden)
- Children's Health Queensland, Queensland (Nicola Callard, Dr Dana Newcomb, Dr Teresa Hall)
- University of Tasmania, Menzies Institute for Medical Research (Dr Kim Jose)
- ARC Centre of Excellence for Children and Families Across the Life Course and the Telethon Kids Institute (Dr Rosemary Cahill)
- Australian Research Alliance for Children and Youth (Sophie Morson and Michael Hogan also representing Thriving Queensland Kids Partnership)
- Social Ventures Australia (Emma Sydenham, Caitlin Graham)
- National Children's Commissioner, Human Rights Australia (Anne Hollonds)
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- OurPlace (June McLoughlin)
- Benevolent Society (Felicia Dingle)
- The Bryan Foundation (Gayle Evans, Matthew Cox)
- FamilyLinQ (Luke Baker)
- Community Hubs Australia (Dr Sonja Hood).

Appendix 1:

Problem statement – Why Integrated Child and Family Hub models?

Ensuring young Australian children have the best possible start to life requires children and families to have equitable and convenient access to quality services and supports. Indeed, by the time children start school, research has demonstrated two clear issues: high rates of preventable health and developmental problems,[3] and clear inequities already evident. [4] These inequities track forward to adulthood[28],[29] and are socially patterned by family adversity [30]and the broader social determinants of health.[31] Addressing inequities early in life has the potential to fundamentally change children's opportunities and create a healthier and more productive future adult population.[32]

As family adversity and social (non-health) determinants of health, development and learning incorporate intersectionality with a number of services and supports, a multi-sector approach is required to prevent and intervene early on these issues. However, current service offerings do not meet the diverse needs of children and their families or effectively address these inequities. For example, a key finding of the National Children's Mental Health and Wellbeing Strategy is that the children's mental health system is overly complex and fragmented, and the onus is on families to try and navigate the system and access appropriate services.[33] In many localities we do not need to add more services or programs for children and families [34] but we need better system integration and coordination to identify early and intervene effectively to address the underlying needs of children and families.

The recently released Australian Childhood Maltreatment Study[35] provides a stark profile of the prevalence and long-term impact of harm inflicted on our youngest citizens. Mathews, Thomas and Scott[36] note the significant cost of not intervening and provide a compelling call to action inclusive of an ecological approach to building capacity in the individual, community and societal domains. The authors close by noting "we can and must invest more, and wisely, in universal prevention at the population level, and in targeted, effective interventions for subpopulations at high risk" (p. S50). This more timely, integrated response to children and families is very much aligned with our recommendation for increased investment in Hubs as a priority area for policy reform.

Economic returns of acting early

There is a clear need for Australia to prioritise investment in effective early intervention services and supports for children and young people.[37] The benefits of effective investment in the early years can extend from improving health and wellbeing for children and families in the short term, and reduced inequity and disadvantage in the long term. A focus on prevention and early intervention is critical as the cost to government of not intervening early is significant and estimated at $15.2 billion annually in high-intensity and crisis services. [36]

Early intervention is a smart investment in a stronger Australia. When we identify and tackle the challenges children and young people face earlier in life, their chances of resilience and recovery are much greater, so their need to rely on services throughout their life is significantly reduced. [36]

A breakeven analysis, conducted for the Benevolent Society showed that it takes only one single child attending Early Years Places to be 'better off' in terms of wellbeing domains for early years places to 'break even' or recover their costs. The analysis suggests that even if a small number of children benefit from systematic offerings in Early Years Places, then the costs of running centres will be covered by the cost savings created over time. [38] In addition, the National Community Hubs Program identified for every $1 invested in the Hubs program, there were $2.2 in social benefits realised in Australia. This indicates that Hubs, such as these are an efficient use of investment. [39]

Appendix 2: Australian policy context

There are a number of Australian state and federal policies that support the need to implement and evaluate integrated, or collaborative, models of care such as Hubs, shown below in Table 3.
In the state and territory context, both Victoria and New South Wales have invested in early childhood education service delivery and introduced a universal offering of free early childhood education for all children in the year before commencing school.

Table 2. Supportive policies for child and family hubs across Australia.

Jurisdiction	Policy
Australia – Federal	National Early Years Strategy (*in development*) National Children's Mental Health and Wellbeing Strategy Productivity Commission Mental Health Inquiry Report Productivity Commission review of the universal early childhood education and care sector Australian Competition and Consumer Commission inquiry into the market for the supply of childcare services
NSW	NSW Building Strong Foundations Program Service Standards New South Wales First 2000 days Framework NSW Government Brighter Beginnings Initiative Joint Commitment to Transform Early Education (with Victorian Government)
Queensland	A Great Start for all Queensland Children: An Early Years Plan for Queensland Kindergarten program reform package State Delivered Kindergarten policy Communities 2032 Strategy Queensland's Strategy for Social Infrastructure
South Australia	South Australian Mental Health Strategic Plan 2017 – 2022 Royal Commission into Early Childhood Education and Care
Tasmania	Tasmania's Child and Youth Wellbeing Strategy
Victoria	Royal Commission into Victoria's Mental Health System Joint Commitment to Transform Early Education (with NSW Government)
Western Australia	Child and Family Adolescent Health Services, Community Health Hubs
ACT	Set up for Success: An Early Childhood Strategy for the ACT
Northern Territory	Great Start Great Future — Northern Territory Early Years Strategic Plan

Appendix 3: Current Child and Family Hubs models

Child and Family Hubs		
Model	**Jurisdiction**	**Scale**
Early years Hubs		
Aboriginal and Torres Strait Islander integrated early years centres	National	75 - 44 Aboriginal and Torres Strait Islander Child and Family Centres (ACFCs) (with commitment for another 6 in NSW) - 31 Multifunctional Aboriginal Children's Services (MACS) Note: Some of these are counted in other models
Child and Family Centres	ACT	3
Child and Family Centres	Northern Territory	6 with plans to build 2 more
Early Years Places	Queensland	56
Children's Centres	South Australia	47
Child and Family Learning Centres	Tasmania	13 centres with commitment and plan to build 5 more (2 were originally funded with a focus on Aboriginal families and children.)
OurPlace	Victoria	10
Health Hubs		
National Aboriginal Community Controlled Health Organisations	National	145
Primary Health Care Hub	National	13
Non-government led Hubs with health partnerships	NSW	7
School Hubs		
Child and Parent Centres	Western Australia	22
Our Place	Victoria	10
Family LinQ	Queensland	2
Yarrabilba Family & Community Place	Queensland	1
Challis Primary School Early Childhood Education Centre	Western Australia	1
Community Hubs	National	98
Other notable Hub models which focus on integrated service delivery in the early years		
Enhancing Children's Outcomes (EChO) Centres	National	40
Connected Beginnings	National	25
Safe Haven	Victoria	2

Note: The information in this table was developed by Deloitte's and adapted to reflect the advice of National Network members.

Appendix 4: Child and family impact stories

Case Study 1 - Holistic and integrated care for an Aboriginal Family in Townsville[40]

A Townsville Aboriginal and Islander Health Service (TAIHS) Family wellbeing worker brought an Aboriginal mother and Aboriginal father who were expecting their first child to Yamani Meta in 2021. The parents were experiencing high levels of stress and the mother feared her baby would be removed by child services because her first born child, now aged in their teens, was removed from her care. The family was provided with case management support and referral though the TAIHS Wellbeing service to address the domains of parenting, family interactions, health, connections (with culturally appropriate services) and material wellbeing.

Both parents were supported to begin attending Bubba Yarns, a program co-facilitated by Yamani Meta midwifery group practice with midwives from the Townsville Hospital. Both parents attended the Bubba Yarns group regularly and were supported to strengthen their relationship, parenting skills and develop a positive outlook on the birth of their child. Weekly engagements for the family also included support to develop their social and emotional wellbeing and antenatal care. Mum returned to Bubba Yarns with her newborn baby days after giving birth having had a positive and complication free birth. Her continued attendance meant that the Yamani team and hospital midwives were able provide information, support and referrals on any questions on her newborn baby's development. Mum has built a strong support network across TAIHS and other health services. Mum joined the Book of the Week program which supports her family to build a home library, enjoy reading at home, connect with the Yamani Early Childhood teacher and learn about the role of parents as first teachers.

Mum continues to seek information and support from staff at Yamai Meta for her child's development and her own postnatal care. The family have strong connections to the Yamani team and have built trust with other services including Townsville Hospital. Although the family have achieved their case plan goals and do not need case management support Mum and Bub continue to attend Bubba Yarns each week and also started attending Yamani Play. On the Parent Empowerment and Efficacy Measure (PEEM) Mum assessed herself as the highest score of 10 and observed that Yamani Meta is the reason for her high score.

Importantly, the ongoing healing journey for Mum continues with the care and support of the Yamani Meta team. Mum experienced extreme domestic violence as a young mother when her first born child was removed from her care. The family have reconnected as a step towards family healing and Mum's firstborn, a young teenager, travelled to Townsville during school holidays to meet and spend time together. The healing and connection to Yamani Meta continues for the family. (SNAICC 2022 p14.)

Note: This case study has been adapted from the full case study provided in the SNAICC publication on good practices of early intervention and family support programs that are being delivered by Aboriginal community-controlled organisations across Australia. The case study was published in the Townsville Aboriginal and Islander Health Service Yamani Meta Family Wellbeing House publication. The case study used the language of 'Mum and 'Bub' and the same language has been used in this example for consistency.

Case Study 2 – Early Years Place run by the Benevolent Society [36]

30-year-old Sarah is in a de facto relationship and has a daughter, Michelle (3 years old) and a son, Jack (5 years old). They live in social housing. Both the children and their father identify as being of Aboriginal descent. Michelle and Jack are both experiencing developmental delays. Sarah left school in Year 9 and does not currently have a paying job. She has a long history of experiencing domestic family violence (DFV) in the home, which has been regularly observed by her children. She wanted to separate from her partner but has struggled to navigate that process. Her partner controls the money, her phone and her access to family and friends. Sarah spends most of her time at home and is very cautious of people she doesn't know.

Sarah found out about The Benevolent Society Early Years Program (EYP) when her doctor at the local Aboriginal and Torres Strait Islander health service suggested she make contact. After calling the service, Sarah was invited to bring Jack and Michelle to the Explorers Playgroup which is specifically designed for children experiencing developmental delays. Michelle and Jack love playing with the other kids and Sarah has felt great relief that she can talk about her parenting experiences with other parents going through similar challenges – suddenly she doesn't feel so different. It feels like a safe place she can come to where there is no judgement, just friends and staff who support her.

Sarah quickly realises the staff are an amazing resource– with an occupational therapist, a speech pathologist and a child and family practitioner all under the same roof. And the support continues, with the EYP providing ongoing targeted support to help Sarah and her children stay on track. In addition to regular supervision provided to all staff, the Team Leader in charge of Sarah's case actively seeks the views from both Sarah and staff about how well the interventions are working and what they could do differently next time. This includes support seeking affordable housing, help finding a school that can best support Michelle's needs and then help to get Sarah a reduction in school fees. Over time, Sarah and her children experience secure housing, improved community connection and Michelle successfully transitions to school.

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National Child & Family
Hubs Network

Child and family hubs: an important ‘front door’ for equitable support for families across Australia

FEBRUARY 2023

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The authors represent the National Child and Family Hubs Network (the Network). The Network is a multidisciplinary group that brings together Australian universities, research centres, medical research institutes, and state government departments. The Network's members are actively involved in conducting research, training, communication, and advocacy related to innovative (and sustainable) integrated community-based Hubs, to support the health and wellbeing of children and families.

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www.childandfamilyhubs.org.au

Background

Ensuring young Australian children have the best possible start to life requires children and families to have equitable access to quality services and supports. Indeed, by the time children start school, research has demonstrated two clear issues: high rates of preventable health and developmental problems, [1] and clear inequities already evident. [2] These inequities track forward to adulthood [3,4] and are socially patterned by family adversity [5] and the broader social determinants of health. [6] Addressing inequities early in life has the potential to fundamentally change children's opportunities and create a healthier and more productive future adult population. [7]

As family adversity and social (non-health) determinants of health, development and learning incorporate intersectionality with a number of services, a multi-sector approach is required to prevent and intervene early on these issues. However, current service offerings do not meet the diverse needs of children and their families or effectively address these inequities. For example, a key finding of the National Children's Mental Health and Wellbeing Strategy is that the children's mental health system is overly complex and fragmented, and the onus is on families to try and navigate the system and access appropriate services. [8] In many localities we don't need to add more services or programs for children and families, [9] but we need better system integration and coordination to identify early and intervene effectively to address the underlying needs of children and families.

One solution increasingly recognised around the world is building connections between existing services to meet the diverse needs of families. [10] This approach is gaining momentum around Australia with models being developed that aim to integrate variations of health, education, social care (including legal and financial), and social support within co-located child and family focused hubs. [11] Enthusiasm for this approach creates an opportunity for coordination, learning and evidence building to ensure a secure and effective policy future.

In this paper we explore what is meant by a child and family hub and identify core components that underpin the delivery of these hubs that have emerged from Australian and international research. The newly established National Child and Family Hubs Network offers the opportunity to consider how hubs can become important 'front doors' to drive equitable access and quality service delivery across Australia.

What is a child and family hub in the Australian context?

Child and family hubs provide a 'one stop shop' for families to support child development and improve child and family health and wellbeing. They do so via two critical roles:

1. improving equitable access to a range of health, education, and social services using a family centred approach
2. providing opportunities to build parental capacity and for families to create social connections.

Currently there are over 100 hubs across Australia providing a non-stigmatising 'front door' for families to access a range of co-located and virtual services and supports. These hubs are located in early childhood services, primary schools, primary health care, non-government organisations, Aboriginal Community Controlled Health Organisations (ACCHOs) and, or available virtually. Each setting provides a potential equitable service platform to engage a wide population of children and their families, particularly those living with adversities. The services within these settings are then able to identify and respond to emerging developmental issues, and health, education, and social issues early in a child's life. These settings also support the promotion of protective supports such as high-quality education, assisting with the transition to school, supporting and connecting families, promoting positive parenting, supporting culture, and providing other safeguards for children's development, conveniently, all in one place where the benefits of the whole are greater than the sum of its parts.

The evidence for integrated child and family hubs

Integration occurs along a continuum from isolated action to communication, coordination and co-location, collaboration, and ultimately integration. [12] Integrated child and family hubs bring together services and supports in a shared, seamless and united way. Although integration is what hubs aim to achieve, there are still likely benefits from steps along the continuum prior to integration.

There is a growing body of evidence (although variably robust) on the effect of integrated care on a range of both service (i.e., more equitable access) and child and family outcomes. Within early childhood services, integrated care and supports have been associated with improved school readiness and parental knowledge and confidence. [13,14,15,16] Co-located and integrated early years and primary school settings have shown trends toward improved child academic outcomes compared to children attending non-integrated models of care and support. [17] Integrated community-based hubs established by non-government organisations have been associated with improved identification of developmental vulnerability and increased access to care for families who might not otherwise engage with these services. [18,19,20,21]

Integrating care within primary health care settings is associated with improved family engagement, [22] coordinated supports across health, social, and education systems, [23] improved child health outcomes, [24] and reduced health care costs. [25] Additionally, ACCHOs address the social determinants of health and health inequity experienced by Aboriginal and Torres Strait Islander communities by delivering integrated, holistic, comprehensive, and culturally appropriate primary health care to the community who controls it. ACCHOs attract and retain Aboriginal clients significantly more than mainstream providers [26] and are more effective than mainstream health services at improving Indigenous health. [27] Evidence from each of the above settings provides promising support for integrated care, however, the lack of robust research required to sustain and evolve integrated hubs is a significant gap in Australia and internationally.

Common core components of hubs

Although the front doors of hubs will look different depending on the community and setting they are located in, there are a number of foundational core components that are common across all hubs that are more likely to lead to effective engagement and equitable implementation. Identifying these core components is important to ensure that new and existing hubs embed these within their development, implementation, and evaluation. Common core components of all hubs that are emerging are outlined in Figure 1. Ongoing research is required to establish the link between these core components and hub efficacy related to integrated family-centred care and child and family outcomes.

There are also setting specific hub components, such as a focus on education and social connections within early years services and primary schools and a focus on navigation for families and practitioners to appropriate services within a health setting. These setting specific components support the main purpose of each setting and are outlined in the outer sections of Figure 1.

For hubs situated within early childhood service settings there is evidence supporting the inclusion of setting specific components such as provision of quality education, parenting support and opportunities and facilities enabling families to make social connections as outlined in Figure 1. [28] Some of these setting specific components are echoed in co-located early childhood and primary school settings, whereby engagement and enrichment activities for children and providing adult engagement, volunteering, learning and employment opportunities are identified as important. [29]

Within primary health care hubs best practice indicates setting specific components such as a wellbeing coordinator role to support caregivers to identify the holistic needs of their child and/or family and assist them to navigate relevant services and supports in the community, social and health sectors; co-location of health, social, legal, and financial care practitioners; and mapped referral pathways within and outside of the hub. [30] Hubs based in non-government organisations (NGO) also echo the importance of setting specific components such as care navigation, outreach by child and family health services, engaging with community and NGO partners with clear governance arrangements, documented triage, referral pathways and a commitment to collective impact between services. [31]

Further research will be required to comprehensively identify common core and setting specific components of hubs and enabling factors across each setting in Australia and understand commonalities and differences between these settings and jurisdictions. There is also a paucity of evidence as to how components are implemented and adapted, such as for rural or regional areas of Australia, multicultural or Aboriginal communities, or when focussed on a specific health or development issues, such as mental health. [29, 32]

Figure 1: Core components of child and family hubs and additional components evident in a range of hubs

A timely policy environment

A number of Australian state and federal policies support the need to implement and evaluate integrated, or collaborative models of care such as hubs. These policies are positioned within health, education, and social service departments exemplifying the need for a multi-sector approach to integrated hubs. See Table 1 for a number of supportive policies for integrated hubs across Australia.

Table 1. Examples of supportive policies for child and family hubs across Australia

Jurisdiction	Policy
Australian	National Children's Mental Health and Wellbeing Strategy [8]
	Productivity Commission Mental Health Inquiry Report [33]
NSW	NSW Building Strong Foundations Program Service Standards [34]
	New South Wales First 2000 days Framework [35]
	NSW Government Brighter Beginnings Initiative [36]
Queensland	Queensland's Strategy for Social Infrastructure [37]
South Australia	South Australian Mental Health Strategic Plan 2017-2022 [38]
Tasmania	Tasmania's Child and Youth Wellbeing Strategy [39]
Victoria	Royal Commission into Victoria's Mental Health System [40]
Western Australia	Child and Adolescent Health Services, Community Health Hubs [41]

Supporting child and family hubs via the National Child and Family Hubs Network

With increasing interest in child and family hubs across most Australian jurisdictions there is currently no coordinated group of organisations implementing and evaluating integrated community-based hubs. Hence, the National Child and Family Hubs Network has been designed to leverage this interest and create an opportunity for collaborative learning and sustainable and effective practice. Over the coming three years the Network aims to:

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

Through this work the Network will enable the vision of all families being able to walk through a hub's welcoming front door and receive the right care and support for their child and family at the right time, leading to improved and equitable health and development outcomes.

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Child and family hubs: an important 'front door' for equitable support for families across Australia

FEBRUARY 2023

National Child & Family Hubs Network

www.childandfamilyhubs.org.au

SVA Social Ventures Australia

Happy, healthy and thriving children

Enhancing the impact of Integrated Child and Family Centres in Australia | May 2023

Social Ventures Australia (SVA) acknowledges Traditional Owners of Country throughout Australia. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present, and emerging. We also accept the invitation in the Uluru Statement from the Heart to walk together with Aboriginal and Torres Strait Islander peoples in a movement of the Australian people for a better future.

About Social Ventures Australia

Social Ventures Australia (SVA) is a not-for-profit organisation that works with partners to alleviate disadvantage – towards an Australia where all people and communities thrive.

We influence systems to deliver better social outcomes for people by learning about what works in communities, helping organisations be more effective, sharing our perspectives and advocating for change.

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Suggestion citation for this report

Social Ventures Australia (2023), *Happy, healthy and thriving: enhancing the impact of our Integrated Child and Family Centres in Australia.*

Executive summary

Children and their families need to be supported to ensure children grow up happy, healthy and thriving. When all young children and families in Australia are flourishing, we create a strong and vibrant society and set the course for a bright future.

Currently, this is far from the case in Australia. Significant inequalities in developmental and educational outcomes between children experiencing socio-economic vulnerability and others exist.[1]

Integrated Child and Family Centres (ICFCs) have the potential to meet many of the needs of children and families experiencing socio-economic vulnerability. They can help shift these outcomes and fill a major gap in the current early years landscape.[2]

This discussion paper examines the barriers and enablers that affect current ICFC models' ability to achieve the best outcomes for children and families. It aims to inform strategies to both strengthen impact of existing ICFC models and scale ICFCs to ensure children who most benefit are able to access them.

Integrated Child and Family Centres (ICFCs) are a service and social hub where children and families can go to access key services and connect with other families. ICFCs usually take the form of a centre that provides a range of child and family services – including early learning programs, maternal and child health (MCH) and family support programs.

ICFCs provide access to a range of tiered services to support families with broader challenges they may be facing. They also provide a space where families can come together to socialise and build social networks.

A child's circumstances affect their health and developmental outcomes. The more disadvantaged a child's circumstances, the poorer their health and developmental outcomes are likely to be.[3] Early intervention is, therefore, critical. Research shows that the failure to redress early inequities results in wide disparity gaps in rates of health and developmental outcomes in adulthood.[4]

ICFCs seek to provide a holistic response to the needs of children and their families and improve the condition under which families are raising young children. An effective ICFC will have the capacity to:

- Identify and support a child's learning and development needs.
- Provide access to early intervention supports.

- Identify broader issues that may be affecting a child's wellbeing, such as poverty, family violence and marginalisation.
- Provide support, referrals, and appropriate services in response.
- Provide a safe space for families to build connections.

Starting Better: A Guarantee for Young Children and Families explores what a world class universal early childhood development system in Australia could look like. ICFCs serve as an important vehicle to deliver on the core elements of the guarantee (except parental leave), and in particular the wrap around navigator service and seamless support for children.

This discussion paper draws on national and international research as well as insights from a series of interviews with ICFC centre leaders, sector leaders and government representatives to identify the complex factors that affect ICFC outcomes. It explores funding mechanisms, operating model, centre leadership, authorising environment, quality and the use of data. The findings contribute to broader questions around what operational, policy and funding structures are needed to best support outcomes for families experiencing socio-economic disadvantage through the ICFC model.

Findings

The current ICFC landscape in Australia is patchy, with diverse models of variable scale and capacity, major gaps in coverage and no national approach to delivery. ICFCs operate under a range of funding mechanisms and operating models. Currently, there is no overall leadership or responsibility for outcomes. Further, quality is essential for ICFC outcomes and there is no overarching approach to measuring or assessing quality.

There are approximately 209 ICFCs across the country, leaving a significant proportion of children and families who would benefit from an ICFC unable to access one, and many are not experiencing the full potential that they can provide due to the varying capacity and quality of existing centres. Modelling undertaken by Deloitte Access Economics identified at least 100,000 additional children aged birth to six who are in need of an ICFC are currently not able to access one.[5] Geographically, this need is spread across 706 communities (Statistical Area Level 2, SA2).

Key findings on the structural enablers for impact

Effective funding for a holistic, child-centred approach is needed.

- An **effective funding model** is a central enabler for ICFCs to be able to operate efficiently, effectively and flexibly to meet the needs of children and families. This requires secure, long-term funding for provision of core services and flexible funding for diverse child and family related services responsive to community needs.
- The **integration 'glue' component** is core to the ICFC operating model. It describes the leadership, structures and practices that bring all the individual services and staff together to create an integrated, holistic service model. The glue function must be valued and recognised in the funding centres receive.

Aboriginal and Torres Strait Islander integrated early years centres are unique in their purpose and structure, and require a unique response.

- **Cultural safety, strength and inclusion** are significant enablers for Aboriginal and Torres Strait Islander integrated early years centres. This model is the most sophisticated and broad in its operating model and service scope but faces the most significant challenges in terms of funding and authorising environment. A unique response is needed to support Aboriginal and Torres Strait Islander integrated early years centres, particularly given their critical role in supporting positive outcomes for children, families and communities.

Centre leadership and workforce are critical.

- Centres are staffed by **committed and dedicated leaders** and staff members who understand their communities and what is needed to have impact. However, structural and funding limitations often limit centre leaders' ability to implement this vision. They face significant burdens and often operate with little support or control.
- **Adequate remuneration** and professional support for centre leaders and the workforce are fundamental for impact. This includes better pay and conditions. Equally important, this also includes professional supports that recognise the challenging and often psychologically demanding nature of their job – such as professional supervision, business and operational support, and professional development.
- **Centre leaders need to be empowered** to be innovative and lead the model to ensure it is high quality and responsive to family needs. Current models range from highly proscriptive and well supported – but with limited scope for centre leaders to lead the model – to very flexible models where centre leaders have a lot of autonomy but minimal support.

There is a need for structures and processes to support consistent high-quality outcomes.

- **Quality** is very important to ensure the best outcomes for children, however there is currently no national quality framework applicable to ICFCs. There is also no formal mechanism to assess quality outside of Early Childhood Education and Care (ECEC) services that fall under the National Quality Framework (NQF). Consistent, national quality assessment tools and measurements, and professional development supports are needed to ensure consistent standards and support best practice.

The operating model supports the structure and practises of the centre.

- ICFC staff needs to be supported to work in a way that is **child-centred and relational**. It is important that all staff members feel they are contributing collectively to the child and family outcomes.
- ICFCs can support families both through formal service delivery and as a **social hub** where families with young children can go to meet and connect with other local families and build their social support networks. For this to occur, ICFCs require a **drop-in, open space** where families can come outside of formal service provision. They also need to ensure staff members are available to connect with families outside of formal service provision. They can do this through informal activities, such as cooking sessions, cultural activities and having the time and capacity to listen and support families with their concerns. These informal activities must be valued and adequately resourced.

- Integration is required throughout all levels of the model, not just at the point of service delivery. Current ICFCs are having to navigate government siloes to deliver an integrated centre. State government departments need to consider how they can provide integrated funding, overcome data sharing barriers and fully incorporate all services, including MCH and allied health, into the model. Better integration is also needed across state and federal government departments to ensure centres are supported to deliver a broad range of services, including childcare, and are not having to report separately on multiple funding streams.
- Comprehensive **allied health** service provision is a systemic gap across ICFC models. Although all interviewees stressed the importance of allied health for early intervention and child development, access to allied health services is limited or absent and usually does not include therapeutic support. Individual centres and families take on the responsibility for finding, accessing and funding allied health services. There is currently no systemic way to provide these critical services.

Governments and funders have an important authorising role in enabling the model.

- **Effective leadership** from government and funders and a supportive authorising environment are important to ensure models are adequately resourced and enabled.
- Governments and funders need to **recognise and value** ICFCs by as a key vehicle to meet the needs of young children and families experiencing disadvantage.
- **Collaboration and partnerships** are required between federal and state governments, and between state government departments. These are critical in many ways. Examples of collaborations and partnerships include facilitating data sharing, enabling child care provision, and streamlining procurement and funding processes.

ICFCs play a key role in supporting children and families. There is a significant opportunity to increase ICFCs' impact by ensuring that all current models can implement the key enablers. The deeper understanding of enablers and barriers presented in this paper also assists in framing a national approach to ICFCs and identifying critical systemic reforms that could see significantly more children in Australia thriving in the early years.

State and territory governments play a key role in this space. Most have an ICFC model operating at some level of scale across their jurisdiction; they are also actively involved in supporting these centres to achieve outcomes that enable children and families to thrive. However, the level of unmet need across the country requires a significant investment and overarching leadership beyond what any individual state can deliver on its own. It highlights a critical national leadership role for the federal government in providing an umbrella for ICFCs to be recognised, defined and supported as a sector, and potentially a greater role in funding and outcome measurement. A tripartite approach is recommended to bring together the federal and state and territory governments, and the sector, to develop a collective approach to drive the necessary reforms.

Key recommendations

1. Create a national approach to ICFCs that includes a broad definition with core components, a national quality framework and a professional learning system. Staff capability building around integrated practice is important to include, recognising ICFCs require a very different way of working.

2. Design and operationalise a funding model specifically for ICFCs that ensures ICFCs are child and family centred, responsive to community need, sustainable and supported to deliver on their role as an integrated service and social hub. This should explore options for pooled, holistic funding.

3. Design a unique funding stream for Aboriginal and Torres Strait Islander integrated early years centres. This funding stream should privilege Aboriginal Community Controlled Organisations (ACCOs) for Aboriginal and Torres Strait Islander children. It should also recognise and support their vision, operations and structures.

4. Ensure ICFCs can provide Early Childhood Education and Care (ECEC) services, including child care, if appropriate in their community.

5. Reform the allied health system to ensure a systematic way for ICFCs to provide access to allied health for children and families.

6. Provide support for centre leaders and the ICFC workforce. This includes competitive remuneration, working conditions, practice frameworks and other necessary supports – such as clinical supervision – to ensure they can thrive in the role.

7. Provide support to further enhance outreach within the ICFC operating model to ensure centres are reaching the most vulnerable members of the community.

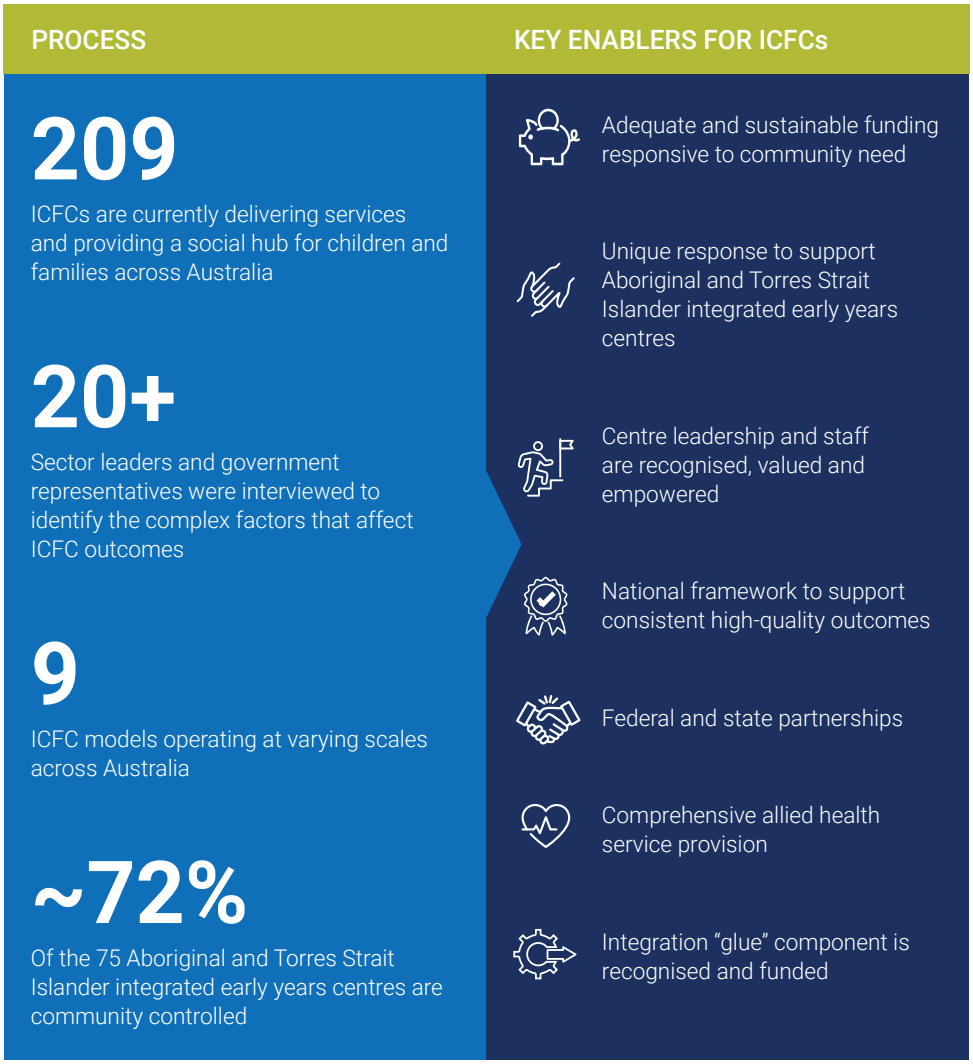
8. Introduce a system stewardship approach to support a shift in government leadership that supports collaboration and integration. This approach should ensure the needs of children and families are the central focus of service design and delivery.

9. Fund evaluation and build the capacity of ICFCs to collect and analyse appropriate data. This allows them to evaluate their service, measure their impact and use learnings to evolve service delivery.

10. Facilitate a process for the federal, state and territory governments, and sector leaders to consider and develop a national plan for recognition, support and growth of the ICFC sector.

Happy healthy and thriving children

Enhancing the impact of integrated child and family centres in Australia



10 Recommendations

1. Create a national approach to ICFCs that includes a broad definition, national quality framework and a professional learning system

2. Design and operationalise an ICFC specific funding model

3. Design a unique funding stream for Aboriginal and Torres Strait Islander integrated early years centres

4. Enable ICFCs to provide Early Childhood Education and Care (ECEC)

5. Reform the allied health system to ensure ICFCs are able to provide access to allied health for children and families

6. Better remunerate and support ICFC leadership and workforce

7. Enhance ICFC outreach services

8. Introduce a system stewardship approach that supports collaboration, integration and a child-centred focus

9. Strengthen funding and supports for evaluation and data collection and analysis

10. Facilitate a process for governments and sector leaders to consider and develop national plan to recognise, support and grow ICFCs

Contents

List of abbreviations

ACCS	Additional Child Care Subsidy
ACCO	Aboriginal Community Controlled Organisation
ACCHO	Aboriginal Community Controlled Health Organisation
ACFCs	Aboriginal Child and Family Centres
AEDC	Australian Early development Census
ARACY	Australian Research Alliance for Children and Youth
CCCF-R	Community Childcare Fund-Restricted grant
CCCH	Centre for Community Child Health
CCP	Child Care Package
CCS	Child Care Subsidy
CFLCs	Child and Family Learning Centres
CHaPS	Child Health and Parenting Service (Tasmania)
COAG	Council of Australian Governments
DCJ	Department of Communities and Justice (NSW)
DECYP	Department of Education, Children and Young People (Tasmania)
ECEC	Early Childhood Education and Care.
EYPs	Early Years Places
ICFCs	Integrated Child and Family Centres
IDC	Interdepartmental Committee
MACS	Multifunctional Aboriginal Children's Services

MCH	Maternal and Child Health.
MCRI	Murdoch Children's Research Institute
NGO	Non-government organisation
NPA IECD	National Partnership Agreement on Indigenous Early Childhood Development
NQF	National Quality Framework
SVA	Social Ventures Australia
QDoE	Queensland Department of Education
VDE	Victorian Department of Education
TBS	The Benevolent Society

List of key terms

Aboriginal and Torres Strait Islander integrated early years centres is a collective term used to describe Aboriginal and Torres Strait Islander Child and Family Centres (ACFCs) and Multifunctional Aboriginal Children's Services (MACS). Some of these centres have been incorporated into state-run models. Although all centres share a common vision and purpose, discussions around structural components are specific to those centres that are run independently of a state-run model.

Childcare is used to describe long day care centres. Although early learning centres is a preferable term, childcare is consistent with the language used nationally when referring to the Child Care Subsidy (CCS).

Children and families experiencing disadvantage is a broad term used to refer to those who are at risk of adverse impacts from being exposed to multiple social and economic stressors. This term includes children and families facing financial hardship, families who have been excluded and marginalised, as well as those living in communities with low socio-economic resources. experiencing socio-economic disadvantage.

Early Childhood Education and Care (ECEC) refers to all forms of childcare (long day care, occasional care, family day care) and preschool. Preschool is referred to as kindergarten in some jurisdictions.

Maternal and Child Health (MCH) is the term used to describe the child and health nursing systems in each jurisdiction.

SNAICC – National Voice for our Children is the national non-governmental peak body for Aboriginal and Torres Strait Islander children

1. Introduction

The first five years of a child's life is a time of rapid development and lays the foundations for health and wellbeing later in life.[6] During this time, children are especially susceptible to external input. They must be nurtured, supported and protected in order to thrive.

Research shows significant inequalities in developmental and educational outcomes exist between children experiencing socio-economic vulnerability and their peers.[7] In Australia, a child's risk of being developmentally vulnerable is closely correlated with the family income and level of socio-economic resources in the community in which they live.[8] The more disadvantaged a child's circumstances, the poorer their health and developmental outcomes are likely to be.[9] Families experiencing disadvantage often experience challenging life circumstances; they also face multiple barriers to individual wellbeing and community participation.[10] This includes complex and cooccurring challenges, such as low income, intergenerational trauma and low levels of parental education.[11] Early intervention has the potential to shift a child's trajectory and create healthier and more productive adults.[12]

Many programs offering integrated early childhood services have been implemented worldwide over the past two or three decades.[13] They are an essential step to ensuring that families facing multiple adversities have positive social networks and access to key services during their children's early years.[14] Integrated systems are designed to be child/family-centred, with positive outcomes for children and families pursued as a key goal rather than service outputs.[15] Australian Research Alliance for Children and Youth (ARACY) has identified universal early years services that provide holistic health, learning and parenting supports along with early needs identification as one of the best investments in early intervention and prevention.[16]

Integrated service delivery can simplify access to key services and ensure children and families can access universal services and tiered supports as needed. They also provide a safe place in the community where families with young children can go to meet other families. Recent research from the Centre for Community Child Health (CCCH) found that ICFCs have the potential to meet many of the needs of children and families experiencing disadvantage and can fill a major gap in the current early years landscape.[17]

The Young Children Thriving program within SVA seeks to create a more proactive and responsive early years system that delivers genuine prevention so that families experiencing hardships and socio-economic disadvantage have what they need to support their children to thrive. As part of this program, we have a specific initiative, Nurture Together, working to better understand and mobilise the potential of ICFCs to provide high-quality, integrated early childhood services and supports to children and families experiencing vulnerability.

This paper explores the key structural and operational components of existing ICFCs and their authorising environments. It is written to better understand the factors that are both enabling and limiting ICFCs from reaching their goals for positive impact for children and families.

This work will contribute to broader questions around what operational, policy and funding structures are needed to best support outcomes for families experiencing socio-economic disadvantage through the ICFC model. It is hoped that this research can be an input to better understanding ICFCs, and the principles and conditions for scale – including their effective inclusion in national and state early childhood policy frameworks as a key support for children experiencing disadvantage and their families.

Outline of paper

Section 1 introduces the paper and provides the background of the research.

Section 2 (context) provides a synthesis and analysis of the key findings from the interviews conducted for this discussion paper as well as current national and international research and their implications for impact of ICFCs on child and family outcomes. This focuses on the main structural and operational barriers and enablers that are impacting on current ICFCs in Australia.

Section 3 (description of ICFC models) provides a description of the four ICFC models included within the scope of this paper. This includes the Aboriginal and Torres Strait Islander integrated early years centres, Tasmania's Child and Family Learning Centres (CFLCs), Queensland's Early Years Places (EYPs) and Victoria's Our Place. Each case study also includes an overview of the key barriers and enablers impacting on each model.

Section 4 (findings) summarises the main findings from the discussion paper and presents recommendations on how ICFCs could be enabled for impact.

Section 5 concludes the paper and puts forward a series of key recommendations.

Methodology

In order to answer the core research questions below, SVA identified a series of the major models represented across Australia today for focus. This was based on a balance of criteria: diversity in scale and scope of model, representation of different types of funding mechanisms, variety of services included and geographic spread.

Key research questions

- What are the key structural and operational enablers for centres?
- What are the key structural and operational barriers faced by centres?
- To what extent do the funding and operating models support the centres to deliver on their vision?
- What is the role of the glue/coordination function and how does it operate?
- What data is being collected and how is it used?

We conducted interviews with ICFC centre leaders, sector experts and state and federal government representatives from across Australia. These interviews provided key information about the structural components of each service, including funding, staffing, data, operating model, authorising environment and integrated service delivery.

In addition to the first-hand experience of those working in the sector, we also collated and reviewed publicly available research and evaluations of ICFCs for inclusion in the case studies and analysis.

This paper does not represent the entire ICFC network in Australia. Limitations in terms of time, resources and access to centre leaders means the paper only includes a sample of Australian ICFC centres. All conclusions and principles in this paper have then been tested with people who participated in the interviews, as well as with a broader group of national sector experts. However, the conclusions in this paper are SVA's and do not represent the views of those who participated in the development of this research.

Interview participants

The centres interviewed for this discussion paper include:

- Bubup Wilam Aboriginal Child and Family Centre (Victoria)
- Cairns and Gordonvale EYP (Queensland)
- Lightning Ridge Aboriginal Child and Family Centre (NSW)
- Nikinpa Aboriginal Child and Family Centre (NSW)
- Queenstown CFLC (Tasmania)
- Redlands EYP (Queensland)
- Tasmanian Aboriginal Children's Centre (Tasmania)
- Wayraparattee CFLC (Tasmania)
- Yappera Children's Service Cooperative (Victoria).

Sector and government interviews include:

- Blaine Patterson and Sonya Parter, NSW Department of Communities and Justice
- Joanne Goulding, THRYVE NSW
- John Burton, SNAICC – National Voice for our Children
- June McLoughlin and Shannon Newman, Our Place
- Myra Geddes and Penny Markham, Goodstart Early Learning
- Paul Prichard, Murdoch Children's Research Institute
- Sakura Franz, Tasmania Department for Education, Children and Young People
- Tim Moore, Murdoch Children's Research Institute
- Yasmin Harman-Smith, Telethon Kids Institute.

2. Context

Early years in Australia

When children are supported in the early years, it supports them to do well at school and into adult life.[18] Research shows that children living in the most socio-economic disadvantaged areas are twice as likely to be developmentally vulnerable in one Australian Early Development Census (AEDC) domain and three times more likely to be vulnerable in two or more domains compared to children in the least disadvantaged locations.[19] In 2021, there was increased developmental vulnerability for children across the socio-economic spectrum but more so for children living in the most socioeconomically disadvantaged areas, reversing previous progress.[20] Aboriginal and Torres Strait Islander children are more than twice as likely as other children to be developmentally vulnerable on one or more domains. Early intervention is critical: research shows that the failure to redress early inequities results in wide disparity gaps in rates of health and developmental outcomes in adulthood.[21]

> **Children and families experiencing disadvantage** is a broad term used to refer to those who are at risk of adverse impacts from being exposed to multiple social and economic stressors. This term includes children and families facing financial hardship, families who have been excluded and marginalised, as well as people living in communities with low socio-economic resources.

Research has found that children's health and development are strongly shaped by the social, economic and environmental conditions in which they are born and live.[22] It is essential that the early years of a child's life are considered within this context, with priority given to initiatives that intervene as early as possible to have a maximum preventive effect. Evidence indicates that in families experiencing disadvantage, investing as early as possible, from birth through age five, provides the highest rate of return for early childhood development outcomes.[23] Research has identified the need to be focusing much more on improving the conditions under which families are raising young children, in addition to investments in high-quality, evidence-based early years services.[24]

Despite the evidence around the importance of the early years and what is needed to support children and families, the current system is not supporting all children to thrive. Research conducted by the Mitchell Institute found that many of the most vulnerable children in Australia are either not attending preschool at all, or they are accessing it at a lower quality and dosage than other children. This contributes to the current situation where nearly a quarter of Australian children arrive at school without the foundational skills they need with a child's risk of being developmentally vulnerable closely correlated with their socio-economic status.[25]

Early childhood development

The broader early childhood development system is often overlooked, underfunded, or considered separate from the universal early childhood education and health systems. Issues around poverty, family violence, mental health and marginalisation are key elements that must be addressed when seeking to improve outcomes for children experiencing hardship and vulnerability. The interplay of causal factors is complex and requires a holistic approach that considers the broader system and supports available to families raising young children. Data from the Millennium Cohort Study in the UK, for example, shows that parenting quality has nearly twice the impact on a child's development than persistent poverty.[26]

The Systems Mapping Report prepared by Orange Compass for the Early Years Catalyst identifies several deeply held societal beliefs that influence early childhood development outcomes.[27] This includes the punitive approach to poverty and undervaluing of children and care work, identified as core attitudes impacting on the structures of the current system. For example, discussions around early childhood education in Australia tend to focus on working parents and women's economic participation. Access to Early Childhood Education and Care (ECEC) is directly tied to the economic activity of a child's parents, meaning that some of the children most likely to need additional support are unable to access ECEC, at all or in sufficient quantities, despite having the most to gain from attendance. ECEC is viewed as merely childminding that is provided by market operators, with the role of government to protect and promote the market, rather than to intervene. Shifting these deep societal beliefs through a broader conversation about children, equity, universal access to early learning and the role of early learning programs and services to support child development is essential if Australia is to start shifting outcomes for the most vulnerable children.

> *"We need to redefine what universal means now. It's about breaking the current definition, which is adult centred instead of child centred. At the moment children are only entitled to things based on what the adults in their lives are doing. Right now if something changes for the adults then the children lose their access. Universal access should mean every child in Australia, regardless of where they were born, regardless of what mum and dad are doing, they all get to come and get the service, whatever that might be – early learning or other services and then for the children who need more and in the communities where the evidence clearly tells us they're going to need more, then we do more and do better."*
>
> **– Myra Geddes, Goodstart Early Learning**

Early Childhood Education and Care (ECEC) refers to all forms of childcare (long day care, occasional care, family day care) and preschool.

Integrated service delivery

Current early years service systems are complex and fragmented. Responsibility for the early years is split across federal and state governments; there is currently no overarching strategy or vision for the early years. Within state governments, early years priorities tend to span education, health and community services portfolios with funding and programs being developed within each of these agencies. Attempting to navigate this complex landscape can leave families experiencing vulnerability feeling humiliated and disempowered.[28] Evidence demonstrates that children and families with the greatest need are least likely to access services or receive the comprehensive support they need.[29] Integrated service delivery, as envisaged in this discussion paper, has the potential to overcome family barriers to accessing a range of key services and can respond holistically to child and family needs.[30]

Integration is often described as a continuum, with increasing levels of cooperation, coordination and collaboration.[31] Along this continuum, service integration involves increasing levels of cooperation, coordination, information exchange, joint planning, responsibility and accountability, and the development of formal partnership structures. Full integration is characterised by the merging of previously independent entities into a single, integrated entity.[32] Current ICFCs in Australia sit along the spectrum of integration, but based on the research for this paper, cannot at this stage be considered a fully integrated entity.

Evidence to support integrated service delivery in the early years

Evidence shows that children and families with the greatest need are least likely to access services or receive the comprehensive support they need.[33]

There is growing evidence on the impact of integrated service delivery for children and families, in a range of service settings, although robustness of this is variable.[34] As identified in the Early Years Impact Report from The Benevolent Society (TBS),[35] it is difficult to prove improved outcomes from an integrated model rather than standalone programs because of a combination of factors, including:

- There are many different services offered by multiple providers within each ICFC.
- Each ICFC is tailored to the individual needs of the cohort.
- There are a wide variety of outcomes sought by the cohorts.
- Government reporting frameworks require collection of output-related rather than outcome-related data.
- There is no publicly available counterfactual data against which to compare the outcomes of ICFCs.
- Measuring lifetime impacts of early childhood prevention-focussed interventions requires substantial investment into longitudinal studies.

However, emerging evidence of the impact of integrated service models includes improved:[36]

- school readiness and parental knowledge and confidence in integrated models focused on early learning
- academic outcomes for children in co-located early years/primary school settings
- identification of developmental vulnerability and increased service access for in community-based hub models
- engagement of families, better coordinated supports and improved child health outcome in integrated community health models.

Definition of ICFCs

This paper defines ICFCs as a service and social hub where children and families can go to access key services and connect with other families. ICFCs usually take the form of a centre that provides a single location for the delivery of a range of child and family services, including early learning programs, maternal and child health (MCH) and family support programs. ICFCs provide access to a range of tiered services to support families with broader challenges they may be facing. They also provide a space where families can come together to socialise and build social networks.

Integrated Child and Families Centres (ICFCs) are a service and social hub where children and families can go to access key services and connect with other families. There are different models of ICFCs in Australia, as described through this paper. The term ICFCs is used as an umbrella term to incorporate all of the models discussed in this paper, including Aboriginal and Torres Strait Islander integrated early years centres.

The Core Care Conditions for Children and Families identified significant key child and family needs that could be met through an ICFC, including:

- secure relationships with primary caregivers
- support to develop emotional and self-regulation skills
- positive early learning environments in the home as well as in ECEC and community settings
- opportunities to mix with other children of different ages and to build social skills
- support to establish regular sleep patterns
- physical opportunities to play and explore
- positive social support networks
- safe and easily accessible places to meet other families
- access to relationally based family-centres services
- access to universal services during antenatal/perinatal/postnatal periods
- access to specialist support services to address additional personal needs (such as mental health issues, family violence)
- information about child care and development and support for managing the challenges of parenting
- availability of learning opportunities to build personal capabilities
- access to support services to address exceptional family needs (such as financial counselling, housing services).

Specific to Aboriginal and Torres Strait Islander children, SNAICC – National Voice for our Children, also identified the role of Aboriginal Community Controlled Organisations (ACCOs) in meeting a child and family's need for a safe space to build cultural pride, confidence and resilience and to build on the strengths and skills of their children.[37]

Although integrated early years models could benefit all children and families, the evidence around the impact of disadvantage on children's development and wellbeing suggests prioritisation for ICFCs should go to families experiencing disadvantage.

ICFCs have a dual benefit. Firstly, they are a social hub where families with young children can go to meet and connect with other local families and build their social support networks. Secondly, they can act as a service hub for the delivery of a wide range of integrated child and family services.[38] It is important, however, that ICFCs are situated within an ecological model to have most impact on the lives of children and families. Broader place-based supports and an enabling policy environment are necessary to truly support all children and families to thrive.

ICFCs are designed to be responsive to community need and therefore the mix of supports they offer will vary. Some centres offer formal Early Childhood Education and Care (ECEC) within the service, whereas others support families to access ECEC through transition support programs (such as Launching into Learning) or structures (such as being co-located with a preschool/school). The infrastructure of an ICFC is also important to its operations. Centres have safe and private consultation rooms; they are also designed in a way to enable families to drop in for unscheduled visits, with spaces for children to play and communal kitchens.

ICFCs also support families through their role as a social hub, which is enabled by having centres open as a drop-in, open space where families can come outside of formal service provision. This is supported by ensuring staff is using culturally safe, child-centred and relational practices and has un-rostered time to be able to sit with clients, talk about issues and engage in casual interactions. These structures and informal activities help to ensure ICFCs provide a welcoming environment that is culturally safe: families feel safe and supported to build relationships with staff and other families. When of high value, the outcomes of this informal work are both immediate and contributing to long-term relationship building and gradual positive sustainable change in families and communities. They also focus engagement around strengths and connection, rather than perceived problems or deficits.[39]

Current ICFC landscape in Australia

There are a range of ICFC models across Australia. The ICFC landscape has evolved over time and includes a patchwork of different funding models, priorities and operating structures. There is poor and inconsistent service coverage nationally: a significant proportion of children who would benefiFC are unable to access one and many not experiencing the full potential that they can provide. Interviewees in some jurisdictions observed that their model has been subject to fluctuating budgets and support depending on the government of the day. There is no overarching strategy or outcomes framework that supports ICFCs across Australia and very little that links these centres nationally.

State and territory governments are the main funders of ICFCs across Australia. There are ICFCs operating in each jurisdiction, though curiously, the two biggest states – Victoria and NSW – are the only states without a dedicated model in place. Some models, such as the Tasmania's Child and Family Learning Centres (CFLCs), are operated by state governments, while others, such as the Queensland's Early Years Places (EYPs), are operated by non-government organisations (NGOs) providers. Aboriginal and Torres Strait Islander integrated early years centres are the only model operating nationally, with many of these centres operated by Aboriginal Community Controlled Organisations (ACCOs).

The federal government does not currently play a major role in the ICFC landscape. Its main role is management of the ECEC system, with the provision of the Child Care Package (CCP) and development and oversight of the National Quality Standards and Early Years Learning Framework. It was originally involved with the establishment of Aboriginal and Torres Strait Islander integrated early years centres. But it discontinued funding for the Aboriginal and Torres Strait Islander Child and Family Centres in 2014, with the remaining centres now receiving a range of funding arrangements through the Child Care Package and state governments. It continues to provide designated funding to MACS through the Community Child Care Fund, as well as the Child Care Subsidy. More recently, the federal government has established the Connected Beginnings program for targeted Aboriginal and Torres Strait Islander communities across Australia.

The table below identifies the ICFC models currently operating in Australia and other notable models focused on integrated service delivery in the early years.

Australian ICFC models

Model	Jurisdiction	Scale	Funded by	Operated by
Aboriginal and Torres Strait Islander integrated early years centres	National	75 – 44 Aboriginal Child and Family Centres (ACFCs) with commitment for another 6 in NSW – 31 Multifunctional Aboriginal Children's Services (MACS) Note: Some of these are counted in other models	Mix of funders including: – federal departments: Department of Education, Department of Human Services – NSW Department of Communities and Justice Grant funding from federal, state and local governments	Mixture of ACCOs, NGOs and local or state government
Child and Family Centres	ACT	3 (1/3 is Aboriginal and Torres Strait Islander services)	Community Services Directorate ACT	Community Services Directorate ACT Government
Child and Family Centres	Northern Territory	6 with plans to build 2 more (All Aboriginal and Torres Strait Islander services)	Department of Education Northern Territory	Mixture of ACCOs, local or state government

Model	Jurisdiction	Scale	Funded by	Operated by
Early Years Places	Queensland	56 (10/56 are Aboriginal and Torres Strait Islander services)	Department of Education Queensland	NGOs
Children's Centres	South Australia	47 (4/47 are Aboriginal and Torres Strait Islander services)	Department for Education South Australia	Department for Education South Australia
Child and Family Learning Centres	Tasmania	13 centres with commitment and plan to build 5 more (2 were originally set up as Aboriginal and Torres Strait Islander services)	Department for Education, Children and Young People Tasmania	Department for Education, Children and Young People Tasmania
Our Place	Victoria	10 sites	Coleman Foundation, with infrastructure provided by Department of Education Victoria	NGOs
Child and Parent Centres	Western Australia	22 (5/22 are Aboriginal and Torres Strait Islander services)	Department of Education Western Australia	Predominately NGOs with one run by local government
Challis Primary School Early Childhood Education Centre	Western Australia	1	Minderoo	Minderoo

Other notable models that focus on integrated service delivery in the early years				
Model	**Jurisdiction**	**Scale**	**Funded by**	**Operated by**
Enhancing Children's Outcomes (EChO) Centres	National	40	Goodstart Early Learning	Goodstart Early Learning
Connected Beginnings	National	25	Department of Education (federal department)	Mixture
Safe Haven	Victoria	2	Department of Education Victoria, Department of Education (federal department), and philanthropic organisations	NGO and local government

Note: There may be other individual community-run centres that have not been captured in this list

Policy context

The election of the Albanese Labor Government in 2022 brought with it a renewed political interest in early years policy. This included significant funding commitments around child care, the opening up of conversations around universal access to early learning, and a commitment to develop a National Early Years Strategy in consultation with the sector. These announcements coincided with significant investment from the NSW and Victorian governments in early childhood education service delivery, including the introduction of a new year of free early learning for all children in both states in the year before school.

This is an opportune time to explore how our early childhood systems could better respond to the needs of children and their families, particularly those experiencing disadvantage. This strategy could include a commitment to see ICFCs available to children experiencing socio-economic disadvantage and optimised for the most impact and potential.

There has been recent interest from governments and stakeholders in identifying opportunities to improve and expand ICFC service provision. Notably:

- The Benevolent Society has developed an **Early Years Impact Measurement Framework** and used it to collect preliminary data from its EYPs in Queensland. It is now building a coalition of partners to

embark on a second stage to create a robust method for measuring the social and economic impacts of integrated early childhood services in Australia.

- Department for Education, Children and Young People (DECYP) in Tasmania has engaged Murdoch Children's Research Institute (MCRI) to develop a **quality improvement tool** to drive improvement in the Child and Family Learning Centres (CFLCs). It has also announced plans to build six new CFLCs.
- Queensland Department of Education (QDoE) has engaged MCRI to develop a **quality improvement tool for the EYPs**.
- The NSW Government has **significantly increased funding to NSW Aboriginal Child and Family Centres (ACFCs)** through the Brighter Beginnings Initiative. This also includes funding to establish more ACFCs and expand the capacity of existing centres.
- SNAICC – National Voice for our Children, partnering with SVA, has developed a **national pilot initiative (THRYVE) to support and represent Aboriginal and Torres Strait Islander integrated early years services** in the delivery of high quality, responsive, accessible, and culturally strong early years supports for Aboriginal and Torres Strait Islander children, families, and communities to thrive. It is currently being piloted in NSW, Western Australia and Victoria.
- The **National Child and Family Hubs Network** has been established by MCRI to bring together relevant stakeholders involved in research, training, communication, and advocacy related to innovative and sustainable integrated community-based hubs, to support the health and wellbeing of children and families.
- The Joint Council on Closing the Gap has established a new Policy Partnership for Early Childhood Care and Development. The Policy Partnership will bring together governments and First Nations representatives to **develop recommendations to improve early childhood outcomes for First Nations children and families**. It has been co-developed with SNAICC – National Voice for our Children and the Commonwealth department with responsibility across ECEC, MCH, child protection and families.

3. Description of ICFC models

Aboriginal and Torres Strait Islander integrated early years services

Overview

Aboriginal and Torres Strait Islander integrated early years centres have existed in Australia for several decades. The centres are engaged in building and strengthening the community and focus on addressing the needs of children and families in a context of cultural safety that actively respects and promotes Aboriginal and Torres Strait Islander identity. The centres play an integral role in Aboriginal and Torres Strait Islander communities and often serve as a community hub. They are connected and trusted by their communities and therefore viewed as having *"tremendous potential to help 'close the gap' for Aboriginal and Torres Strait Islander children"*.[40]

Aboriginal and Torres Strait Islander integrated early years centres is a collective term used to describe Aboriginal and Torres Strait Islander Child and Family Centres (ACFCs) and Multifunctional Aboriginal Children's Services (MACS). Some of these centres have been incorporated into state-run models. Although all centres share a common vision and purpose, discussions around structural components are specific to those centres that are run independently of a state-run model.

Cultural safety involves creating a service environment that is safe and welcoming for Aboriginal and Torres Strait Islander peoples. Cultural safety is an important enabler for the participation of Aboriginal and Torres Strait Islander children in early years services.

Despite the demonstrated success of the model,[41] funding for Aboriginal and Torres Strait Islander integrated early years centres has been inconsistent. The funding mechanisms have changed multiple times, and no tier of government has taken overall responsibility for the sustainability or quality of the centres. As a result, there is significant variation in the availability, quality and mix of services available and only a small number of centres nationally. There are currently 75 Aboriginal and Torres Strait Islander integrated early years centres, meaning that most Aboriginal and Torres Strait Islander families and children do not have access to a

dedicated Aboriginal and Torres Strait Islander integrated early years centre. Some Aboriginal and Torres Strait Islander integrated early years centres have been incorporated into the state-run model whereas others run independently. Although all centres share a similar purpose and vision, discussions around the structural components of the model are specific to those centres that operate separately to a state-run model.

Multifunctional Aboriginal Children's Services (MACS)

The Multifunctional Aboriginal Children's Services (MACS) model was developed in the early 1980s. They were developed to provide an integrated approach to child development to improve the lives of Aboriginal and Torres Strait Islander children who experience disadvantage in a culturally relevant setting.

MACS were first funded by the federal government in 1987 under the Budget Based Funding program (BBF). The BBF programme provided operational funding for Early Childhood Education and Care (ECEC) services in locations where the market did not adequately support viable operation of the service, specifically in regional and remote communities and where there were additional needs for culturally appropriate services. Approximately 80% of BBF services focused on Aboriginal and Torres Strait Islander children.[42] This funding ended in 2018 and these services were transferred to the federal Child Care Package (CCP).

Since transferring to the CCP, MACS are able to apply for Community Child Care Fund-Restricted (CCCF-R) grant funding to supplement their income from the Child Care Subsidy (CCS) to ensure centres remain viable. However, CCCF-R funding is a transitional arrangement and the ongoing sustainability of these centres has not been secured. Further, MACS currently remain outside the provision of the National Quality Framework (NQF). This means many are not currently regulated, assessed or supported for quality improvement in a similar manner to other ECEC services. There is also a lack of clarity around how MACS will be regulated consistently across jurisdictions.

Aboriginal Child and Family Centres (ACFCs)

In 2009, the Council of Australian Governments (COAG) entered into the National Partnership Agreement on Indigenous Early Childhood Development (NPA IECD) to achieve Closing the Gap targets for Aboriginal and Torres Strait Islander children. This agreement included joint funding over six years to establish 38 ACFCs across Australia. ACFCs were to provide a mix of services responsive to community needs, including child care, early learning and parent and family support services. The centres were to be underpinned by integration of their management, governance and service systems.

Despite many ACFCs only becoming operational in 2014, federal funding for the 38 ACFCs was discontinued in 2014 after the six-year joint funding period. This was despite many ACFCs having achieved positive outcomes relating to the NPA IECD indicators. For example, in NSW, an evaluation of the ACFCs found the proportion of Aboriginal and Torres Strait Islander children attending the ACFCs who had all age-appropriate health checks increased from 81% to 95%, and the proportion who were fully immunised increased from 92% to 99%.[43] It also found that on average 78% of children attending child care through an ACFC had not previously accessed an early learning service, suggesting the centres were already contributing significantly to long-term aims of the NPA IECD to see an increased proportion of Aboriginal and Torres Strait Islander children and families accessing a range of services.

ACFCs now operate under various state and territory funding models delivering services and programs that are supported through a mix of funding arrangements. NSW has recently committed funding to build six more ACFCs and the Northern Territory is also continuing to expand its model.

Key components of the model

Aboriginal and Torres Strait Islander integrated early years centres are designed to be a flexible, community-centred model that facilitates the participation of Aboriginal and Torres Strait Islander children in ECEC and connect families to an array of integrated, tailored and culturally appropriate supports for themselves and their children aged birth to eight years. Centres provide child care, preschool and/or occasional care, and a mix of other universal and targeted programs. All centres offer playgroups, often described as a 'soft entry point' to bring families into the service. The centres each have a unique identity and service mix based on community need.

The centres attempt to address a far wider range of needs beyond what is addressed in mainstream ECEC services. They seek to build on community strengths, cultural identify and pride, and provide a "*trusted community owned and driven entry point to tackle the trauma, poverty, dislocation and disempowerment many Aboriginal and Torres Strait Islander families experience*".[44]

The main funding instrument for Aboriginal and Torres Strait Islander integrated early years centres is the CCS. Centres can also access the CCCF Open Grants, which target services operating in selected disadvantaged communities and are intended to supplement fee income. MACS may also receive funding through the CCCF-R, which is intended to supplement the income of former BBF services.

The majority of centres are operated by ACCOs. Others are operated through a range of governance structures by non-Indigenous organisations and government, with various Aboriginal and Torres Strait Islander community advisory and input arrangements.

Enablers

Aboriginal and Torres Strait Islander integrated early years centres adopt a strengths-based approach that strives to building a community connected by cultural pride and safety rather than emphasising perceived deficits. Nearly 75% of centres are community-controlled, which ensures local ownership of the services and contributes to the employment of local Aboriginal and Torres Strait Islander peoples. The centres incorporate the three key factors that have emerged from research as being central to improving the access of Aboriginal and Torres Strait Islander children in ECEC: local ownership of programs, employment of local people, and incorporation of culture within services.[45]

Aboriginal and Torres Strait Islander integrated early years centres demonstrate a deep commitment to the broader development and wellbeing of children. Centre leaders are invested in achieving high quality outcomes for children and provide supports far beyond the scope of their funding. For example, centre leaders described driving families long distances to access health services or providing additional informal supports to families who needed help navigating Centrelink. Parental support for these practices can be seen through the very high proportion of Aboriginal and Torres Strait Islander children attending each centre and the extensive waiting lists for centres.

> *"Yappera researched historical data that details why families are accessing Yappera and what factors are important to them in accessing an Aboriginal Early Years Service . Culture is always the priority, connection to other families, connection to the educators in Yappera with a high proportion of Aboriginal people."*
>
> **– Stacey Brown, Yappera Children's Service**

When they are funded adequately Aboriginal and Torres Strait Islander integrated early years centres incorporate ECEC, other early learning programs such as playgroups, family supports, MCH, allied health and other services defined by community need. They also have a specific goal to support and build the community. They often act as a community hub and provide programs, such as Elders groups and community events to help achieve this goal.

> *"I believe it's not just services that are important… it's also community activities that bring networking and help people form their relationships. I think those things are often seen as less beneficial, but they are important for our culture. It's about being together and supporting each other."*
>
> **– Emma Beckett, Nikinpa Aboriginal Child and Family Centre**

NSW ACFCs receive funding from Department of Communities and Justice (DCJ), which recognises and supports their role as an integrated service. This funding is intended to support the mission of an ICFC to provide services in a holistic, child-centred and integrated fashion. The funding is additional to CCS and is an important enabler for integration.

SNAICC – National Voice for our Children has established the THRYVE Pilot Project to supporting a strong, expanded and sustainable Aboriginal and Torres Strait Islander early years sector to see more children and families thriving. Initially the pilot will work in three states – New South Wales, Western Australia and Victoria – to grow, strengthen and support ACCOs that provide early learning services across the three jurisdictions. THRYVE is supporting ACCOs to overcome many of the significant structural barriers identified above.

Barriers

Funding is a key barrier for Aboriginal and Torres Strait Islander integrated early years centres. This is due to the lack of an overarching funding mechanism unique to Aboriginal and Torres Strait Islander integrated early years centres that supports their broad mission to support and strengthen children and families and build the community. This presents numerous challenges including:

- Funding comes from multiple different sources that all have separate application and reporting processes making it complex for centres to manage.
- Funding is often inadequate to cover the full cost of delivering outcomes.
- Funding is often insecure or short term in nature.
- Funding is predominately delivered as subsidies attached to individual children rather than block funding to a centre, which would support viability and ensure centres are enabled to offer support to children and families based on need rather than their ability to pay.

CCP is a mainstream funding package that was not designed to support integrated service delivery nor the family support model offered by these centres. The disconnect between the purpose of Aboriginal and Torres Strait Islander integrated early years centres and this funding undermines the ability of centres in their mission to support and strengthen children and families and build the community. It fails to recognise the essential role these centres play in their communities and their potential to make a significant contribution towards ensuring more Aboriginal and Torres Strait Islander children are growing up in a culturally safe and secure environment and able to access the full benefits of early learning.

MACS are reliant on Community Childcare Fund-Restricted grant (CCCF-R) to support their operations in non-viable markets. However, CCCF-R operates as a temporary, stop-gap measure within the broader context of the CCP that is misaligned with the mission and purpose of Aboriginal and Torres Strait Islander integrated early years centres.[46] This lack of funding sustainability and the process of transitioning to the NQF are significant issues for MACS. Due to funding deficits, some MACS no longer provide integrated services and operate as a long day care only.[47]

Similar to other ICFCs, Aboriginal and Torres Strait Islander integrated early years centres also face challenges accessing allied health services and other health services. This is exacerbated in rural and regional areas.

The centres also face challenges recruiting and retaining an Aboriginal and Torres Strait Islander workforce. They are heavily reliant on the skills of the centre leader who has a large, complex and challenging workload. Being an important worker in the community also puts a significant personal burden on leaders. Leaders describe feeling as though they are never able to leave work: they are regularly approached by families in supermarkets or at the football oval. This makes it incredibly difficult for leaders to have any downtime from the challenging work environment.

> *"We continually say we work with the most vulnerable of the Australian population. And so we also employ some of the most vulnerable people from the Australian population. And for that reason, sometimes some of us aren't great workers or have a lot of things in our lives… for me it's about the pay, that's a big thing, and the stress levels of the job. If we can reduce that stress a bit, by having more than the basic ratios for staff, then I think that's a good thing."*
>
> **– Emma Beckett, Nikinpa Aboriginal Child and Family Centre**

Enablers

- Aboriginal and Torres Strait Islander integrated early years centres use a strengths-based model promoting culture, identity and community resilience.
- Many centres are run by ACCOs with strong cultural strength, trust and connections to community.
- Leadership and staff are ideally from the local community.
- There is a deep commitment to the broader development and wellbeing of children.
- Centres have ECEC as well as broader integrated supports for child and family development and wellbeing.
- Centres have strong connections to other networks.
- Centres have excellent leadership.
- They have flexible funding from NSW DCJ supports integration in ACFCs.
- There is THRYVE Pilot Project supporting ACCOS that provide early learning services across NSW, WA and Victoria.

Barriers

- There is disconnect between the purpose of centres and CCP funding.
- There is no funding for integration/glue (except NSW ACFCs).
- There is limited support for centre leaders.
- Centres are not well supported by government policy that translated into programs or funding.
- Limited data collection and absence of formal evaluations
- There are structural barriers preventing data sharing across federal and state governments.
- Centres face challenges in recruiting and retaining Aboriginal and Torres Strait Islander workforce.
- Centre face difficulties accessing allied health services and other health services.

Tasmanian Child and Family Learning Centres

Overview

The Child and Family Learning Centres (CFLCs) were announced in 2009 as a whole-of-government initiative intended to change the way services were delivered to children and families. They were designed as a place-based collaborative service delivery model,[48] with a single point of entry to a range of early childhood services including universal, targeted and specialist services.

The centres are designed to meet three key priorities:

1. Provide high quality learning, health and wellbeing services and programmes that support children and families to learn, grow and thrive together.
2. Build each community's sense of belonging with their centre as a place of importance.
3. Create and maintain strong and flexible partnerships between everyone involved in each centre's community.

At the time the CFLCs were established, Tasmanian children lived amongst the most disadvantaged communities in Australia and had the worst education and health outcomes in adult life compared to other states and territories.[49] Twelve centres opened from 2011 to 2014 in areas with a high proportion of children under four, high levels of disadvantage and strong community support for a CFLC. There are plans to build six more centres. In 2018 the Tasmanian Government announced that six more CFLCs would be established across Tasmania. One of the new centres opened in late 2022 and the remaining five will open in 2023 and 2024, bringing the total number of centres in Tasmania to eighteen.

The model has been evaluated as a promising place-based initiative that addresses social determinant of inequalities in child development.[50] It has been found to be achieving diverse outcomes for children, families and communities, including to access services and supports, enhance parent-child relationships, foster parent growth, and promote children's development, wellbeing and readiness for school.[51]

Key components of the model

CFLCs are funded by the Tasmanian Department for Education, Children and Young People (DECYP). Each CFLC receives a secure, ongoing staffing and operational budget. The funding supports the glue role undertaken by the centre, as well as core operations and a flexible funding component. This enables an operating model whereby a core set of services, operations, staffing, infrastructure and principles underpin the model, complemented by flexibility, innovation and community engagement to ensure each centre is responsive to their community.

Each centre is funded for the equivalent of four full time employees that include a centre leader, community inclusion worker, centre assistant and an education officer (teacher). Centres have additional budget to employ local parents or community members as required, for adjunct care and centre assistant roles. In 2022, DECYP increased support to CFLCs by providing funding to all operational centres for 0.2FTE of a social worker, speech and language pathologist and psychologist to each centre.

CFLCs also include the Child Health and Parenting Service (CHaPS) onsite (referred to in this paper as MCH). The MCH service is valued as an important universal access point to the centre. Centre leaders describe families coming to see the nurse who might then show them around the centre, introduce them to the centre team and provide them with information about programs and services on offer. The MCH service can also make formal referrals to relevant key services.

The CLFC model emphasises both the service and social hub components of ICFCs. The model ensures centres are available as drop-in, open spaces for families to bring their children and ensures staff members are available to engage with and support families outside of formal service provision. Staff members are supported through the Family Partnership Model practice framework to engage with families in a way that is strengths based, welcoming and family-centred.

In setting up the model, DECYP determined that the CFLCs would be best enabled through a collaborative partnership approach rather than attempting to create a fully integrated model. This stemmed from concerns that fully integrating all services and supports into a single entity would create a more rigid model that would be unable to be iterative or responsive to community needs. A partnership model was seen as more agile and collaborative with the rationale that it forces all stakeholders to work collaboratively to build connections and a shared vision and purpose, which should lead to greater changes across the service system.

CFLCs offer a range of services and programs, some of which are run by the centre and others provided by other government agencies and non-government providers. The mix of services and programs offered is different at each centre depending on community need and the availability of clinicians, although early learning programs and MCH services are core services available at all centres. CFLCs do not offer ECEC, although some may be co-located with an ECEC service.

The CFLC model includes allied health as a core service offering at each centre. The allied health staff supports to screen children for potential issues, build the capacity of CFLC staff delivering the programs and support with referrals. Allied health services are funded consistently across centres, however one rural centre leader described challenges accessing the allocated service provision due to the time needed for clinicians to travel to and from the centre. Further, similar to all other ICFC models, therapeutic supports are not available through the model.

Supporting families with the transition to school is part of the CFLC remit and this may involve speaking with families about school preparations, accompanying families to attend the Launching into Learning program at the local school. Ten of the 18 CFLCs are built/will be built on or adjacent to a government school. An evaluation of the CFLCs found that CFLC users felt their children were better prepared for school and that they had closer links with schools than parents who hadn't used the service.[52]

Evaluations of the model have found them to be achieving positive outcomes for children and families. One study found that CFLCs helped to overcome barriers to parents accessing early childhood services. Parents who had used a CFLC judged their experience of early childhood services and supports more positively than those that had not used a CFLC and parents' experiences of centres aligned with the best-practice principles from the Early Years Learning Framework for Australia.[53] Another study found CFLCs were achieving diverse outcomes for children, families and communities. These outcomes include accessing services and supports, promoting children's development, wellbeing and readiness for school, enhancing parent-child relationships, fostering parent growth, changing family circumstances and strengthening communities.[54]

DECYP provides operational support to CFLCs through centre improvement plans and continuous improvement tools. The newly developed CFLC Quality Improvement Tool has been designed to drive the learning and improvement of CFLCs to create the conditions that support children's wellbeing, lifelong learning and successful transitions to school. The Quality Improvement Tool guides the development of the improvement plan for each CFLC. Centre leaders meet regularly with the Early Years Partnerships and Projects team in DECYP and each CFLC has its own centre improvement plan that feeds into the department's overarching strategic plan. Centre leaders meet fortnightly online and quarterly face-to-face with other centre leaders from across the state.

CFLCs are from open Monday to Friday for approximately 50 weeks of the year. Centres have some flexibility regarding opening hours, which are determined by the centres based on the needs of the community and staff. In addition to the services and programs described above, centres are open for families to drop in during opening hours. Centres have play areas for children, kitchens, toys and quiet areas.

Enablers

Secure, ongoing funding is an important enabler for centres. It enables them to work across diverse timescales from immediate response to long term activity.[55] Restoring trust and rapport with previously disengaged families takes time, energy and good will, and allowing staff the time and security of tenure required to engage in this work has helped build strong relationships between CFLCs and community.[56]

Centre leaders describe a positive working relationship with DECYP and felt supported to achieve their goals. DECYP supports a culture of continuous improvement and has recently commissioned MCRI to develop the Quality Improvement Tool, a self-reflection tool for centres to identify opportunities to improve their practices. Conversations with DECYP staff demonstrate a deep commitment to the model, with staff openly reflecting on the journey of the model and sharing successes and challenges they have faced. CFLCs are valued within government as an important part of the essential infrastructure within a community.

The design and delivery of centres is centralised within DECYP using the CFLC Functional Design Brief, meaning there is a large degree of consistency across the model. Centres are all of a similar size and receive similar budgets. Each centre has been purpose built and the infrastructure has been intentionally designed to support family and child outcomes.

The open, drop-in nature of the CFLCs provides a place where communities feel they belong, can make new friends and widen their social support networks. There is a strong sense of community ownership in some centres and parents identified CFLCs as a place "they felt they could go at any time, even when 'at their worst".'[57] They also provide a venue for children's social interaction that might otherwise be missing.[58] The way in which the CFLC structure effectively enables critical informal work is a key enabler. For example, staff describes the impact of having time to sit and have a cup of tea with families and engage in casual conversation as a critical enabler to both addressing immediate needs and building longer term trust with families.[59] This informal work is critical to building relationships, recruiting families into additional services and identifying and responding to their priority needs.

> *"…so last Friday we had families everywhere, we were cooking food, we had a dad in cooking for everyone. We got a new social work student, and she was saying that she raised her children and she lived in the next town down the road, and she said that the lovely thing is that … people can drop in any time during the day. It's not like a program which is set between 9-10.30am every day and you can only go then, people can come in here any time."*
>
> **– CFLC Centre Leader**

The CFLC model uses the findings of evaluations and research to learn and evolve. DECYP commissioned evaluations of the physical spaces at each CFLC and used this information to inform the design of the new centres. The evaluation considered how the physical space was being used by families and practitioners and what needed to be improved in future centre design.[60] Common themes that were identified included the need to continue to have the kitchen at the heart of the centre, more staff office spaces and the need for the CFLC to be clearly demarcated as an entity separate from other co-located facilities. Learnings from these evaluations have been incorporated into the CFLC Functional Design Brief for the build of the new centres.[61] The model has also been examined in other studies looking at issues, such as the impact of outreach on family engagement and the impact of co-location on service collaboration.[62]

Barriers

The CFLC model has been implemented with a high degree of consistency across the 13 sites. Centres are supported centrally by DECYP who are highly invested in ensuring the success of the model. Similar to other community services, this creates a tension for the model in terms of the degree to which individual centre leaders feel they are able to lead the model, be innovative and responsive to community need, versus the need for central oversite to ensure consistency of the model so that centres are delivering evidence-based practice. Some interviewees described wanting to be able to implement the model differently but not feeling able to do so and the challenge of agitating for change when everyone involved in operations and service delivery is a government employee.

> *"… we're all tied to certain KPIs which are often imposed from other places. There needs to be greater freedom and autonomy in order to truly meet the unique needs of the community that we say we're most interested in turning the curve for…"*
>
> **– Paul Prichard, MCRI**

Similar to other ICFCs, CFLCs face challenges integrating services that are funded by agencies other than DECYP into the model. This is especially true of the MCH service, which is co-located at each centre, but not always well integrated. Research with CFLC practitioners identified restrictions around data sharing as the most significant barrier to more collaborative practice.[63] Although the research found that the co-location of services in CFLCs was contributing to cross-sectoral collaboration, it concluded that families experienced services as distinct and separate rather than integrated.

Data collection by centres in the past has been limited to attendance data. The open-door approach of the centre means people can attend without an appointment, which can make it challenging to collect data. Since late 2022 all centres are mandatorily collecting attendance data for the various programs they run including children and families who drop into a centre to play. The data is stored by DECYP and tracks a child's attendance from a CFLC through to the end of school years. This is a significant development and has the potential to enable a more sophisticated understanding of the role of CFLCs in improving outcomes for children.

Capacity to provide outreach support was also raised by CFLCs as a barrier to achieving outcomes for children and families experiencing vulnerability. The small staffing numbers at each centre makes it difficult

for a staff member to be away from the centre for long periods of time. This is especially difficult in remote areas where travel time is significant. Safety was also raised as a concern around home visiting. DECYP is exploring how to better support outreach within the model and is looking at partnerships with other organisations as a key mechanism to enable these activities. Additionally, each centre has a large vehicle available to transport families and children to and from the centre, and to provide outreach support targeted at those who need it most.

> *"For us to do outreach here you actually need more staff to do it and to do it really well, because people who are living in isolated circumstances… their needs are very significant."*
>
> **– CFLC Centre Leader**

Having centres open Monday–Friday for 50 weeks of the year was raised as a barrier in interviews. Although centre leaders recognised the benefit for families in knowing that the centre was always available, it can be challenging for centre leaders to allocate time to plan, hold team meetings or reflect on their work.

> *"I've essentially given up trying to have a staff meeting with all of my staff… So it's like alright, we'll have some minutes and some outcomes, and we'll just crack on from there. Because people shouldn't have to stay. We're open from 8am–4pm, and they shouldn't have to stay for a staff meeting. Everybody's got lives and families."*
>
> **– Vikki Iwanicki, Queenstown CFLC**

Enablers

- CFLCs have flexible, secure funding.
- There is designated funding to ensure high quality professionals employed at each centre.
- Flexible bucket of funding to employ/broker additional services is available.
- There are purpose-built centres designed to support core components of the model.
- Social hub components are supported throughout the model, including drop-in, open spaces and staff available outside of formal service provision.
- There is a large degree of consistency across the model.
- Several evaluations and studies have been undertaken on the model to support learning and evolution.
- CFLCs are well supported by government policy.
- Allied health embedded in the model.

Barriers

- There is tension between centre leaders being able to be innovative and responsive to community need, and the need for central oversite and consistency.
- Integrating services that are funded by agencies other than DECYP into the model are challenging.
- There was limited data collection, however, this is now changing since introducing mandatory attendance data collection.
- Outreach is a key part of the model but not well resourced. DECYP is exploring how partnership model could enable outreach services.
- There are limited opportunities for planning or team activities away from face-to-face time with clients.
- Therapeutic allied health supports are not available through the mode

Queensland Early Years Places (EYPs)

Overview

The Early Years Places (EYPs) were designed as an integrated hub providing a range of Early Childhood Education and Care (ECEC), health and family support services to local families. They were envisaged as a 'one-stop shop' to deliver or broker universal and targeted supports for families experiencing vulnerability. The first EYPs were established in the early 1990s. This was followed by significant new investment in 2006 to establish four Early Years Centres. In 2017 a common identity was created for all integrated services, which had been established under a range of different initiatives and funding since the early 1990s. All centres operate under the Integrated Service Delivery Guidelines and have common expectations and outcomes. There are currently 56 EYPs across Queensland.

Key components of the model

The EYP model is based on outsourced service delivery by an NGO through a service agreement with the Queensland Department of Education (QDoE). Sites were selected using a needs-based assessment of socio-demographic characteristics of a community, as well as availability of facilities. EYPs operate in a mix of service delivery settings, including standalone centres and satellite centres. EYPs also operate centres that are co-located on school sites, health sites, ECEC sites or other sites (such as community centres and ACCOs).

Key aspects of the model are:

1. universal and targeted service activities delivered by early childhood educators, child health nurses and family
2. support staff working collaboratively for families with young children in the community

3. established and effective referral pathways and holistic service delivery initiatives
4. locally responsive and culturally appropriate programs, services and environments
5. services being co-located or in close proximity to other community services
6. cooperative, coordinated or collaborative relationships with neighbouring service providers.[64]

EYPs receive funding for three-year periods from the QDoE. EYPs vary in size and receive different amounts of funding depending on the centre's catchment, size and staff. EYPs have some flexibility over how they spend their budgets. The general allocations of funds are 80% for staff costs, 20% for operating costs including programming and engagement, and up to 10% for organisational costs. Centres can use this funding to broker in other services if they choose.

MCH and appropriate allied health services are core elements of the EYP model. These health services are provided through a range of mechanisms. These mechanisms include formal partnerships with local Hospital and Health Services, and other partnerships or informal arrangement – including, with Aboriginal Community Controlled Health Organisation (ACCHOs). However, not all EYPs have local arrangements in place, which means they are not able to provide MCH or allied health supports.

Each EYP provides a range of different services and programs to meet the needs of the community. These are either provided directly by the EYP or in partnership with a broader network of organisations and practitioners. For example, Cairns EYP partners with Wuchopperen Health Service to have an Aboriginal and Torres Strait Islander family support worker and an early childhood educator to support the capacity building of the EYP to work with Aboriginal and Torres Strait Islander families.

EYPs also offer targeted supports for families that have been identified as needing extra support. These families are referred to a key worker who supports the family to identify their needs and then works in partnership with other services to provide wrap around supports.

> *"Targeted support is about supporting families with whatever they need. A lot of the work is around supporting with parenting, also with supporting access to material resources. There is a continuum of complexity with families...we sometimes work with families referred by Child Safety, and there might be domestic violence, homelessness, substance misuse, all those different issues, although we tend not to see a lot of substance misuses. And then on the lower end of the spectrum it might be child development, behaviours, parenting, that sort of stuff."*
>
> **– Cassy Bishop, Cairns and Gordonvale EYP**

The EYP model is very service-focused, with less focus on drop-in sessions and social networks. Centres do have the flexibility to offer drop-in sessions; both centre leaders interviewed for this discussion paper highlighted their intentions to start offering these sessions.

The centres provide supports and programs intended to increase access to, and participation in, preschool. Some EYPs operate or are co-located with a preschool, long day care or limited hour care – and provide information and support with funding. Other EYPs have partnerships with local providers to improve access.

The flexibility of this model lends itself to being able to be scaled across many different locations, although the success of this scaling is not known. Apart from an evaluation after the first four centres were completed, there have not been any further publicly released.

Enablers

The EYP model is one of the largest in Australia. It is supported by secure, long-term funding and significant service flexibility on expenditure. The model is delivered by NGOs who have strong relationships and familiarity with the local context. Centres run by large, well-resourced NGOs are able to leverage these networks and additional resources.

Each EYP receives a flexible budget to allocate as needed, based on QDoE operating guidelines. This flexible approach is best suited to centres run by well-established NGOs that are able to provide significant operational support. It is not clear how well the model works without access to this support. QDoE reporting and relationship managers work closely with centres regarding the programs and services offered.

> *"I think TBS, for my staff in particular, what attracts a lot of us and what keeps us here is the values and just the way the organisation works. It is very focused on the family and the children that we're working with."*
>
> **– Cassy Bishop, Cairns and Gordonvale EYP**

Place-based supports were also identified as important enablers for EYPs. Cairns EYP described the benefit of belonging to both the Cairns South Together place-based collective impact collaborative, and the Communities for Children early intervention and prevention program for young children. These place-based initiatives strengthened their connections with other services. They provided a forum whereby local service providers could discuss local challenges and opportunities for children and families.

Approximately half of the EYPs are located in Connect 4 Children locations, which is a Queensland government place-based initiative intended to improve the wellbeing of children from birth to five years old. Connect 4 Children has a strong focus on partnerships and integration of services within a community.[65] EYPs in Connect 4 Children locations play a significant role in supporting the implementation of the 'birth to five' plans developed in each community. Although more research is needed into the interaction between an ICFC and a place-based initiative, situating an ICFC in a location with a strong, collaborative network has the potential to strengthen the impact of both.

EYP leaders also described their strong working relationship with QDoE as an important enabler. Centres are supported in a continuous improvement process; they report regularly on their achievements and successes. Centre leaders have regular contact with a designated relationship manager from QDoE. Centre leaders found these meetings to be useful and felt well supported by the department.

Medium and larger centres employ a multidisciplinary team who are expected to work collaboratively towards shared and agreed outcomes, with shared planning, programming and review used as key strategies. Smaller EYPs often have only one employee. It is unclear what impact this has on outcomes for children and families.

> *"I was thinking about what makes integration work, and I think integration comes down a lot to the personality and attitudes of the people in the roles."*
>
> **– Cassy Bishop, Cairns and Gordonvale EYP**

Barriers

The degree to which integrated working happens in practice is unclear. Interviewees and the 2012 evaluation noted competing expertise, information sharing, concerns around privacy boundaries and structural barriers (such as incompatible IT systems) as barriers.[66] Consistent with reflections from other Australian models, having MCH nurses employed separately to the EYP was seen to cause problems with data sharing, shared values and integrated ways of working.

Although MCH and allied health supports are a key part of the EYP model, some centres do not have localised arrangements in place with health providers, which means they are unable to provide these services. One centre described only being able to get an MCH nurse once a fortnight for a drop-in session and being unable to get allied health supports at all. Centres also described long waiting lists for child health checks; people can wait up to a year for the 3- or 4-year-old check. Without adequate access to key professionals, the integrated service delivery model is significantly weakened.

Interviewees observed that smaller EYPs without the backing of a big, well-established NGO have difficulties in obtaining sufficient funding and not being able to attract the quality of staff that they need. The process undertaken by QDoE to develop minimum standards was seen as an essential step to overcome these challenges.

The diversity across centres means there was a mixed response from interviewees around what was or was not working well. For example, although the flexible nature of funding is seen as an enabler to centres delivering on their mission, there were mixed responses as to whether the funding each centre received was adequate. One centre manager reflected on the need to seek out grant funding to deliver necessary services, whereas others felt the funding was sufficient for their needs. Further, the staffing envelope varies significantly across centres: smaller EYPs only have a single worker and larger centres have more than 10 employees. It is unclear how centres are able to offer a broad range of holistic supports without a multidisciplinary team or whether the size of a centre affects the outcomes it is able to achieve.

The EYP model is very service-focused, with less focus on the centre as a safe space for families to spend time or come to drop-in sessions. Centres describe a model whereby families only come into the centre to enquire about or participate in a service. However, both centres discussed wanting to facilitate drop-in sessions where parents are able to bring their child to the centre, have a cup of tea and meet other families. Centre leaders felt that having centres located in convenient locations, such as school or community sites, increases the likelihood that parents would drop in.

Enablers

- EYPs have flexible, secure funding.
- EYPs have flexible service delivery; they can deliver programs responsive to community need and broker in supports.
- EYPs are able to benefit from support of large NGOs with additional resources, programs and networks.
- EYPs are able to leverage existing services and networks.
- EYPs are well supported by government policy.
- Outreach is a key part of the model.

Barriers

- Smaller centres that aren't run by well-established NGOs may face funding, operational and sustainability challenges.
- There is limited integration between QDoE and other departments.
- MCH is not fully integrated into the model; some centres don't have access to MCH at all.
- There is limited data collection and absence of formal evaluations.
- EYPs are very service focused but have limited focus on social hub role and informal support.
- Outreach is a key part of the model but not well resourced.
- There are difficulties accessing allied health services and other health services.

Our Place

Overview

Our Place is a place-based initiative operating in 10 communities across Victoria. It started in 2012 with Doveton College. After the original success of the Doveton Model,[67] Our Place partnered with the Victorian Department of Education (VDE) to expand the approach to nine further sites. The expansion is not attempting to replicate Our Place as a model but rather use the principles and key elements of the approach at 13 schools in Victoria.

The Our Place approach supports the education, health and development of children and families in disadvantaged communities by utilising the universal school platform. The approach incorporates a systems-change lens, focusing on influencing changes in policies and practices that address the structural causes of disadvantage.

Our Place does not describe themselves as an ICFC, however it fits within the definition of ICFCs used in this paper as it incorporates a holistic, wrap-around approach that recognises the importance of attempting

to meet many of a child's, and family's needs, in the one place. Integration is a key part of its approach as an enabler, bringing community and service providers together to support families. The Our Place approach seeks to overcome barriers to educational achievement by focusing on supporting high-quality learning environments and supporting improvements to the service system.

In addition to early learning, Our Place works in partnership with VDE, local government and early learning providers. They focus on a child's educational journey through school and support parents through adult engagement and education. Each Our Place site is built upon five core elements:

1. high quality early learning, health and development
2. high quality schooling
3. wrap-around health and wellbeing services
4. engagement and enrichment activities for children
5. adult engagement, volunteering, learning and employment.

Our Place is interested in how schools and Early Childhood Education and Care (ECEC) services can be better integrated to support children as they move from the early years into school. It also supports early years services and schools in their provision of high-quality teaching that meets the needs of children. This includes working with early years services and school principals and leadership teams to provide the necessary supports to shape their services in response to the community, with a particular focus on supporting children and communities experiencing disadvantage.[68] Our Place is trying to join up the service system to get better access for families and to improve the quality of what is being delivered.

> *"We sit on a universal platform in each of our sites, we have community engagement and community facilitator roles, we engage with community and service providers and we join the dots"*
>
> **– June McLoughlin, Our Place**

Key components of the model

Our Place operates as a navigator trying to bring local child and family organisations and practitioners together to practice in a more integrated way. Our Place sites are located on school sites, with many services, supports and clinicians available on site. Sites also develop broader relationships with local service providers, so they are better able to support children and families with 'warm referrals' to services available on site or elsewhere in the community.

The approach also includes a health and wellbeing component, with the long-term goal of having a GP and paediatrician at each site. Our Place works to locate a suite of allied health staff on site and build further relationships with local community health services and networks.

The approach focuses heavily on evidence-based practice. For example, Our Place includes an adult capacity building and education strategy, based on the evidence that a mother's education makes a significant impact to child outcomes. It promotes high quality teaching and learning, and supports this across its sites by bringing experts to speak to sites about current thinking and practice. It has introduced 'baby college' for

mums in their third trimester, recognising the evidence around starting early to support vulnerable families. These components are then being evaluated to build further evidence around what is working to support quality change.

Practitioners are supported to use family-centred practice principles. This shifts the focus from programs and services to a relational approach. This approach focuses on supporting children and families by understanding the goals and aspirations of families and working alongside them to help achieve these goals. Our Place's first rule for each site is 'know your community'. This means each site will be different; it responds to local needs. Our Place is not attempting to be a replication project, but rather a place-based model with core elements that are implemented at each site.

> *"If you take a stance that you're led by the family and part of that is bringing different services that the family might need together you are more likely to score higher if you did a scale of how integrated you are."*
>
> **– June McLoughlin, Our Place**

Our Place is supported by long-term funding from the Colman Foundation, site specific funding from other philanthropic organisations, six-year backbone funding from the Paul Ramsay Foundation for central operations, and significant co-investment from VDE in the form of enabling infrastructure and shared governance. Although still tied to outcomes, Our Place describes the philanthropic funding it receives as more accommodating of the time and resourcing it takes for this work to happen effectively. VDE has provided the infrastructure for the project, including the capital works required to ensure each of the 10 sites is suitable for the Our Place approach.

Enablers

Key philanthropic funders are party to the Our Place Philanthropic Alliance Agreement. The alliance enables philanthropy to work with Our Place in a collaborative, long term relationship on systemwide issues beyond those at a site level. With a standardised approach to reporting and governance of philanthropic funding across all sites, this alliance also enables Our Place to operate with minimal overheads and administration. The Our Place Philanthropic Alliance is an example of how funders, and specifically philanthropy, can leverage their contributions by working collaboratively to support the strategic objectives of a project.

> *"If you think about collective impact, there's often the absence of funding at the site level for things to happen. We have the privilege of having funding for the backbone and having funding to support the site work to happen, supported at an outcomes and strategic level by the backbone in partnership with government."*
>
> **– Shannon Newman, Our Place**

Our Place works in partnership with VDE, which ensures that the work is understood, supported and aligned with the department's priorities. The partnership is supported through a whole-of-government

Interdepartmental Committee (IDC). IDC was established to provide a structure across government to authorise the goal of integrated services required to operate the ten sites under one umbrella. The IDC ensures work is conceptually aligned with system-level service delivery reforms. In practice, this provides a valuable authorising environment for government funded services and programs to work differently together. It also supports suitable new government reforms to be delivered in Our Place sites under existing site-level governance.

Our Place works with early years providers and schools together to explore continuity of learning and teaching practices. Through this focus, Our Place is attempting to shift power dynamics between ECEC and schools by empowering both early childhood practitioners and school educators through communities of practice. These communities of practice are brought together to share learnings and develop more joined up ways of working. Our Place has identified and advocates for broader policy shifts to support this integration, such as joined-up curriculum and pedagogy, resolving staffing issues between ECEC services and schools, and reforms to the early years of school.[69]

Our Place employs a research and evaluation team who undertake significant analysis and research on the approach. Our Place supports a continuous improvement approach at a site level and across the organisation. It describes this as starting with the end in mind, having clear outcomes at the start and continuously testing whether what is happening on the ground is contributing to those outcomes. It then has the necessary flexibility and funding to be able to change approaches if things aren't working. This work has been further enabled through the development of a shared data protocol with VDE, which supports access to relevant government held data about Our Place sites. Our Place is documenting their findings at both a site level and at a strategic outcomes level. Over time these reports will be made available for public use.

Our Place was able to capture a significant amount of meaningful data from the original Doveton Approach. It was able to link children's data from early learning, school performance and attendance, and involvement and engagement in enrichment activities undertaken by the school. This has provided a rich data source in which to consider the impact of the Doveton approach on children who participated. Through a longitudinal study, Our Place was able to demonstrate that year 3 students at Doveton College who had attending the early learning centre on site showed significant academic advantage over peers who attended early learning elsewhere or not at all.[70]

Barriers

Similar to all ICFC models discussed in this paper, Our Places faces difficulty accessing adequate allied and other health supports at each site. Their aspiration is to have comprehensive health provision at each site. But this is difficult to achieve in practice due to sector-wide shortages in staffing, fragmented funding and eligibility models and, in some sites, a lack of suitable infrastructure. For example, they have been able to secure regular allied health access at four sites and occasional access at another two sites. Two sites have regular access to a GP.

Working in partnership with VDE provides significant opportunities and enablers to the model. However, as with any cross-organisational partnership, this requires negotiation and investment of time to build a shared understanding and mutual trust. This includes navigating the challenge of working alongside government while still trying to maintain the independence of the initiative. In the long term, Our Place seeks to change

the operations of government funded services to make services more accessible to families. This requires a balance of both working with and supporting existing systems, while also modelling how systems and organisations could work differently to achieve real change for families and communities.[71]

One challenge Our Place and VDE have faced is the selection of suitable sites to be turned into Our Place sites. The criteria for site selection included: areas that were highly disadvantaged and culturally diverse, the capacity to have the required infrastructure, and an existing or planned early learning centre on the site. However, the selection process had limited time for consultation with sites, meaning engagement from school principals was mixed and the quality of early learning centres varied. As a result, significant time was required to develop relationships and governance structures at each site.

Our Place works as an influencer within each site, bringing together the various services and stakeholders to practice in a more integrated way. However, it does not have any authority over the individual services meaning it has relatively limited ability to directly influence service quality. Our Place promotes quality improvement by supporting early years centre leaders and educators through communities of practice and access to international advisers.

> *"You can't just march in there and make assumptions and say we're going to do blah blah, how do you know that's what's needed? You know, family-centred practice principles, person-centred principles. We've got our framework and our structure of what we know the evidence says are the best buys, but what do those best buys look like at Westall or Robinvale or Morwell? They're all different, as they need to be."*
>
> **– June McLoughlin, Our Place**

As an independent philanthropic organisation, Our Place has a different risk appetite to government. Our Place's approach is to be exploratory and try different approaches. If something is not working, it can stop and try an alternative option. Supporting this approach on the ground requires authorisation and support from government, which can be challenging but is enabled through the partnership arrangements and the IDC. Our Place cite the importance of having champions within government to overcome these challenges as they arise.

Finally, data collection is a significant challenge for Our Place. Since expanding to a state-wide initiative, it is they more limited in the data it is able to collect. This is because there are now a range of organisations and stakeholders involved in service delivery across the 10 communities, which makes data sharing arrangements more complex than in the original Doveton site. For example, Our Place is currently unable to access granular child level data or have longitudinal tracking to be able to answer big questions around what is happening in disadvantaged communities and how place-based work can support better opportunities for children and families.

Enablers

- Our Place has long term, secure and flexible funding.
- Our Place Philanthropic Alliance Agreement collaborative approach supports the strategic objectives of a project.
- Victorian Government partnership supports strategic direction, shared governance and alignment with systems level service delivery reforms.
- Our Place has a well-resourced backbone team.
- Our Place has a strong research capability and an ability to evolve approach based on learnings.

Barriers

- Our Place is unable to access granular child-level data for meaningful evaluation.
- Sufficient consultation is not included in site selection process, which led to some sites not being initially ready for Our Place approach.
- There is limited ability to directly influence service quality as it does not have authority over services.
- Challenges of working in partnership with government while still maintaining independence and control exist.
- Our Place faces difficulties accessing allied health services and other health services.

4. Findings

This research has highlighted significant diversity among Integrated Child and Family Centres (ICFCs) service models, and strong alignment on core features, enablers and barriers. ICFCs can meet many children and families' needs when they are enabled by a well-designed funding model that recognises the breadth of their activities, when they have well supported leadership and staff, and when they are empowered to ensure service delivery and supports are responsive to community need.

The core features of ICFCs that were consistent across all models were early learning, MCH, family support services, allied health and the glue/integration function. The informal, drop-in nature of ICFCs is also an important core feature that enables ICFCs to serve as a social hub for parents and children, as well as a service hub.[72] Further, the child-centred, relational way in which staff work within an ICFC is a critical enabler.

> **Early learning** is a broad umbrella term to describe a range of activities and programs intended to support a child's educational development in the early years. Early learning includes playgroups, toy libraries, childcare, preschool, transition to school programs and other similar programs. Early learning is used to describe the elements of an ICFC that are distinct from health or family supports.

The key findings from this research include:

Aboriginal and Torres Strait Islander integrated early years centres are unique in their purpose and structure, and require a unique response.

- **Cultural safety, strength and inclusion** are significant enablers for Aboriginal and Torres Strait Islander integrated early years centres. This model is the most sophisticated and broad in its operating model and service scope but faces the most significant challenges in terms of funding and authorising environment. A unique response is needed to support Aboriginal and Torres Strait Islander integrated early years centres, particularly given their critical role in supporting positive outcomes for children, families and communities.

Centre leadership and workforce are critical.

- Centres are staffed by **committed and dedicated leaders** and staff members who understand their communities and what is needed to have impact. However, structural and funding limitations often limit centre leaders' ability to implement this vision. They face significant burdens and often operate with little support or control.
- **Adequate remuneration** and professional support for centre leaders and the workforce are fundamental for impact. This includes better pay and conditions. Equally important, this also includes professional

supports that recognise the challenging and often psychologically demanding nature of their job – such as professional supervision, business and operational support, and professional development.

- **Centre leaders need to be empowered** to be innovative and lead the model to ensure it is high quality and responsive to family needs. Current models range from highly proscriptive and well supported – but with limited scope for centre leaders to lead the model – to very flexible models where centre leaders have a lot of autonomy but minimal support.

There is a need for structures and processes to support consistent high-quality outcomes.

- **Quality** is very important to ensure the best outcomes for children, however there is currently no national quality framework applicable to ICFCs. There is also no formal mechanism to assess quality outside of Early Childhood Education and Care (ECEC) services that fall under the National Quality Framework (NQF). Consistent, national quality assessment tools and measurements, and professional development supports are needed to ensure consistent standards and support best practice.

Effective funding for a holistic, child-centred approach is needed.

- An **effective funding model** is a central enabler for ICFCs to be able to operate efficiently, effectively and flexibly to meet the needs of children and families. This requires secure, long-term funding for provision of core services and flexible funding for diverse child and family related services responsive to community needs.
- **The integration 'glue' component** is core to the ICFC operating model. It describes the leadership, structures and practices that bring all the individual services and staff together to create an integrated, holistic service model. The glue function must be valued and recognised in the funding centres receive.

The operating model supports the structure and practises of the centre.

- ICFC staff must be supported to work in a way that is **child-centred and relational.** It is important that all staff members feel they are contributing collectively to the child and family outcomes.
- ICFCs can support families both through formal service delivery and as a **social hub** where families with young children can go to meet and connect with other local families and build their social support networks. For this to occur, ICFCs require a **drop-in, open space** where families can come outside of formal service provision. They also need to ensure staff members are available to connect with families outside of formal service provision. They can do this through informal activities, such as cooking sessions, cultural activities and having the time and capacity to listen and support families with their concerns. These informal activities must be valued and adequately resourced.
- **Integration** is required throughout all levels of the model, not just at the point of service delivery. Current ICFCs are having to navigate government siloes in order to deliver an integrated centre. State government departments need to consider how they can provide integrated funding, overcome data sharing barriers and fully incorporate all services, including MCH and allied health, into the model. Better integration is also needed across state and federal government departments to ensure centres are supported to deliver a broad range of services, including childcare, and are not having to report separately on multiple funding streams.
- Comprehensive **allied health** service provision is a systemic gap across ICFC models. Although all interviewees stressed the importance of allied health for early intervention and child development, access to allied health services is limited or absent and usually does not include therapeutic support. Individual centres and families take on the responsibility for finding, accessing and funding allied health services. There is currently no systemic way to provide these critical services.

Governments and funders have an important authorising role in enabling the model.

- **Effective leadership** from government and funders and a supportive authorising environment are important to ensure models are adequately resourced and enabled.
- Governments and funders need to **recognise and value** ICFCs as a key vehicle to meet the needs of young children and families experiencing disadvantage.
- **Collaboration and partnerships** are required between federal and state governments, and between state government departments. These are critical in many ways. Examples of collaborations and partnerships include facilitating data sharing, enabling child care provision, and streamlining procurement and funding processes.

The key structural and operational barriers and enablers impacting on ICFCs are detailed in the next few sections. Each component is described and key themes impacting on ICFCs broadly are explored, as well as specific issues impacting on individual models.

Funding

Key findings

- An effective funding model is a central enabler for ICFCs.
- Complex jurisdictional funding arrangements prevent ICFCs from effectively delivering a full range of early years programs and services. In practice this means:
    - State funded ICFC models find it difficult to incorporate childcare services (which are managed federally).
    - Services funded by different government departments are not fully integrated, specifically Maternal and Child Health (MCH).
    - Aboriginal and Torres Strait Islander integrated early years centres are undermined by the limitations of Child Care Subsidy (CCS) funding and the lack of any overarching funding that recognises the holistic nature of their work.
- Long term, secure funding allows ICFCs to work towards long-term goals and provides certainty around tenure for staff and program availability for families and children.
- Funding needs to support the breadth of ICFC goals and core components, including:
    - core service delivery (early learning programs, MCH, parenting programs and other health services)
    - social hub role and informal staff work (staff being available to support families outside of formal service delivery)
    - effective integration, leadership and coordination (the glue)
    - flexible, additional service delivery that is responsive to community need.
- Block funding provides centres with flexibility and ensures their viability in thin markets.
- Future funding models should explore options for pooled, holistic funding that can be used to develop centres that are truly integrated, responsive to community need and able to provide key universal and targeted services in a safe, welcoming environment.

Overview

Available literature and interviews conducted for this research highlight that funding is a critical enabler for ICFCs. A well-designed funding model that supports the breadth of an ICFC's mission, its responsiveness to community need and continuous improvement is a key enabler for centres' effectiveness and impact. This includes adequate long-term funding that supports service delivery, coordination and integration, and the flexibility to ensure centres are responsive to community need. Funding must be stable and secure to enable integration and collaborative practices,[73]support ongoing staff tenures and promote the long-term vision of centres. Funding also needs to be flexible to ensure centres are able to bring in specific supports, programs or activities as identified by the community.[74]

Funding for the early years is shaped by the complex jurisdictional arrangements that see key services split between federal and state government responsibility and subject to major government siloes. Specific to ICFCs, the federal government has overall responsibility for funding childcare services, and state and territory governments having responsibility for preschool, maternal and child health and relevant community services (such as child protection). The federal government is also responsible for funding key health supports, such as the NDIS and primary health care, as well as having funding responsibility for many services specific to Aboriginal and Torres Strait Islander communities.

These complex jurisdictional arrangements have a significant impact on existing ICFC funding models. Most ICFCs are funded exclusively by state governments and only offer services for which they have responsibility. Although this ensures these models are funded by a well-designed, simple funding model, it limits them from being able to offer federally funded services, such as child care, allied health (specifically therapeutic services) and other health services (such as GPs and paediatricians).

Aboriginal and Torres Strait Islander integrated early years centres described the most acute funding related barriers. These centres are primarily funded through CCS and are undermined by the limitations of this funding instrument and the lack of any overarching funding mechanism that recognises the breadth of the integrated work they undertake.

Future funding models for ICFCs should explore options for pooled, holistic funding that cover all key ICFC components and can be used to develop centres that are truly integrated, responsive to community need and able to provide key universal and targeted services in a safe, welcoming environment. The needs of the community should drive funding for the centres, rather than funding being directed by the complex responsibilities of state and federal governments. The establishment of a national partnership between the federal and state governments would ensure ICFCs are able to deliver a wide range of services and supports to meet the needs of children and families.

State funded models

State funded ICFC models have a funding model that recognises and supports their role as an integrated service. Their core funding instrument tends to be block funding from their respective education departments. This block funding supports the operations of the centres and ensures they have flexibility and security. The funding covers three different components that work together to support an ICFC. These components are:

1. the coordination and integration role undertaken by the centre (the glue)
2. core operations
3. flexible funding to support additional staffing or program delivery in response to community need.

State funded ICFCs interviewed shared that they are adequately resourced to deliver on their goals. They also benefit from simplified reporting requirements as they only need to report on a single funding stream that considers the breadth of their operations. Some centres may apply for additional grants to deliver specific events or programs, but these additional funding streams were not identified as being necessary to supplement their core funding.

The degree of flexibility within the core components is also relevant. The Tasmanian model prescribes the number of FTE and job titles that are required at each centre, whereas the Queensland model, which outsources service delivery to not-for-profits, provides greater autonomy to centres to determine what staff members are needed. A more rigid funding envelope with a flexible component ensures consistency across a jurisdiction and provides greater central control over each centre. On the other hand, less prescriptive funding in an outsourced model enables local service providers to use their own strengths and experience to shape a service that is responsive to community need.

A funding model must recognise and enable the goals and corresponding breadth of activities undertaken by ICFCs. In practice this means:

- Funding for the 'glue' that enables successful integration and multidisciplinary service delivery.
- Providing ongoing, secure block funding that allows long term planning and employment of staff on secure tenures.
- Funding holistic operations rather than just program delivery, recognising that fostering social hubs and the accompanying informal work – such as, drop-ins, taking time to talk to families, helping a family with Centrelink, cooking classes etc. – is core to successfully engaging and retaining families in an ICFC, and meeting core family needs.
- Investing in strong leadership through various mechanisms, such as professional supervision, business and operational support, and professional development.
- Providing adequate funding so that ICFCs can pay wages that value and recognise the complexity of the work undertaken by centre staff.
- Providing flexible funding so that centres are able to be responsive to community need.

Child Care Package

The CCS funding is designed as a subsidy for working families attending childcare services operating in a competitive market environment. The funding does not support integrated service delivery or the family support model offered by Aboriginal and Torres Strait Islander integrated early years centres.

> *"We do multiple things for these children, we do child protection work, we do health and wellbeing work, we do early years work, we do school transitions. We do all these different things and we only get funding for early years, that's all we get funding for."*
>
> **– Lisa Thorpe, Bubup Wilam Aboriginal Child and Family Centre**

Childcare is used to describe long day care centres. Although early learning centres is a preferable term, child care is consistent with the language used nationally when referring to the Child Care Subsidy (CCS).

There is a misalignment between the purpose of the CCS and the core purpose and mission of ICFCs that holistically support the most vulnerable children and families within their community.[75] CCS does not support the integration function that is a core component of an ICFC. It also does not support the social hub, informal work, health or infrastructure requirements of an ICFC.

CCS also does not support Aboriginal and Torres Strait Islander integrated early years centres in their mission to support culture, pride and community building for Aboriginal and Torres Strait Islander communities. Aboriginal and Torres Strait Islander integrated early years centres are a place of cultural safety – in particular for people who have been excluded from, and discriminated against, by mainstream systems. They undertake activities beyond traditional child care to encourage participation and provide other important child, family and community supports.[76] This work is time consuming, expensive, and not recognised in the funding or policy agendas that underpin the CCP. These centres were never intended to be competitive in an open market and their closure would be determinantal to efforts to meet Closing the Gap targets.

> *"The government needs to change the way they fund the early years. The CCS is for mainstream services and is driven by workforce participation. We have to change that for Aboriginal people. Our services are focused on prevention - we have highest rates of domestic violence and child protection rates – all those statistics that we all know. So why is our preventative space in the early years funded by CCS? If you want to close the gap we need to change the way that Aboriginal early childhood development is funded by the Commonwealth."*
>
> **– Lisa Thorpe, Bubup Wilam Aboriginal Child and Family Centre**

Additional Child Care Subsidy

The Additional Child Care Subsidy (ACCS) provides additional fee assistance to families and children facing barriers to accessing affordable child care. ACCS is a complicated subsidy that places a significant administrative burden on services.[77] ACCS is time limited and needs to be regularly re-applied for, meaning it is uncertain and families may face a gap in subsidy as they wait to see whether their application is approved,

putting centres in a position where they need to either cover the gap costs for families or refuse care to a child. It is challenging for families to plan work when access to care may be interrupted or refused.

Further, ACCS requires families to continually prove the extent of their hardship, entrenching a deficit-based model. For families that have had involvement in the Child Protection system, anecdotal evidence suggests they may be fearful of disclosing their vulnerability to access ACCS due to fears it could trigger a notification. For Aboriginal and Torres Strait Islander children, labelling a child as 'vulnerable' can exacerbate intergenerational trauma inflicted by policies around the forced removal of children in the context of the Stolen Generation. SNAICC – National Voice for our Children has raised concerns from their members of families who refuse to take up the ACCS payment because of the stigma and implied risk of intervention from child protection services.[78]

Activity test

The CCS includes an activity test that restricts the number of hours of subsidised care a family is entitled to based on the amount of recognised activity parents engage in each fortnight. This measurement is based on the recognised activity of the parent who undertakes the fewest hours, usually the mother. Families that fall below the activity test requirements (engaged in up to 8 hours of recognised activity per fortnight) and meet means test requirements (family income <$72,466) are entitled to 12 hours (one day) of care a week. The activity test acts as a barrier to the children most at risk of developmental vulnerability accessing the benefits of ECEC. A recent report from Impact Economics found that the current activity test is contributing to 126,000 children from the poorest households missing out on ECEC, with Aboriginal and Torres Strait Islander families over five times more likely to be limited to one day of subsidised care per week.

> *"The introduction of the Activity Test runs counter to and undermines an extensive range of government policies intended to close the gap in outcomes for Aboriginal and Torres Strait Islander children."*
>
> **– SNAICC – National Voice for our Children, Submission to the House of Representatives Standing Committee on employment, education and training: inquiry into education in remote and complex environments**

The federal government has recently announced changes to the activity test that will provide Aboriginal and Torres Strait Islander children with access to 36 hours (3 days) of care per fortnight. The changes will come into effect in July 2023.[79] This is substantially below the evidence-based recommended dose of at least 15 hours of high-quality ECEC per week,[80] however it is an improvement on the current situation.

> *"Why can't we bring children [who are excluded from CCS] to a service to support them? How would that not support child protection, development outcomes and the health and wellbeing of our children? It is a total no brainer."*
>
> **– Lisa Thorpe, Bubup Wilam Aboriginal Child and Family Centre**

Community Child Care Fund-Restricted grants

Multifunctional Aboriginal Children's Services (MACS), one of the two models included in this paper as Aboriginal and Torres Strait Islander integrated early years centres, were first funded by the federal government under the Budget Based Funding (BBF). The BBF provided grants based on the number of available places; centres were able to offer these places based on need. This meant that services could choose to offer places at a very low fee for families and had ongoing funding even if they were unable to fill all their places each year.

The BBF program provided secure block funding to MACS acknowledging that the services would not be viable under a market-based model.[81] These centres have now been transitioned to CCS with supplementary support from the Community Child Care Fund-Restricted (CCCF-R) grant. However, CCCF-R operates as a temporary, stop-gap measure within the broader context of the CCP, which is misaligned with the mission and purpose of Aboriginal and Torres Strait Islander integrated early years centres.[82] Many MACS are dependent on CCCF-R to remain viable; some are no longer providing additional services beyond long day care due to inadequate resources.

> *"We have always advocated for a sustainable funding model. If the services were just paid for the licenced places, then we could allocate places based on our waiting list and priority of access. The CCS model has forced us to shift our thinking from community based and what the needs of the child and family are to this business model, where it's all about how much money is coming through the door and maximising the CCS allocation received which is predominantly targeted at working families"*
>
> **– Stacey Brown, Yappera Children's Service**

With the challenges for MACS transitioning to CCS, the CCCF-R funding is currently filling the gap to at least keep service doors open. This funding is not available to ACFCs, despite operating in similar communities and serving a similar purpose.

Complexity of managing multiple sources of funding

Due to the inadequacy of CCS for supporting the integrated, holistic mission of Aboriginal and Torres Strait Islander integrated early years centres, centres have to derive funding from grants and other funding initiatives. Funding comes from various sources – including federal, state and local governments and the philanthropic sector – with some services managing upwards of seven funding streams.

Many centre leaders report spending a large part of their time seeking out and applying for funding, as well as managing grants, with reporting processes for individual grants onerous and inconsistent. The procurement processes that governments set up to apply for and secure funding were described in interviews as onerous and burdensome. Grant rounds may not be open for sufficient time periods; there is limited support provided to centres to assist them in applying for grants. Reporting on these various funding streams adds to this ongoing burden.

The short term, one-off nature of some funding also means that centre leaders are not only having to divert their focus to fundraising, but they are also unable to provide certainty around employment or service continuity to their staff or families.

> *"I feel that my role as a leader in an Aboriginal Early Years Service has shifted from leading pedagogy to administration based …the heavy burden of reporting on different streams of funding – whether it's data or milestone reporting, it's now consuming a majority of my time. … if you've got 8 streams of funding that's 8 steams of reporting you have to do, and in a lot of instances that's quarterly. So data, compliance, KPIs - you are reporting against all of these performance indicators, budgets and other reporting requirements. In order to be viable, we have to explore different funding options outside CCS which is a mainstream model that only funds placements that cover on-costs, not all the unique additional programs that our Aboriginal Early Years Services offer."*
>
> **– Stacey Brown, Yappera Children's Service**

Centres describe having to report on funding in a siloed manner, contrary to the nature of the integrated services they are providing. Centres may use multiple funding streams to fund a program, but then need to demarcate which part of a program was funded by each funder when reporting on how funds were spent.

> *"These services are incredibly overburdened with reporting, their funding comes from a number of different lines and a number of different moving parts and they have to report on all of those different octopus arms at different times."*
>
> **– Joanne Goulding, THRYVE NSW**

Integration or glue funding

Funding to support integration is critical for an ICFC. This requires a funding mechanism that recognises the role of integration within an ICFC, rather than it just being a hub that delivers various services. State funded ICFC models are well supported to provide this glue function. However, despite a glue function being integral to the operation of Aboriginal and Torres Strait Islander integrated early years centres, it is not recognised in any funding they receive. The centres face a challenging funding landscape where individual centres are responsible for attempting to pull together a range of services into an integrated, holistic service model and seeking philanthropic funding and other grants to fill funding gaps.

NSW funding for ACFCs

NSW ACFCs (Aboriginal Child and Family Centres) receive a funding stream from the NSW Department of Communities and Justice (DCJ) that supports the coordination and integration role undertaken by the centres. It provides a significant complement to the CCS funding, which enables the NSW ACFCs to implement more of the breadth of their mission. This funding is flexible three-year funding that recognises the additional work undertaken by ACFCs outside of the activities funded by CCS. It recognises the success of ACFCs in contributing to outcomes around early intervention and is also intended to support the development of ACCOs. There is a desire from centres to make the funding more long-term, so they have greater certainty over planning and staff tenure.

Flexible funding allows centres to choose which activities would benefit their community without needing to seek out individual grant funding each time. It also frees up a centre leader's time to focus on the centre.

> *"…if the money allows us the flexibility then that is really valuable for the child and family centres because you can be reactive to what your community needs are."*
>
> **– Emma Beckett, Nikinpa Aboriginal Child and Family Centre**

Conclusion

Funding is one of the most critical elements impacting on ICFCs being able to deliver the best outcomes for children and families. What has emerged from this research is that the issue is not always the amount of funding that is being received, but rather the nature of the funding and how centres are allowed to spend it. Funding that recognises and supports the complexity of integrated service delivery is a key enabler to ensure centres can provide holistic, wraparound supports that are shown to have positive outcomes for children and families. To be effective funding should be:

- Flexible: Centres need discretion over how their funding can be spent ensuring they are able to lead a centre that is responsive to community needs.
- Secure: Long-term, ongoing funding that allows centres to plan long-term, provide security of tenure to their workforce and provide certainty around service provision to families.
- Support the breadth of an ICFC's operations: This includes funding for integration, core service delivery, and additional services or programs as needed by the community. Funding also supports ICFCs to act as a social hub by ensuring infrastructure is suitable for drop-in visits and staff have dedicated time outside of formal service delivery to support families.
- Aligned with the mission of the model: The funding needs to be intentionally designed for ICFCs recognising the unique ways in which they work and the complex needs of the children and families they are supporting.

In addition, a unique funding stream is needed to support Aboriginal and Torres Strait Islander integrated early years centres to continue to provide the best outcomes for their children, families and communities.

Recommendations

1. Design and operationalise a funding model specifically for ICFCs that ensures ICFCs are child and family centred, responsive to community need, sustainable and supported to deliver on their role as an integrated service and social hub. This should explore options for pooled, holistic funding.
2. Design a unique funding stream for Aboriginal and Torres Strait Islander integrated early years centres that privileges ACCOs for Aboriginal and Torres Strait Islander children, and recognises and supports their vision, operations and structures.

Operating model

This research reinforces that the ICFC operating model is intended to enable an integrated service offering through the provision of core services that are either co-located or accessed through referral networks. The model focuses on a very deliberate way of working that is child-focused, relational and multidisciplinary. Unlike a hub model, which offers a single front door to access a range of services, ICFCs are designed to be a space where families with young children can come regardless of whether they are accessing a specific service, and where staff members are trained to build relationships with families in order to make them feel safe, identify their needs and provide appropriate supports.

Key findings

- Each model has a unique operating model, but they all include the same core components: the glue, core universal service provision of early learning, health and family support, access to targeted supports where needed, and the ability to prioritise other services and supports responsive to community need.
- The operating model is as much about which services are delivered as it is about how they are delivered. Ways of working, leadership and workforce are critical parts of the model.
- The glue is a central part of the ICFC operating model that distinguishes it from other early years services. It refers to the integration function that brings the individual services and staff together to create an integrated, holistic service model.
- Early childhood development is a key focus of ICFCs. This includes early learning services and programs, such as playgroups, toy libraries, ECEC and transition into school supports. They also include family supports, MCH and other health services. These services and supports are delivered in an integrated, child-centred way that responds holistically to family needs.
- Comprehensive allied health service provision is a systemic gap across ICFC models. Although all interviewees stressed the importance of allied health for early intervention and child development, access to allied health services is limited or absent and usually does not include therapeutic support. Individual centres and families take on the responsibility for finding, accessing and funding allied health services. There is currently no systemic way to provide these critical services.
- Centre leaders are essential to a high functioning ICFC and should be adequately supported and remunerated. They also need flexibility to adapt the model in response to learnings and community need.
- ICFCs rely heavily on the quality of their workforce and centre leaders to be able to deliver the best outcomes for children and families.

Overview of operating models

Child and Family Learning Centres (CFLCs)
CFLCs are purpose-built centres located in areas of high need. The model is operated and staffed by Department for Education, Children and Young People (DECYP). Each centre is funded for four specified FTEs, as well as receiving a flexible funding bucket to employ additional staff as needed. DECYP has a high level of involvement with the centres.

Early Years Places (EYPs)
EYPs are funded by the Queensland Department of Education (QDoE) who outsources centre operation to NGOs. Centres range significantly in size, staffing and funding. EYPs may be standalone centres, co-located on school sites, ECEC sites, health sites, community sites or delivered through a hub and spoke model.

Aboriginal and Torres Strait Islander integrated child and family centres
The Aboriginal and Torres Strait Islander integrated early years centres vary widely depending on which jurisdiction they are in and how they were originally established. They are run by a mix of ACCOs and other NGOs. They have a high degree of autonomy and there is significant variation between centres, although they all share a common vision and approach. Many of the centres operate with a dual early learning and health focus and are funded through a range of mechanisms.

Our Place
Our Place sites are located in areas of high need with a culturally diverse population. Each site is located on a government primary school site with a co-located ECEC service. Our Place is supported by long-term funding philanthropic funding. The Victorian Department of Education (VDE) contributes the infrastructure for the project, including the capital works required to ensure the suitability of each site. Our Place does not deliver services but rather facilitates partnerships that enable local services and stakeholders to work together in a more integrated way to ensure services are more accessible to those who need them most.

Integration or 'glue'

The glue is core to the ICFC operating model. It describes the leadership, structures, practices and infrastructure that bring the individual services and staff together to create an integrated, holistic service model. It also includes the networks that centres have with other services and the way in which a centre can support a family to navigate the complex and fragmented early childhood development system. This integration component with highly skilled staff, multidisciplinary teams, relational, child-centred ways of working, a well-designed physical space, and strong networks is as important as the service delivery component.

Effective implementation of the glue component requires its articulation and prioritisation in the design and management of the ICFC model, adequate funding and resources allocated, and staff capability for this way of

working. This has been an important enabler for the state funded ICFCs, which are appropriately funded and supported for this component. Our Place describes their key role as being the glue, bringing together various services and practitioners to practice in a more joined up, integrated way.

Despite a glue function being integral to the operation of Aboriginal and Torres Strait Islander integrated early years centres, it is not recognised in any funding they receive, except for the NSW Aboriginal Child and Family Centres (ACFCs). The funding from the NSW Department of Communities and Justice (DCJ) is specifically intended to fund the glue role, recognising that CCS funding and other available grants do not cover this function. For other Aboriginal and Torres Strait Islander integrated early years centres, the glue function tends to be performed by centre leaders who are not funded nor supported in this work. This is a significant barrier for these centres and undermines them in their ability to fully deliver on their purpose and vision.

Services

ICFCs offer a range of core universal services that act as key entry points into the model. The model is designed so that some families will only use the centre to access the specific service they require, whereas other families will make full use of the space as a place to come with their children outside of formal service provision. Centres are staffed by highly qualified practitioners who can identify children and families requiring additional supports, provide wrap around supports as needed and make referrals to other relevant services.

A key differentiator between ICFCs and other early learning services is the integrated way in which services are delivered. Although a child might attend a playgroup, embedded within playgroups are specialists, such as speech pathologists or child and family practitioners who are able to provide additional support to children and families. Playgroups are often targeted to specific cohorts, such as children with disability or young mums, helping parents to build connections and learn from peers. The Benevolent Society identified the key strengths of the EYP model as being able to engage socially vulnerable families into a support system, retain them for as long as they require support, and identify child development and safety risks at the earliest possible stage.[83] The ICFC operating model is designed to enable regular, low dosage, long-term engagement with families. Higher intensity supports are available for children and families who need them, although secondary and tertiary supports are not usually available within the ICFC but are accessed through referral networks.

Early learning

Early learning supports are a central component of ICFCs, with education departments a key funder for most models. ICFCs offer early learning programs and supports, and employ staff with early learning qualifications to support children and families outside of formal service delivery. All models have a strategic focus on supporting children to access early childhood education and transition to school. Centres have reasonable autonomy regarding which programs and services they offer. All centres interviewed offered playgroups with a mix of other programs, such as toy libraries, preschool, child care and specific educational programs – such as Launching into Learning –[84] available at individual centres depending on community need.

Preschool refers to the early childhood education program in the year before school. Also referred to as kindergarten in some jurisdictions.

Despite ICFCs having a strategic focus on early learning, it is not clear what role centres play in ensuring children receive high-quality ECEC services at a necessary dosage. Some centre leaders discussed their role in supporting families to access ECEC through formal and informal conversations, providing transport and facilitating access visits to local schools. The Working Together program in Tasmania currently offers from two to three days of free, high-quality preschool for three-year-old children from disadvantaged backgrounds in a childcare setting and there are plans to expand this program to provide access through CFLCs. Some EYPs offer ECEC whereas others focus on providing information and supports to parents.

Centre leader is used to describe the role of director, manager or leader of an individual ICFC.

Aboriginal and Torres Strait Islander integrated early years centres include ECEC within the model, which ensures Aboriginal and Torres Strait Islander children have access to culturally safe, high-quality services. All centre leaders described waitlists for their centre demonstrating the demand among the community for the ECEC services.

Many state funded ICFCs do not include ECEC services, meaning children only experience a relatively low dosage of support from ICFCs depending on how often their parents attend the centre. High quality ECEC is one key intervention that supports children in the early years; it can help to overcome some of the barriers faced by children growing up with adversity. There are significant cognitive and emotional benefits for children who receive high quality ECEC.[85] These effects are strongest for children from poorer backgrounds and for children whose parents have little education.[86] Evidence supports at least 15 hours of high quality ECEC per week; children experiencing socio-economic disadvantage may benefit from even more.[87]

Although strong evidence did not emerge from this research on whether ECEC should be delivered through an ICFC or externally, interviews with centre leaders from centres that do provide ECEC saw its inclusion as beneficial for children and families. One Aboriginal and Torres Strait Islander integrated early childhood centre leader described ECEC as an important universal soft entry point into the centre. It supports ICFCs to deliver on their remit to provide access to a range of key services under one roof. It can also provide a mechanism to oversee service quality by supporting shared values and ways of working across the early learning service and ICFC, and ensuring all staff are working collaboratively to achieve outcomes for children and families. It also means that centre staff members are able to provide supports for families who need assistance with CCS or other subsidies. This may help to overcome issues around accessibility and affordability that prevent families from accessing ECEC services.

There are significant implementation challenges for including ECEC within the ICFC operating model, although learnings from centres that include ECEC could help to overcome these challenges. The highly regulated nature of ECEC services demands many additional requirements, for example they require separate and more specific spaces to the broader ICFC. One Tasmanian centre leader described needing to build two identical playgrounds to keep the children attending the co-located childcare centre separate from other children attending the ICFC.

There is also a significant challenge in terms of funding, with childcare funding being controlled by the federal government. As state governments do not typically provide child care due to current funding arrangements, ICFCs may need to engage an external organisation to run a childcare centre. This would be especially challenging for the Tasmanian model, which is directly operated by the state government. The recent announcement from the Victorian government to open 50 new government owned and run childcare centres will be an interesting case study in the role of state governments in childcare provision.[88]

Importantly, the funding challenges faced by Aboriginal and Torres Strait Islander integrated early years centres demonstrates the importance of not having ICFCs rely on CCS as their primary funding mechanism. Adding childcare services run by an external organisation to an ICFC or developing supplementary funding mechanisms, such as the NSW DCJ funding, are options that would support the inclusion of ECEC within ICFCs.

Family support

The family support component recognises that there is a need to support parents to achieve the best outcomes for their children. Research has confirmed the significant impact parenting quality has on a child's development,[89] family circumstances like housing and income and the need for early childhood interventions that support families as well as children. In the context of ICFCs, family support is an umbrella label for a range of formal and informal services, and supports that are both universal and targeted in nature. ICFCs play a role in delivering these supports as well assisting families by supporting them to access external services through referrals and outreach support.

> **Family support** is a broad term used to describe a range of programs and services aimed at supporting parents and families more broadly. This term is used to include universal parenting programs (such as Triple P or Circle of Security), as well as more targeted supports that are broader than parenting (such as family violence services, alcohol and drug services and housing).

The formal universal services offered by ICFCs include parenting programs, such as Triple P, Circle of Security and Empowering Parents Empowering Communities. Our Place runs a program called Baby College for local mums in their third trimester. Parenting programs are intended to support parents as they transition into parenthood, strengthen child-parent bonds, and assist with challenging child behaviours. In addition, playgroups are also used to support parents by helping them build networks with other parents, and providing parenting advice and support in real time. Playgroups are often cohort specific, such as young mums or children with disability, meaning parents can meet parents from a similar background, learn from peers and have their parenting practices confirmed by others.[90] Aboriginal and Torres Strait Islander integrated early years centres also run Elders groups, cultural programs and community events.

ICFCs provide a holistic response to the needs of children and families that go beyond service provision to address the conditions under which families live. They do this by supporting families in various ways, such as providing opportunities for families to come together and build networks, and build pride in their culture. They also provide support and comfort to families as needed. Centre leaders described providing advocacy

for families, specifically when dealing with government services, such as child protection or Centrelink. One Tasmanian CFLC described a Friday session where families come together to cook and share stories; another ran a program called Out on Country, which takes families outdoors to reconnect with the land.

ICFCs also provide access to a range of intensive supports for families, including to redress parental/carer risk factors. Interviews with Aboriginal and Torres Strait Islander integrated early years centres and CFLCs described providing legal support to families, specifically around family violence. Interviewees also mentioned providing access to support with mental health, drugs and alcohol and housing.

The Benevolent Society described a program run at their EYPs called Team Around the Child/Family, which is used to identify the multiple needs of parent and children and bring together the relevant people into an intervention system around the family and to integrate separate treatments, therapies and programs into a streamlined approach.[91] Our Place provides access to adult education programs recognising the impact of a mother's level of education on child outcomes.

Maternal and Child Health (MCH)

MCH services are a core part of the ICFC operating model. MCH programs are funded by state governments and provide free universal primary health service for families with young children. All ICFCs include co-located MCH services and valued the service as an important entry point for families. Although a core part of the ICFC service offering, the degree to which MCH programs are integrated into the ICFC varied from centre to centre. MCH is funded separately to ICFCs by the relevant health department or Aboriginal Community Controlled Health Organisation and tends to operate independently of the ICFC.

> **Maternal and Child Health (MCH)** refers to the free universal primary health service available to all families and carers with new babies. The model is different in each Australian jurisdiction, however there is a consistent core service offering of health and development checks for babies with a qualified child health nurse. Child health nurses can refer families into more targeted or intensive supports if required.

When the services do work well together, the MCH nurses are able to refer families to services offered by the ICFC, facilitate introductions with ICFC staff and encourage families to participate in activities run at the centre. Some families attend an ICFC purely to see the MCH nurse, which then exposes them to the centre and helps build familiarity. One Tasmanian centre described the benefit of having an MCH nurse available for both drop-in and scheduled appointments, as well as being available for informal conversations with families. However, centre leaders also shared challenges around data sharing, shared values and integrated ways of working between MCH nurses and ICFC staff. One centre leader described the level of cooperation and integration with the MCH service as dependent on individual personalities and motivation.

Allied health

The ICFC operating model depends on allied health supports as a key early intervention measure. Allied health professionals are often embedded into ICFC programs – such as playgroups, long day care or preschools – to screen children for potential issues, build the capacity of ICFC staff delivering the programs and support with referrals.

The Tasmanian CFLCs employ allied health practitioners on staff from their core budget. Others, such as some Aboriginal and Torres Strait Islander integrated early years centres, broker in allied health supports through specific grants, such as School Readiness Funding in Victoria. Queensland EYPs tend to broker in additional allied health services as needed.

However, even with allied health identified as a key component of all ICFC models, the demand for these supports far outstrips supply in all locations. Interviewees expressed frustration that they were unable to employ allied health within their centre. One Aboriginal and Torres Strait Islander integrated early years centre leader, who had previously been able to employ an occupational therapist and speech therapist full time under the now ceased Their Futures Matter funding in NSW, described the benefits for children of having allied health practitioners in house. Within the centre, early childhood educators were able to make a referral to allied health who were able to do screening and assessments and develop a plan for each child. This meant that children were receiving supports before they started school. Without access to specific funding for allied health centres describe being unable to compete with the rates available to allied health clinicians under the NDIS.

Waitlists were also identified as a significant barrier to access, with one centre leader describing an 18-month waiting list for access to an occupational therapist and many interviewees reported state-wide shortages of allied health professionals. Challenges around waitlists for allied health practitioners are not unique to ICFCs but present a significant barrier to ICFCs being able to deliver the best outcomes for children and families.

Comprehensive allied health service provision is a systemic gap across ICFC models. Centres and families take on responsibility for accessing allied health supports. Although some centres have allied health professionals on staff, none had access to therapeutic supports and there is no systemic way for centres to secure access. Responsibility for accessing and paying for allied health services falls onto families to fund privately or through the NDIS.

Other health services

ICFCs may also provide additional health services onsite. Some Aboriginal and Torres Strait Islander integrated early years centres have a GP on site that is funded through an ACCHO. Our Place also described their long-term goal of having a GP and paediatrician at each site, although this is difficult in practice due to sector-wide shortages in staffing, fragmented funding and eligibility models and, in some sites, a lack of suitable infrastructure.

Some Aboriginal and Torres Strait Islander integrated early years centres also have effective referral pathways through the ACCHO to access paediatricians if needed. This is not the case for all Aboriginal and Torres Strait Islander integrated early years centres, with one regional centre describing four-year wait times for a local paediatrician and another trying to access a private paediatrician but being told the waitlist was so long they were no longer taking names.

> *"The difference between a kid seeing a paediatrician as a three-year-old and having two years to do the things they need to be doing compared to seeing someone as a five-year-old and having two months until they go to school… totally different outcomes for those kids."*
>
> **– Emma Beckett, Nikinpa Aboriginal Child and Family Centre**

Ways of working

Effective ways of working are critical to enabling ICFCs to move from co-located services to a more integrated and holistic service offering. It is important that services are supported to engage in relational practice, where informal interactions with families are valued as much as service provision and where all staff members feel they are contributing collectively to the child and family outcomes. A relationally focused practice framework can support family-centred best practice. For example, Tasmania uses the Family Partnership Model practice framework to support staff to engage with families in a way that is strengths based, welcoming and family centred. Our Place described relational ways of working as shifting the focus from programs and services to focusing on supporting children and families by understanding their goals and aspirations and working alongside them to help achieve these. A workforce that is high quality and has the time and space to support families in this way is critical.

> *"We had one mother here, and she hadn't been here for five years, and she said she didn't come back after she lost her children because she felt judged. And I said, 'how do you feel now?' and she said 'it doesn't feel judgy at all.' So that's the other thing – we have to make sure all the staff are on the same page in terms of being really welcoming and open to supporting families with those very difficult circumstances."*
>
> **– CFLC Centre Leader, Tasmania**

Integration is more than co-location and requires a multidisciplinary team approach to holistic service delivery.[92] This requires shared planning, vision and leadership among all members of the ICFC team. In practice, effective ways of working can be challenging to adopt and enforce. The 2012 evaluation of the EYP model identified a reliance on goodwill and relationships to drive the integrated nature of the model, particularly in relation to integrated and multidisciplinary teams.[93] This sentiment was reflected in interviews with other services.

Leadership

Numerous interviews with centre leaders and others in the sector reiterated the importance of strong leadership for effective ICFC service delivery and outcomes. High-quality leadership is a key enabler for ICFCs, but the degree to which services feel they are dependent on a single outstanding individual has been identified as an operational risk across all ICFC models. The personal, complex and face-to-face demands of the centre leader's role makes it difficult to mitigate against this risk. Instead, centre leaders need to be supported through competitive remuneration, working conditions, practice frameworks and other necessary supports to

ensure they can thrive in the role. Goodstart Early Learning discussed the importance of clinical supervision provided to their centre leaders as a way to support their mental and professional wellbeing, enabling them to support their staff, which contributions to staff retention and wellbeing.[94]

The centre leader supports a multidisciplinary team and is responsible for driving a culture of integration, collaboration and continuous improvement. Centre leaders have a key role in supporting the glue of a centre, specifically supporting staff through a process of practice change as they adjust to working in an integrated culture. Many professionals who work in ICFCs will come from more siloed service backgrounds where their expertise was valued for what they could achieve as an individual practitioner. Adjusting to an integrated practice model is a significant shift and requires support, leadership and ongoing guidance to ensure a successful transition. Centre leaders also provide face-to-face supports to families and children, many of them coming from early learning or allied health backgrounds.

Centre leaders are also responsible for the operational management of the centre. Depending on the ICFC model, this may include workforce management and development, fundraising, budgets, and planning. Many centre leaders have no experience in business management – the support they receive when commencing in the role is essential to ensure they can successfully run the centre and focus on achieving outcomes for children and families.

In terms of progressing the ICFC model and ensuring high quality services and supports for children and families it is essential for decision makers influencing the authorising environment to consider how they can best support centre leadership, who are in turn able to support their workforce. It is critical that people working closest to children and families can focus on their needs rather than having to divert their energy to operational challenges.

Workforce

The workforce challenges facing the early learning sector are well documented. Early childhood educators are undervalued, underpaid and work in extremely demanding environments.[95] However, unlike a childcare or preschool setting, ICFCs employ a mix of staff, many of whom are not early childhood educators or teachers. The unique pressures faced by the ICFC workforce are not well documented. Interviews suggested that working in a multidisciplinary team adds an additional challenge for staff. The workforce has to be both qualified in their individual area of practice, as well as able to work collaboratively in a multidisciplinary team. Further research exploring the unique working environment for ICFC employees is needed to understand how the operating model can best support them to achieve the best outcomes for children and families.

Centre leaders described the ICFC working environment as challenging, complex and intense. Centre staff is often faced with challenging behaviours from children and families who may be suffering from trauma and may suffer from vicarious trauma themselves. One centre leader described having to be engaged in a child protection report against a mother attending the centre, and then needing to support the mother after the children were removed.

> *"… you're in the room with the kids, you're dealing with those kids and those families and you're trying to support them. You can't have a crappy day, you've got to come in there every day and give 100%."*
>
> **– Emma Beckett, Nikinpa Aboriginal Child and Family Centre**

Further, centres, such as in Tasmania, are open from Monday to Friday for 50 weeks of the year. Interviewees commented on the challenge of having time for planning and team building when there is no break from face-to-face operations with clients.

Many interviewees also remarked on the challenge of recruiting staff to work in ICFCs due to competition from schools, NDIS services or other employers who were seen to offer better wages or conditions. Short term funding contracts were also identified as a barrier to staff recruitment. One centre leader in a remote location in Tasmania commented on the challenge of recruiting an Education Officer with a teaching qualification (which is a requirement of the CFLC model) when the local school was able to offer substantially more annual leave as well as additional remote working loadings. Poor childcare provision also impacted on workforce retention.

> *"I'm struggling to get staff and the impact of not having a fully functional childcare centre here is hard enough, but in our other local towns it's impossible, there is no childcare. We've got educated women in particular that are not able to go back to work that are completely reliant on their partner often for everything right down to the vehicle."*
>
> **– Vikki Iwanicki, Queenstown CFLC**

Interviews further raised discussions around the benefit of employing local staff. This was seen to help the community feel more comfortable and welcome within the ICFC. It also helps to overcome some of the barriers of distance that are experienced especially by rural and remote ICFCs. In rural and remote areas ICFCs are an important employer of local residents, providing both a community and economic benefit.

> *"The moment we open the door to the new parent who's plucked up the courage to visit for the first time, and they're met by someone from their local community, someone who looks like them… It does something quite profound in relation to their construction of the place, their preparedness to give it a go a second time."*
>
> **– Paul Prichard, MCRI**

Aboriginal and Torres Strait Islander integrated early years centres also face specific challenges attracting, retaining and supporting their Aboriginal and Torres Strait Islander workforce. Aboriginal and Torres Strait Islander ECEC staff plays a crucial role in supporting Aboriginal and Torres Strait Islander children to grow up strong in their culture.[96]

Place based supports

ICFCs are placed in communities with high levels of socio-economic disadvantage that demonstrate readiness and need for the service. The integrated nature of ICFCs is dependent on the availability of other services to build an integrated network. Being able to leverage existing networks is a strong enabler for ICFCs and there is benefit in viewing ICFCs as part of a wider community ecosystem rather than an end in themselves. This works effectively where there is a high quality ICFC situated in a local community with a strong network. For example, the Cairns EYP has been able to successfully leverage other place-based initiatives and networks, such as Cairns South Together and Communities for Children.

Location

Queensland EYPs, Our Place and some Tasmanian CFLCs are located on school sites. This is a strategic design feature that is intended to meet a number of objectives, including supporting school transitions, ensuring convenience for families that have a child at school and raising awareness and improving access to the ICFC by positioning it alongside a prominent community site. It also reduces infrastructure costs by locating the centre on a site already owned by the state government. It is not clear whether the co-location of ICFCs and schools does improve outcomes for children and families, but it could support in the expansion of ICFCs by reducing infrastructure costs for governments.

Further research is needed to understand how ICFCs can be located on school sites without acting as a barrier to families who do not feel safe accessing the school. Anecdotal evidence from focus groups in Tasmania suggest parents are supportive of having centres located on school sites.[97] They identified the co-location as important for building connections and familiarity with the school and making local friends who then went on to the same school. Families who felt anxious about school found that the exposure they gained through attending the CFLC co-located on the school site made them feel safe and more comfortable. However, concerns have also been raised in the available research regarding families who are reluctant to go into the school because they see schools as representing mainstream institutions that have excluded them or because they have had negative experiences in a school. SNAICC – National Voice for our Children has raised the need for ICFCs to be kept operationally and structurally separate from schools, even if co-located, to ensure there is still the opportunity for community control. As relationships between schools and Aboriginal and Torres Strait Islander communities are highly variable, ACCO-run early years services can play a key role in bridging that relationship and preparing children for a successful start to mainstream schooling.[98]

Outreach

All ICFC models include outreach components within the operating model. Although there is no clear definition of what constitutes outreach there was strong consensus from centre leaders, consistent with other external research, that some families were especially vulnerable and living in complex social circumstances that prevented them from engaging fully in available services.[99] Outreach was described in interviews as including a range of activities: home visits, running playgroups in external locations, such as shopping centres or playgrounds, providing transport to bring children and families to the centre, and accompanying a family to an appointment or service. Some interviewees emphasised the benefit of having a local community member attend outreach activities as an enabler to engagement with the family.

Despite all ICFC models including outreach components in their operating model, interviewees discussed the challenges of conducting outreach. Interviewees described how home visits required one or two centre staff to be away from the centre from long periods of time; this affected their capacity to deliver services within the centre. Some interviewees described the cost of outreach as being prohibitive, with petrol and tolls cited as significant costs for centre budgets. Safety was also raised as a concern, especially regarding home visits. Many centres had reduced their outreach activities as a result of these challenges and saw the reduction in outreach as a major barrier to being able to engage with the most vulnerable families in the community.

Conclusion

Although each ICFC operating model is structured differently, there is broad consensus around the core components of the model being the glue, core universal service provision of early learning, health and family support, access to targeted supports where needed, and the ability to prioritise other services and supports responsive to community need. The diversity across operating models reflects the unique way in which each model has been established and how they are operationalised. Centre leadership and workforce are key enablers for centres and should be recognised and supported through remuneration, conditions and professional supports. Centres also require adequate ongoing supports to ensure they are successfully established and maintained to able to achieve the best outcomes for children and families. Access to other critical services and outreach are important components to ensure more vulnerable families can access ICFCs and the supports they need. More support is needed to ensure outreach activities continue to be part of the ICFC model.

Recommendations

1. Ensure ICFCs can provide ECEC services, including childcare, if appropriate in their community.
2. Reform the allied health system to ensure a systemic way for ICFCs to provide access to allied health for children and families.
3. Provide support for centre leaders and the ICFC workforce, including competitive remuneration, working conditions, practice frameworks and other necessary supports, such as clinical supervision, to ensure they can thrive in the role.
4. Provide support to further enhance outreach within the ICFC operating model to ensure centres are reaching the most vulnerable members of the community.

Authorising environment

ICFCs need to be embedded and supported by government policy, including through high level strategies that are translated into clear programs or funding. Government leadership is important in supporting a culture of continuous improvement within centres and ensuring a culture of integration. ICFCs face challenges as they try to deliver an integrated service offering while navigating siloed, complex government funding and policy

arrangements. ICFCs require substantial time and resourcing during the establishment phase. Co-design with community is essential to ensure services are best able to meet the needs of parents and children.

Key findings

- The lack of collaboration or partnership between federal and state governments and between state government departments is a significant barrier to ICFCs being able to provide an expansive package of early years services and programs to meet their mission for children and families.
- ICFCs have to be embedded in government policies and strategies that are translated into clear programs and funding, and evaluated.
- Siloed service responsibilities between federal and state governments makes it challenging for state managed ICFC models to provide CCS funded services.
- State ICFC models are run by a single government department, which makes integration at government level challenging.
- ICFCs attempt to provide integrated services while navigating siloed government structures and processes.
- Establishment processes take time and need to be well supported by funders.
- Co-design is a critical component but not currently well incorporated into any model.
- Funders have an important role to play in establishing quality improvement processes and building a culture around continuous improvement.

Government policy

The extent to which the goals of ICFCs are supported and enabled by government policy is an important enabler. High level strategies that are translated into clear programs or funding and evaluated, are especially important. The Tasmanian CFLCs are identified as a key initiative in the current Tasmanian Child and Youth Wellbeing Strategy;[100] they have been consistently funded since the first centre opened in 2011. Likewise, Queensland EYPs are identified as a key initiative in their current Early Years Plan.[101]

Brighter Beginnings, the NSW Government initiative providing funding to the NSW ACFCs, is a core component of the NSW Government's Early Years Commitment.[102] There is also representation from ACFCs on the NSW Aboriginal Early Childhood Education Advisory Group, which contributed to the development of the Aboriginal Children's Early Childhood Education Strategy.[103] The vision of the Strategy is that "all Aboriginal children in NSW can access quality early childhood education (ECE) and are supported to embrace their culture and identity for a strong start to lifelong learning".[104]

Aboriginal and Torres Strait Islander integrated early years centres are an important component of Closing the Gap targets and priority reforms, but there is no funding tied to these targets. Aboriginal and Torres Strait Islander integrated early years centres contribute to the Closing the Gap target to increase the proportion of Aboriginal and Torres Strait Islander children enrolled in 4-year-old early childhood education to 95% by 2025 and to increase the proportion of Aboriginal and Torres Strait Islander children assessed as developmentally

on track in all five domains of the AEDC to 55%.[105] The centres are also important in reducing the rate of over representation of Aboriginal and Torres Strait Islander children in the child protection system. Further, the National Agreement on Closing the Gap includes building the community-controlled sector as a priority reform.[106] The accompanying Sector Strengthening Plan presents an opportunity to improve the support the sustainability of these centres.[107]

For many Aboriginal and Torres Strait Islander integrated early years centres, there is a significant gap between their inclusion in government policies and reforms, and the translation of this into programs and funding. This serves as a barrier to Aboriginal and Torres Strait Islander integrated early years centres being adequately supported through funding or government leadership.

Government leadership

The lack of collaboration or partnership between federal and state governments, and between state government departments is a significant barrier to ICFCs being able to provide an expansive package of early years services and programs to meet their mission for children and families. Integration of ICFCs is still very much focused on the service level, sometimes regional, but not within the higher structures of state or federal governments. Rather than having unified funding and operational structures feeding into the centres, decisions around service priorities are influenced by government priorities. For example, despite the EYP model including MCH and allied health as a key element of the model, the lack of integration between Queensland Department of Education and Queensland Health mean each centre needs to negotiate a parentship with a health provider, leaving some EYPs without any access to MCH or allied health supports. Also, the lack of integration between state and federal governments seems to be a barrier to centres attempting to deliver federally funded programs, in particular child care. Jay Weatherill, former Premier of South Australia, described being unable to include child care in the South Australian Children's Centres his government established because they didn't have a partnership with the Commonwealth.[108]

> *"At a macro policy level there needs to be intergovernmental agreements between the Commonwealth and State/Territory governments to better enable ECEC and state funded and/or regulated preschool to be in the same building, and/or by the same service, including state government services such as public schools. They should address funding, regulation, and delivery. Without these agreements, integrating ECEC and preschool is going to be hard."*
>
> **– David Ansell, Thrive by Five**

System stewardship is an approach to governance that attempts to unify participants within a system around a shared vision. The Front Project has examined the potential of a system stewardship approach to steer the ECEC system towards high quality, long-term outcomes.[109] The approach asserts that all participants in a system are jointly responsible for the health of the system and governments would need to relinquish power to enable power and autonomy in others. The approach also provides an opportunity to reimagine the ECEC system with children and families at the centre. In the context of ICFCs, system stewardship would support a shift in government leadership that supports collaboration, integration and ensuring the needs of children and families are the central focus of service design and delivery.

Improved government leadership and collaboration would ensure clear decision-making processes and responsibility for outcomes across a model. Programs and services offered through ICFCs can contribute to many outcomes, including early learning, health, early intervention and community building. Ensuring the involvement of multiple government stakeholders, including various government departments across state government, in developing measurement frameworks would help to support ICFCs in identifying and achieving the full breadth of possible outcomes. This would also help ensure more levers are available to decision makers to improve quality or adjust service offerings based on community need.

Governance and high-level authorising structures impact the extent to which ICFCs act as a hub of independent services rather than a single platform that provides something that is greater than the sum of its parts. ICFCs are often asked to provide an integrated service while navigating siloed government structures and processes. This is especially the case for many of the Aboriginal and Torres Strait Islander integrated early years centres that are attempting to pull together siloed, often disparate programs and services to create an integrated offering. This undermines the effectiveness of centres because it diverts the attention of centre leadership away from service delivery to navigating this complex landscape and limits possible service offerings. It also means that there are no clear government-wide processes or structures supporting centres to achieve success.

Similarly, there are considerations around whether an ICFC can ever be truly integrated when a single government department oversees the model. All state-run models, except ACT, are led by the relevant education department (the ACT model is led by the Community Services Directorate). Other components, such as MCH, are then brought into the model through partnerships with the relevant health department. Concerns were raised across a number of interviews about the extent to which a health and education hub can truly integrate when one department leads policy development, funding and decision-making processes. It is unclear what structures would be needed to ensure a more holistic authorising structure where multiple departments are invested in ensuring centres are delivering the best outcomes for communities. The Victorian government Interdepartmental Committee (IDC) that oversees Our Place could provide a useful case study.

Our Place Philanthropic Alliance

The Our Place approach demonstrates the potential for beneficial governance arrangement through philanthropic supporters. Key philanthropic partners have signed the Our Place Philanthropic Alliance, which enables these organisations to work together in a collaborative, long-term relationship on issues beyond those at a site level. The Our Place Philanthropic Alliance is an example of how funders, specifically philanthropy, can leverage their contributions by working collaboratively to support the strategic objectives of a project. A key challenge for ICFCs is attempting to provide integrated services on the ground while navigating a siloed authorising environment. The Alliance is attempting to both overcome some of those siloes and provide expertise and support to Our Place.

Establishment processes

There was strong consensus from interviewees that establishment processes take time and should be well supported. Strong governance arrangements should include the necessary supports and resources to ensure each centre is set up to succeed. Our Place shared that establishing a new site is a two-year process of networking, building relationships and working with the community before even developing an implementation plan for the site.

Establishment processes need to include engagement with service providers and stakeholders as well as the community. Co-design with local communities is important to build community ownership and trust, an ensure responsiveness to community need, as well as in some situations avoid risk that it is viewed as a collection of government initiatives. Research has found that engaging parents in co-design and co-production processes ensures that their needs can be better met by the services. This was found to be especially true for families with the most disadvantaged and marginalised background.[110] Interviews with centre leaders did not identify co-design as a central feature of any of the models. More work is needed to consider how co-design processes can be better used by service providers to ensure ICFCs are developed in a way that best meets the needs of the community.

Staff and services also need time to be trained in new, integrated ways of working that may be a significant shift to how they previously operated. Centre leaders need adequate training and support to ensure they can successfully lead the organisation. An important observation from a sector leader working with Aboriginal and Torres Strait Islander early years centres is the lack of business or operational support that was provided to centre leaders at inception. This undermines centre leaders and acts as a barrier to centres being able to run an effective centre and achieve the best outcomes for families.

Quality improvement processes

Centre leaders from Tasmanian CFLCs and Queensland EYPs felt supported by government as the funding body. Both models have a strong culture of continuous improvement and centres are being challenged to consider how they can improve their outcomes. Both Queensland's Department of Education and Tasmania's Department of Education, Children and Young People (DECYP) have recently developed quality improvement tools to support centres.

DECYP has undergone a process of service and stakeholder engagement to develop its quality improvement tool to support CFLCs to reflect upon and improve their practices. The tool identifies the key elements that are regarded as producing quality outcomes for children and families. It provides guidance to centres on these elements, and helps them to identify their own practices and how these could be improved.

The CFLC quality improvement tool focuses on five key domains that were developed in consultation with families, centre leaders and DECYP staff. These five key domains are early learning, family engagement, integrated services, CFLC leadership and staffing, and CFLC enablers (which includes flexible funding and reporting, collaborative improvement planning, meaningful data and supporting school improvement leaders in their understanding of CFLCs). The tool can be adjusted to suit the needs of the individual centre and

community and is intended to be used broadly as needed, including to support individual team members, to support CFLC team planning, and to support broader team planning with other service providers in the CFLC .

Conclusion

Authorising environments under which ICFCs are established and delivered can support an ICFC to deliver a more fully integrated service that is responsive to the needs of community. Enabling structures can promote quality improvement practices, support integrated ways of working and contribute to the strategic direction of an ICFC. However, the lack of evaluation and evidence around ICFCs in Australia makes it difficult to conclude which overarching structures have the most impact on ensuring ICFCs achieve the best outcomes for children and families. There is a role for governments and funders to consider how funding, provision of diverse multiple services, quality relational practice and operating processes could be better supported and enabled by strong integration and frameworks that centres are supported to adopt.

Recommendations

1. Introduce a system stewardship approach to support a shift in government leadership that supports collaboration, integration and ensuring the needs of children and families are the central focus of service design and delivery.

Quality and outcomes

Key findings

- High quality services are essential to outcomes, but there is currently no consistent measure of quality for services outside the ECEC-focused NQF.
- Centres face many challenges around data collection. Improved data capture would support centres to understand usage patterns, better target supports and measure outcomes.
- Measuring and attributing success to individual components of their model is a challenge for all ICFCs.
- The development of a national outcomes framework would help identify and measure the effectiveness of ICFCs, and ensure they are focused on achieving a broad range of outcomes for children and families.

ICFCs are beneficial for all children and families, but prioritised for children and families experiencing disadvantage. Yet there is not a clear understanding around who currently uses ICFCs, who else would benefit from using an ICFC, and what outcomes ICFCs are able to achieve for children and families. Centre leaders felt that they were not collecting adequate data and did not always know how to use data that they did have.

Improved data capture and support would help to better understand current usage patterns, enabling centres to know exactly who is accessing the service and how much focus and support is needed to reach other families. It would also support in identifying and measuring outcomes across ICFCs and identifying which locations would be best supported by an ICFC in the future.

Data and evaluation

Collecting and analysing meaningful data is a significant barrier for ICFCs and impacts on their ability to be able to measure outcomes and refine service delivery for ongoing improvement and outcomes for children and families. Interviews identified a number of reasons for this, including:

- The informal, drop in nature of ICFCs means many families are not enrolled in a formal service or only attend the centre on an ad-hoc basis.
- Families attending centres may feel nervous or distrusting of attempts by centres to collect data about them.
- The impact of ICFCs tends to be cumulative and long term, making it difficult to measure change as a result of a single program.
- Issues around Aboriginal data sovereignty can affect if and how data concerning Aboriginal and Torres Strait Islander children and communities is collected.

A challenge for all ICFCs is attempting to measure and attribute success to individual components of an integrated model. As described in an analysis of CFLCs, "approaches that address wicked problems cannot be modelled, resourced, or evaluated on a simple input-process-output basis".[111] Both formal and informal activities enable outcomes for children and families and being able to separate out the successful components is problematic. This is an ongoing challenge for many programs and services attempting to support families experiencing disadvantage.

Further, ICFCs rarely receive funding for evaluation: many are not funded or supported to undertake data collection and analysis. Structural barriers around data sharing prevent ICFCs from being able to access data from other government departments, such as health, and prevent data sharing between state and federal agencies.

Findings from the Tassie Kids study highlight the importance of data that can track a child's service usage from birth to school. It is also linked to child outcomes in order for governments understand how services are being utilised, address inequalities and ultimately improve outcomes for children. The study also recommends greater developmental monitoring in the early years, recognising that by the time children start school more than one-fifth are identified as developmentally vulnerable. ICFCs could play an important role in this data collection.[112]

It is important that future funding of ICFCs considers how data can be better used to improve service delivery. This includes better assessments of quality and quality improvement, and collecting data that enables services to measure their impact and evolve in response.

Quality

Research shows that high quality ECEC programs can significantly reduce both the levels of developmental vulnerability and the gap between children experiencing disadvantage and other children that is evident at school entry.[113] Extensive research has shown that children from socially disadvantaged backgrounds are the most likely to benefit from exposure to ECEC.[114] However, the positive effects of early childhood education programs are contingent upon, and proportionate to, their quality.[115]

There is currently no formal way to assess the quality of ICFCs. For centres that include long day care or preschool, these services will be assessed under the National Quality Framework (NQF). However, the NQF rating is only applicable to the formal ECEC services and does not consider any other elements of an ICFC. It is essential that tools are developed to support ICFCs and their broader authorising environments to identify and provide high-quality services and supports. These include quality frameworks at a centre level, as well as a nationally consistent quality framework. An understanding as to what quality looks like in an ICFC and clarity around outcomes is needed as a first step.

At a centre level, alternative quality frameworks should be explored, such as the Sustained Shared Thinking and Emotional Wellbeing Scale that is used by Goodstart Early Learning. Both the Tasmanian Government and Queensland Government are currently implementing quality improvement frameworks that have been developed specifically for their ICFCs. To support both individual service quality and the processes that enable integrated practice and holistic service delivery, it is important that quality frameworks apply to everyone working at an ICFC, including child and health nurses and other health supports.

Quality assurance around processes was also raised during interviews. This refers to processes that enable ICFCs to achieve their goals, such as co-design, community engagement and ways of working within centres.

Outcomes

ICFC models identify a variety of outcomes that they are trying to achieve, including outcomes focused on early learning, school readiness, early identification of need, engagement with targeted supports, child and maternal health, social connection, child safety and community building. It is necessary for each ICFC model to develop its own outcomes framework to support ICFCs identify and work towards specific outcomes. Queensland, for example, is currently undertaking a co-design process with all EYPs to develop an outcomes framework to move all services to a more consistent model.

A consistent, national outcomes framework is also recommended to help identify and measure the effectiveness of ICFCs. It is also recommended to ensure ICFCs are focused on achieving a broad range of outcomes for children and families, recognising their capacity to improve holistic life-long health, development and wellbeing for children, their families, and the communities in which they live. This must include a recognition that some ICFCs are more focused on early learning and development outcomes, whereas others, such as the NSW ACFCs, are focused on early intervention and link outcomes to Closing the Gap targets.

Discussions to create a national outcomes framework for ICFCs need to consider the role of ICFCs in ensuring children can access high quality ECEC services at a sufficient dosage. Research is clear that children experiencing disadvantage and vulnerability benefit from attending high quality ECEC services.[116] Many ICFCs

do not include ECEC services, meaning many children only experience a relatively low dosage of support from ICFCs depending on how often their parents attend the centre.

Conclusion

The complex range of services and supports offered by ICFCs makes it difficult to measure and analyse outcomes. However, without this data and analysis, ICFCs are unable to properly understand who is and is not accessing the centres, whether their practises and supports are of a sufficient quality, and what outcomes they are able to achieve for these children and families. As is already happening in a number of models, consistent outcomes framework, quality improvement tools and data collection mechanisms are needed to support centres. Funding for evaluation is also needed so that centres are able to learn and improve their practises, and relevant staff is supported in data collection and analysis. A national approach to data and outcomes could also support in ensuring efforts to scale ICFCs are targeting the communities that would most benefit from the model.

Key recommendations

1. Fund evaluation and build the capacity of ICFCs to collect and analyse appropriate data in order to evaluate their service, measure their impact and use learnings to evolve service delivery.

Unique strengths and challenges

Importance of culture for Aboriginal and Torres Strait Islander integrated early years centres

A key finding from the current research is the significant value placed on culture and inclusion by Aboriginal and Torres Strait Integrated early years centres. This strengths-based approach supports a community connected by cultural pride and safety rather than perceived problems. This appears to be a crucial enabler for the success of these centres, creating not just a non-judgemental and welcoming environment, but a positive reason to engage. Research shows that "ensuring all our children have access to culturally safe quality early learning gives them the best chance to transition to school as ready and confident learners, proud of who they are".[117] Some centres have up to 100% of children attending identifying as Aboriginal and Torres Strait Islander,[118] demonstrating the importance of culture and pride as a core reason for families to attend Aboriginal and Torres Strait Integrated early years centres.

Interviews with centre leaders identified the importance of this strengths-based approach in building a strong, dedicated local workforce. The centres employ local Aboriginal and Torres Strait Islander people, which has been identified as a key factor critical to addressing the cultural access barries faced by Aboriginal and Torres Strait Islander children and families.[119] Further, nearly 75% of Aboriginal and Torres Strait integrated early years centres are Aboriginal Community Controlled Organisations (ACCOs). Local ownership of programs improves service access and participation, improving outcomes for children and the community.[120]

Aboriginal and Torres Strait Islander integrated early years centres are unique among ICFCs in promoting culture and pride as core enablers for service outcomes. Their dedication to the local community and the value placed on local knowledge was a strong narrative that came through in interviews with centre leaders.

A unique funding stream is needed to support Aboriginal and Torres Strait Islander integrated early years centres. This would protect the identity and mission of the centres and ensure they are not having to compete with mainstream centres.

> *"It won't necessarily cost more but it will mean more access for Aboriginal children. The funding needs to go through ACCOs and it needs to be different to mainstream childcare funding. ACCOs need access to a bucket of funding for childcare that is not focused on the deficits of the child and family [as ACCS currently is]. The government tried CCS and it didn't work. Do something different. Change the way you fund it. Don't welfare-ise it. We need access that looks after us as families to be the best we can be."*
>
> **– Lisa Thorpe, Bubup Wilam Aboriginal Child and Family Centre**

Regional and remote ICFCs

The ICFC model incorporates place as a key strength. It is intended as a place within a local community that families with young children can go to meet and connect with others and access a range of services.[121] Ideally, it should be walkable for families, or accessible by public transport. The integrated nature of the model also requires strong networks and access to a range of other services that families may need such as mental health services, financial support or housing services. Despite this, current ICFCs are often servicing large geographic areas, often in populations that don't have access to private transport.

ICFCs in regional and remote communities have identified the dispersed nature of the population and large geographic areas as barriers to being able to support some children and families. Regional and remote communities often lack reliable public transport, which means families without access to a car are simply unable to get to the centre. One regional Tasmanian CFLC leader described servicing a community where a high proportion of people are unlicensed. Where a family does have access to a vehicle, the father typically takes it to work leaving mothers at home with the children without access to a vehicle. Although some ICFCs may provide transport, in remote areas this was felt to not be feasible due to the time and expense needed to cover such large distances. Centres try to run outreach activities outside of the main centre, but this also requires additional, dedicated funding and time. One EYP in Queensland described servicing communities that were spread over various islands. There were significant ferry charges to reach each island, as well as the time needed to travel from one to the next.

Service availability and accessibility is generally poorer in rural and regional areas, which makes it challenging for rural and regional centres to support children and families to access the supports they need. For example, an Aboriginal and Torres Strait Islander integrated early years centre in regional NSW described substantial

wait lists for local doctors and allied health professionals, meaning they often drove families large distances to the closet city to be able to gain access more quickly. A regional Tasmanian CFLC leader described the challenge of not having local allied health professionals available to support families. Although the CFLC model includes the provision of a social worker and psychologist for one day per week, these clinicians were not locally based, which meant they were having to spend a significant portion of their allocated hours travelling to and from the centre. This reduced the amount of time they had available to support children and families there.

Rural and remote ICFCs identified strong networks as an important enabler. One Aboriginal and Torres Strait Islander integrated early years centre in regional NSW described a good working relationship with the local TAFE that enabled her to provide Certificate III and Diploma courses on site for the community to build, upskill and strengthen the local workforce. Conversely, an Aboriginal and Torres Strait Islander integrated early years centre in remote NSW described a poor relationship with their local TAFE whereby they were unable to get a trainer to provide any onsite training and the Aboriginal Liaison Officer was based in a city three hours away.

5. Conclusion

This discussion paper set out to identify the key enablers and barriers affecting the ability of Integrated Child and Family Centres (ICFCs) to deliver the best outcomes for children and families. It looked at the ICFC landscape in Australia with a specific focus on four models: Aboriginal and Torres Strait Islander integrated early years centres, Child and Family Learning Centres (CFLCs), Early Years Places (EYPs) and Our Place. These models were selected because of their diversity in funding and operating models, level of scaling, willingness to participate in the research and resource constraints.

The research was initially very focused on the structural components of each model and how these were affecting outcomes. What became evident throughout the process is the complexity of factors that affect the outcomes produced by these centres. ICFCs are enabled by individual components being able to leverage off each other to produce something that is far more than a sum of its parts. Each model is unique in its structure, and within models there is often significant diversity between centres. This makes it difficult to compare models as a whole or to identify which specific components within a model are serving as barriers or enablers. The research does, however, demonstrate the impact that is possible if centres are adequately funded, supported and led by strong centre leaders. It demonstrates the need for governments and funders to recognise and value ICFCs as a key service that can meet many of the needs of children and families experiencing disadvantage.

Recommendations:

1. Create a national approach to ICFCs that includes a broad definition with core components, a national quality framework and a professional learning system. Staff capability building around integrated practice is important to include, recognising ICFCs require a very different way of working.

2. Facilitate a process for the federal, state and territory governments and sector leaders to consider and develop a national plan for recognition, support and growth of the ICFC sector.

A key finding from this research is the importance of their role as a safe place that families can come with their children. This is enabled by having centres open to families outside of formal service provision and ensuring staff are using culturally safe, child-centred and relational practices and have un-rostered time to be able to sit with clients, talk about issues and engage in casual interactions. This requires outstanding centre leadership that can build and lead a multidisciplinary team to work collaboratively to meet the needs of children and families. Centre leaders are also crucial to enabling integration across a centre, and have the

capacity to innovate and drive the model in response to community need. In terms of progressing the ICFC model and ensuring high quality services and supports for children and families, it is essential for decision makers influencing the authorising environment to consider how they can best support centre leadership, who are in turn able to support their workforce and the children and families attending the centre.

The research also identified the integration/glue function as a key driver of outcomes. This function is what differentiates ICFCs from early years services delivered in standalone settings and contributes to ICFCs being able to deliver more than the sum of their parts. Rather than ICFCs being a location with a range of co-located services, the integration function helps to ensure these services are working holistically to support a child. It also ensures that children and families can access services and supports beyond those offered by the ICFC through effective networks and referrals. An effective funding model for ICFCs must recognise and value the importance of the integration function.

The discussion paper has focused on the core components of ICFCs that are consistent across the models. As detailed earlier, these include early learning programs, MCH, family supports, allied health and the 'glue'. Each centre offers a different mix of programs and supports for each core component. Quality is an important issue that must to be measured in a consistent way to support centres to improve their processes to drive outcomes. In terms of core components of the model, availability of ECEC is one of the most notable differences across ICFCs. Some centres offer child care and preschool onsite whereas others may only provide information to parents about available ECEC services in the area. Evidence supports at least 15 hours of high-quality ECEC per week, and children experiencing vulnerability may benefit from even more.[122] Although the funding mechanism and structural requirements to provide child care and preschool are often cited as barriers to service provision, any future expansion of existing or new ICFCs should include ECEC as a core component.

ICFCs have made a significant contribution to individual families, children and communities in Australia over the past 20 or 30 years, and with adequate funding and support, could have far more impact for the young children and families across Australia experiencing disadvantage today. The findings from this paper demonstrate the opportunity that currently exists to both recognise and improve the outcomes of current ICFCs and to explore pathways to scale to ensure more children and families can benefit from these centres. The recommendations included below provide guidance around how that could be progressed. It is hoped that this research can be an input to better understanding ICFCs and the principles for scale, including their effective inclusion in national and state early childhood policy frameworks as a key support for children experiencing disadvantage and their families.

Key recommendations

1. Create a national approach to ICFCs that includes a broad definition with core components, a national quality framework and a professional learning system. Staff capability building around integrated practice is important to include, recognising ICFCs require a very different way of working.

2. Design and operationalise a funding model specifically for ICFCs that ensures ICFCs are child and family centred, responsive to community need, sustainable and supported to deliver on their role as an integrated service and social hub. This should explore options for pooled, holistic funding.

3. Design a unique funding stream for Aboriginal and Torres Strait Islander integrated early years centres that privileges ACCOs for Aboriginal and Torres Strait Islander children and recognises and supports their vision, operations and structures.

4. Ensure ICFCs can provide ECEC services, including child care, if appropriate in their community.

5. Reform the allied health system to ensure a systemic way for ICFCs to provide access to allied health for children and families.

6. Provide support for centre leaders and the ICFC workforce, including competitive remuneration, working conditions, practice frameworks and other necessary supports – such as clinical supervision – to ensure they can thrive in the role.

7. Provide support to further enhance outreach within the ICFC operating model to ensure centres are reaching the most vulnerable members of the community.

8. Introduce a system stewardship approach to support a shift in government leadership that supports collaboration, integration and ensuring the needs of children and families are the central focus of service design and delivery.

9. Fund evaluation and build the capacity of ICFCs to collect and analyse appropriate data in order to evaluate their service, measure their impact and use learnings to evolve service delivery.

10. Facilitate a process for the federal, state and territory governments and sector leaders to consider and develop a national plan for recognition, support and growth of the ICFC sector.

Endnotes

Executive summary

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CHILDREN'S CENTRE EVALUATION

Evaluation Report: a report on the measurement of process and impacts

A COLLABORATION BETWEEN

FRASER MUSTARD CENTRE

Government of South Australia
Department for Education

TELETHON KIDS INSTITUTE
Discover. Prevent. Cure.

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Acronyms used in this report:

Acronym	Meaning
AEDC	Australian Early Development Census
DECD	Department of Education and Child Development
FCP	Family and Community Program
EYS	Early Years System
CALD	Culturally and Linguistically Diverse
ECEC	Early Childhood Education and Care
ECCE	Evaluation of Children's Centres in England
TFD	Toronto First Duty
BBBF	Better Beginnings, Better Futures
EHS	Early Head Start
CC	Children's Centre
GOM	Guardianship of the Minister
DOB	Date of Birth
EDID	Education ID
SRC	Social Research Centre
LBOTE	Language Background other than English
CaFHS	Child and Family Health Service
LOTE	Language other than English
SEIFA	Socio-Economic Index for Areas
ABS	Australian Bureau of Statistics
ARACY	Australian Research Alliance for Children and Youth
EYLF	Early Years Learning Framework

1. Executive Summary

The Telethon Kids Institute through the Fraser Mustard Centre was engaged to undertake a three-year evaluation of South Australian Children's Centres for Early Childhood Development and Parenting (Children's Centres). The overall aims of the evaluation were to measure process and impact of the integrated services in Children's Centres (described in the Overall Three Year Evaluation Plan; see Brinkman & Harman-Smith (2013). The qualitative component of the evaluation was completed in 2013 (Harman-Smith & Brinkman, 2013).

This current report details the findings from three components of work that set out to measure:

- how well service integration was working in Children's Centres
- parents' experiences of accessing services and supports
- what services and supports are being offered and utilised in Children's Centres
- who has been able to access services and who may be missing out
- parents' support needs
- the impact of attending a Children's Centre on children's development.

1.1. Background

Children's Centres in South Australia are tasked to provide universal services with targeted support in order to impact population outcomes in four areas:

1. Children have optimal health, development and learning.
2. Parents provide strong foundations for their children's healthy development and wellbeing.
3. Communities are child and family friendly.
4. Aboriginal children are safe, healthy, culturally strong and confident.

(Department for Education and Child Development, 2011)

The quantitative component of the evaluation, forming the final stage of the Three Year Evaluation, and reported herein, builds upon the themes identified in earlier focus groups and interviews conducted between March and May 2013.

Utilising a range of quantitative data, this report seeks to address the following questions:

1. Do Children's Centres provide families with effective pathways that assist families to access the range of services and support that they need? How does this happen?
    a. What services and supports are available in Children's Centres and do these meet community needs?
    b. What are the referral pathways to additional support?
    c. What system level changes/supports/challenges are there to support Children's Centres?
    d. How do these referral processes and pathways differ to those in the broader community?

2. What are the facilitators and challenges for Children's Centre staff working together collectively for the benefit of children? Where do staff see their work along the integration continuum?
3. What are the processes that enable partnerships and governance groups (parent advisory, leadership group and partnership groups) to respond to community needs effectively?
4. How does the mix of services and programs available to families differ across Children's Centres?
5. Who is accessing services and supports in Children's Centres (reach) and how much support are they receiving (dose)?
6. What impacts does utilising services and supports in a Children's Centre have on parents' parenting practices, wellbeing and social connectedness?
7. What difference does attending an integrated service setting make to children's development when they start school?
    a. Do children who attend preschool in a Children's Centre have better child development outcomes in their reception year than (comparable) children who attend other types of government funded preschools?
    b. Were children who attended preschool in a Children's Centre less likely to be identified by their reception teacher as requiring further assessment?

1.2. Method

The quantitative evaluation uses three data sets to address the evaluation questions, including: survey data, de-identified Family and Community Programs data from Children's Centres, and de-identified 2015 Australian Early Development Census (AEDC) data linked to SA Government preschool data.

1.2.1. Survey data

The first component of work reported here is a state-wide survey of people working in, working with, or utilising services in a Children's Centre. The aims of the survey were threefold. Firstly, the survey was designed to follow up on facilitators and challenges to the operation of integrated services in Children's Centres that were identified in earlier focus groups and interviews; previously reported in the Qualitative Evaluation report (Harman-Smith & Brinkman, 2013). Secondly, the survey aimed to measure the potential impact of integrated service provision on families' access to supports and services. Thirdly, the survey asked about parenting practices and parental wellbeing to identify parents' support needs. The survey was distributed to parents attending a Children's Centre and those who had not attended a Children's Centre, but an insufficient number of surveys were returned from parents who had not attended a Children's Centre, thus comparisons between the groups are unable to be drawn.

1.2.2. Family and Community Programs data

The second component of work analysed de-identified administrative data to report on the mix of services provided in Children's Centres, how this differs across South Australia, and the likely reach and dose of services across communities.

1.2.3. Linked 2015 AEDC and preschools data

The final component of work utilised de-identified South Australian government funded preschool data linked to child development outcomes from the 2015 AEDC to measure the impact of attending preschool in Children's Centre on children's developmental outcomes in their first full-time year of school.

1.3. Findings

Findings are presented in relation to seven evaluation questions, with key findings summarised here.

Do Children's Centres provide families with effective pathways that assist families to access the range of services and support that they need? How does this happen?

a. What services and supports are available in Children's Centres and do these meet community needs?

   A broad range of services are available across Children's Centres, with the majority of these recorded as being provided by Centre staff. Centres defined community in a number of ways, but reported a better understanding of the needs of families accessing the Centre, than they did of the families living in the local area. Irrespective of their backgrounds, the vast majority of parents reported that services and supports available to them met their needs and that staff in Centres provided well-informed support and referrals, were committed to helping them, and were approachable. Fewer parents reported feeling engaged in planning what happens in Centres. These findings suggest that Centres are working in a service provision way and an opportunity exists to expand parents' engagement in planning in order work in a community building way.

b. What are the referral pathways to additional support?

   Centres were reported to be building referral networks in the community and improving relationships between external service providers. Non-education staff tended to undertake this work through attending network meetings. While this work is reflected in referral pathways across a broad range of service providers, an opportunity exists to further build referral pathways and gain greater coverage in referral networks. The importance of building these referral pathways was demonstrated by increased service use in Centres for children aged 0 to 2 years where there was a Child and Family Health Service or an Antenatal service onsite.

c. What system level changes/supports/challenges are there to support Children's Centres?

   The professional development program for Children's Centres was valued by the leadership and used to enhance their knowledge about providing integrated services. In contrast, professional support from the DECD's Early Childhood Development Strategy team was rated highly but room for improvement existed in utilisation by staff who needed support in establishing integrated services.

d. How do these referral processes and pathways differ to those in the broader community?

Although Centres were not reported to be reducing duplication of services in their area, they were reported to be helping to improve referral pathways in the broader community. This included:

- achieving earlier identification of vulnerable children and families
- providing new knowledge or skills for team members
- improving the capacity to reach more children and families
- providing a clearer pathway for families to the supports and services
- improving access to specialist services and preschool programs.

Overall, few parents reported that there were services they were not able to access. As expected, parents generally reported higher usage of universal services than targeted services. When parents reported not being able to access services and supports, barriers to access tended to be cost, wait times, or a lack of available services. Families with additional needs tended to report greater difficulty accessing services.

What are the facilitators and challenges for Children's Centre staff working together collectively for the benefit of children? Where do staff see their work along the integration continuum?

Leadership was rated highly in around two thirds of sites. Where leadership was not rated highly, integrated service delivery was also rated as less functional. There was a high level of concordance between staff and service provider experience of leadership and directors' ratings of their level of control in sites. That is, where staff and service providers rated leadership highly, directors also reported feeling that they had control over the way the staff team functioned at the site, and vice versa.

What are the processes that enable partnerships and governance groups (parent advisory, leadership group and partnership groups) to respond to community needs effectively?

The governance structure developed for centres specifies the role of three governance groups—parent engagement, partnership, and leadership. Findings from both the qualitative and quantitative components of the evaluation highlighted opportunities for further development of this governance structure. Specifically, opportunities exist to improve parent engagement and the functionality of partnership groups. The extent to which other mechanisms were used to engage families and service providers in the community was not able to be determined from this evaluation. The ability of Centres to work with the community to plan in partnership is increased when structures to support this are put in place and utilised as intended. Leadership groups comprised of Centre staff were reported to be functioning well. These findings suggest that Centres have an opportunity to develop parental engagement, and in doing so make further gains towards achieving their goal of working inclusively.

How does the mix of services and programs available to families differ across Children's Centres?

There was a great deal of variation in the range and number of services and supports available across Centres. While some Centres provided a large range of program types and many sessions, others provided a smaller range of program types and fewer sessions. The most commonly available supports were:

- parenting support services (e.g., parenting programs, domestic violence support)
- family support (e.g., Family Service Coordinator consultations)
- supported playgroups (e.g., Learning Together, facilitated playgroups, allied health playgroups, Save the Children)
- community groups (e.g., cooking/art/craft/music groups, cultural parent groups, yoga)
- health services (e.g., maternal child health, health information sessions, allied health).

Given that these types of programs are relevant to most communities, it is encouraging that this is reflected in the data. However, the evaluation is not able to determine with any certainty whether variation in the range and number of services available in Centres is due to community level variation or some other driver related to the capacity of Centres to deliver services. To ensure that the needs of communities are met and that service provision is context dependent, Centres should document the planning process, including: identified needs, available resources, planned response, intended reach (who is the support aiming to reach), and envisioned outcomes. This will better enable Centres to monitor the extent to which services and supports meet the needs of communities.

Who is accessing services and supports in Children's Centres (reach) and how much support are they receiving (dose)?

Data available for the evaluation was not sufficient to determine reach or dose for children and families. Determining reach and dose of Centres is important and should be prioritised. At the outset of the evaluation, a data gap analysis was conducted to determine what data was being collected in Children's Centres. The data gap analysis also sought to inform what data should be collected administratively to report on the ongoing value of Children's Centres in the South Australian service mix. This data gap analysis identified that only Preschool, Occasional Care, and Long Day Care enrolment information was being routinely collected in Children's Centres.

Following this data gap analysis, a proposal to extend data collection in Children's Centres to capture Family and Community Programs (FCP) use was developed in conjunction with the Office for Education and Early Childhood (then the Office for Children and Young People). The proposal was progressed and the Early Years System (EYS; capturing preschool and occasional care information for SA government preschools) was expanded to enable the capture of FCP utilisation data.

Five pilot sites tested the data collection enhancements in Term 1 2015. After this time, the system was progressively rolled out to support centres to begin to enter data. By Term 4 2015 all sites had been supported by the EYS staff to set up information about the programs and services available in their sites. This initial set up was undertaken to enable sites to then enter information about children and families accessing these services. Three terms of data were made available to the evaluation team by late August 2016. Although it is clear that the data was incomplete, it was not possible for the evaluation team to assess the degree to which this was the case, thus limiting the extent the data could be utilised to report on FCP utilisation in Children's Centres.

Where data was entered, it was evident that the vast majority of children were enrolled for a single service during a term in a Children's Centre, with few children making use of multiple services. Although reach and dose could not be determined, the service provision data that was available was analysed to examine whether particular population groups were accessing services in Children's Centres more so than others. Compared to SA population distributions, children using universal services in Centres tended to live in more disadvantaged areas, come from an Aboriginal Torres Strait Islander[1] background, and live in remote areas of the state. Children from CALD backgrounds, however, appeared to be under-represented in the group of children attending a Children's Centre. In contrast, targeted supports tended to be more heavily utilised by families living in more socio-economically advantaged suburbs, and families who are from English speaking backgrounds. These preliminary findings indicate that although Children's Centres are located in areas of higher need, and thus attract families from suburbs with greater socio-economic disadvantage, additional supports in Children's Centres tended to be utilised more heavily by families from less disadvantaged communities. Opportunities exist to further investigate the referral pathways into the targeted services provided through Children's Centres to understand why higher need families are less likely to access these services.

Although minimal service use data limits the ability of the evaluation to definitively determine reach of services, the evaluation highlights the importance of administrative data collected in centres being used to monitor the effectiveness of any targeting strategies.

[1] Throughout the remainder of this paper, we use the term Aboriginal to refer to the first peoples of Australia, that is, people who identify as being of Aboriginal and/or Torres Strait Islander descent, although it is noted that no one word can sufficiently capture the diversity of Australia's first people.

What impacts does utilising services and supports in a Children's Centre have on parents' parenting practices, wellbeing and social connectedness?

Self-report parenting measures used in this evaluation provide some insight into the mechanisms that may be supporting children's development. Instead of providing a decisive conclusion about the impact of Centres, these measures are used to differentially identify needs of families and whether these are being met for all families using Centres. On the whole, parents using Children's Centres reported high levels of wellbeing, social connectedness and positive parenting practices. Although this was not universally true, with families who had additional support needs reporting less favourable outcomes.

Although the evaluation did not seek to measure the specific impact of the various range of parenting supports and programs available in Centres, this should be considered at the Centre level. Collecting information about the impact of specific parenting supports on parents can help to evaluate the appropriateness of programs for addressing families' needs.

What difference does attending an integrated service setting make to children's development at the start of their first school year?

a. Do children who attend preschool in a Children's Centre have better child development outcomes in their reception year than (comparable) children who attend other types of government funded preschools?
b. Were children who attended preschool in a Children's Centre less likely to be identified by their reception teacher as needing further assessment?

Preschool Census (2014) and AEDC (2015) data were linked and analysed to determine whether children who attended preschool in a Children's Centre had better child development outcomes in their reception year than (comparable) children who attended other types of government funded preschools. Matched samples of children from within Children's Centre communities allowed for a comparison of the developmental outcomes of children with similar demographic characteristics. Children who attended preschool in a Children's Centre had near identical levels of developmental vulnerability on Physical Health and Wellbeing, Emotional Maturity and Language and Cognitive Skills to children who attended standard preschools. The level of vulnerability was a little higher on the Social Competence domain and a little lower on the Communication and General Knowledge domain for children attending Children's' Centre preschools. There was no significant difference between children who attended a Children's Centre preschool and children who attended a standard preschool in the probability of being developmentally vulnerable on one or more domains. The percentage of children with special needs status was a little lower for children who attended preschool in a Children's Centre. There was, however, no evidence that children were more or less likely to have additional (undiagnosed) needs requiring further assessment than children who attended a standard preschool.

1.4. Recommendations

The report makes 25 recommendations for enhancing the provision of integrated services in South Australian Children's Centres:

1. Opportunities exist for Children's Centres to use population data at the community level to assess and monitor changes in child and family needs over time, and the extent to which current strategies are working to address needs.
2. Develop the vision of Children's Centres to include a clear model for how these work with or service communities. This must include: intended outcomes, means to achieve these outcomes, and supporting structures that enable implementation.
3. Promote Children's Centres to families by strategically identifying and building referral pathways to and from agencies that are connected to families, from conception through to school age. Agencies may include: community health, hospital antenatal and paediatric services, housing services, child protection agencies, and social services.
4. At the executive level, continue to strengthen cross-agency partnerships and negotiate agreements that facilitate the strengthening or establishment of local partnerships. Cross-agency agreements should seek to address challenges to working in partnership; how information and data is shared to support the identification of the needs of families; formal referral processes; and reduction of duplication for families (e.g. reducing the need to fill in multiple enrolment forms to access a range of services at a single site).
5. Continue to provide professional support and training opportunities aligned to the vision of Children's Centres.
6. Community Development Coordinators in Children's Centres should seek to identify gaps in services relative to population needs. These opportunities may involve addressing a lack of services or insufficient services to address the scale of the need. Mapping gaps in services must happen in all communities, irrespective of the level of disadvantage of an area.
7. At a whole of state planning level, an opportunity exists for the Department for Education and Child Development to refine the mix of universal services and targeted supports to ensure all communities have appropriate services available to them.
8. An opportunity exists to ensure that universal services to support parents are available in all communities and that these services have sufficient capacity to support the number of resident families. Further, there is an opportunity to ensure that targeted supports are matched to the scale of an issue, and resourcing reviewed with an emphasis on meeting existing need and bolstering early intervention resources that can help mitigate future need for high-cost intensive services.
9. Further develop the leadership model for Children's Centres and consider broadening the role to recruit staff from a range of disciplines.
10. Further develop the line management model of Children's Centre leadership.
11. For new sites, recruit leaders based on capacity to manage a multidisciplinary team rather than education management experience.
12. Role descriptions for all staff should be developed to reflect key outcomes of the roles specified along with the skills required to work effectively in the role.

13. Further develop the governance structure of Children's Centres and align this to the vision for Centres' work with communities.
14. An opportunity exists to develop a reporting plan and reporting framework for Children's Centres. In doing this, it will be important to consider the Children's Centres Outcome Framework and how this is currently being used.
15. Investigate barriers impacting on the collection and entering of enrolment and attendance information for Family and Community Programs.
16. An opportunity exists to respond to identified challenges and enablers by consulting with Children's Centre staff to design and implement a strategy to improve the capacity of sites to collect and enter data.
17. Mandate administrative data collection in the same way it is mandated for other government provided services.
18. Consider implications of mandating data collection for service provision partners and what data sharing agreements will need to be negotiated at an agency level to best support planning and program monitoring.
19. Refine assessment and intake criteria and associated processes for the additional targeted support services.
20. An opportunity exists to design intake assessments in such a way that specific needs of families are matched to available services and that these are delivered as locally as possible.
21. Continue to engage all families in the community in universal services. Where universal services in Children's Centres are at capacity, connect families to similar services in the community.
22. Geographical boundaries for services should only exist for services that are available in each community to ensure that the capacity of each service point is utilised.
23. Opportunities exist for Children's Centres to create strong links between all Early Childhood Education and Care services (government and private long day care and preschool providers) and community health across suburbs to ensure all families have access to additional services and supports that have been located in Children's Centres for the benefit of the whole community (rather than solely the children attending ECEC services in a Children's Centre).
24. Consider the role Children's Centres might play in the prevention/early intervention arm of a reformed child protection system in SA.
25. Opportunities exist to measure and evaluate the impact of targeted supports, such as parenting programs or supported playgroups, to ensure these are having the desired effect for the target issue they seek to improve.

2. Introduction

2.1. Children's Centres in South Australia

To reduce the impact of social inequality on children's outcomes, the South Australian Government has established a number of Children's Centres for Early Childhood Development and Parenting (Children's Centres) across South Australia. At the outset of the evaluation, 34 Children's Centres were in operation across South Australia. By mid-2018, the Department for Education and Child Development will have established 47 Children's Centres across South Australia.

Children's Centres have been located in areas of community need to enable the provision of high quality services, especially to children and families who may not otherwise have access to these supports. Children's Centres are based on a model of integrated practice, bringing together education, health, care, community development activities, and family support services in order to best meet the needs of children and families.

Specifically, Children's Centres are tasked to provide universal services with targeted support in order to effect population outcomes in four areas:

1. Children have optimal health, development and learning.
2. Parents provide strong foundations for their children's healthy development and wellbeing.
3. Communities are child and family friendly.
4. Aboriginal children are safe, healthy, culturally strong and confident.

(Department for Education and Child Development, 2011).

In Centres with particular needs, the team includes staff with expertise to provide targeted support, including:

- Family Service Coordinators are employed to improve outcomes for children and families experiencing disadvantages, parenting difficulties and child development issues. Staff work within the education and care setting and provide targeted responses including counselling, service coordination, group work intervention, and referrals, as well as taking an early intervention and prevention approach to improve the take up of services by vulnerable children and families.
- Allied Health staff in the fields of occupational therapy and speech pathology utilise primary prevention and early intervention approaches to strengthen parenting skills and improve children's developmental outcomes.
- Health Promotion Officers have a particular focus on Aboriginal children and promote strategies to increase staff, parents and children's knowledge and skills in healthy eating (including breast feeding), active play and oral health.
- Child & Family Health Clinic staff may be based full-time or part-time at the Centre and include maternal health nurses, who provide child health checks.
- Inclusive Preschool Programs provide a localised and inclusive model of preschool education for children with disabilities and high support needs. Children may have severe multiple

disabilities, autism, global developmental delay, or a combination of physical, social and cognitive needs.

During the evaluation period, five Children's Centres have also established community based antenatal services to support pregnant mothers to connect with services and supports available in the community that can provide assistance to them beyond the birth of their child.

2.2. Integrated service provision for children and families—evidence from the literature

The bringing together of services in a model of integrated practice has been a government policy response to inequalities in children's outcomes around the world (Lynch, Law, Brinkman, Chittleborough, & Sawyer, 2010). In theory, integrated services seek to bring together otherwise independent services in order to: improve client access to services; reduce strain on limited resources by increasing efficiency of service provision; and improve outcomes for clients by increasing the capacity of service providers through the sharing of professional knowledge across disciplines (Moore, 2008; U.S. Public Health Service, 2000).

However, there is limited understanding of both the factors affecting the establishment of integrated practice and the effect of integrated practice on the target population. Thus, reviewers of integrated service provision research have surmised that the policy approach of integrated children's services is ahead of our understanding of how best to achieve integrated practice (Siraj-Blatchford & Siraj-Blatchford, 2010). Nevertheless, the literature that has reported on integrated early childhood services suggests a number of factors are likely to be important for successful functioning of these services (for a review see Moore, 2008). These factors can be broadly grouped into:

1. shared philosophy of and commitment to integration
2. strong leadership
3. preparedness: clear vision
4. well-developed policies
5. strategic planning
6. appropriate resource
7. communication
8. monitoring and evaluation of outcomes.

Whilst several studies have reported on the process of establishing integrated services, research examining the impact of such services is limited. To date, evidence concerning impact of integrated early childhood services comes largely from national evaluations of the UK Government Sure Start program, Head Start and Toronto First Duty.

Introduced in 1999 and implemented on a large scale, Sure Start Children's Centres aim to improve the health and wellbeing of young children and families living in disadvantaged communities (Belsky, Melhuish, Barnes, Leyland, & Romaniuk, 2006). The national Sure Start evaluation has measured impacts on children and families a number of times. Initially, early findings were presented in 2006 for 9-month-old and 36-month-old children (Belsky et al., 2006). A subsequent evaluation in 2008 reported on outcomes at age 3 years for the children that were 9-months-old in the first evaluation

(Melhuish, Belsky, Leyland, & Barnes, 2008). Additionally, follow-up evaluations have reported on outcomes for these children at 5 and 7 years of age (NESS, 2010, 2012).

In the first national evaluation of Sure Start, small positive effects were identified for six of the 14 measured outcome variables (four parental outcome measures, two child outcome measures) and adverse effects of the program were reported for the three of the 14 outcome variables for the most vulnerable populations (three child outcome measures) (Belsky et al., 2006). In the subsequent evaluation of the effects on three-year-olds (the 9-month-old sample in the first evaluation), positive effects were identified for five of the 14 measured outcomes (two parental outcome measures, two child outcome measures, one service usage measure) and one child outcome measure showed a negative effect for black-Caribbean children (Melhuish et al., 2008).

By the time children were 5 years old, six of 21 measured outcomes (four parental outcome measures, two child outcome measures) showed positive effects for Sure Start communities and two negative effects were identified (two parental outcome measures) (National Evaluation of Sure Start Team, 2010). At the age of 7 years, positive effects were found for Sure Start communities for four of 15 measured outcomes (four parental outcome measures). It is difficult to determine whether limited population impact of Sure Start was due to limited reach of services into the population or limited efficacy of services. Indeed, Lloyd and Harrington noted that the quantitative evaluation results did not reflect 'on-the-ground' experience, where large impacts "transforming the lives of children and families", were often observed (pp 97; 2012).

Inconsistency between 'on-the ground' experience and evaluation findings might be attributable to a number of factors. Lack of widespread outcomes may have resulted from poor reach of services into the community. Alternatively, services may not have had sustained measurable impacts. The Sure Start evaluation sampled randomly from the entire community living in local Sure Start areas—if Sure Start programs were not widely used within target populations, it is possible that effects were not easily detected. Service usage data would be needed to determine the proportion of the community that was utilising services and whether demographic characteristics of service users differed from those of the general community. Further, knowledge of which families accessed services might have helped to understand findings of adverse effects, such as those reported for the most vulnerable members of the communities from the Sure Start programs (Melhuish et al., 2008), who may have been less able to engage with Sure Start services and for whom other methods of service provision may have been more appropriate.

In addition to these evaluations, the UK Department for Education commissioned a six-year Evaluation of Children's Centres in England (ECCE). Commencing in 2011, the evaluation focuses on Children's Centres located in the most disadvantaged communities. Presently the evaluation has gathered data on services on offer across centres (Poole, Fry, & Tanner, 2014), as well as information on service delivery, multi-agency working and integration, and programme reach (Sylva et al., 2015). Most recently, the evaluation gathered data from families who used centres at three time points; when the child was aged 9–18 months, two and three years old. Information collected included level of involvement with the centre, participation in other services, physical and mental wellbeing, parenting and family functioning, and child development (Maisey, Poole, Chanfreau, & Fry, 2015).

The next stage of the evaluation will use this data to explore potential associations between families' use of children's centres and child and family outcomes. Yet to be undertaken, the results of this component of the evaluation will be an important addition to the scarce evidence-base concerning impact of integrated early childhood services on child and family outcomes.

In Canada, the Toronto First Duty (TFD) program launched in 2001 with the goal to develop a universally accessible system of service integration across early childhood in order to promote healthy child development. Evaluation of the program's implementation process and outcomes has been conducted over the course of the project through mixed methods, case study and quasi-experimental methodologies (for a summary see C. Corter & Pelletier, 2010; Pelletier, 2012). Exploration of the impact of participation in integrated early learning environments on child outcomes revealed evidence for short-term positive impacts on children's social-emotional development as measured by the Early Development Instrument—a teacher assessment tool that assesses school readiness (C. Corter et al., 2007). This impact was seen in both pre and post comparisons in TFD sites and also in quasi-experimental comparisons with demographically-matched communities. Further, more recent analyses have demonstrate that higher TFD dose, after demographic controls, predicted children's cognitive, language and physical development (Patel, Corter, Pelletier, & Bertrand, 2016).

In Australia, the Victorian Government's Best Start program is similar to Sure Start, with the aim to improve the health, development, learning and wellbeing of children and their families. Best Start provides funding for universal services to work in partnership with one another for the benefit of children from infancy through to transition to school (Raban et al., 2006). Much like the national evaluation of Sure Start, the evaluation of Best Start relied on community level data; a methodology which aims to measure population change, fitting for programs designed to target populations. However, effects of Best Start programs may be underestimated because, as acknowledged by the evaluators, it became apparent that Best Start was not reaching the entire target population but rather smaller regions within the community. As with Sure Start, effects of Best Start were found to be small and limited. Of the 15 indicator areas, only five showed small changes that could potentially be contributed to the effect of Best Start (Raban et al., 2006).

A recent South Australian study (Krieg, Curtis, Hall, & Westenberg, 2015) tracked children attending Children's Centres as they transitioned to school, examining the impact of integrated childcare and preschool programs—namely the dose and quality of such—on children's early school outcomes. Results demonstrated that lower quality childcare is of less benefit to disadvantaged children, whilst all children benefit equally from higher-quality childcare. While this is an important advance in the evidence for integrated early childhood services, this research only looks at childcare and preschool, has a very small sample size, and no comparison group.

Table 2.2-1 and Table 2.2-2 summarise the impacts of attending an integrated service setting for children and parents, as reported in the literature. Impacts are not consistently reported across domains of children's development or for parenting outcomes. Considering the mixed findings to date, it is important to continue to evaluate both the process and impact of this service model in new contexts.

Table 2.2-1 Comparison of literature results

CHILD OUTCOMES					
PAPER/REPORT	PHYSICAL HEALTH AND WELLBEING	SOCIAL COMPETENCE	EMOTIONAL MATURITY	LANGUAGE AND COGNITIVE SKILLS (SCHOOL BASED)	COMMUNICATION SKILLS AND GENERAL KNOWLEDGE
SURE START - BELSKY ET AL. (2006) * 9-MONTH-OLD AND 36-MONTH-OLD CHILDREN	No change - both age groups	No change - age 9 months Poorer social functioning—children (36 months) of teenage mothers Greater social competence—children (36 months) of non-teenage mothers	Reduced behavioural problems—children (36 months) of non-teenage mothers	No change - age 9 months Lower tested verbal ability—children (36 months) from workless or lone parent households	
SURE START - MELHUISH ET AL. (2008) * 3-YEAR OLD CHILDREN (THAT WERE 9 MONTHS IN FIRST EVALUATION)	No change	Increased independence—*age 3*	Improved social behaviour—*age 3* Adverse effects on social behaviour - *black-Caribbean children age 3*	No change	
SURE START - NESS (2010) *FOLLOW-UP EVALUATION WHEN CHILDREN WERE AGED 5	Lower BMIs—*age 5* Better physical health—*age 5*	No change	No change	No change	
Sure Start - NESS (2012) *Follow-up	No change	No change	No change	No change	

evaluation when children were aged 7					
ECCE Strand 2 - Maisey et al. (2015)	Reduced health problems–*age 3*	No change	Reduced behavioural problems—*age 3*	Increased verbal ability—*age 3*	
ECCE Strand 4 - Sammons et al. (2015)	No change	Increased social skills—*age 3*	Reduced externalising behaviour—*age 3*	Increased cognitive ability—*age 3*	
Toronto First Duty (TFD) - Corter et al. (2008)	No change	Improved social competence—*approx. age 6*	Improved emotional maturity—*approx. age 6*	No change	No change
TFD - Patel et al. (2016)	Improved outcomes—*age 4–5*	No change	No change	Improved outcomes—*age 4–5*	Improved outcomes—*age 4–5*
Victoria's Best Start Program - Raban et al. (2006) * Various ages	Increased physical activity			Increased literacy skills	
Tasmania Evaluation - Taylor et al. (2015) * Ages 0-5		Parent-reported improvements in interactions with other children & adults	Parent-reported improvements in behaviour, concentration & listening	Parent-reported improvements in speech, pre-reading & writing skills	
South Australia Study - Krieg et al. (2015)		No change	No change	Increased cognitive development—*age 4–5*	
Better Beginnings, Better Futures (BBBF) - Roche et al. (2008) * Participated in intervention		Parent-reported improvements in social interactions for children—*ages 14–15* Self-reported reduction in positive social	Teachers reported fewer emotional problems & fewer hyperactive/inattentive behaviours—*ages 14–15* Increased self-reported		

programs when aged 4-8	interactions—*ages 14–15*	emotional problems & lower self-esteem—*ages 14–15*	
BBBF—De V.Peters et al. (2010) * Participated in programs when aged 4-8	Improved social functioning - grades 6 (ages 11–12) and 9 (ages 14-15)	Fewer emotional & behavioural problems - grades 3 (ages 8-9), 6 (ages 11–12) & 9 (ages 14–15)	Improved school outcomes—grades 6 (ages 11–12) & 9 (ages 14–15)
Early Head Start (EHS)—Boyd et al. (2005)		Reduced aggressive behaviour– *age 3* Less negative behaviour towards parents during play—*age 3* Improved concentration—*age 3*	

Table 2.2-2 Comparison of literature results - parents

PARENT/FAMILY OUTCOMES					
PAPER/REPORT	PARENTING/FAMILY FUNCTIONING	EMPLOYMENT	SOCIAL CONNECTEDNESS	CHILD PROTECTION	HEALTH/WELLBEING
SURE START - BELSKY ET AL. (2006)	Improved parenting—non-teenage mothers			No change	No change
SURE START - MELHUISH ET AL. (2008)	Reduced negative parenting More stimulating home environment			No change	No change
SURE START - NESS (2010)	Less harsh discipline Less chaotic home environment More stimulating home environment Less likely to attend school meetings				Increased life satisfaction Increased depressive symptoms - *mothers*
SURE START - NESS (2012)	Less harsh discipline More stimulating home environment Less chaotic home environment—*for boys*			No change	Increased life satisfaction—lone parents & workless households

ECCE Strand 2 - Maisey et al. (2015)	Increased positive parenting More positive family functioning				No change
ECCE Strand 4 - Sammons et al. (2015)	Positive effects on family functioning Reductions in parent-child dysfunctional interactions				Improved mental health status—*mother* Improved physical health status - *mother* Reduced parental distress
Victoria's Best Start Program - Raban et al. (2006)	Increased attendance at maternal & child health visits		Positive community outcomes	No change	Increased breastfeeding rates
Tasmania Evaluation - Taylor et al. (2015)	Lower self-reported parenting competence	Positive education & employment outcomes	Parents reported centres were successfully engaging, supporting & working with families to give their children the best start in life Improved child, family, school & community connection		
BBBF—Peters et al. (2010)	More positive ratings of marital satisfaction Improved family functioning		Greater social support	Positive neighbourhood-level effects	

2.3. Stage 2—Quantitative Evaluation of Children's Centres in South Australia

The Telethon Kids Institute through the Fraser Mustard Centre was engaged to undertake a three-year evaluation of these South Australian Children's Centres. The evaluation commenced in 2012 with an interim evaluation report published in 2013. Evaluation works were put on hold in 2014 to enable Children's Centres to collect administrative data about the programs and services being provided to children and families. This data was first collected in Term 4 2015, enabling the evaluation work to recommence in 2016.

The overall aims of the evaluation are to measure process and impact of integrated services in Children's Centres (described in the Overall Three Year Evaluation Plan; see Brinkman & Harman-Smith, (2013). The evaluation employs a mixed-method research design. The second stage, reported herein, uses three sets of data to measure how service integration is working in Children's Centres, parents' experiences of accessing services, their support needs, and the impact of attending a Children's Centre on children's development.

This stage of the evaluation follows from an earlier qualitative investigation, comprising focus groups and interviews, which was used to inform the development of the questionnaires for the survey and shape the quantitative analysis. The qualitative evaluation component investigated facilitators and challenges to providing integrated services in Children's Centres, along with the potential impacts of this model of service provision on children and families, referral pathways to additional supports, and the extent to which the integrated service setting improves access to the services and supports families need during children's early years (Harman-Smith & Brinkman, 2013).

The Overall Three Year evaluation was informed by three key evaluation questions to support the Department to explore the model of integration in Children's Centres, how well it was working and where it could be improved:

1. Do Children's Centres provide families with effective pathways that assist families to access the range of services and support that they need? How does this happen?
    a. What services and supports are available in Children's Centres and do these meet community needs?
    b. What are the referral pathways to additional support?
    c. What system level changes/supports/challenges are there to support Children's Centres?
    d. How do these referral processes and pathways differ to those in the broader community?
2. What are the facilitators and challenges for Children's Centre staff working together collectively for the benefit of children? Where do staff see their work along the integration continuum?
3. What are the processes that enable partnerships and governance groups (parent advisory, leadership group and partnership groups) to respond to community needs effectively?

An additional four questions were developed over the course of the evaluation to further explore the key questions, along with the impact on children and their families:

1. How does the mix of services and programs available to families differ across Children's Centres?
2. Who is accessing services and supports in Children's Centres (reach) and how much support are they receiving (dose)?
3. What impact does utilising services and supports in a Children's Centre have on parents' parenting practices, wellbeing and social connectedness?
4. What difference does attending an integrated service setting make to children's development at the start of the school year?
    a. Do children who attend preschool in a Children's Centre have better child development outcomes in their reception year than (comparable) children who attend other types of government funded preschools?
    b. Were children who attended preschool in a Children's Centre less likely to be identified by their reception teacher as needing further assessment?

This final report presents the findings from the quantitative evaluation works and synthesises these with the findings of the first qualitative stage of the evaluation.

3. Method

The following section describes the data sets utilised in this evaluation report. It presents this in turn for the three sets of data: survey, Family and Community Programs administrative data, de-identified linked 2015 AEDC and South Australian preschool data.

3.1. Survey

3.1.1. Recruitment

Sampling

Four groups of participants were recruited from a range of adults working in, working with or using services in Children's Centres:

1. Staff working in (i.e. educators, Community Development Coordinators, Family Service Coordinators, and Allied Health) and Service Providers working with Children's Centres (e.g. Community groups, Health, Child and Youth Health)
2. Directors of Children's Centres and Heads of School Early Years
3. Parents and Carers using services in a Children's Centre
4. A comparison group of parents and carers who have not used services in a Children's Centre

The participant demographics and characteristics are presented in section 3.1.1 Participants.

Method of approach

The method of approach for each group of participants varied due to the differing nature of the groups and these are described below.

1. Parents and Carers at Children's Centres

No parent contact details were made available to researchers. Parents were invited to complete the questionnaire either online or in a paper version (dependent on a parent's access to the internet). Where parents had access to the internet and the Children's Centres routinely communicated with the parents via email, the Children's Centre sent an email invitation to complete the survey, which contained a link to the questionnaire. The text contained in the invitation is presented in Appendix A. Where the centre had no email address for a parent, or was aware that the parent did not have access to the internet, the centre placed an invitation to complete the questionnaire along with the questionnaire in the child's pigeon hole. Additionally, Centres displayed information about the survey on their notice boards and interested parents either completed the questionnaire online or requested a paper copy. Parents were asked to place completed paper copies in a sealed box in Centres, and these were collected by researchers at the end of the survey period.

Experience from focus groups and advice from Centres about recruitment highlighted that families who are typically difficult to engage in services were less likely to take part and provide feedback about their experiences. Importantly, Children's Centres work to engage these families with targeted supports, therefore it is important to know about the experiences of these families. For families who might not have responded to written invitations to take part it was more appropriate to speak to parents directly about the survey. This required the staff in Centres, who were familiar to families, to

approach parents to explain the evaluation and invite them to take part in the survey. In these circumstances, staff presented information about the research, its aims, and what participation involved verbally rather than in a formal letter of invitation. Researchers discussed with staff appropriate recruitment strategies in order to ensure that ethical guidelines for recruitment were maintained and parents did not feel pressured or obliged to take part.

In all instances, parents provided consent to take part prior to completing the questionnaire. The online questionnaire began with a consent page that appeared before any questions, and the paper version of the questionnaire had a consent page attached preceding the questions. Text relating to consent is presented in Appendix B.

2. Parents and Carers Comparison Group

In order to determine appropriate school sites from which to recruit a sample of parents who were likely to be demographically similar to those parents who accessed services and supports in Children's Centres, we identified South Australian schools in demographically similar communities. To do this we utilised feeder preschool data (provided by the Department for Education and Child Development), school demographic data (published on the MySchools website), and community level population data (published on the Social Health Atlas). Comparison school sites were then approached by the lead researcher to explain the evaluation, the aims of the survey, what would be involved in taking part and to invite the school to distribute surveys to parents of children in reception. Of the 53 schools identified, 29 agreed to distribute surveys.

No parent contact details were made available to researchers. Instead, school staff distributed an invitation letter and consent form along with the survey to parents. Parents were either sent this information via email or provided with the information in hard copy. Parents were given the opportunity to either complete the questionnaire online or in a paper version (dependent on the school's information distribution preferences). Many schools reported that they had difficulty in collecting completed surveys from parents and that they did not have the capacity to follow up with parents. A few schools actively reminded parents about the surveys and encouraged these be completed and returned, although this was infrequent. All returned surveys were anonymously collected by the schools in a sealed envelope to ensure the confidentiality of the information provided by parents.

Parents provided consent to take part prior to completing the questionnaire. The online questionnaire began with a consent page that appeared before any questions, and the paper version of the questionnaire had a consent page attached preceding the questions. Text relating to consent is presented in Appendix B.

3. Children's Centre staff and Service Providers working with Children's Centres

Invitations to complete the survey online were disseminated to Children's Centre staff and Service Providers via the Children's Centre Director. Directors sent an email invitation to complete the survey, which contained a link to the questionnaire. The text contained in the invitation is presented in Appendix A. Consent to take part was collected prior to completing the questionnaire. The online

questionnaire began with a consent page that appeared before any questions. Text relating to consent is presented in Appendix B.

4. Directors of Children's Centres and Heads of School Early Years

Researchers emailed invitations to complete the survey online to directors. Appropriate email distribution lists for directors were obtained from the Early Childhood Development Strategy Team within the Department for Education and Child Development. The text contained in the invitation is presented in Appendix A. Consent to take part was collected prior to completing the questionnaire. The online questionnaire began with a consent page that appeared before any questions. Text relating to consent is presented in Appendix B.

3.1.2. Participants

Participants in each of the groups were broadly representative of the populations from which they were drawn. Demographic data for each group are summarised below. Additionally, service usage data for parents and carers and data summarising the professional backgrounds and experience of staff are included as relevant.

Parents and Carers at Children's Centres

Table 3.1-1 Parent and carer (N=214) demographic characteristics and service usage

		N	%
AGE (YEARS)			
	18–22	9	4.2
	23–25	9	4.2
	26–30	34	15.9
	31–35	70	32.7
	36–40	59	27.6
	> 40	33	15.4
GENDER			
	Male	10	4.7
	Female	204	95.3
ABORIGINAL OR TORRES STRAIT ISLANDER			
	No	210	98.1
	Yes	3	1.4
	Unknown	1	0.5
LANGUAGE BACKGROUND OTHER THAN ENGLISH			
	Yes	31	14.5
	No	183	85.5
NUMBER OF CHILDREN			
	0	1	0.5
	1	70	32.7
	2	93	43.5
	3	36	16.8
	4	10	4.7
	≥ 5	4	1.9
CHILDREN WITH SPECIAL NEEDS			
	No	177	83.1
	Yes	36	16.9
FIRST SERVICE USED IN CHILDREN'S CENTRE			
	Preschool	32	15.0
	Long Day Care	49	23.0
	Occasional Care	17	8.0
	Play Group	60	28.2
	Parenting Program	18	8.5
	Parenting Support Services	4	1.9
	Specific Support	6	2.8
	Community Group	6	2.8
	Health or Food Course	0	0.0
	Aboriginal Program	0	0.0
	Family Services	0	0.0
	Speech and Language Therapy	0	0.0

		N	%
	Occupational Therapy	0	0.0
	Child Youth Health Nurse	13	6.1
	Other	8	3.8
OTHER SERVICES USED IN CHILDREN'S CENTRE			
	Preschool	57	26.8
	Long Day Care	35	16.4
	Occasional Care	39	18.3
	Play Group	56	26.3
	Parenting Program	39	18.3
	Parenting Support Services	12	5.6
	Specific Support	4	1.9
	Community Group	13	6.1
	Health or Food Course	15	7.0
	Aboriginal Program	0	0.0
	Family Services	13	6.1
	Speech and Language Therapy	15	7.0
	Occupational Therapy	10	4.7
	Child Youth Health Nurse	26	12.2
	None	57	26.8
	Other	20	9.4
LENGTH OF TIME USING CHILDREN'S CENTRES			
	< 1 year	90	42.3
	1-2 years	45	21.0
	2-3 years	41	19.2
	> 3 years	37	17.4

Parents and Carers Comparison Group

732 hard copy surveys were delivered to schools, along with an electronic link to the online survey. Two schools opted for an electronic link only, which they distributed via an email to parents. 39 surveys (20 hard copy and 19 electronic) were returned. Of the 39 parents who completed the survey, 21 reported having utilised services in Children's Centres. Based on the information collected, it was also not possible to determine accurately whether these parents had used a Children's Centre or another program within the community. Thus only 18 survey responses from parents who had not utilised services in Children's Centres were available for comparison analyses. This number was considered to be too small to enable any comparisons to be drawn between those parents who utilised services in Children's Centres and those who have not.

Table 3.1-2 presents the demographic characteristics and reported service for parents recruited through schools. No further analyses of this survey data were conducted.

Table 3.1-2 Parent and carer comparison group (N=39) demographic characteristics and service usage

		N	%

		N	%
Age (years)			
	18-22	0	0
	23-25	4	10.3
	26-30	10	25.6
	31-35	15	38.5
	36-40	5	12.8
	> 40	5	12.8
Gender			
	Male	4	10.3
	Female	35	89.7
Aboriginal or Torres Strait Islander			
	No	35	89.7
	Yes	4	10.3
	Unknown	0	0.0
Language Background other than English			
	Yes	4	10.3
	No	35	89.7
Number of children			
	0	0	0.0
	1	6	15.4
	2	12	30.8
	3	10	25.6
	4	6	15.4
	≥ 5	5	12.8
Children with special needs			
	No	32	82.1
	Yes	7	17.9
Have you or your child used any services at any of the Children's Centres?			
	Yes	21	53.8
	No	18	46.2
First service used in Children's Centre			
	Preschool	15	71.4
	Long Day Care	2	9.5
	Occasional Care	0	0.0
	Play Group	2	9.5
	Parenting Program	1	4.8
	Parenting Support Services	0	0.0
	Specific Support	0	0.0
	Community Group	0	0.0
	Health or Food Course	0	0.0
	Aboriginal Program	0	0.0

		N	%
	Family Services	0	0.0
	Speech and Language Therapy	0	0.0
	Occupational Therapy	0	0.0
	Child Youth Health Nurse	0	0.0
	Other	1	4.8
OTHER SERVICES USED IN CHILDREN'S CENTRE			
	Preschool	8	38.1
	Long Day Care	0	0.0
	Occasional Care	1	4.8
	Playgroup	3	14.3
	Parenting Program	2	9.5
	Parenting Support Services	0	0.0
	Specific Support	0	0.0
	Community Group	2	9.5
	Health and Food Course	1	4.8
	Aboriginal Program	1	4.8
	Family Services	1	4.8
	Speech and Language Therapy	4	19.0
	Occupational Therapy	2	9.5
	Child Youth Health Nurse	6	28.6
	None	6	28.6
	Other	0	0.0

Children's Centre Staff and Service Providers

Table 3.1-3 Service provider (N=129) characteristics and experience

		N	%
ABORIGINAL OR TORRES STRAIT ISLANDER			
	No	118	95.2
	Yes	6	4.8
ROLE WITHIN THE CHILDREN'S CENTRE			
	Community Development Coordinator	25	32.5
	Family Services Coordinator	9	11.7
	Allied Health Practitioner	2	2.6
	Preschool Educator	19	24.7
	Long Day Care Educator	3	3.9
	Occasional Care Educator	1	1.3
	School Support Officer	2	2.6
	Administration Officer	5	6.5
	Other	11	14.3
TIME IN ROLE			
	< 1 year	13	10.5
	1-2 years	32	25.8
	2-3 years	28	22.6
	> 3 years	51	41.1

Directors and Heads of School Early Years

Table 3.1-4 Director and Heads of School Early Years (N=26) characteristics and experience

		N	%
ABORIGINAL OR TORRES STRAIT ISLANDER			
	No	25	96.2
	Yes	1	3.8
TIME IN ROLE (YEARS)			
	< 1	2	7.7
	1-2	4	15.4
	2-3	1	3.8
	≥ 3	19	73.1
PREVIOUS EXPERIENCE WORKING IN CC			
	Yes	7	26.9
	No	19	73.1
PREVIOUS ROLE			
	Same	1	14.3
	Different	6	85.7
PREVIOUS EXPERIENCE OF WORKING IN AN INTEGRATED SERVICE SETTING			
	Yes	20	76.9
	No	6	23.1

3.1.3. Design and Analysis

A series of three questionnaires (one each for: parents; staff and service providers; and directors) was developed to measure:

- the factors that were said to be effecting process (raised in focus groups and interviews)
- the impact of integrated service provision on people working in, working with, and using services in Children's Centres.

As far as possible, questions included in the questionnaires were drawn from published questionnaires with comparable measurement aims. A large proportion of the questions for people working in or with Children's Centres (staff, service providers, and directors) were drawn from a tool developed for a national evaluation of outcomes of working in partnerships in the Children's Centre model (Grealy, Rudland, & Lai, 2012). This tool was considered appropriate because the services evaluated are based on the same model as Children's Centres in South Australia. Additionally, many of the national survey tool's measurement aims reflect the themes identified in the qualitative component of this evaluation and are thus appropriate for inclusion in the present survey.

3.2. Family and Community Programs data

The Early Years System (capturing preschool and occasional care information for SA government preschools) was expanded to enable the capture of Family and Community Program (FCP) utilisation data. Five pilot sites tested the data collection enhancements in Term 1 2015. After this time, the system was progressively rolled out to support centres to begin to enter data. By Term 4, 2015 all sites had been supported by the EYS staff to set up information about the programs and services available in their sites to enable them to then enter information about children and families accessing these services.

3.2.1. EYS data extracted for the evaluation

Child and adult demographic data is collected at enrolment. Enrolment forms also collect parental consent for this information to be used for DECD business purposes and in a de-identified form for research purposes. Human research ethics approval was gained for obtaining this EYS data for the Children's Centre evaluation. EYS FCP data extracted for the purposes of this evaluation include:

Child level demographic information:

- gender
- CALD status
- suburb and postcode of residence
- date of birth
- Aboriginal status
- Guardianship of the Minister (GOM) status.

Adult level demographic information:

- adult's relationship to the child
- gender
- suburb and postcode of residence
- CALD status
- date of birth
- Aboriginal status
- highest year of school completed
- highest qualification achieved
- disability status
- single parent status.

Program level information:

- program name
- program type
- program duration (start and end date)
- program provider
- session duration.

Enrolment and attendance:

- number of sessions for which a child or adult was enrolled in a program
- number of sessions a child or adult attended.

Extracted data summary

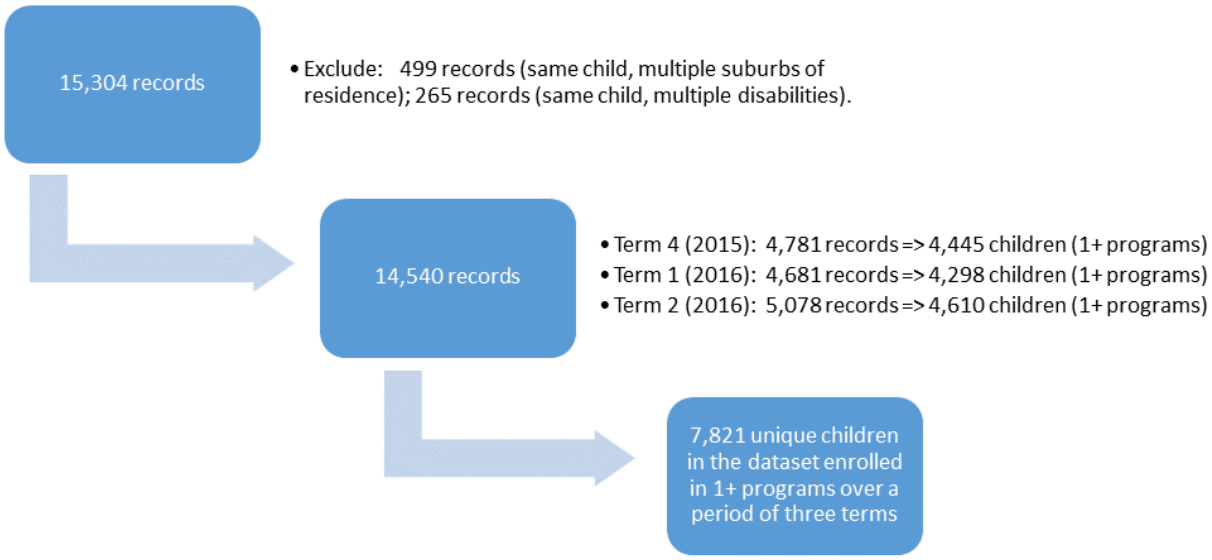

Figure 3.2-1and Figure 3.2-2 present the number of records extracted from the EYS for children and adults attending Children's Centres in Term 4 2015, Term 1 and Term 2 2016. The flow charts illustrate the number of service records and how many unique children and adults these relate to. The flow charts also include cases that were excluded from analyses. A total of 7,821 children and 1,124 adults were recorded as having utilised one or more services in a children's centre across the three terms.

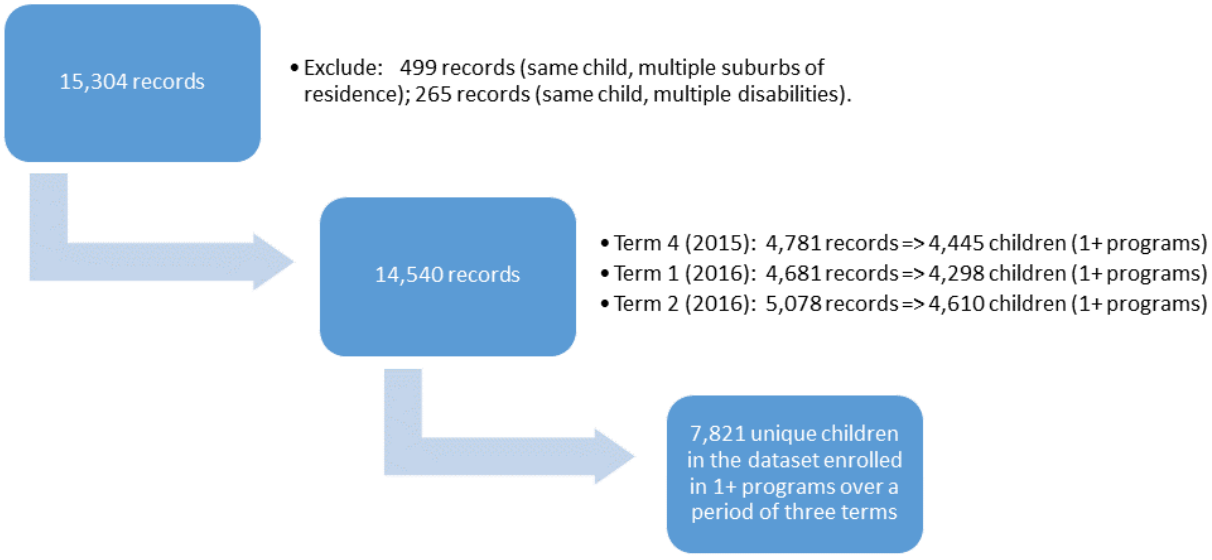

Figure 3.2-1 Child records extracted from the EYS

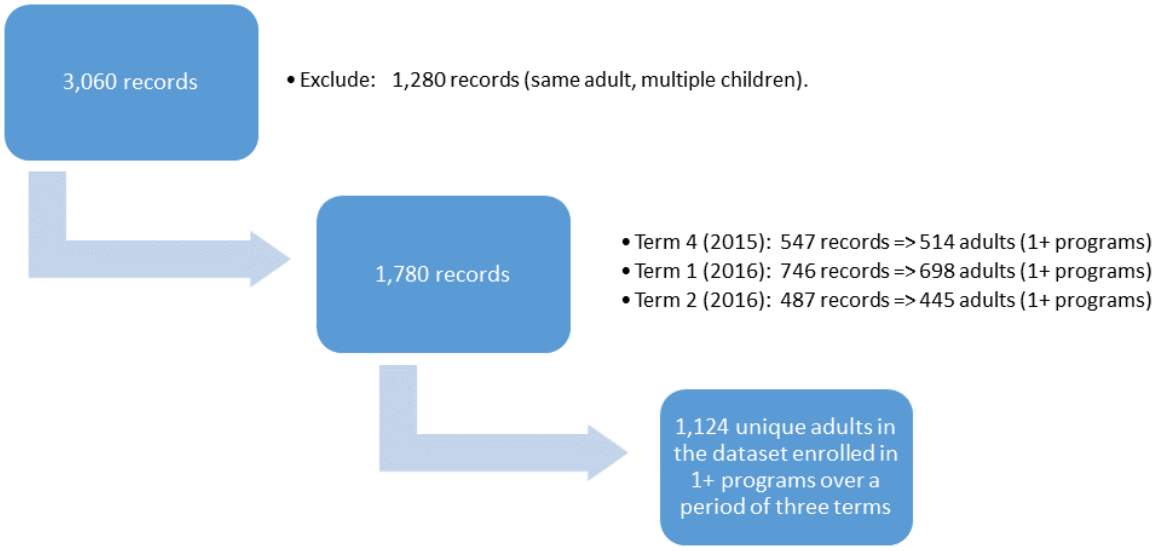

Figure 3.2-2 Adult records extracted from the EYS

3.2.2. Incomplete and missing data

The commencement of enhanced data collection for all children and adults attending FCPs has presented challenges for Children's Centres. Therefore, there is a great deal of missing information in the data extracted. It is unclear how many records are missing completely, i.e. there is no way to know how many children or adults who have attended a FCP have had no enrolment information collected or entered. Outlined below is the extent of missing data for the records that have been entered in the EYS for child and adult demographic information. Note, the proportion of missing data varies by term and this is indicated by presenting the range across terms (e.g. 3–8%).

Child level demographic information

- gender (100% complete)
- CALD status (100% complete)
- suburb and postcode of residence (100% complete)
- date of birth (100% complete)
  - DOB was deleted for 20 records
  - in these cases, the children were <0 years of age or greater than 8 years of age when the data was extracted, suggesting the DOB was incorrectly entered
- Aboriginal status (missing for 3–8% of records and <2% not stated)
- GOM status (Missing data for about 3–8% of records)
- disability status
  - there is a 'no-disability' option but this was only selected in 3–8% of records
  - there were a large number of NULL options (80–83% of records)
  - while these may represent 'no disability' this is impossible to know for sure.
  - children could have multiple disabilities recorded in the database

- we recoded the disability variable so that each child had a 'YES' or 'NO' on each of the different types of disabilities

Adult level demographic information

- adult's relationship to the child (100% complete)
- gender (100% complete)
- suburb and postcode of residence (100% complete)
- CALD status (100% complete)
- date of birth (Missing for 60%)
- Aboriginal status (missing for 76–77% of the sample)
- highest year of school completed (missing for 73–75% of records)
- highest qualification achieved (missing for 78–81% of records)
- disability status (100% missing)
- single parent status (100% missing).

Program enrolment data for children and adults

Children's Centres varied in the extent to which they entered enrolment data for children and adults. Overall, a much larger number of child attendance records were entered than adult records. In part this may be because preschool data for children is a mandated collection and this is included in the child records. Table 3.2-1 and Table 3.2-2 present the number of child and adult enrolment records for each term. Children and adults can be enrolled in multiple programs and across multiple terms. That is, 30 records do not necessarily represent 30 children but may be 15 children each attending two programs. Alongside enrolment records, the tables also present the number of program types running at sites for which enrolment data was entered. Both the number of program types with enrolment data and the number of enrolments are presented to demonstrate variance across centres. This data may also help to identify potential factors impacting upon data collection.

Table 3.2-1 Child enrolment records by term

	Total number of program types with data on children's enrolment			Total number of records for children enrolled in programs		
	Term 4 (2015)	Term 1 (2016)	Term 2 (2016)	Term 4 (2015)	Term 1 (2016)	Term 2 (2016)
Centre 19	5	5	6	241	247	284
Centre 32	2	4	5	203	202	281
Centre 41	4	4	4	273	263	263
Centre 40	6	5	5	181	194	211
Centre 24	7	6	6	206	175	191
Centre 29	7	8	8	189	201	188
Centre 18	7	7	7	166	153	176
Centre 3	2	3	3	163	161	168
Centre 20	4	5	6	147	159	162

	Total number of program types with data on children's enrolment			Total number of records for children enrolled in programs		
	Term 4 (2015)	Term 1 (2016)	Term 2 (2016)	Term 4 (2015)	Term 1 (2016)	Term 2 (2016)
Centre 14	6	5	7	159	143	159
Centre 39	3	3	2	159	140	147
Centre 25	3	2	2	127	143	146
Centre 33	7	7	6	109	124	146
Centre 38	7	7	7	166	132	141
Centre 30	6	7	6	100	236	139
Centre 15	3	4	7	39	73	136
Centre 27	2	2	3	176	132	135
Centre 26	3	3	4	118	115	133
Centre 1	2	2	2	130	112	114
Centre 42	4	4	4	139	112	112
Centre 13	6	5	5	113	100	111
Centre 7	2	3	4	102	104	108
Centre 8	2	5	6	127	100	107
Centre 10	3	3	3	114	102	104
Centre 6	8	5	6	87	104	100
Centre 4	5	6	7	101	94	98
Centre 5	4	4	4	97	94	93
Centre 23	1	2	2	83	85	85
Centre 28	3	2	2	124	79	80
Centre 34	2	3	5	14	29	70
Centre 36	4	3	4	65	55	68
Centre 12	2	3	2	54	62	58
Centre 16	3	3	3	52	52	56
Centre 22	1	1	1	57	50	54
Centre 21	2	2	2	54	52	53
Centre 9	8	4	4	59	58	52
Centre 35	3	2	2	54	53	52
Centre 31	4	4	4	86	37	50
Centre 37	1	2	2	35	37	38
Centre 17	1	1	1	36	19	19
Centre 2	0	0	0	0	0	0
Centre 11	0	0	0	0	0	0

Note

[1] The Learning Together program has been excluded from this list because this program provider enters data into EYS separately. Additionally, the data for this program entered for Children's Centres was minimal and not consistent across sites.

[2] Information on the program type was missing for 330 records, and these have been excluded from this table.

Adult enrolment information was far more variable across centres and this is indicated in Table 3.2-2 with divisions in the table representing the extent to which enrolment data was entered. Of the 42 centres, six centres consistently entered a large number of adult records over the three terms; seven centres started with a low level of data entry and this increased across the three terms; six centres started with a higher level of data entry and this decreased over time; nine centres entered very minimal data; and the remaining 14 centres entered no adult enrolment data.

Centres that entered a larger number of adult records tended to do so across a number of program types. It is not possible to determine the completeness of the adult program data, but for centres where both the number of records was high and the number of programs was high, it is more likely that these reflect actual numbers of adult enrolments. For centres with variable data, low numbers of program types and increasing or decreasing records over time, it is less likely that this reflects the actual numbers of adults attending programs.

Table 3.2-2 Adult enrolment records by term

		Total number of program types with data on adult enrolment			Total number of records for adults enrolled in programs		
		Term 4 (2015)	Term 1 (2016)	Term 2 (2016)	Term 4 (2015)	Term 1 (2016)	Term 2 (2016)
Large number of enrolments entered	Centre 24	4	4	4	126	149	93
	Centre 18	5	6	4	61	73	30
	Centre 20	1	2	3	55	79	74
	Centre 40	4	3	2	50	49	36
	Centre 29	4	4	5	42	51	54
	Centre 26	2	2	1	21	20	19
Increased data entry over time	Centre 3	1	2	4	6	15	30
	Centre 13	1	4	4	3	13	10
	Centre 39	1	4	5	4	35	32
	Centre 30	0	3	1	0	50	32
	Centre 8	0	1	4	0	4	12
	Centre 33	0	0	2	0	0	18
	Centre 34	0	1	2	0	4	11
Drop off in data entry over time	Centre 15	2	0	0	17	0	0
	Centre 38	5	4	3	38	43	3
	Centre 41	2	2	0	38	39	0
	Centre 6	2	2	1	13	18	7
	Centre 28	3	3	1	8	11	3
	Centre 5	4	5	1	49	44	6
Minimal data entry	Centre 4	1	1	0	7	9	0
	Centre 25	1	1	1	4	4	2
	Centre 31	1	0	0	4	0	0

		Total number of program types with data on adult enrolment			Total number of records for adults enrolled in programs		
		Term 4 (2015)	Term 1 (2016)	Term 2 (2016)	Term 4 (2015)	Term 1 (2016)	Term 2 (2016)
	Centre 16	1	0	0	1	0	0
	Centre 7	0	1	0	0	5	0
	Centre 12	0	1	0	0	6	0
	Centre 14	0	0	3	0	0	6
	Centre 32	0	1	0	0	1	0
	Centre 36	0	1	1	0	1	8
No data entry	Centre 1	0	0	0	0	0	0
	Centre 2	0	0	0	0	0	0
	Centre 9	0	0	0	0	0	0
	Centre 10	0	0	0	0	0	0
	Centre 11	0	0	0	0	0	0
	Centre 17	0	0	0	0	0	0
	Centre 19	0	0	0	0	0	0
	Centre 21	0	0	0	0	0	0
	Centre 22	0	0	0	0	0	0
	Centre 23	0	0	0	0	0	0
	Centre 27	0	0	0	0	0	0
	Centre 35	0	0	0	0	0	0
	Centre 37	0	0	0	0	0	0
	Centre 42	0	0	0	0	0	0

3.3. Linked 2015 AEDC and preschools data

3.3.1. Methodology – Data linkage of preschool and AEDC data

Data to explore the impact of attending preschool in a Children's Centre on children's development at school entry was drawn from two administrative datasets.

1) AEDC data (2015) for government school children (n = 13,811)

a. Demographic information – child surname, first name and DOB - in the AEDC file was matched against records in the pre-population data file[2] provided to the Social Research Centre (SRC) prior to the 2015 census
b. 97.9% were matched using this method (n = 13,527)
c. 2.1% could not be identified in the pre-population data (n = 291)[3]

2) Preschool census data (2014) for government funded preschools (n = 20,986)
   a. These records were checked against the records in the AEDC dataset for matching EDIDs. For those children that did not "match" to any of the AEDC cases based on EDID, a second check of the records was conducted to see whether any cases matched based on child-level demographic information – child surname, first name and DOB. A total of 12,325 records[4] (58.7%) were matched using this method. Reasons for non-matching would include children who attended a government funded preschool but an Independent or Catholic primary school, children who moved interstate between preschool and reception, children who attended preschool for an additional year (2015), children whose parents opted out of the AEDC collection.

3.3.2. Analysis Sample

A total of 13,818 children attending government schools were captured in the 2015 AEDC data collection. Most of these children (88.4%, n = 12,229) were matched in the preschool census data from 2014. However, 11.6% (n = 1,609) could not be matched in the data file. This group would comprise children who did not attend preschool at all, children who attended preschool in a private long day care centre, children who moved from interstate to start reception in 2015, and children who had unmatchable records due to significant changes in surname.

Of the 12,229 "matched" children, a small number of children attended a preschool in a government funded child care centre (n = 271). These children were excluded from the analyses because this type of preschool setting is qualitatively different to a "standalone" preschool. Although some Children's Centres also offer long day care, the aim of the comparison is to explore the benefit of services and supports that are in addition to preschool, thus comparisons with standalone preschools were deemed most appropriate. Another two children were excluded as they attended a preschool but information on the preschool type was missing in the dataset.

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[2] The pre-population file was extracted from the school enrolments database in February 2015.

[3] These children most likely started school late (after Feb 2015) but before the end of the AEDC census period

[4] On further examination of these records, 116 duplicate records were identified. After removal a total of 12,229 children had matched preschool and AEDC data.

The resulting sample was made up of 11,936 children where 17.9% (n = 2,139) attended a preschool program within a Children's Centre preschool and 82.1% (n = 9,797) attended a preschool program in a standalone (i.e. not child care centre or Children's Centre) government funded preschool (hereafter referred to as a *standard preschool*).

We were interested in understanding whether children who attended preschool within a Children's Centre had better development at school entry than children who attended a standard preschool. However, the demographic characteristics of children who attend Children's Centres are likely to be different to those who attend standard preschools because Children's Centres have been located in areas of South Australia with high need. This was confirmed in Table 3.3-1, which shows that children who attended a Children's Centre preschool were more likely to live in a socio-economically disadvantaged community than children who attended a standard preschool. Children attending a preschool in a Children's Centre were also more likely to be male, Aboriginal, have a language background other than English and live outside of the major cities, which are all factors that are associated with poorer child development outcomes at school entry. On this basis alone, we would expect children who are attending a Children's Centre preschool to have poorer development than children attending a standard preschool, even if the Children's Centre model of integrated services and support is improving children's holistic development more than would be expected from preschool attendance alone. As such, it is essential to adjust for the underlying demographic characteristics of children in the statistical models. Nonetheless, adjustment of these socio-demographic factors in the statistical model will not capture all differences between communities that do and do not have a Children's Centre because we only have limited community-level information available for these models.

Table 3.3-1. Demographic characteristics of children attending different types of preschools

		Standard Preschool (n = 9,797)		Children's Centre Preschool (n = 2,130)	
		N	%	N	%
Sex of child	Male	5056	51.6%	1124	52.5%
	Female	4741	48.4%	1015	47.5%
Aboriginal status	Yes	452	4.6%	203	9.5%
	No	9345	95.4%	1936	90.5%
Language Background other than English	LBOTE	1542	15.7%	426	19.9%
	English only	8255	84.3%	1713	80.1%
Socio-economic status of the community where the	Quintile 1 (most disadvantaged)	2323	23.7%	752	35.2%
	Quintile 2	2255	23.0%	612	28.6%
	Quintile 3	1962	20.0%	401	18.8%

child lives	Quintile 4	1871	19.1%	261	12.2%
	Quintile 5 (least disadvantaged	1379	14.1%	112	5.2%
Geographical remoteness of community where the child lives	Major Cities of Australia	6916	70.6%	1396	65.3%
	Inner Regional Australia	1041	10.6%	302	14.1%
	Outer Regional Australia	1430	14.6%	312	14.6%
	Remote Australia	339	3.5%	90	4.2%
	Very Remote Australia	63	0.6%	38	1.8%

The other way to explore child development differences between children with different preschool experiences is to explore the geographical areas that form the catchment zone for the Children's Centres, and select a "matched" group of children who live in this same area but attended standard preschools. To define the catchment zone for the Children's Centres, we selected the 1,968 children who attended a Children's Centre preschool and explored the AEDC local communities where they resided.

Table 3.3-2 shows a snapshot of the local communities and the number and percentage of children who attended standard and Children's Centre preschools within each one. In some local communities, most of the children attended preschool at the Children's Centre (e.g. Adelaide CBD, Angle Park, Athol Park, and Balaklava) so these areas were included in the catchment zone. In other communities, there were no children who attended a preschool in a Children's Centre (e.g. Aberfoyle Park) so these were deemed to be outside the catchment zone. As a general rule, all communities where 10% or more of the children attended preschool in the Children's Centre were included within the catchment zone. This rule excluded communities such as Athelstone where only a small number and percentage of children attended the Children's Centre.

Table 3.3-2. Number and percentage of children who attended standard and Children's Centre preschools within local communities.

	Standard Preschool		Children's Centre Preschool		Total	
	N	%	N	%	N	%
Aberfoyle Park	101	100%	0	0%	101	100%
Adelaide	4	19%	17	81%	21	100%
Albert Park	5	83%	1	17%	6	100%
Alberton/Queenstown/Port Adelaide	24	100%	0	0%	24	100%
Aldgate	29	97%	1	3%	30	100%
Aldinga Beach	75	74%	27	26%	102	100%
Allenby Gardens/Beverley	18	100%	0	0%	18	100%
Andrews Farm	77	68%	37	32%	114	100%
Angaston and surrounds	26	70%	11	30%	37	100%
Angle Park	3	27%	8	73%	11	100%
Angle Vale	17	89%	2	11%	19	100%
Ardrossan/Maitland and surrounds	31	100%	0	0%	31	100%
Ascot Park	10	77%	3	23%	13	100%
Athelstone	41	91%	4	9%	45	100%
Athol Park	5	25%	15	75%	20	100%
Balaklava	2	14%	12	86%	14	100%
Balhannah and surrounds	7	100%	0	0%	7	100%
Banksia Park	28	97%	1	3%	29	100%
Barmera	26	100%	0	0%	26	100%
Beaumont	16	100%	0	0%	16	100%
Belair	26	100%	0	0%	26	100%

This final sample was made up of 5,415 children where 35.2% (n = 1,905) attended a Children's Centre preschool and 64.9% (n = 3,510) attended a standard preschool. Figure 3.3-1 presents information about the sample of children available for analysis.

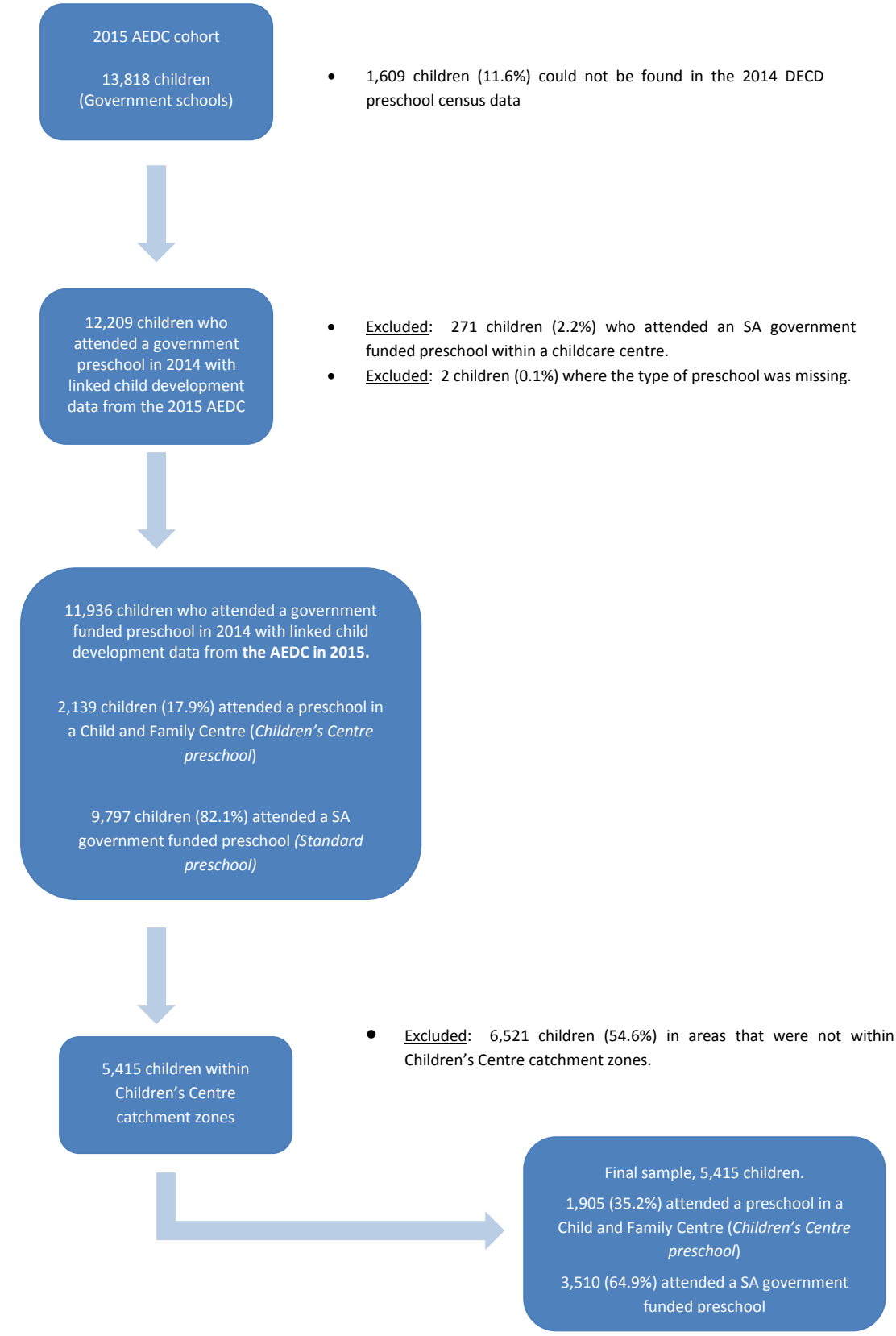

Figure 3.3-1. Participant flowchart

In this sample of children (n = 5,415), the two groups were better matched based on the socio-economic status of the communities where they live, suggesting the matching worked well. The two groups were also better matched based on their language background with between 18 to 20% of children with a language background other of English attending each different type of preschool. However, there were still substantial differences in the percentage of children in standard vs. Children's Centre preschools who were Aboriginal, which is likely to be related to the inclusion of Child and Family centres with a specific focus on Aboriginal children and families along with the broader focus across Children's Centres on engaging Aboriginal families in Centres.

Table 3.3-3. Demographic characteristics of children attending different types of preschools

		Standard Preschool (n = 3,510)		Children's Centre Preschool (n = 1,905)	
		N	N	%	%
Sex of child	Male	1,800	51.3%	1,005	52.8%
	Female	1,710	48.7%	900	47.2%
Aboriginal status	Yes	196	5.6%	180	9.4%
	No	3,314	94.4%	1,725	90.6%
Language Background other than English	LBOTE	634	18.1%	374	19.6%
	English only	2,876	81.9%	1,531	80.4%
Socio-economic status of the community where the child lives	Quintile 1 (most disadvantaged)	1,305	37.2%	691	36.3%
	Quintile 2	968	27.6%	561	29.5%
	Quintile 3	646	18.4%	360	18.9%
	Quintile 4	427	12.2%	207	10.9%
	Quintile 5 (least disadvantaged	163	4.6%	85	4.5%
Geographical remoteness of community where the child lives	Major Cities of Australia	2,659	75.8%	1,215	63.8%
	Inner Regional Australia	370	10.5%	287	15.1%
	Outer Regional Australia	378	10.8%	279	14.6%
	Remote Australia	93	2.6%	87	4.6%
	Very Remote Australia	10	0.3%	37	1.9%

4. Findings

Findings are presented here as they relate to the evaluation questions. Analyses of all three data sets are used and this is dependent on the question and the data that is best suited to address it. Themes that emerged from focus groups and interviews are also outlined as these relate to the evaluation questions and the findings from the quantitative works.

4.1. Do Children's Centres provide families with effective pathways that assist families to access the range of services and support that they need? How does this happen?

4.1.1. What services and supports are available in Children's Centres and do these meet community needs?

To meet their brief, to provide universal services with targeted support, Children's Centres should aim to provide services for all families residing in their catchment areas. Additionally, targeted strategies should be used to provide additional support to families facing greater challenges. Importantly, Centres should seek to employ community engagement strategies to reach those families who experience barriers to accessing services and supports. Thus, the way in which services and supports are planned is an important component of service provision in Children's Centres. In focus group and interviews, staff, service providers, and Centre directors indicated that the way in which services and supports were planned to meet community needs varied across Children's Centres. Moreover, the way in which the community of the Children's Centre was defined varied. Focus group and interview participants sometimes spoke of community as those people who utilised the Centre and at other times as the families living in the local area, or a combination of the two.

The FCP administrative data are first presented to examine quantitatively the range of services and supports offered in centres and the organisations providing these services. Secondly, the state-wide survey is presented to examine the way community was defined, how well community needs were understood, and the extent to which services and the way these are provided in Children's Centres meet the needs of families in the community.

Range of services available in Children's Centres

Programs available in Children's Centres, and included in analyses, were categorised into 10 program types (e.g. adult learning, Aboriginal-focussed support, community group, community/parent led playgroup, etc.).

Table 4.1-1 presents both the number of programs running across all Centres and the number of sites providing each program type. Of the 10 program types, five (adult learning, Aboriginal-focussed support, community/parent led playgroup, staff capacity building, and targeted playgroup) were available at fewer than half of Centres. There were no program types recorded as being available across all sites. More intensive supported groups were offered in a greater number of sites than parent or community run universal services (community group and community/parent led playgroup).

Table 4.1-2 presents the range of organisations providing each service type. Focus group and interview participants noted the broad range of services being provided by a range of organisations. This was not borne out in the EYS administrative data, where services tended to be recorded as being provided primarily by Centre staff. This may be a result of the limitation of the EYS in recording when programs or services are provided in partnership (i.e. not a sole service provider).

Table 4.1-1 Number of programs and program types available across Children's Centres

	Term 4-2015		Term 1-2016		Term 2-2016	
	Sites	Programs	Sites	Programs	Sites	Programs
Aboriginal Focussed Support	13	36	15	49	14	41
Community Group	28	64	34	92	30	76
Community/Parent Led Playgroup	13	18	16	25	15	22
Family Support	33	44	31	51	31	46
Health	23	50	24	73	20	56
Parenting Program	27	79	29	100	25	82
Parenting Support Services	40	206	40	244	40	218
Supported Playgroup	36	102	37	138	36	118
Targeted Playgroup	7	11	10	16	10	15
Targeted Support Group	27	83	30	101	29	92

Table 4.1-2 Percentage of program types provided by organisations partnering with Children's Centres

Program Provider	Program - Description									
	Aboriginal Focussed Support (N=32)	Community Group (N=11)	Community/ Parent Led Playgroup (N=63)	Family Support (N=23)	Health (N=6)	Parenting Program (N=42)	Parenting Support Services (N=30)	Supported Playgroup (N=243)	Targeted Playgroup (N=17)	Targeted Support Group (N=19)
Allied Health	.0%	.0%	.0%	.0%	.0%	.0%	6.7%	19.8%	.0%	15.8%
Anglicare SA	.0%	.0%	.0%	.0%	.0%	.0%	6.7%	.0%	.0%	.0%
Community Development	18.8%	72.7%	100.0%	.0%	.0%	23.8%	16.7%	11.1%	29.4%	42.1%
DECD	.0%	.0%	.0%	.0%	.0%	.0%	.0%	38.3%	.0%	.0%
Family Services Co-ordinator	40.6%	.0%	.0%	100.0%	.0%	76.2%	.0%	23.0%	.0%	.0%
Health SA	9.4%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	21.1%
Lutheran Church of Australia	.0%	18.2%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	.0%
Multiple Births Association	.0%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	70.6%	.0%
MyTime	.0%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	21.1%
Peer Support Group	.0%	9.1%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	.0%
Private providers	.0%	.0%	.0%	.0%	100.0%	.0%	33.3%	.4%	.0%	.0%
Relationships Australia	.0%	.0%	.0%	.0%	.0%	.0%	36.7%	.0%	.0%	.0%
Save the Children	31.3%	.0%	.0%	.0%	.0%	.0%	.0%	7.4%	.0%	.0%

Note

[1]This data is based on the Term 2 2016 extract from the EYS.

Definition of community

Three survey questions explored staff, service providers', and directors' perception of who made up the community of a Children's Centre. Respondents were asked to rate the extent to which they agreed or disagreed with the following statements:

1. Our community is made up of the families who use the Centre
2. Our Community is made up of the families who use the Centre and those families who are not using the Centre but live in the local area
3. Most families who use our Centre come from our local area

Survey findings echoed the sentiments expressed in focus groups and interviews that 'community' was defined in a number of ways. Centres often referred to community as those families using the Centre, but also referred to the 'broader community' when speaking about families who may not be accessing the centre but who they would like to be able to engage. Figure 4.1-1 and Figure 4.1-2 below illustrate that across the state, staff, service providers, and directors tended to agree that the community of a Children's Centre was made up of the families who utilised services, but more so that community was made up of those families who lived in the local area who may not be utilising services in the Centres. Most staff, service providers and directors reported that families using the Centre came from the local area.

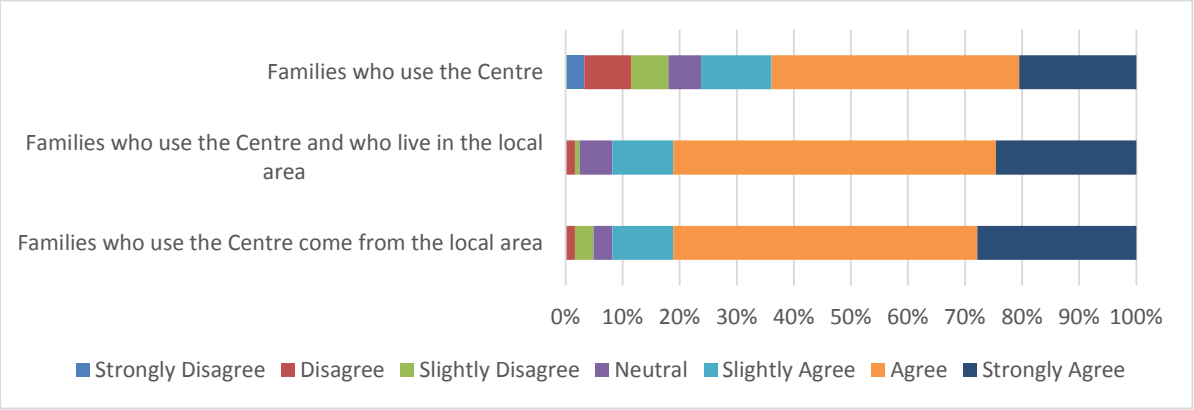

Figure 4.1-1 Staff and service provider perceptions of community

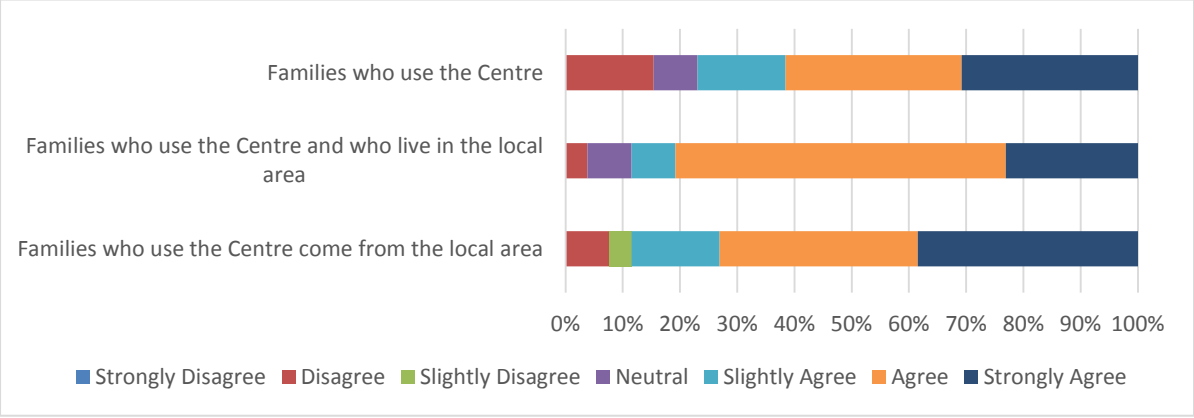

Figure 4.1-2 Director perceptions of community

Understanding the needs of community

Directors, staff, and service providers were also asked two questions that sought to explore the extent to which they understood the strengths and needs of the community and how their understanding differed for families attending the Centre and those who lived in the local area. Specifically, respondents were asked to rate the extent to which they agreed or disagreed with the following:

1. The Centre understands the strengths and needs of the families who use our Centre
2. We understand the strengths and needs of the families who live in our local area

Figure 4.1-3 and Figure 4.1-4 illustrate that staff, service providers, and directors reported having a stronger sense of understanding of the strengths and needs of the families who utilised the Centres than they did of the families who lived in the local area.

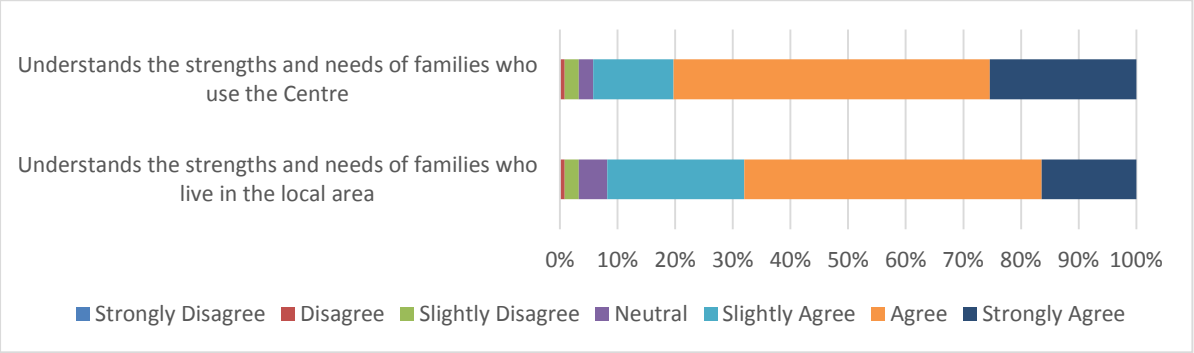

Figure 4.1-3 Staff and service provider's understanding of the strengths and needs of families

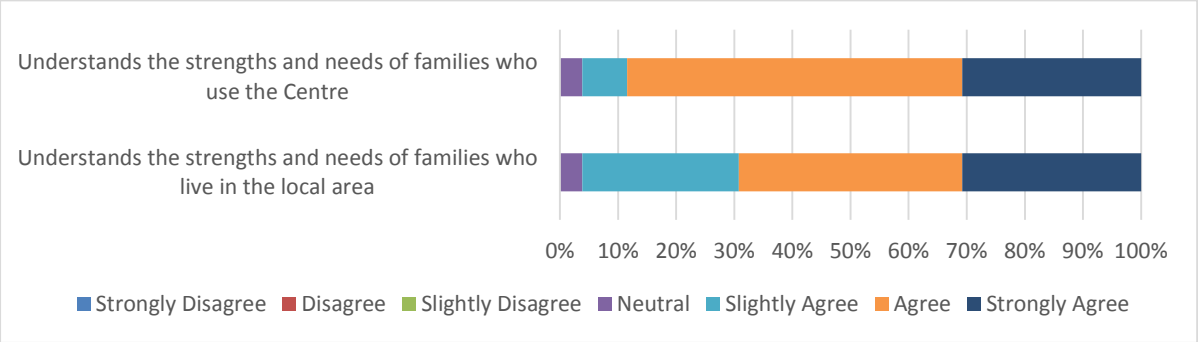

Figure 4.1-4 Director's understanding of the strengths and needs of families

Parent perceptions of influence in centres

A set of six questions explored the extent to which families felt their needs were catered for in the Centre and the extent to which families could influence the services and supports available to them. Parents were asked to rate the extent to which they agreed or disagreed with the following:

1. The Children's Centre provides programs and services that meet my child(ren)'s needs
2. The Children's Centre provides programs and services that meet my needs
3. The Children's Centre staff understand the issues that are important to me
4. The Children's Centre incorporates my ideas into the Centre

5. The Children's Centre listens to my ideas
6. I am able to influence what happens in the Children's Centre

As illustrated in Figure 4.1-5, parents tended to agree that services and supports available in Centres met their needs and their children's needs and that staff in Centres understood the issues that were important to them. Fewer parents reported that Centres incorporated their ideas, listened to their ideas or that they could influence what happened in the Centre. This again echoed themes raised in focus groups, where parents felt well supported but reported variable feelings of ownership over the direction of the Centre. These findings suggest that Centres are working in a service provision way and opportunities exist to expand parents' engagement in order to work in a community building way.

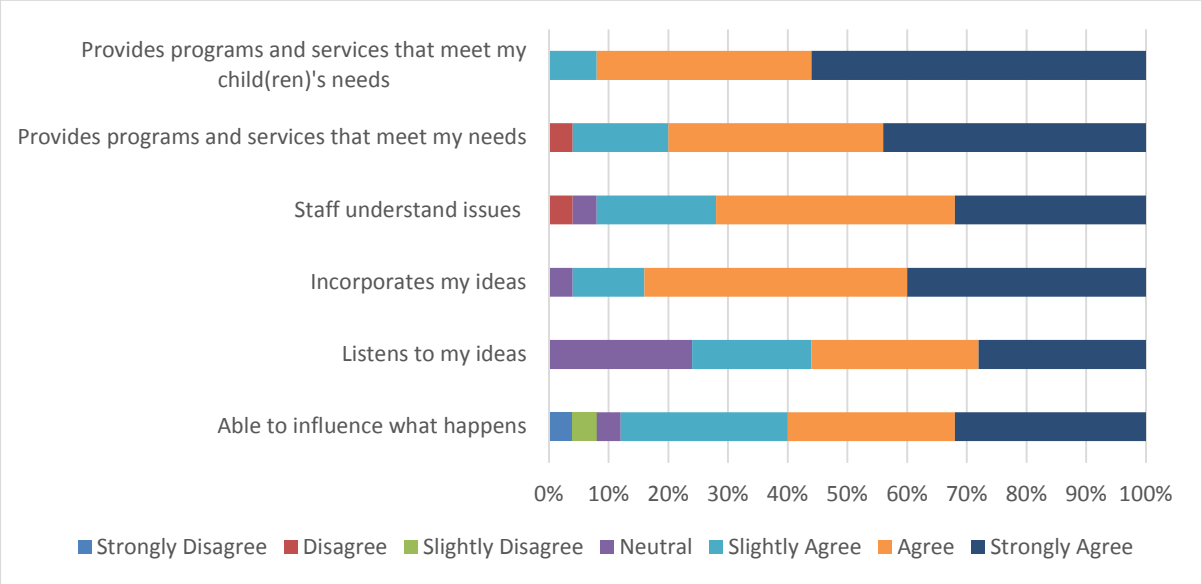

Figure 4.1-5 Parent perceptions of influence in Centres

Although parents reported having opportunities for engagement, additional analyses were conducted to explore the degree to which this differed for families with differing demographic characteristics. A non-parametric analysis of variance (Kruskal-Wallis) was used to explore the extent to which demographic groups differed in their ratings of Centre involvement.

Firstly, single parents (M = 5.9, n = 31) reported a greater sense of involvement in the design and implementation of programs and services in Centres than parents living in two-parent households (M = 5.5, n = 165), and this was a statistically significant difference (p = 0.36). Secondly, parents who had more than one child attending Centres also reported feeling more involved in the design and implementation of programs and services in Centres, with ratings significantly increasing for each additional child (p = 0.48). Finally, parents who had been attending the Centre for longer also reported feeling more involved (p = .002). Parents who had been attending a Children's Centre for three or more years reported feeling the most involved in the design of services (M = 5.8, n = 36), compared to parents who had attended a Centre for less than one year (M = 5.3, n = 86).

There were no differences in levels of perceived involvement for parents in relation to whether they or their child had a disability, parent's level of education, the age of the child attending the Centre, gender of the parent, Aboriginal background, and language background. The relationship between number of children attending the Centre, time using the Centre and parental engagement demonstrates that more exposure to the Centre may be a factor in the level of involvement parents feel. Moreover, the absence of difference across most demographically distinguished groups of parents is an encouraging finding. In focus groups, parents from a vast range of backgrounds reported feeling engaged in Centres, their views respected, and their needs considered. The present findings suggest that this is experienced irrespective of cultural background, gender, and age of children.

Parents' experience of staff

In focus groups, parents reported experiencing a high level of support and understanding from Centre staff. Parents also reported that staff directed them to relevant services and supports when they expressed concerns or difficulties. Parents reported feeling comfortable talking to staff about difficulties they were experiencing and that they did not feel judged or stigmatised.

To measure the extent to which this was experienced for parents utilising Children's Centres, six questions from the parent survey asked parents to rate how strongly they agreed with the following:

1. The Children's Centre staff are well informed about services and supports I can access
2. I trust the advice of staff working in the Children's Centre
3. I feel comfortable talking to the Children's Centre staff about issues in my life
4. I feel comfortable talking to the Children's Centre staff about concerns I have about my child(ren)
5. If I have a problem that the Children's Centre staff cannot help me with, they make sure they link me with someone that can help
6. The Children's Centre staff are committed to helping me

Parent responses are presented in Figure 4.1-6. Consistent with focus group findings, most parents agreed or strongly agreed that staff in Centres provided well informed support and referrals, were committed to helping them, and were approachable.

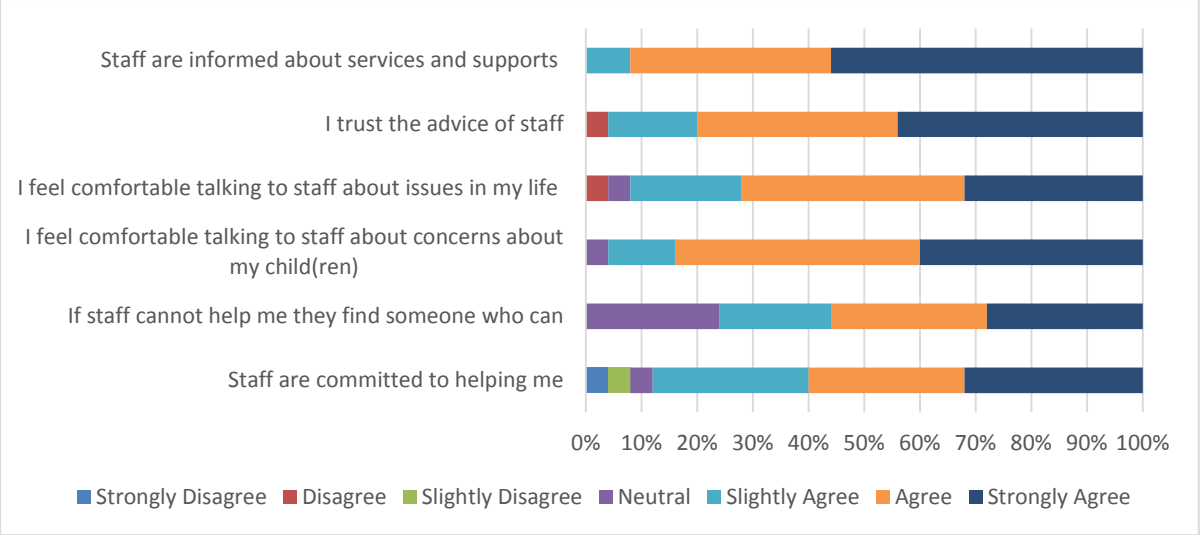

Figure 4.1-6 Parent perceptions of staff at Children's Centres

Demographic differences in parent reports were also explored to examine the extent to which the findings were true for all parents. There were no differences for parents from culturally diverse backgrounds, single parents, men or women, number of children using Centres, or parents who had a disability medical condition or whose child had a disability or medical condition.

Although all groups of parents reported a generally high (a median score of six out of a possible score of seven) level of support, a non-parametric analysis of variance (Kruskal-Wallis) indicated that parents with lower education reported significantly more positive experiences of staff (p = .006) (high school or part high school education (M = 6.4, n = 43), TAFE (M = 6.2, n = 58) than those who had completed university (M = 5.9, n = 103)).

The length of time attending a Children's Centre was also significantly associated with differing perceptions (p = .009). Parents who had been attending a Children's Centre for more than three years reported Centres as the most friendly and trusted sources of advice (M = 6.4, n = 36), compared to those attending Centres for two to three years (M = 6.1, n = 40), one to two years (M = 6.4, n = 44), and less than one year (M = 5.9, n = 87). Although, respondents with an Aboriginal and Torres Strait Islander background tended to rate their experiences of Centres more highly than non-Indigenous respondents, too few survey responses were collected from families with an Aboriginal or Torres Strait Islander background to draw reliable comparisons.

Relationship between influence in Centre and experience of staff

Parent's experience of staff was significantly and positively associated with parents feeling like they were active partners in Centres (Spearman's rank-order correlation r = .509, p = .016). That is, parents who reported higher levels of involvement also tended to report more positive experiences of staff. To further examine this relationship, Centre level scores were created by aggregating respondent scores for each Centre. Aggregated scores for Centres were grouped into high and low categories, corresponding to the mean Centre rating falling above a score responding to 'agree' in the survey response options. As shown in Table 4.1-3, of the 22 Centres with parent responses, four Centres were consistently rated as having high parental involvement in the Centre. In contrast, 16

Centres were rated as having high experiences of staff. There was no relationship between parent reported involvement in Centres and their experience of staff ($\chi^2 = 1.83$, $p = .180$).

Table 4.1-3 Parent's experience of staff and whether they felt like active partners in the design and implementation of services by Children's Centres

			Experience of staff		
			Low	High	Total
Active partners in design	Low	Count	6	12	18
	High	Count	0	4	4

4.1.2. What are the referral pathways to additional support?

In focus groups and interviews, staff, service providers, and directors spoke about Children's Centres as service provision hubs in their communities. Participants also noted that Children's Centres were connecting service providers to each other and to families. However, discussions indicated that referral pathways were informal rather than formal, and relied upon relationships that were developed between individual staff within the Children's Centres and within service provider organisations. Surveys further explored these themes and asked staff, service providers, and directors to rate referral processes and pathways across Children's Centres and the factors that facilitate these.

Building service networks

Two survey questions explored staff, service provider's, and director's perception of the way in which Children's Centres support the building of local service provision networks. Staff, service providers, and directors were asked to rate the extent to which they agreed or disagreed that:

1. Children's Centres build positive relationships with external agencies
2. Children's Centres help improve relationships between government and non-government agencies

Figure 4.1-7 and Figure 4.1-8 below demonstrate that there was broad agreement that Children's Centres operated in a way that built positive working relationships in the community of service providers, although directors tended to rate this more highly than staff and service providers. These findings echo the themes that arose in focus groups and interviews.

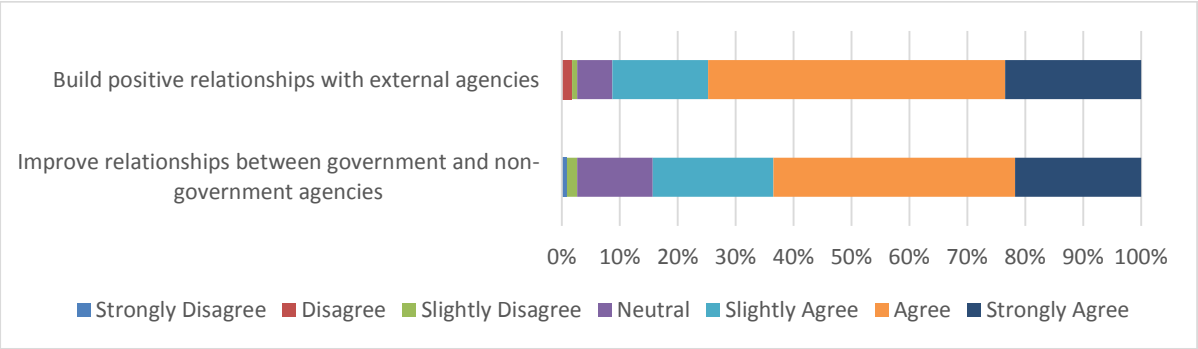

Figure 4.1-7 Staff and service provider perceptions of service networks

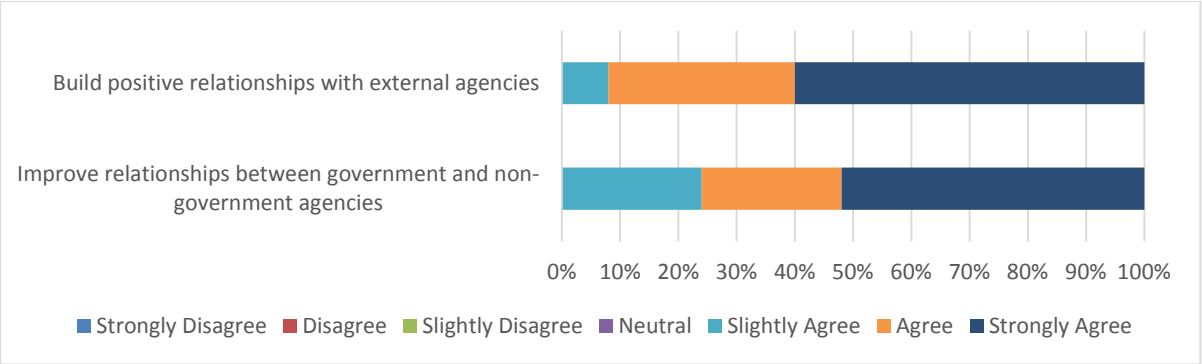

Figure 4.1-8 Director perceptions of service networks

When asked about the network groups and meetings that staff, service providers, and directors were currently involved in, 43% of staff and service providers and 76% of directors reported that they participated in a broad range of network groups and meetings. To examine whether network meetings were attended more by some staff in Centres than others, the frequency of meeting reports were explored for the range of staff groups. Most Community Development Coordinators (78%) and Family Services Coordinators (88%) reported attending a range of network meetings in addition to Governance Group meetings. In contrast, most Preschool Educators (74%) reported that they did not attend additional meetings.

Too few allied health, long day care occasional care, and school support staff took part to compare answers for these groups. Additional meetings included regional leadership meetings, school-based staff and team meetings and preschool director association meetings. The ability of additional staff to connect with local networks was similarly reported in focus groups and interviews. This demonstrates the importance of the community development and family service coordinator roles in Centres to facilitate the development of local professional networks.

Referral Pathways

Focus group and interview participants noted that enhanced service provider networks resulted in improved referral pathways for children and families in the community. To examine the extent to which referrals and pathways functioned in Children's Centres, staff, service providers, and directors were asked to indicate if they were aware of various services in the area and whether there were referral pathways from the Children's Centres to those services in place. As can be seen in

Table 4.1-4 and Table 4.1-5, staff, service providers, and directors were generally aware of services in the area and referral pathways to those services. While there was high awareness of some services, there were not, however, always referral pathways available. Staff, service providers and directors reported similar levels of awareness of services and referral pathways. Examination of how this differs across services in the community highlights areas where there is potential to improve local links for the benefits of families.

Table 4.1-4 Proportion of staff and service providers who were aware of various services and whether there were referral pathways available

Referral Pathway	Know of Service (Yes)	Referral Pathway Available (Yes)
Speech Pathologist	98%	97%
Maternal and child health	93%	90%
Mental health	88%	78%
Sexual/Reproductive health	58%	27%
General Practitioners	91%	63%
Disability services	93%	84%
Social and emotional wellbeing	94%	83%
Local primary schools for school transition	96%	90%
Playgroups run by facilitators	95%	92%
Local kindergartens	96%	89%
Local childcare services	92%	79%
Child safety	80%	62%
Parent and family support	94%	91%
Transport	70%	55%
Financial assistance for families	80%	71%
Housing services	79%	62%
Drug and alcohol services	73%	50%

Table 4.1-5 Proportion of directors who were aware of various services and whether there were referral pathways available

Referral Pathway	Know of Service (Yes)	Referral Pathway Available (Yes)
Speech Pathologist	100%	92%
Maternal and child health	100%	92%
Mental health	100%	76%
Sexual/Reproductive health	56%	28%
General Practitioners	96%	56%
Disability services	96%	80%
Social and emotional wellbeing	92%	76%
Local primary schools for school transition	100%	92%
Playgroups run by facilitators	100%	88%
Local kindergartens	100%	96%
Local childcare services	100%	92%
Child safety	88%	68%
Parent and family support	96%	88%
Transport	84%	64%
Financial assistance for families	80%	68%
Housing services	88%	68%
Drug and alcohol services	84%	64%

Connecting families to supports in their children's early years

In focus groups and interviews, staff, service providers, and families noted the difficulties experienced by families seeking services and supports in the years before children commenced preschool. Families reported not knowing about what services and supports were available to them and had difficulty finding information when they were in need.

Antenatal and community maternal child health services (in South Australia the Child and Family Health Service (CaFHS)) provide universal health and support services for children and their families during pregnancy, infancy, and early childhood. Antenatal services focus on providing care during pregnancy, while the CaFHS focus on providing services for families and children from birth to school entry. By including such services within an early childhood and parenting setting (such as Children's Centres), parents and their children can be supported to engage early with parenting support and their communities during children's early years.

In focus groups participants noted that where good relationships existed between CaFHS nurses and Centres, families were connected to services and supports in Centres when their children were younger. Connections with maternal child health nurses were reported to be variable and not always systemically supported, but reliant on local relationships. In several sites, antenatal services and or CaFHS are delivered within the Children's Centre. To examine whether this improved the uptake of services for younger children, the age profiles of children enrolled in Children's Centres with and without antenatal services and/or a child health nurse were examined. Table 4.1-6 demonstrates that having antenatal and maternal child health services on site increased the proportion of younger children enrolled in Children's Centres. Specifically, where these services were located in a Children's Centre there was a higher proportion of children aged 0 to 2 years enrolled in the Centre compared to those Centres without either service. While both service types increased early enrolments, a CaFHS nurse on site had a larger impact on early enrolments than antenatal services.

Table 4.1-6 Number and proportion of children enrolled in Centres with a CaFHs service and/or antenatal service

		Does the Children's Centre have a CaFHS service and/or antenatal services?							
		CaFHs (No), Antenatal services (No) 28 Centres		CaFHs (No), Antenatal services (Yes) 4 Centres		CaFHs (Yes), Antenatal services (No) 7 Centres		CaFHs (Yes), Antenatal services (Yes) 1 Centres	
		N	%	N	%	N	%	N	%
Child—Age group	0-2 years	974	59.2%	233	64.5%	635	74.7%	-	-
	3-4 years	609	37.0%	123	34.1%	206	24.2%	-	-
	> 5	61	3.7%	5	1.4%	9	1.1%	-	-
	Total	1644	100.0%	361	100.0%	850	100.0%	-	-

Note

[1] Child level data on all programs except Learning Together, preschool, preschool support programs and occasional care programs. N = 3,693 records from Term 4 (2015), Term 1 (2016) and Term 2 (2016) combined

[2] A single Children's Centre had both antenatal and CaFHs services and this centre had minimal data in the EYS, so data has been suppressed in this table.

[3] Two Children's Centres had no child-level information so they have been excluded from this table.

4.1.3. What system level changes/supports/challenges are there to support Children's Centres?

Focus groups and interview participants considered that two key system-level supports enhanced the capacity of the Children's Centres' leadership teams to work in an integrated service setting. The first was the professional development program, which was said to be helping people develop an understanding of working in partnership to meet community needs and develop a model of integrated practice. The second was the support provided by the Early Childhood Development Strategy Team, which was said to help staff from non-education backgrounds negotiate challenges they encountered in their work.

A number of challenges were also identified for the management of Children's Centres. Primarily these were related to governance structures around line management and workload of directors. In addition, the physical structures of Children's Centres were identified as either facilitating or hindering integrated service provision. Specifically, the layout of office space (staff teams together or separated) either brought staff together and encouraged incidental information sharing and discussion or made it difficult for staff to stay connected to activities and staff in other areas of the Centre—necessitating increased scheduled meetings and intentional connection with other staff. These factors were further explored in the survey of staff, service providers, and directors.

Professional development and central support

Four survey questions explored the extent to which directors agreed that professional development and central support from the Early Childhood Development Strategy Team facilitated the building of integrated services in centres. Directors were asked to rate the extent to which they agreed or disagreed with the following statements:

1. The professional development program provides training that is relevant to my work in developing integrated services
2. I attend professional development to increase my knowledge about providing integrated services
3. The Early Childhood Development Strategy team has skills and knowledge to help me develop integrated services in my site
4. When I need support in relation to establishing integrated services in my site, I contact someone from the Early Childhood Development Strategy team

Figure 4.1-9 below demonstrates that the majority of directors agreed or strongly agreed that the professional development program provided training that was relevant to work related to developing integrated services. Furthermore, most directors agreed or strongly agreed that they

utilised professional development to increase their knowledge about providing integrated services. While most directors agreed or strongly agreed that the Early Childhood Development Strategy team had skills and knowledge to help them develop integrated services in their site, less than half reported that they utilised the team when they needed support in relation to establishing integrated services in their site.

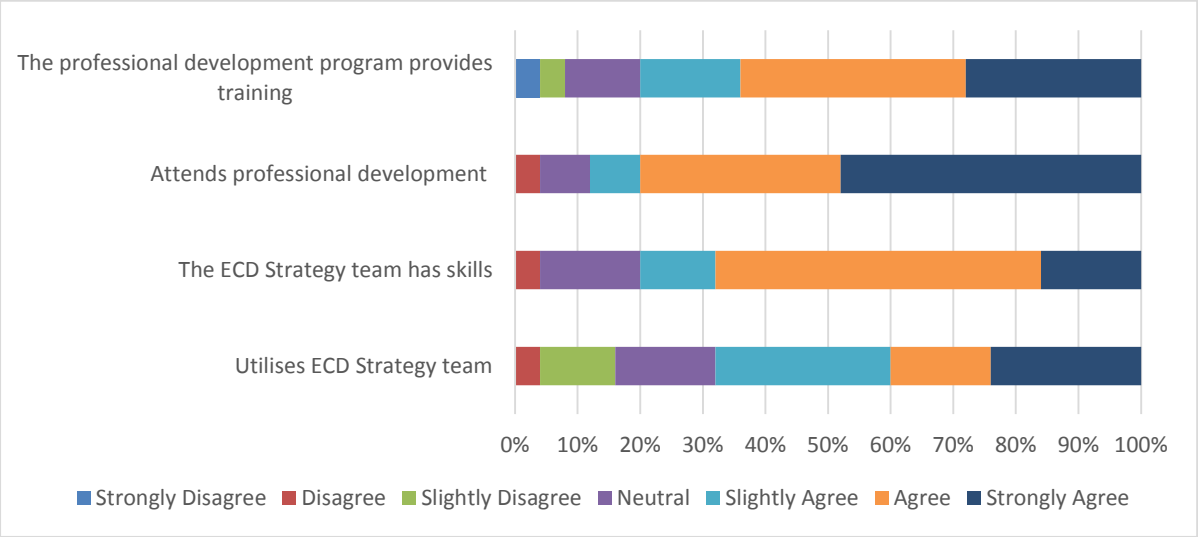

Figure 4.1-9 Director perceptions of the professional development program and the Early Childhood Development Strategy team

Impact of the physical space on integrated service provision

To explore the impact of physical space, one survey question asked staff, service providers, and directors to rate the extent to which the physical space in Centres supported integrated service provision. As shown in Figure 4.1-10, most respondents agreed that the physical space in Centres promoted integrated service provision. Although physical space was extensively discussed by focus group and interview participants, this did not appear to be a substantial issue.

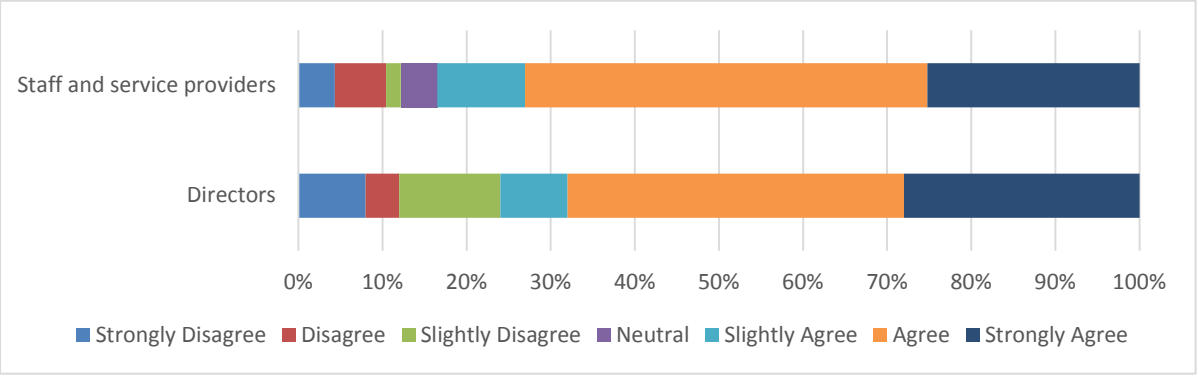

Figure 4.1-10 Staff, service provider and director perceptions of whether the physical space promotes integrated support to families

4.1.4. How do these referral processes and pathways differ to those in the broader community?

In focus groups and interviews, parents reported that referral pathways were functioning better in Children's Centres than in standalone preschool or child care settings. However, not all parents identified improved access to services through referral pathways. Staff, service providers, and directors noted that once families were using the Children's Centre, the capacity of staff and the quality of relationships between service providers and the Centre were important for improving referral pathways. Additionally, the increased capacity of staff to work with vulnerable children and their families, resulting from working in an integrated setting, was said to increase the rate of identification of families needing support.

Eight survey questions explored the extent to which staff, service providers, and directors agreed that Children's Centres help achieve the following outcomes:

1. Earlier identification of vulnerable children and families
2. New knowledge or skills for team members
3. Improved capacity to reach more children and families
4. A clearer pathway for families to the supports they need
5. Improved access to specialist services
6. Improved access to preschool programs
7. Reduced duplication of services in our area
8. The provision of the right service at the right time

Figure 4.1-11 and Figure 4.1-12 below indicate that the majority of staff, service providers, and directors agreed or strongly agreed that Centres were improving the way in which families were supported and connected to relevant services. Staff, service providers, and directors also tended to agree or strongly agree that Children's Centres helped to achieve earlier identification of vulnerable children and families, provided new knowledge or skills for team members, improved the capacity to reach more children and families, provided a clearer pathway for families to the supports and services, and improved access to specialist services and preschool programs.

While most staff and service providers agreed or strongly agreed that Centres supported families to connect with the right service at the right time, directors did not agree to the same extent. Fewer staff, service providers, and directors agreed or strongly agreed that Children's Centres reduced duplication of services in the area. For most of the eight outcomes, directors reported higher levels of agreement than staff and service directors.

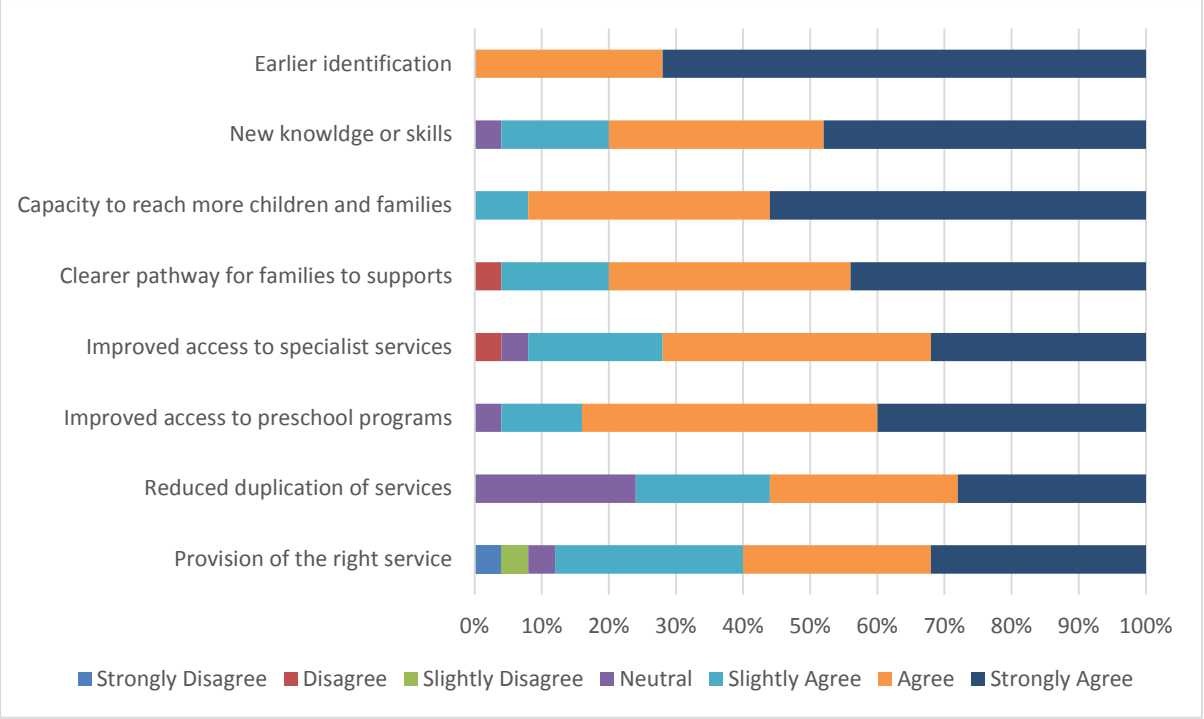

Figure 4.1-11 Staff and service provider perceptions of referral processes and pathways

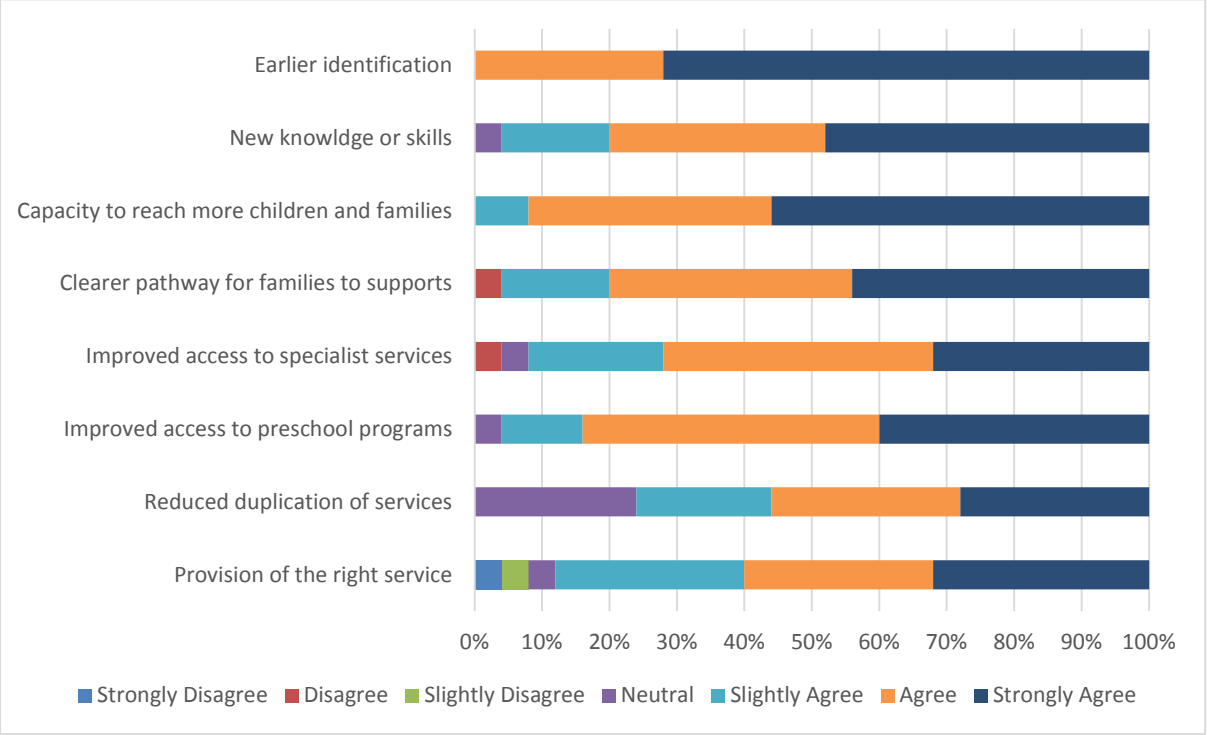

Figure 4.1-12 Director perceptions of referral processes and pathways

Improving access to services

To examine which services families were able to access and which were needed but could not be accessed, parents were asked to select from two different lists of services. One was a list of services

they used for their children in the past 12 months, and the other was a list of services with a focus on families that they accessed for themselves. Parents were also asked to select the services that they needed for their children or themselves but were not able to access.

As illustrated in Table 4.1-7 and

Table 4.1-8, parents generally reported higher usage of universal services for both their children (e.g. playgroup or parent–child group and general practitioner or other health centre services) and for themselves (such as bulk-billing GP services and Centrelink or the Family Assistance Office). Universal services are those that are available to all children and families in the population.

In contrast, targeted services were reported to be used less frequently. These are services that are available to groups within the population that meet specific criteria, be they cultural, issue specific or demographic specific. Targeted services included services such as Aboriginal and language support for children and drug or alcohol services. Overall, few parents reported that there were services they were not able to access.

Table 4.1-7 Proportion of services used for children and services needed but not accessible

	Services used	Services needed but not accessible
Playgroup or parent-child group	51%	3%
Maternal & child health centre/phone help	17%	1%
Maternal and child health nurse visits	18%	1%
Paediatrician	23%	3%
Hospital emergency department	32%	1%
Hospital outpatients clinic	12%	1%
General Practitioner or other health centre	63%	2%
Early education services	15%	1%
Aboriginal services	1%	0%
Family support services	5%	1%
Language support services	2%	1%
Disability services	4%	1%
Therapy/counselling services	7%	1%
Other mental health or behavioural services	5%	2%
Dental Services	34%	2%
Other medical specialists	11%	1%
Speech therapy	16%	3%
Other Specialist	13%	4%
Other child specific services	10%	3%
None of the above	9%	77%

Table 4.1-8 Proportion of services used for families and services needed but not accessible

	Services used	Services needed but not accessible
Parent line/help line	18%	1%
Parenting education courses or programs	19%	1%
Relationships Australia	4%	1%
Other counselling services	10%	1%
Parent support groups	7%	1%
Bulk-billing GP services	70%	2%
Antenatal classes or health services	9%	1%
Drug or alcohol services	0%	0%
Adult mental health services	8%	1%
Migrant or ethnic resources	1%	1%
Housing services	2%	1%
Employment services	3%	1%
Disability services	3%	2%
Charities	5%	1%
Australian Breastfeeding Association	9%	1%
Church or religious group	14%	0%
Other medical or dental services	26%	2%
Centrelink or the Family Assistance Office	56%	1%
Other family support services	2%	1%
Relationship education service	1%	0%
Relationship counselling	3%	1%
Parenting information	26%	1%
None of the above	8%	82%

Barriers to access

To examine the barriers that prevented parents from accessing the services they needed for their children, parents were asked to select any barriers from a list of 12 (illustrated in Figure 4.1-13). Parents reported that the main reasons they were unable to access services for their children included having to wait too long for appointments, the services required were too expensive, and the services were not available. Parents were also asked to select the reasons that they could not access services for themselves (see Figure 4.1-14), and the barriers were the same as those for child services.

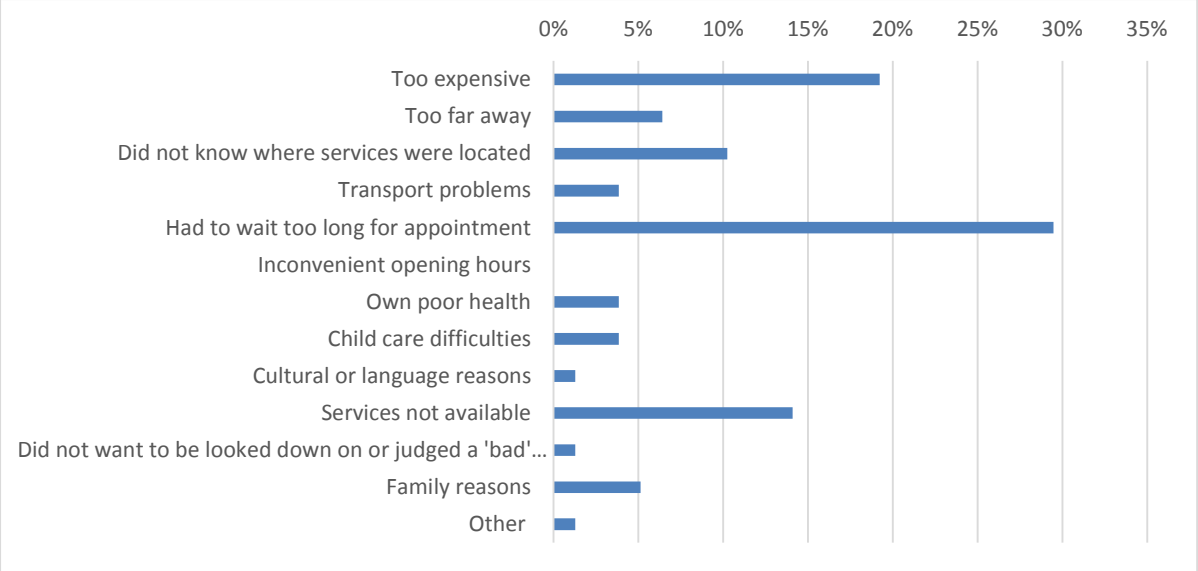

Figure 4.1-13 Reasons parents could not access child services and percentage of parents who responded in each category

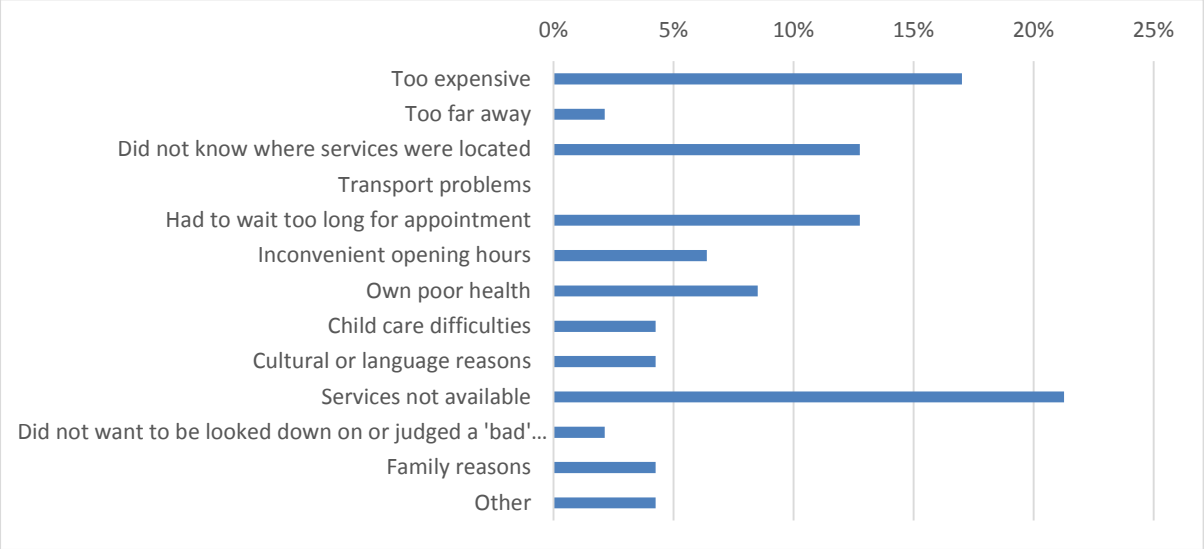

Figure 4.1-14 Reasons parents could not access family services and percentage of parents who responded in each category

Table 4.1-9, whether parents or children identified as Aboriginal appeared to somewhat increase the likelihood of not being able to access child (but not family) services. Additionally, families where parents or children identified as having a medical condition or disability appeared to have more difficulty accessing both child and family services. Similarly, families in which the child spoke a language other than English at home appeared to have a slightly increased likelihood of not being able to access child or family services. Whether the current household situation consisted of a single or two-parent structure and parent education did not appear to have much influence on being able to access child and family services. However, caution must be taken when interpreting these findings due to the small number of families in these samples.

Chi-Square Tests of Independence were conducted to determine whether there were any significant associations between service use and differing demographic characteristics. Differences were found for both use of services and access to services for two demographic groups—children with a disability and children who spoke English as a second language. In relation to service usage, children who had a disability ($p < .001$) tended to use more services and children who spoke a language other than English at home tended to use fewer services ($p = .019$).

Access to services was reported to be more difficult for families in which parents reported having a disability ($p = .002$). In families in which no parent had a disability, 2.3% reported not being able to access two or more services. In comparison, 17.2% of families where a parent had a disability reported not being able to access two or more services.

Table 4.1-9 Number and proportion of families who could and could not access child and family services across demographic characteristics

	Child Services				Family Services			
	Can access all services		Cannot access one or more		Can access all services		Cannot access one or more	
	N	%	N	%	N	%	N	%
Parent identifies as Aboriginal								
Yes	2	66.7%	1	33.3%	3	100%	0	0.0%
No	163	81.5%	37	18.5%	173	86.5%	27	13.5%
Parent has a medical condition[1]								
Yes	21	72.4%	8	27.6%	22	75.9%	7	24.1%
No	145	82.9%	30	17.1%	155	88.6%	20	11.4%
Current household situation								
Single parent	26	83.9%	5	16.1%	28	90.3%	3	9.7%
Two-parent	134	81.7%	30	18.3%	142	86.6%	22	13.4%
Parent education								
University completed	82	80.4%	20	19.6%	87	85.3%	15	14.7%
Technical, Trade, TAFE or some Uni.	48	82.8%	10	17.2%	51	87.9%	7	12.1%
Partial or completed High School	34	82.9%	7	17.1%	37	90.2%	4	9.8%
Child has a medical condition[1]								
Yes	26	76.5%	8	23.5%	25	73.5%	9	26.5%
No	139	82.2%	30	17.8%	151	89.3%	18	10.7%
Child speaks other LOTE								
Yes	24	77.4%	7	22.6%	24	77.4%	7	22.6%
No	142	82.1%	31	17.9%	153	88.4%	20	11.6%
Child identifies as Aboriginal								
Yes	5	71.4%	2	28.6%	7	100%	0	0.0%
No	160	81.6%	36	18.4%	169	86.2%	2	13.8%

Note

[1]medical condition or disability of 6 or more months

4.2. What are the facilitators and challenges for Children's Centre staff working together collectively for the benefit of children? Where do staff see their work along the integration continuum?

In focus groups and interviews, several factors, related to the way in which staff work together, were said to be facilitating or impeding integrated service provision. The way in which site leadership supported staff to work together, and also the relationships between staff that enabled information sharing and working together toward a common goal were said to be factors. Where integration was said to be working well, staff were reported to: share professional knowledge; engage in shared curriculum planning; and work collaboratively to holistically support children and families. These themes were explored further in the survey of staff, service providers, and directors.

Children's Centre team functioning

Four survey questions explored staff, service providers', and directors' perceptions of team functioning. Staff, service providers, and directors were asked to rate the extent to which they agreed or disagreed that:

1. The whole team works together toward a commonly understood goal.
2. Team members readily share information to help in the support of clients.
3. There is a high level of trust between team members.
4. There is policy and procedure in place to support the sharing and exchange of client information.

Additionally, staff and service providers were asked to rate the extent to which they agreed or disagreed that:

5. My role is understood and valued by my team mates.
6. Children's Centre team members have planned for how the roles work together.

Figure 4.2-1 and Figure 4.2-2 illustrate that the majority of respondents believed that integration was working well in Children's Centres. That is, staff shared information to support families and that they worked together toward a common goal.

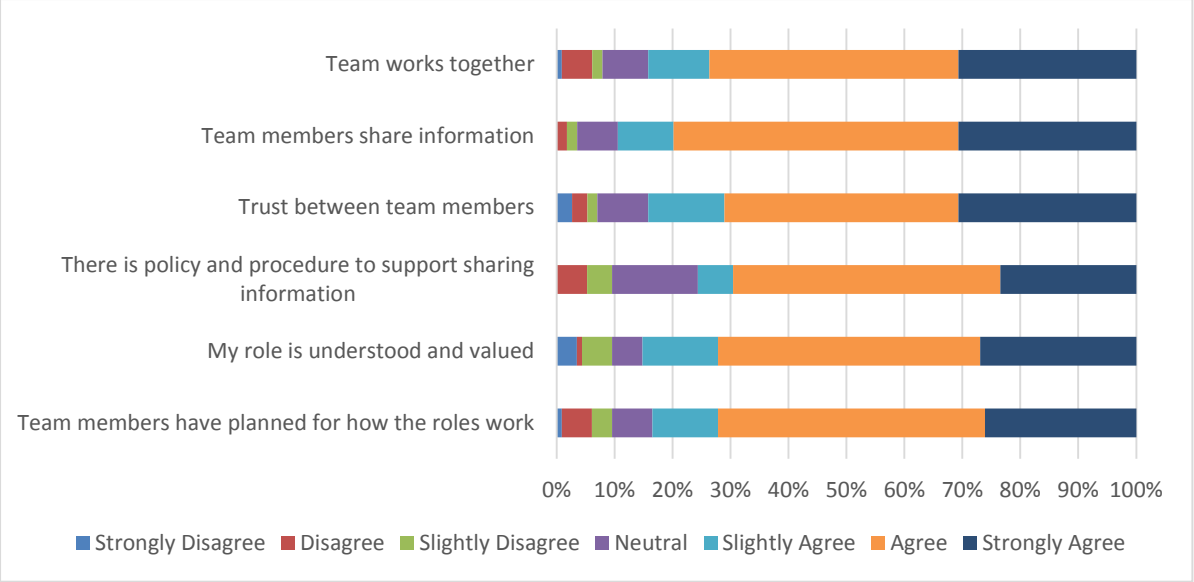

Figure 4.2-1 Staff and service provider perceptions of integration

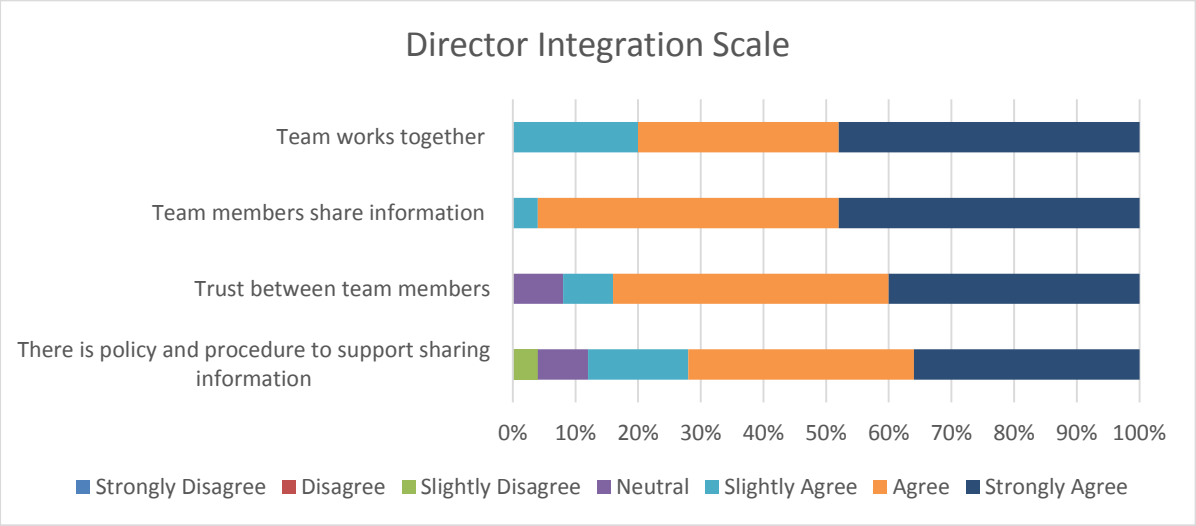

Figure 4.2-2 Director perceptions of integration

Leadership in Children's Centres

Six questions explored staff and service providers' perceptions of leadership at Children's Centres. Staff and service providers were asked to rate the extent to which they agreed or disagreed that:

1. The Children's Centre Director is accountable for how well the team works together at the Centre.
2. The Children's Centre Director has a clear vision for integrated service provision at the Centre.
3. I have a say in how I deliver services in the Centre.
4. I feel encouraged to contribute to planning activities in the Children's Centre.
5. My ideas and knowledge are valued.
6. I feel confident in sharing my professional opinions.

As illustrated in Figure 4.2-3, around four in five staff and service providers agreed or strongly agreed that the Children's Centre director was accountable for how well the team works together at the Centre and had a clear vision for integrated service provision. Staff and service providers also tended to agree or strongly agree that they had a say in how they delivered services in the Centre, that they felt encouraged to contribute to planning activities, that their ideas and knowledge were valued and that they felt confident in sharing their professional opinions.

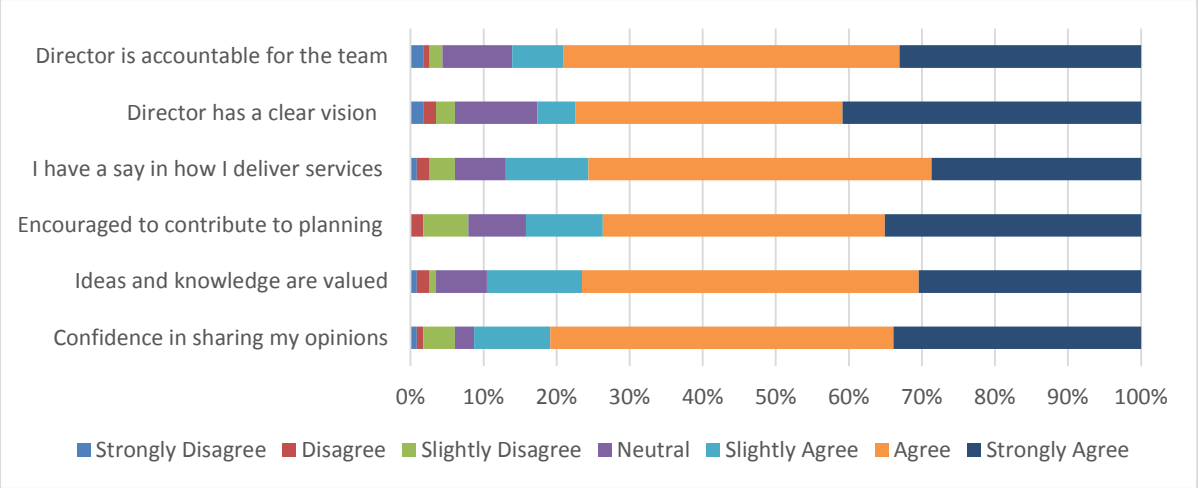

Figure 4.2-3 Staff and service provider perceptions of leadership

Three survey questions explored directors' perceptions of leadership at Children's Centres. Specifically, directors were asked to rate the extent to which they agreed or disagreed with the following:

1. My current level of authority over staff across the site is adequate for managing a multi-disciplinary team.
2. If there is a problem in the staff team at my site, I have adequate authority to impact staff behaviour.
3. I have adequate input into staffing at my site to enable me to develop a cohesive staff team.

Figure 4.2-4 indicates that the majority of directors agreed or strongly agreed that their level of authority over staff across the site was adequate for managing a multi-disciplinary team, that they had adequate authority to impact staff behaviour, and that they had adequate input into staffing at their site to enable them to develop a cohesive staff team. These findings suggest that leadership issues related to control over staffing in sites raised in focus groups and interviews are not overly pervasive.

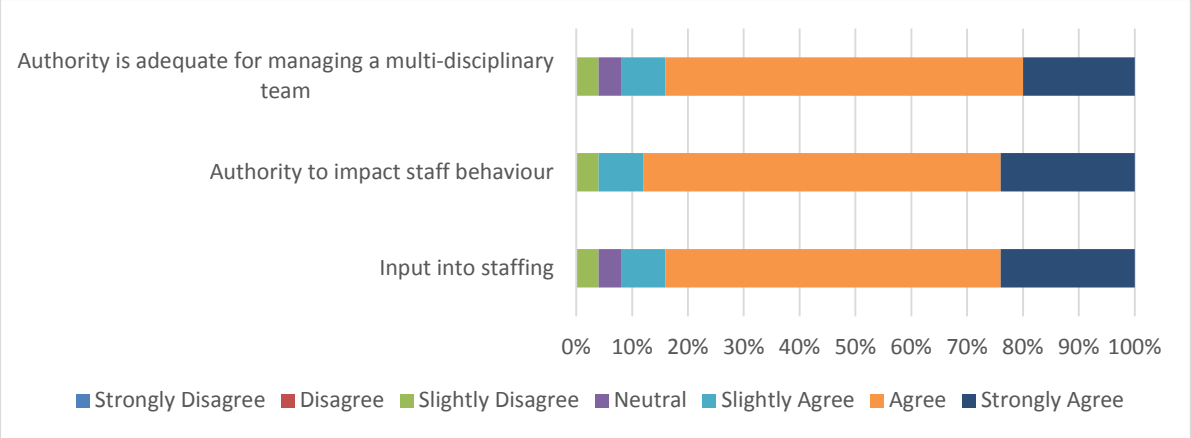

Figure 4.2-4 Director perceptions of leadership

Four questions examined directors' roles in Children's Centres. Specifically, directors were asked to report on the extent to which they agreed or disagreed with the following:

1. I was aware of the demands of the role before becoming a Director or Head of School Early Years in the Children's Centre.
2. Being a Director or Head of School Early Years in the Children's Centre is professionally rewarding.
3. The role of Director or Head of School Early Years in the Children's Centre is sufficiently resourced.
4. The role of Director or Head of School Early Years in the Children's Centre model is well understood.

Echoing the themes raised in focus groups that directors felt they had become a director of a Children's Centre before learning what that entailed, only around half of the directors surveyed agreed or strongly agreed that they were aware of the demands of the role before taking on the role (see Figure 4.2-5). Fewer still agreed that the role was sufficiently resourced. In contrast, almost all directors agreed or strongly agreed that being a Director or Head of School Early Years in the Children's Centre was professionally rewarding. While most directors agreed or strongly agreed that the role of Director or Head of School Early Years was well understood, there was less consensus that this was the case. Overall these findings suggest that opportunities exist to develop the parameters of the leadership role and purposeful recruitment of staff.

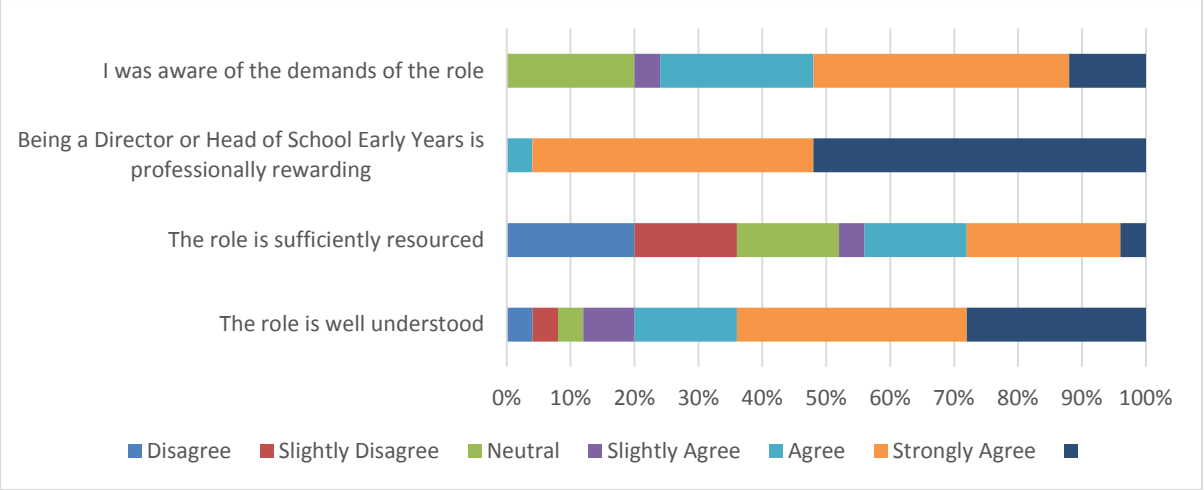

Figure 4.2-5 Director perceptions of their role in Children's Centres

Relationship between leadership and integration functioning

To explore the relationship between leadership and how well integration was working in centres, aggregated leadership and integration scores were generated for each centre. Staff and service provider rankings of how well integration was working in Centres was positively correlated to the ratings of directors (r = .430, p = .041).

Based on aggregated ratings, Centres were grouped into high or low leadership and integration groups based on the overall ratings they received from staff and service providers. Staff and service providers tended to rate how well integration was functioning in sites similarly to the directors of those sites, (r = .430, p = .041). A Chi-Square test was conducted to examine the extent to which Centre leadership ratings were related to ratings of how well integration was working at the site.

As shown in Table 4.2-1, of the 33 sites for which responses were received by staff and service providers, 13 were rated as having low leadership and 20 as having high leadership scores. Similarly, staff and service providers rated 14 Centres as having low integration and 19 as Centres where integration was working well. The majority of Centres fell in either the low-low or high-high groups, with only seven Centres being rated as high on one dimension and low on another (χ^2 = 10.45, p < .001). The same analysis conducted from the responses of directors (see Table 4.2-2), showed a similar relationship between perception and how well integration was working (χ^2 = 12.89, p < .001).

These findings indicate that leadership at a Centre level plays an integral role in the functioning of integrated sites and echoes the themes raised in focus groups. With both leadership and integration being rated as low in around one third of Centres, the opportunity to make further improvements in this area is highlighted

Table 4.2-1 Staff and service provider perceptions of leadership and integration by Children's Centres

			Integration		
			Low	High	Total
Leadership	Low	Count	10	3	13
	High	Count	4	16	20
Total			14	19	33

Table 4.2-2 Director perceptions of leadership and integration by Children's Centres

			Integration		
			Low	High	Total
Leadership	Low	Count	6	2	8
	High	Count	1	16	17
Total			7	18	25

Furthermore, as demonstrated in Table 4.2-3, where directors felt they had less control over staff, staff and service providers also tended to rate the quality of leadership less favourably. Conversely, where leadership was rated high, directors also tended to rate the adequacy of their level of control highly ($\chi^2 = 5.96$, $p = .015$).

Table 4.2-3 Director and staff and service provider perceptions of leadership by Children's Centres

			Staff and Service Provider Leadership		
			Low	High	Total
Director Leadership	Low	Count	5	2	7
	High	Count	3	13	16
Total			8	15	23

4.3. What are the processes that enable partnerships and governance groups (parent engagement, leadership, and partnership groups) to respond to community needs effectively?

The Interim report of the focus group and interview findings highlighted that there was a great deal of disparity in the functioning of governance groups in Centres and that their value and the rate at which they were considered relevant to the functioning of the sites varied. Specifically, partnership, leadership, and governance groups were not identified as being operational in each site. Where groups were operational, the composition, the role and the function of the groups was said to vary across sites. Some groups were said to work well if the members of the group saw the benefits of working in partnership. In other instances, partnership groups were said to be unproductive due to: inconsistent attendance; lack of interest from partners; or comprising partners who were not authorised to make decisions. In some sites, it seemed as though partnership groups had low levels

of participation from partners, which was limited to information sharing or consultation. In other sites, partnership groups appeared to have higher levels of participation from partners, whereby partners were engaged in shared planning, discussed data sources, shared knowledge of the community, set goals, distributed tasks, and implemented plans.

In order for the evaluation to comment on the processes that enable partnership and governance groups to meet community needs, it was necessary to first understand the extent to which these groups existed and their perceived role in the planning of services. Surveys of directors and service providers included items to measure and quantify the magnitude of these factors.

Figure 4.3-1 and Figure 4.3-2 highlight the diversity of staff, service providers' and directors' experience of governance groups. Parent engagement groups were reported most frequently as either not existing, or if they did exist, not functioning well. The findings indicate that there is opportunity to adjust the governance structures of Centres to make these both relevant and pragmatic. In focus groups and interviews the less than optimal functioning of governance groups was attributed to several issues. These included the time commitment required from group members, understandings of the function of the groups, and the value placed on the group at a Centre level. Below, we explore the extent to which the functions of the groups, as these were conceptualised for the Children's Centre model, were perceived by survey respondents.

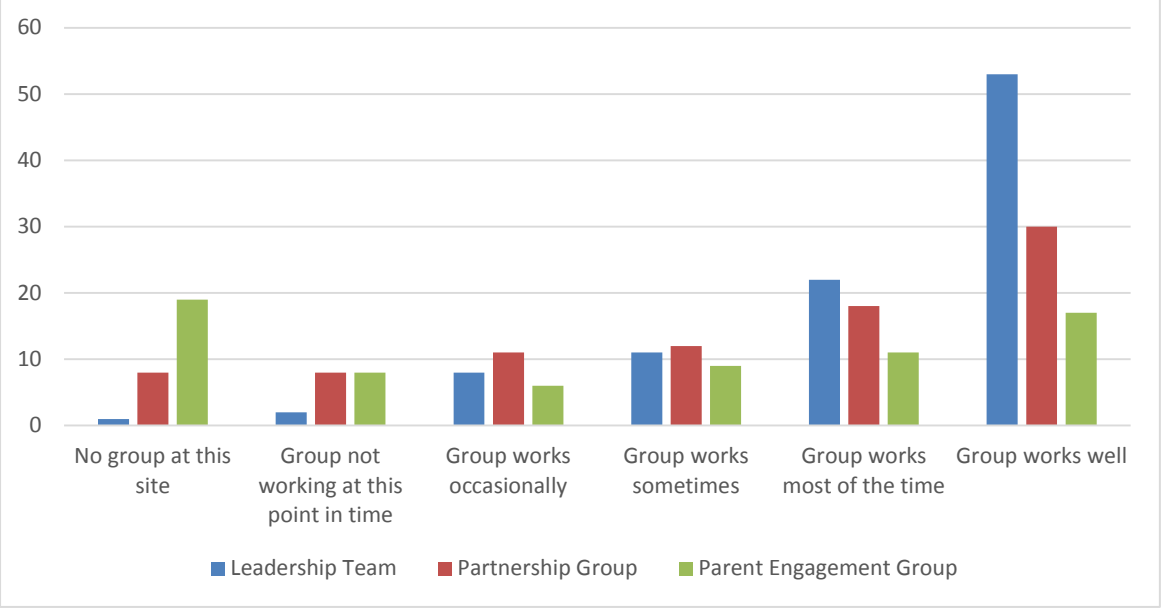

Figure 4.3-1 Staff and service provider perceptions of how well governance group work at Children's Centres

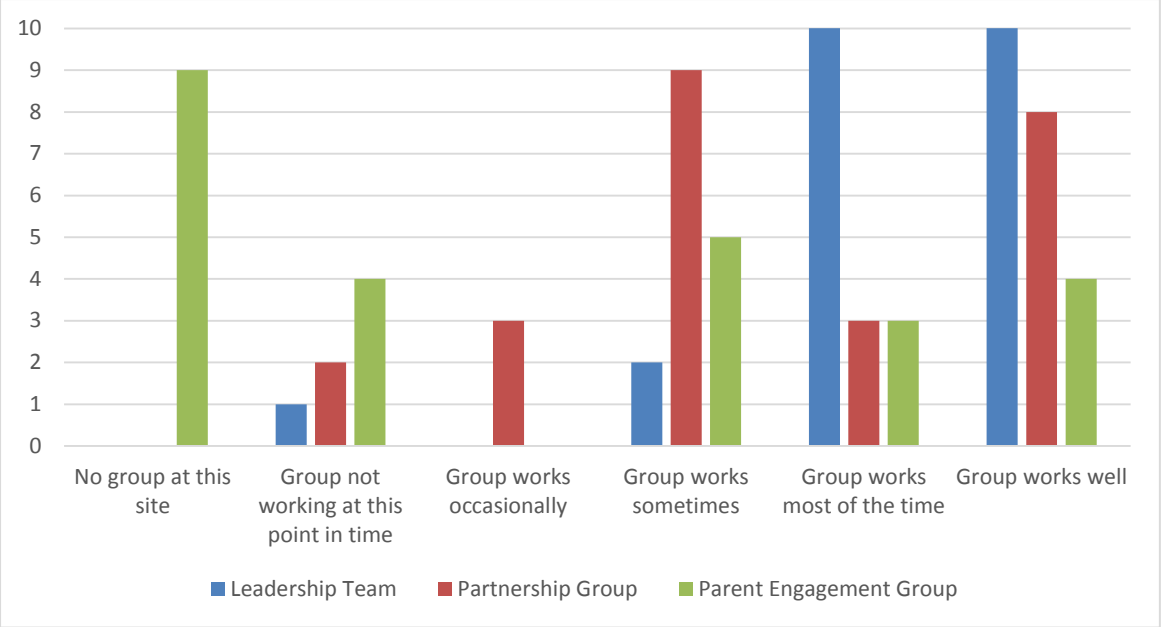

Figure 4.3-2 Director perceptions of how well governance groups work at Children's Centres

Parent engagement groups

Seven questions asked staff, service providers, and directors to report on the extent to which they agreed about the functions of the parent engagement group. These are separated in this report into 'influencing the Centre', 'engaging the community', and 'volunteering and training'.

Influencing Centre activities and directions

The parent engagement group's influence over the Centre was asked about through three survey questions. Staff, service providers, and directors were asked to indicate the extent to which they agreed or disagreed with the following functions of the parent engagement group:

1. Connects with families and the community to obtain their views.
2. Contributes to the development of the Centre's vision and values.
3. Provides advice on programs and services needed.

Overall, there was not strong agreement that the parent engagement group should help set the directions of the Centre. Figure 4.3-3 shows that just under half of staff, service providers, and directors agreed or strongly agreed that parent engagement groups should be used to connect with families and the community to obtain their views to contribute to the development of the Centre's visions and values (see Figure 4.3-4). Moreover, just over half of the staff and service providers and just under half of directors agreed or strongly agreed that parent engagement groups should be utilised to gather advice from parents about the range of services and supports that families need. However, there was a considerable degree of uncertainty for all three questions, with a large proportion of respondents neither agreeing nor disagreeing.

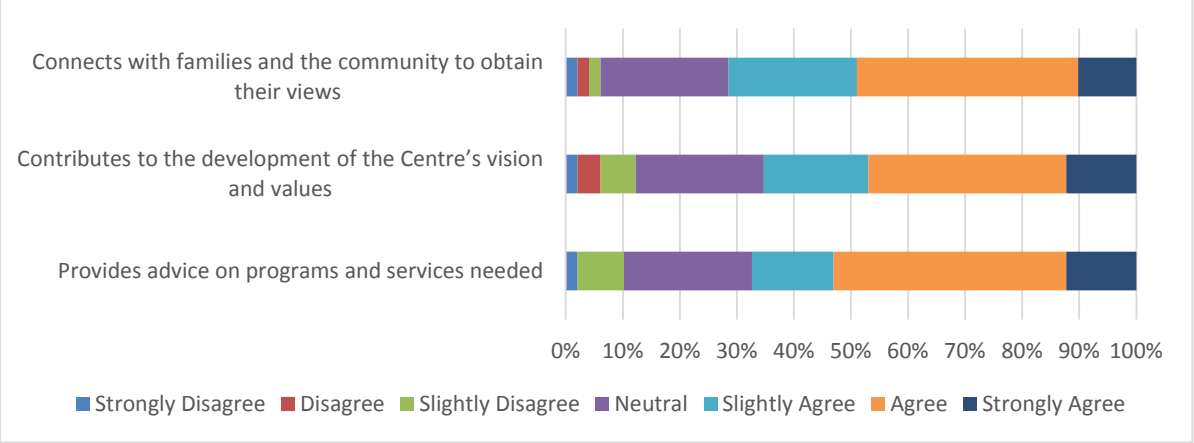

Figure 4.3-3 Staff and service provider perceptions of parent engagement groups' influence over Centres

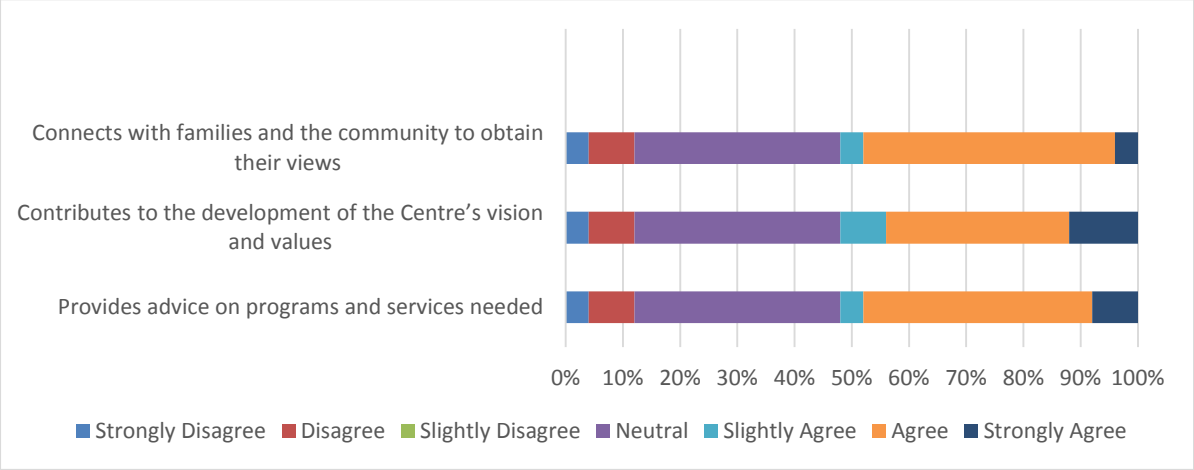

Figure 4.3-4 Director perceptions of parent engagement groups' influence over Centres

Engaging the community

Engaging the community through the parent engagement group was asked about in two ways. Firstly, staff, service providers, and directors were asked to report on the extent to which they agreed that the parent engagement group could advise on how to encourage families and communities to participate and engage in the Centre. The second question asked about the extent to which respondents agreed that the parent engagement group could be used to promote the Centre in the community.

Figure 4.3-5 and Figure 4.3-6 indicate that less than half of the staff, service providers, and directors agreed that a function of the parent engagement group was to provide advice around encouraging family and community participation. In contrast, over half of staff and service providers agreed or strongly agreed that a function of the group was to promote the Centre within the community. Similarly, directors also tended to report more agreement with this function.

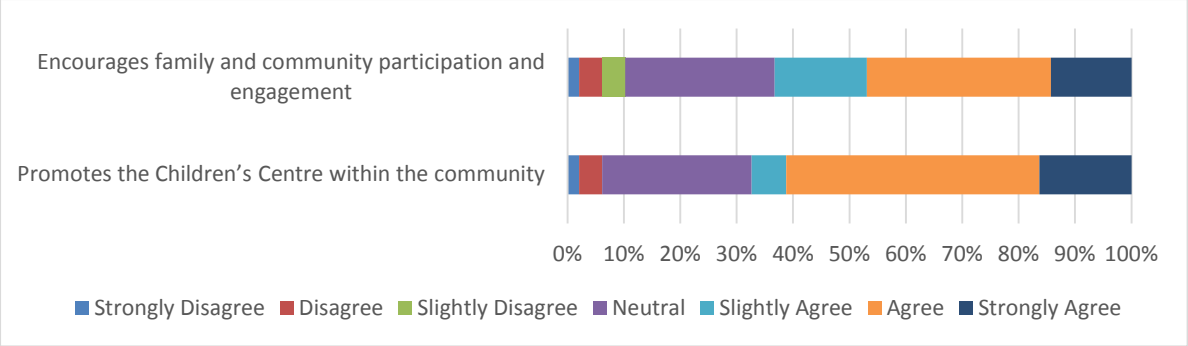

Figure 4.3-5 Staff and service provider perceptions of engaging the community through parent engagement groups

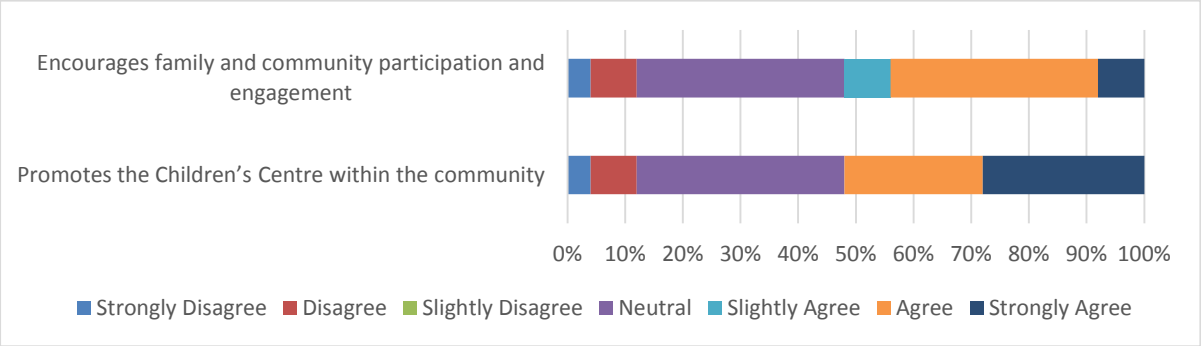

Figure 4.3-6 Director perceptions of engaging the community through parent engagement groups

Volunteering and training

The two final functions of the parent engagement group explored in the survey were volunteering and participating in training opportunities. Both these functions are ways in which Centres can contribute to capacity building in the community—that is, providing parents with opportunities to develop skills that can enhance their employment opportunities. Responses are presented in Figure 4.3-7 and Figure 4.3-8.

Overall, a minority of staff, service providers, and directors agreed that this was a function of the parent engagement group. Staff and service providers tended to agree more strongly than directors that undertaking volunteer work in Centres was a function of the parent engagement group. Similarly, few service providers, and directors agreed that participating in training opportunities was a function of the parent engagement group.

Staff, service providers, and directors were asked to rate the extent to which they agreed or disagreed about the following functions of the Parent Engagement group:

1. Undertakes volunteer work within the Centre.
2. Participates in training opportunities.

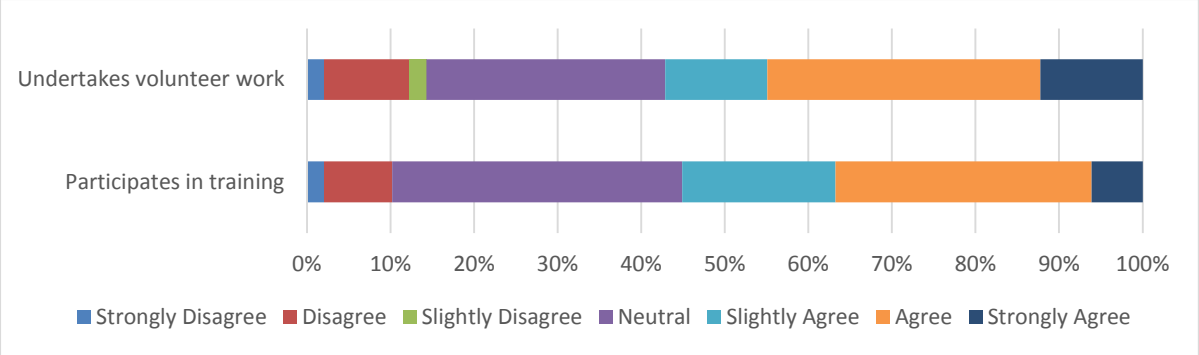

Figure 4.3-7 Staff and service provider perceptions of volunteering and training through parent engagement groups

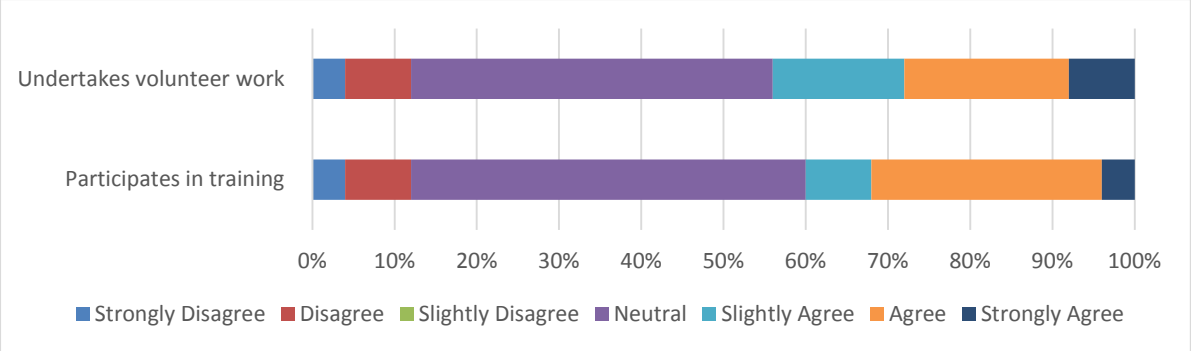

Figure 4.3-8 Director perceptions of volunteering and training through parent engagement groups

Leadership groups

Seventeen survey questions asked staff, service providers, and directors to report on the extent to which they agreed about the functions of the leadership group. These are separated in this report into 'influencing Centre activities and directions', 'operational functions', 'evaluation and monitoring' and 'information sharing'.

Influencing Centre Activities and Directions

Influencing Centre activities and directions through the leadership group was asked about through seven questions. Overall there was strong agreement that influencing Centre activities and directions was the function of the leadership group. Figure 4.3-9 and Figure 4.3-10 below present staff, service providers', and directors' responses.

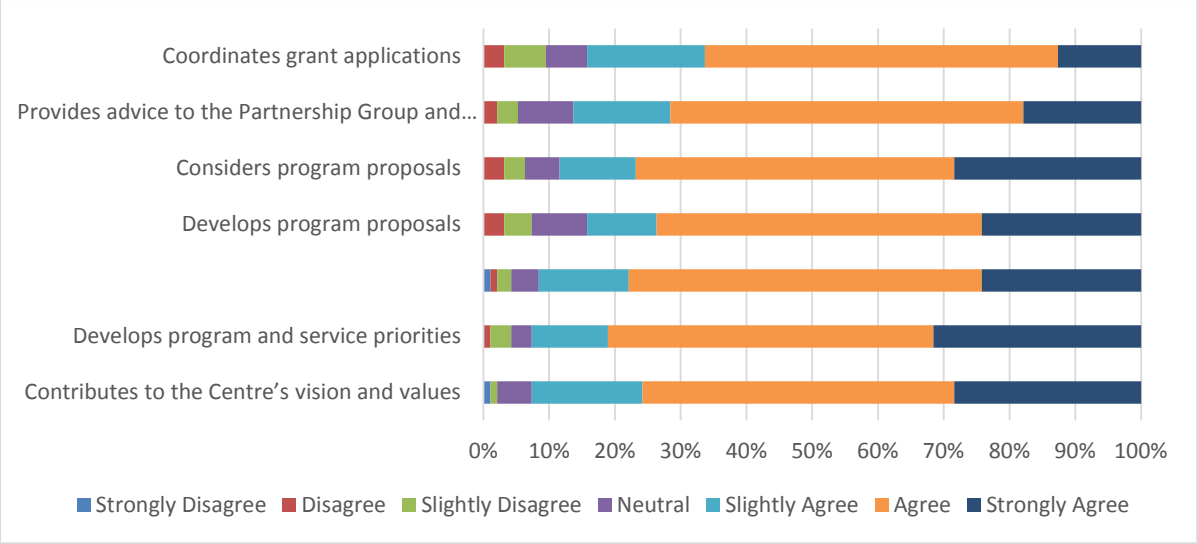

Figure 4.3-9 Staff and service provider perceptions of leadership groups' influence over Centres

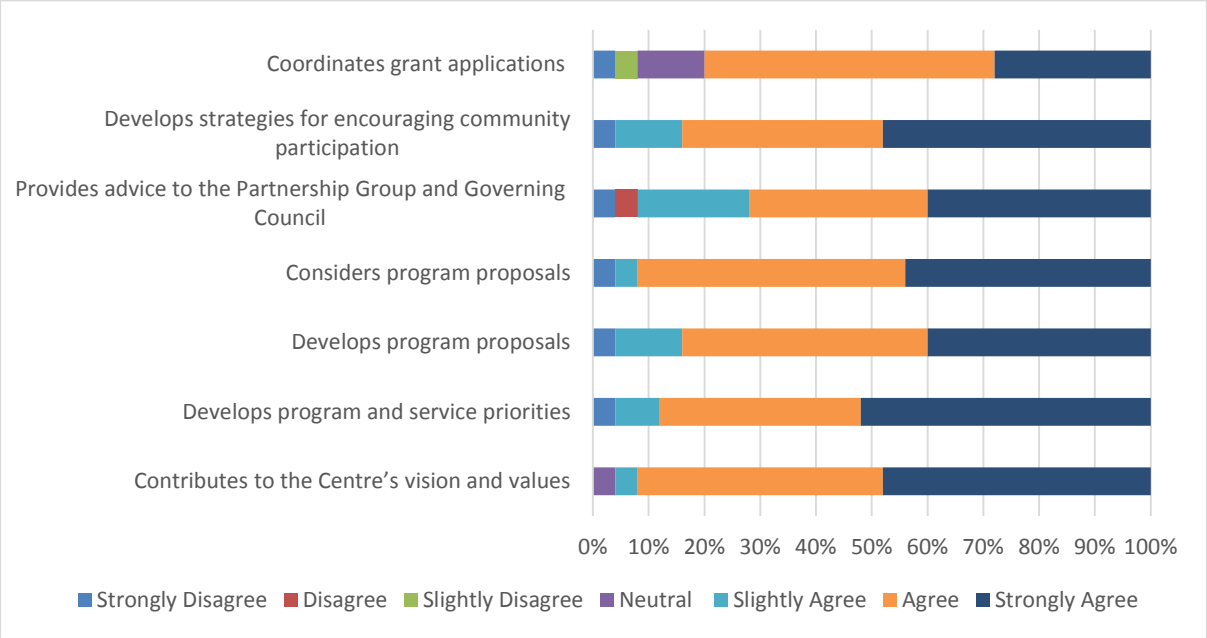

Figure 4.3-10 Director perceptions of leadership groups' influence over Centres

Operational Functions

The operational functions of the leadership team were examined through five survey questions. Figure 4.3-11 and Figure 4.3-12 present the findings. Overall, there was agreement among staff, service providers and directors with the operational functions of the leadership group.

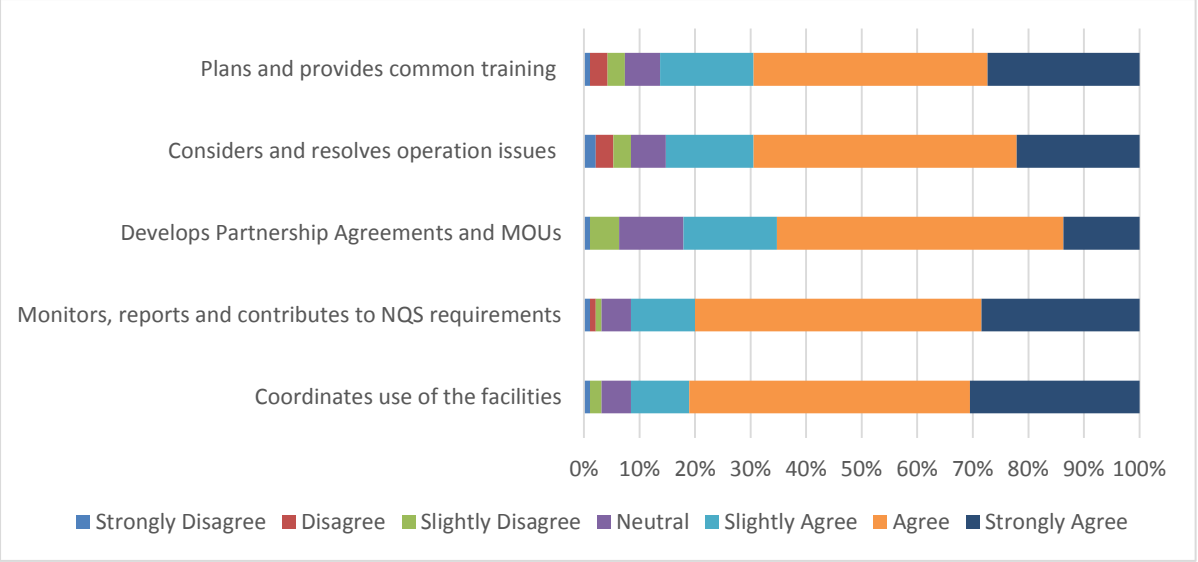

Figure 4.3-11 Staff and service provider perceptions of the operational functions of leadership groups

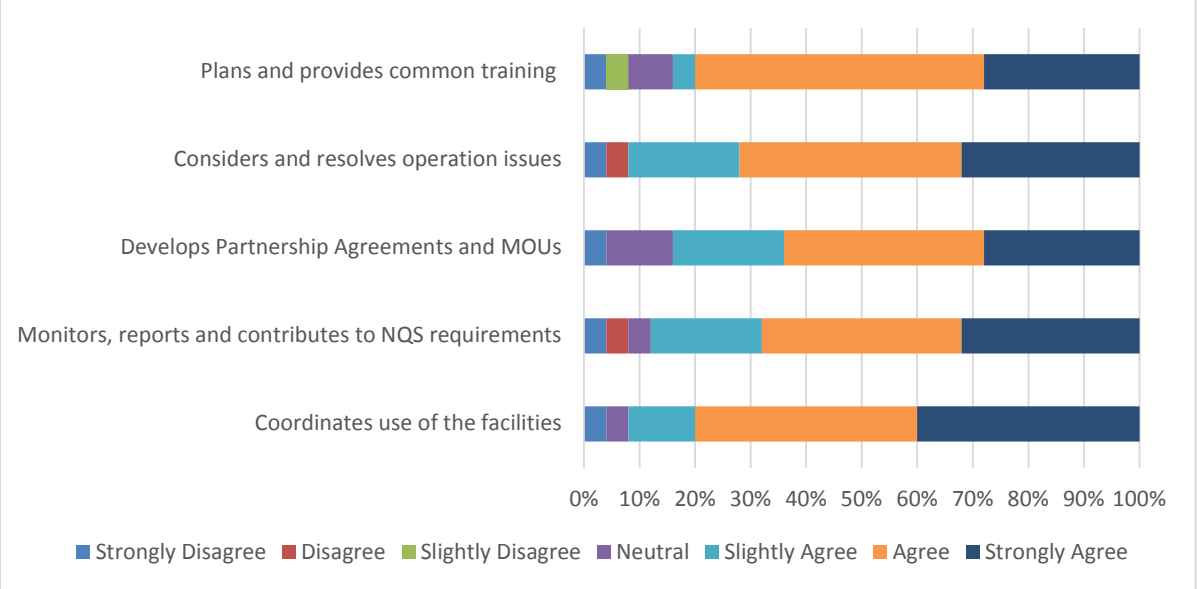

Figure 4.3-12 Director perceptions of the operational functions of leadership groups

Evaluation and monitoring

Evaluation and monitoring were asked about in three ways. Figure 4.3-13 and Figure 4.3-14 indicate that most staff service providers and directors agreed that sharing and analysing relevant data and research, monitoring service outcomes, and undertaking data collection, monitoring and reporting against agreed outcomes were functions of the leadership group.

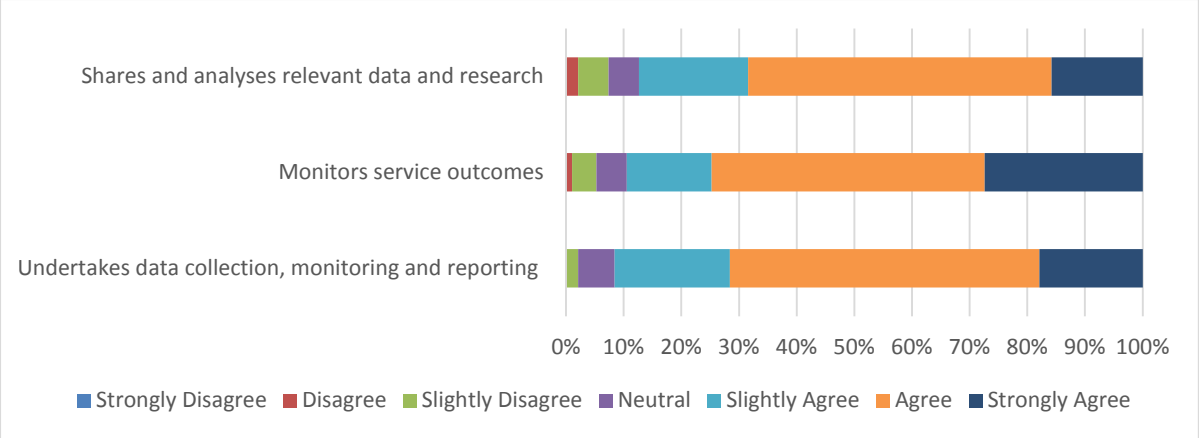

Figure 4.3-13 Staff and service provider perceptions of evaluation and monitoring through leadership groups

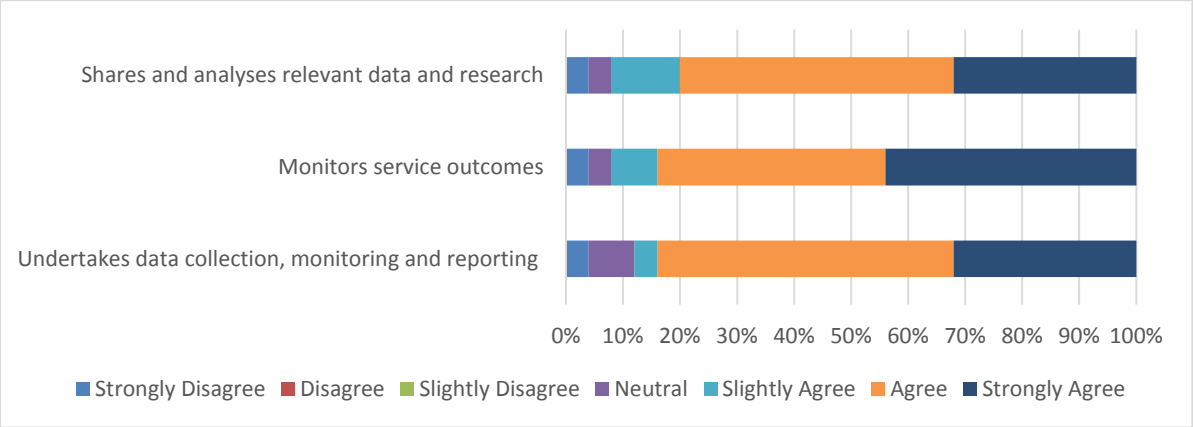

Figure 4.3-14 Director perceptions of evaluation and monitoring through leadership groups

Information Sharing

The final function of the leadership group was information sharing, which was asked about in two ways. Firstly, staff, service providers and directors were asked to report on the extent to which they agreed that the leadership team shares information about programs and practices. The second question asked about the extent to which the leadership team shares strategies and responses for individual children and families.

Staff, service provider and director responses are presented in Figure 4.3-15 and Figure 4.3-16. Again, there was agreement amongst staff and service providers, and amongst directors that information sharing was a function of the leadership group.

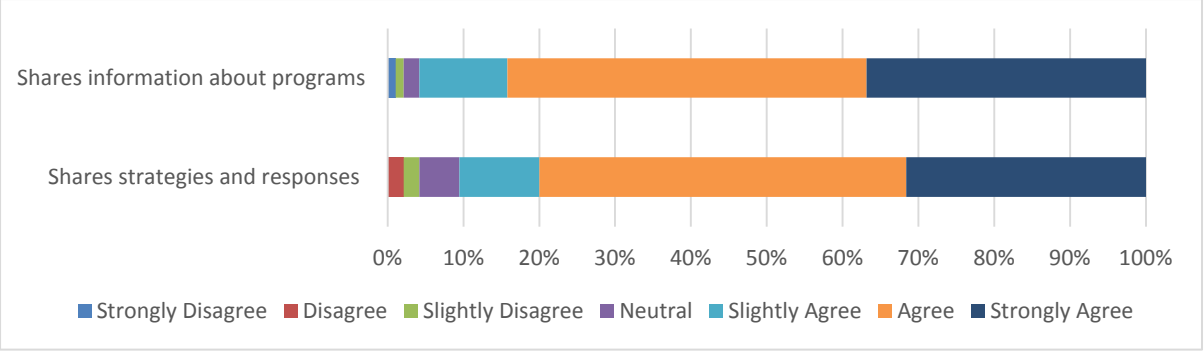

Figure 4.3-15 Staff and service provider perceptions of information sharing through leadership groups

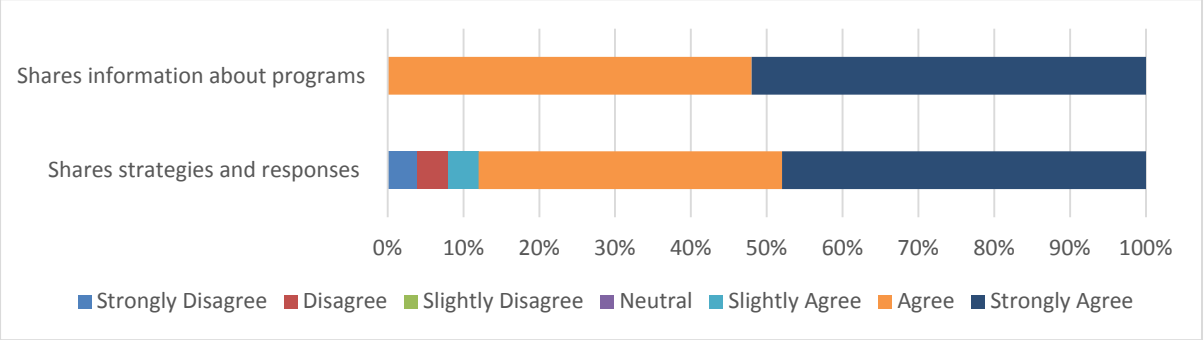

Figure 4.3-16 Director perceptions of information sharing through leadership groups

Partnership groups

Seven questions asked staff, service providers and directors to report on the extent to which they agreed about the functions of the partnership group. These are separated in this report into 'influencing centre activities and directions', 'engaging the community' and 'evaluation and monitoring'.

Influencing Centre Activities and Directions

Influencing Centre activities and directions through the partnership group was asked about through four survey questions. Staff, service providers, and directors were asked to rate the extent to which they agreed the following statements were functions of the partnership group:

1. Contributing to Centre planning.
2. Ensuring research and best practice underpin advice and directions.
3. Coordinating agency activities and services in response to community needs.
4. Developing Children's Centre visions and values.

Figure 4.3-17 and Figure 4.3-18 indicate that there were staff, service providers and directors who did not consistently agree that influencing Centre activities and direction was a function of the partnership group.

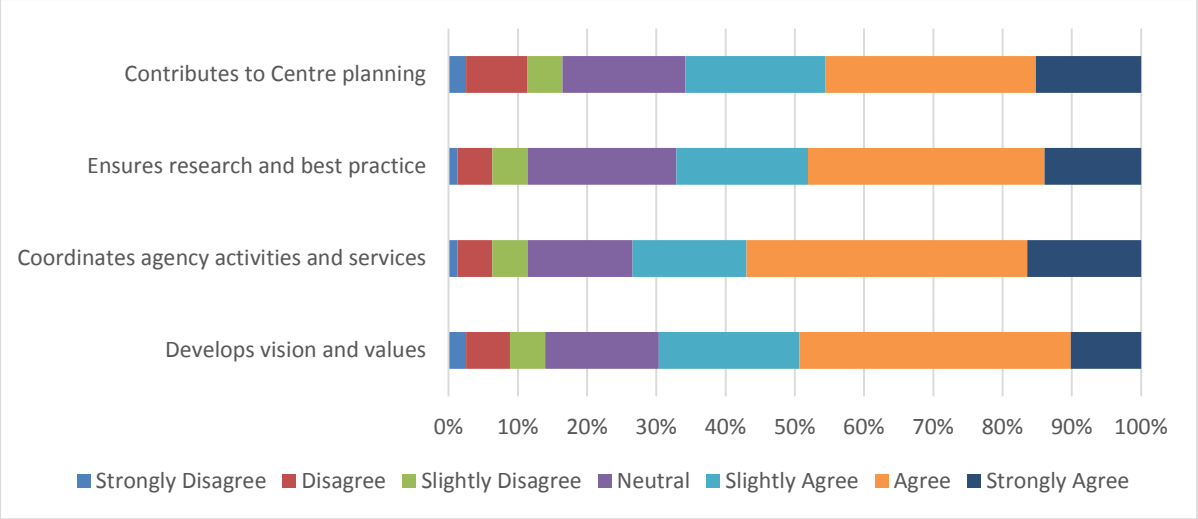

Figure 4.3-17 Staff and service provider perceptions of partnership groups' influence over Centres

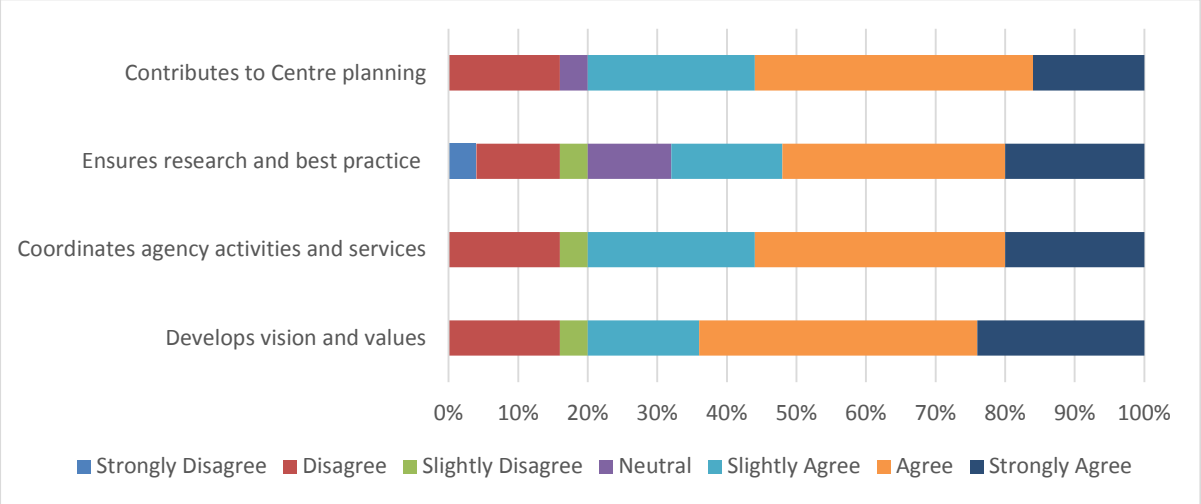

Figure 4.3-18 Director perceptions of partnership groups' influence over Centres

Engaging the Community

Engaging the community was asked about in two ways. Firstly, staff, service providers and directors were asked to report on the extent to which they agreed or disagreed that the partnership group identifies opportunities for collaborative action. The second question asked about the extent to which respondents agreed or disagreed that the partnership group establishes and monitors community consultation in the Centre. Figure 4.3-19 and Figure 4.3-20 indicate that there was not a consistent view that engaging the community was a function of the partnership group.

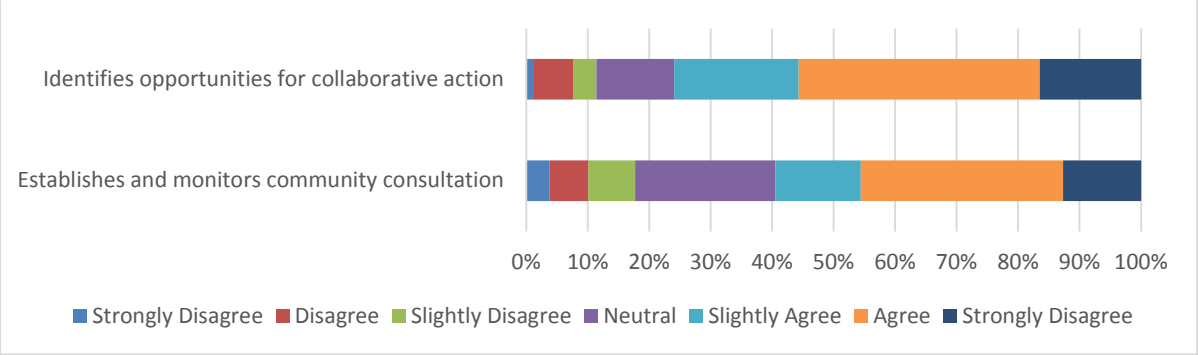

Figure 4.3-19 Staff and service provider perceptions of engaging the community through partnership groups

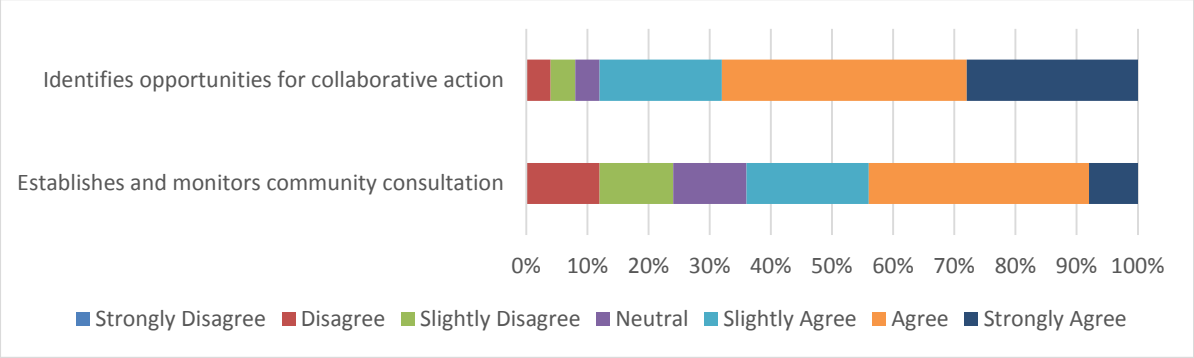

Figure 4.3-20 Director perceptions of engaging the community through partnership groups

Evaluation and Monitoring

The final function of the partnership group, evaluation and monitoring, was asked about through one question. Staff, service providers and directors were asked to report on the extent to which they agreed or disagreed that considering reports on programs and monitoring outcomes was the function of the partnership group. Figure 4.3-21 and Figure 4.3-22 indicate that staff, service providers and directors did not consistently agree that partnership groups should be involved in evaluation and monitoring.

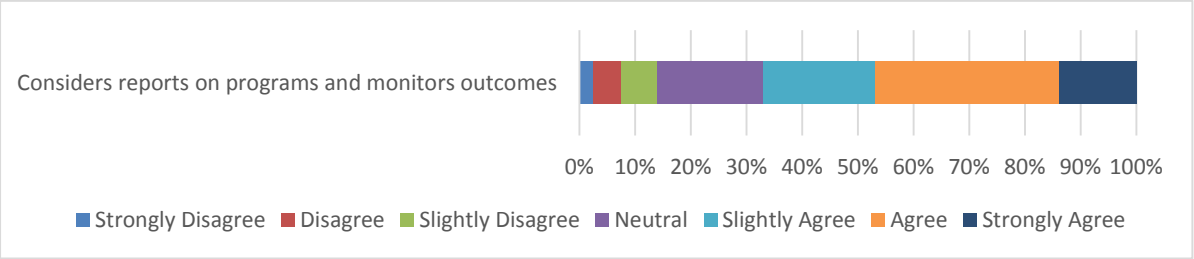

Figure 4.3-21 Staff and service provider perceptions of evaluation and monitoring through partnership groups

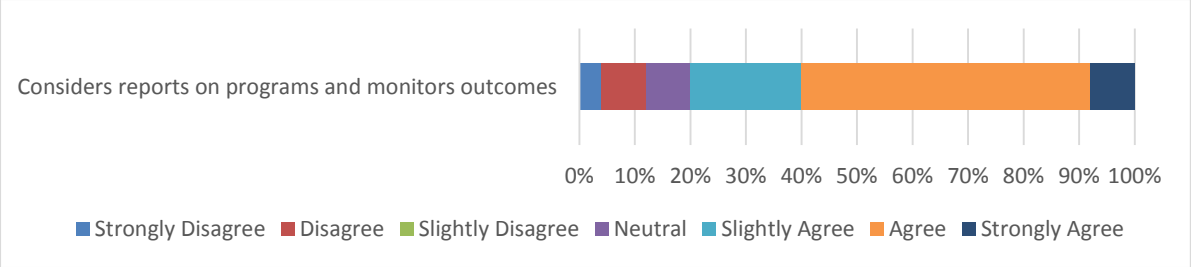

Figure 4.3-22 Director perceptions of evaluation and monitoring through partnership groups

Summary of governance group findings

Taken together, these findings indicate that an opportunity exists to further develop the functions of governance groups and negotiate a governance structure that can operationalise the vision of Children's Centres.

4.4. How does the mix of services and programs available to families differ across Children's Centres?

In 4.1 we presented the EYS data that showed the range of services available through Children's Centres. Here we present the extent to which service availability varied across sites.

Figure 4.4-1 and Figure 4.4-2 illustrate variation in the number and range of programs at the centre level; the first for the number of programs available and the second for the number of program types available. A great deal of variation is evident, with some centres offering both a large range of service types and many programs, while others offered few programs and/or a small range of program types.

Analyses of the EYS data demonstrated that overall there was little variation from term to term in both the range and number of programs offered in Children's Centres. Nevertheless, for a few Centres there was large variation over time. For example, centres at John Hartley and Gawler offered far more programs in Term 1 2016 than in either Term 4 2015 or Term 2 2016. For both these Centres, the range of program types remained steady across two terms, with the number of programs offered spiking only in Term 1 2016. Similar, but smaller spikes in number of programs were evident for several other centres. This may have been related to a hive of activity at the start of a new school year. Table 4.1-1 shows that a greater number of programs across all program types were available in Term 1 (refer to 4th column in the table).

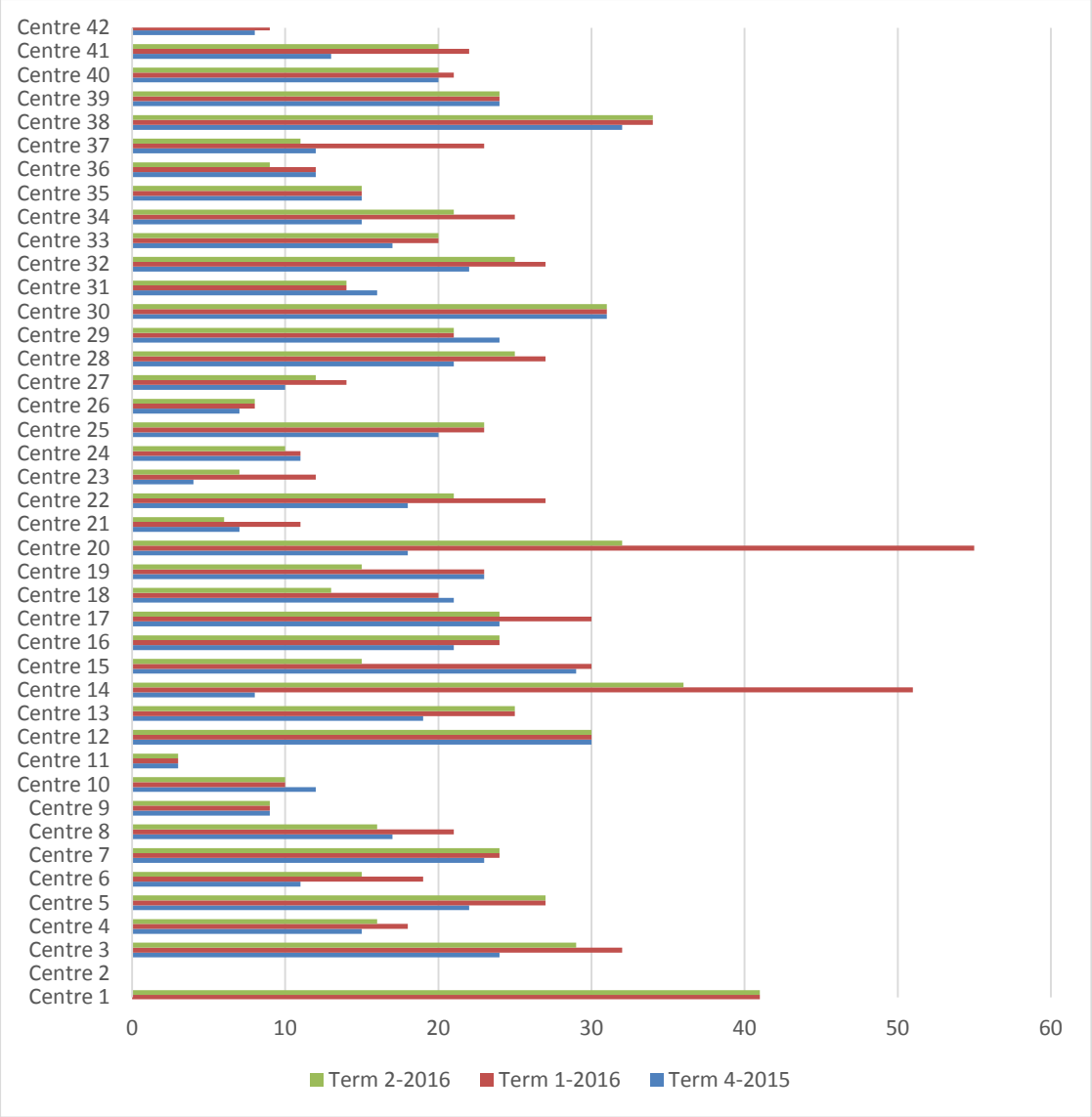

Figure 4.4-1 Number of programs offered in each Children's Centre taken from three terms of EYS administrative data

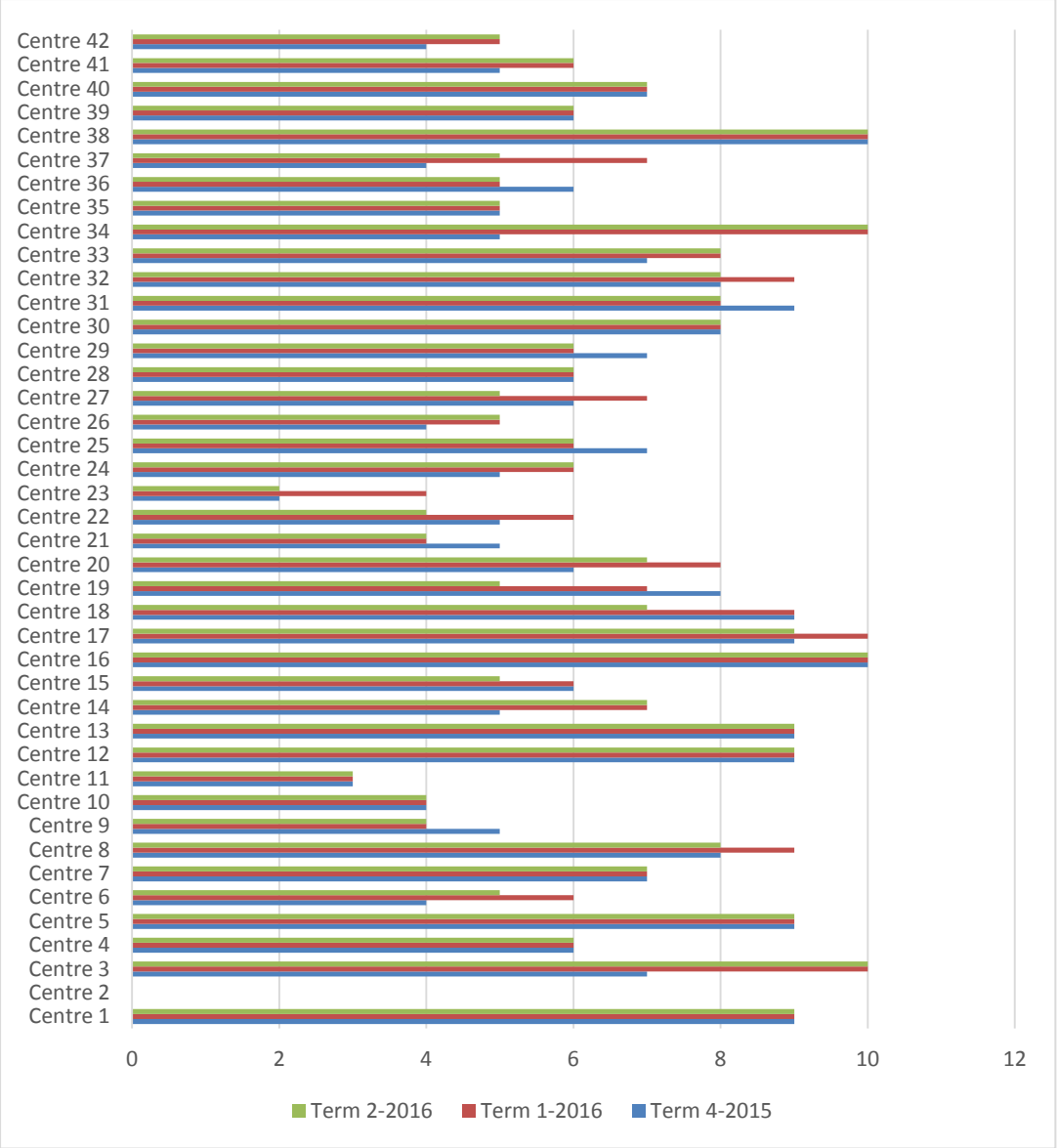

Figure 4.4-2 Number of program types offered in each Children's Centres taken from three terms of EYS administrative data

4.5. Who is accessing services and supports in Children's Centres (reach) and how much support are they receiving (dose)?

Survey data from parent report and the EYS administrative data were utilised to examine service usage in Children's Centres. In the present evaluation, neither data set could be used to accurately assess reach and dose—administrative data was not consistently collected and entered into the EYS and the survey was not designed to measure reach or dose. Instead, data are presented here to examine service usage patterns and differential service use for population groups. Analyses are presented separately for children and parent service use. With sufficient data collection, service usage data will be able to be linked to other education, health and child protection data to measure the impact of dose on children's outcomes. Moreover, more reliable data collection will enable

Centres to determine whether there are groups in the community who may be under-represented in Children's Centre service use.

Service utilisation—parent report

Parents who completed the survey were asked what services they first used in a Children's Centre. This information was gathered to gain a better understanding of the way in which parents came to utilise Centres. Parents were also asked what additional services they had used in Centres. Figure 4.5-1 shows that parents most frequently reported utilising universal services, such as preschool, long day care, playgroup, and occasional care first, but also subsequently.

Targeted supports such as parenting programs, family services, and allied health were less frequently reported and were very rarely reported as the first service families used. Child youth health nurse was also infrequently reported as a service used first or subsequently. Just over one in four respondents reported using no other services in a Children's Centre.

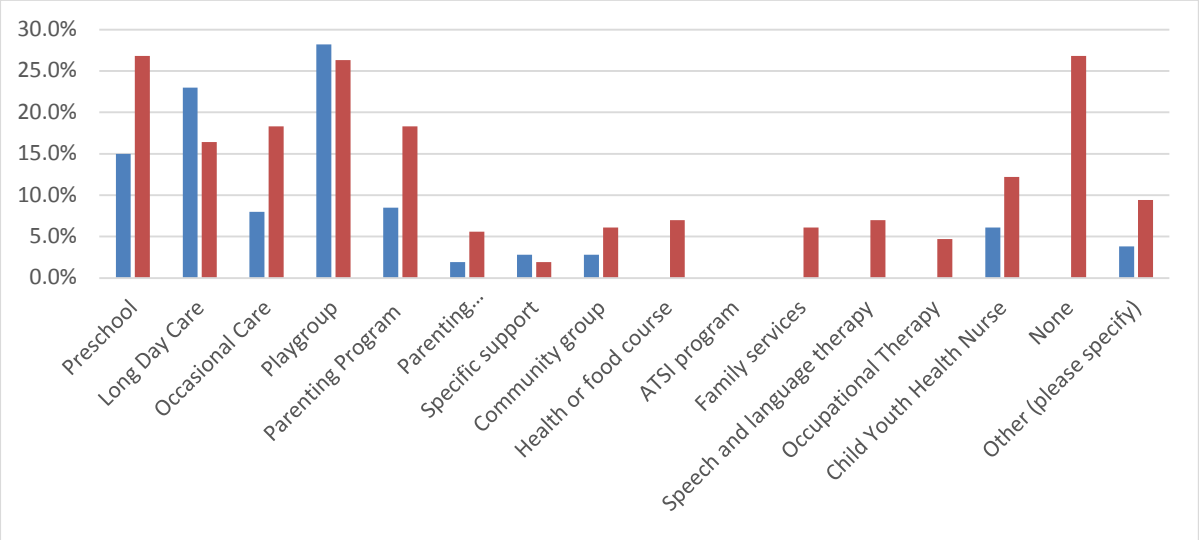

Figure 4.5-1 Parent reports of services used in Children's Centres

Children

The EYS administrative data was used to explore services accessed by children, how this differed across demographic groups, ages of children attending programs, and the extent to which children were enrolled in multiple programs. Caution should be taken in drawing conclusions from this early administrative data, given the amount of missing data and resultant small sample sizes in some population groups.

Table 4.5-1 presents enrolment data for children for each of the three data collection terms and in relation to the program type. Education and care services were most heavily recorded. Additional FCP data suggests other services were used by fewer than 15% of children enrolled in Centres. This figure does not correspond with survey data where parents reported much higher use of FCPs in Centres. This discrepancy is likely to have resulted from a dearth of data being collected and entered about FCP use. Another possible, but less likely explanation is that survey respondents were over

representative of families using FCP programs (i.e. families only using education and care services were under-represented among survey respondents).

Table 4.5-1 Number and percentage of children enrolled in programs for each of the three data collection terms

	2015 - Term 4		2016 - Term 1		2016 - Term 2	
	N	%	N	%	N	%
Preschool	2533	53.9%	2352	51.4%	2412	49.4%
Occasional Care	1177	25.0%	1010	22.1%	1032	21.1%
Supported Playgroup	365	7.8%	608	13.3%	771	15.8%
Preschool Support Programs	310	6.6%	218	4.8%	233	4.8%
Playgroup	54	1.1%	93	2.0%	140	2.9%
Parenting Program	60	1.3%	69	1.5%	56	1.1%
Targeted Support Group	48	1.0%	65	1.4%	57	1.2%
Parenting Support Services	42	.9%	39	.9%	44	.9%
Aboriginal Focussed Support	30	.6%	34	.7%	35	.7%
Targeted Playgroup	20	.4%	25	.5%	34	.7%
Community Group	17	.4%	24	.5%	34	.7%
Bus Service	32	.7%	8	.2%	8	.2%
Health	9	.2%	15	.3%	20	.4%
Family Support	4	.1%	20	.4%	9	.2%

Notes

[1] Children can be enrolled in multiple programs, so a total has not been provided

[2] The following programs have been combined (Playgroup and Community/Parent Led Playgroup into Playgroup; Inclusive Preschool Program, Preschool Speech and Language, Preschool Support Program and Preschool Bilingual Program into Preschool Support Programs)

[3] A small number of children were enrolled into "adult learning" programs, and these records were excluded from the table

[4] The Learning Together program has been excluded from this list

To examine the range of FCPs utilised for children based on their age, three age groups were created—0–2 years, 3–4 years, and 5+ years. As shown in Table 4.2-2, children aged 0–2 years tended to be enrolled most frequently in occasional care and supported playgroups. The pattern of enrolment varied only in that supported playgroup attendance appeared to reduce for the 3–4-year-old group. Again, a dearth of data collected about children's FCP use means that this data should be considered preliminary and interpreted with caution.

Table 4.5-2 Number of children of different ages enrolled in programs

	Child—Age group		
	0-2 years	3-4 years	≥ 5
Family Support	5	4	0
Health	11	9	0
Bus Service	0	7	1
Community Group	17	17	0
Targeted Playgroup	21	11	2
Aboriginal Focussed Support	20	15	0
Parenting Support Services	20	21	1
Targeted Support Group	32	18	3
Parenting Program	38	18	0
Playgroup	72	68	0
Preschool Support Programs	0	224	9
Supported Playgroup	540	228	1
Occasional Care	519	512	1
Preschool	27	2338	47

Notes

1 Children can attend multiple programs

2 The Learning Together program has been excluded from this list

3 The following programs have been combined (Playgroup and Community/Parent Led Playgroup into Playgroup; Inclusive Preschool Program, Preschool Speech and Language, Preschool Support Program and Preschool Bilingual Program into Preschool Support Programs)

Additional analyses were conducted to explore the demographic characteristics of children utilising programs in Centres. Demographic distributions in Centres were compared to the South Australian distributions to examine the extent to which children attending Centres are representative of all children in SA. Compared to SA population distributions, children attending Centres tended to live in more disadvantaged areas, come from an Aboriginal background, and live in remote areas of the state (see Table 4.5-3). Children from culturally and linguistically diverse (CALD) backgrounds appeared to be under represented in the group of children attending a Children's Centre.

Table 4.5-3 Number and proportion of child characteristics in the EYS system over three terms

		N	%	SA %*
Child—Age group	0-2 years	3655	25.2%	-
	3- 4 years	9520	65.6%	-
	> 5	1345	9.3%	-
Child—Gender	F	6916	47.6%	48.6%
	M	7624	52.4%	51.4%
Child—Aboriginal status	Yes	1774	13.2%	5.3%
	No	11648	86.8%	94.7%
Child—Culturally and Linguistically Diverse (CALD)	No	12148	83.5%	80.9%

		N	%	SA %*
	Yes	2392	16.5%	19.1%
CHILD—GUARDIAN OF THE MINISTER (GOM) STATUS	No	13399	98.4%	-
	Short Term	87	0.6%	-
	Until 18	137	1.0%	-
SEIFA IRSAD QUINTILE WITHIN AUSTRALIA	Most Disadvantaged	5660	38.9%	24.5%
	2	4526	31.1%	23.7%
	3	2478	17.0%	18.7%
	4	1456	10.0%	18.8%
	Most Advantaged	417	2.9%	13.9%
REMOTENESS LEVEL—BASED ON POSTCODE	Major Cities of Australia	11138	76.6%	72.1%
	Inner Regional Australia	726	5.0%	10.3%
	Outer Regional Australia	1518	10.4%	13.4%
	Remote Australia	576	4.0%	3.1%
	Very Remote Australia	582	4.0%	1.2%

Notes

[1] Characteristics of the 7,821 children in the EYS system over the three terms.

*SA population distributions were generated from the 2015 Australian Early Development Census data. Data not captured in the Census is indicated with a -.

Focus group and interview participants reported that once families were engaged with a Children's Centre, staff sought to support them to connect with a range of services. Analyses of the EYS data were conducted to examine the extent to which children were connected to multiple supports and services. Table 4.5-4 illustrates that the vast majority of children were enrolled for a single service during a term in a Children's Centre, with few children making use of multiple services.

Table 4.5-4 Number of children attending one or multiple programs across the three term collection times

		N	%
2015—TERM 4	1 program	4148	93.3
	2 programs	259	5.8
	3–5 programs	38	.9
	Total	4445	100.0
2016—TERM 1	1 program	3967	92.3
	2 programs	284	6.6
	3–5 programs	47	1.1
	Total	4298	100.0
2016—TERM 2	1 program	4196	91.0
	2 programs	369	8.0
	3-5 programs	45	1.0
	Total	4610	100.0

To examine the extent to which service usage differed for population groups, demographic characteristics of children attending programs were further explored in relation to whether the program was a universal service or targeted support. Table 4.5-5 and Table 4.5-6 present this data with cases of over representation highlighted in grey and cases of under representation highlighted in yellow.

Caution should be taken in drawing conclusion from this data, especially where there were small numbers of children recorded as using services. For universal services, boys tended to be over represented in health service utilisation in Children's Centres. Aboriginal children had higher rates of preschool and health service usage when compared to the composition of the population. With the exception of playgroup, families living in areas with high socio-demographic disadvantage were more highly represented in universal service usage data.

Targeted supports tended to be more heavily utilised by parents of girls, families living in less socio-economically disadvantaged suburbs, and families who are from English speaking backgrounds. There was mixed representation in service usage data for families living in regional and remote regions, with some services more heavily utilised and others underutilised.

No population comparisons could be drawn for children under the Guardianship of the Minister (GOM). However, overall these children tended to have low reported universal service use—most children enrolled only in preschool with several of these receiving preschool supports.

Although caution should be taken in drawing conclusions from this data—given small numbers of cases in some instances—it appears that some groups in the community are less likely to access both universal services and targeted supports.

Table 4.5-5 Characteristics of children who attend different types of universal programs

		Community Group		Health		Occasional Care		Playgroup		Preschool		
		N	%	N	%	-	%	N	%	N	%	SA %*
Child - Age group	0-2 years	17	50.0%	11	55.0%	519	50.3%	72	51.4%	27	1.1%	-
	3-4 years	17	50.0%	9	45.0%	512	49.6%	68	48.6%	2338	96.9%	-
	> 5	0	.0%	0	.0%	1	.1%	0	.0%	47	1.9%	-
Child - Gender	F	17	50.0%	8	40.0%	472	45.7%	64	45.7%	1162	48.2%	48.6%
	M	17	50.0%	12	60.0%	560	54.3%	76	54.3%	1250	51.8%	51.4%
Child - Aboriginal status	Yes	0	.0%	9	56.3%	65	6.6%	2	2.1%	419	17.7%	5.3%
	No	22	100.0%	7	43.8%	927	93.4%	95	97.9%	1947	82.3%	94.7%
Child - Culturally and Linguistically Diverse (CALD)	No	22	64.7%	20	100.0%	798	77.3%	122	87.1%	2071	85.9%	80.9%
	Yes	12	35.3%	0	.0%	234	22.7%	18	12.9%	341	14.1%	19.1%
Child - Guardian of the Minister (GOM) status	No	22	100.0%	16	100.0%	1004	99.5%	97	100.0%	2361	98.0%	-
	Short Term	0	.0%	0	.0%	4	.4%	0	.0%	19	.8%	-
	Until 18	0	.0%	0	.0%	1	.1%	0	.0%	29	1.2%	-
SEIFA IRSAD Quintile within State or Territory	Most Disadvantaged	4	11.8%	16	80.0%	413	40.0%	16	11.4%	953	39.5%	24.5%
	2	10	29.4%	2	10.0%	268	26.0%	9	6.4%	614	25.5%	23.7%
	3	3	8.8%	0	.0%	105	10.2%	13	9.3%	264	10.9%	18.7%
	4	16	47.1%	2	10.0%	181	17.5%	75	53.6%	489	20.3%	18.8%
	Most Advantaged	1	2.9%	0	.0%	65	6.3%	27	19.3%	92	3.8%	13.9%
Remoteness level - based on postcode	Major Cities of Australia	29	85.3%	4	20.0%	821	79.6%	117	83.6%	1866	77.4%	72.1%
	Inner Regional Australia	1	2.9%	0	.0%	56	5.4%	0	.0%	162	6.7%	10.3%
	Outer Regional Australia	2	5.9%	10	50.0%	72	7.0%	22	15.7%	269	11.2%	13.4%
	Remote Australia	0	.0%	0	.0%	54	5.2%	0	.0%	40	1.7%	3.1%
	Very Remote Australia	2	5.9%	6	30.0%	29	2.8%	1	.7%	75	3.1%	1.2%

Note *Census data collected in the AEDC

Table 4.5-6 Characteristics of children who attend different types of targeted programs

		Aboriginal Focussed Support		Parenting Program		Parenting Support Services		Preschool Support Programs		Supported Playgroup		Targeted Playgroup		Targeted Support Group	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%
Age group	0-2 years	20	57.1%	38	67.9%	20	47.6%	0	.0%	540	70.2%	21	61.8%	32	60.4%
	3-4 years	15	42.9%	18	32.1%	21	50.0%	224	96.1%	228	29.6%	11	32.4%	18	34.0%
	> 5	0	.0%	0	.0%	1	2.4%	9	3.9%	1	.1%	2	5.9%	3	5.7%
Gender	F	18	51.4%	34	60.7%	25	56.8%	100	42.9%	393	51.0%	17	50.0%	24	42.1%
	M	17	48.6%	22	39.3%	19	43.2%	133	57.1%	378	49.0%	17	50.0%	33	57.9%
Aboriginal status	Yes	20	62.5%	0	.0%	3	7.3%	43	18.5%	18	3.2%	0	.0%	0	.0%
	No	12	37.5%	42	100.0%	38	92.7%	189	81.5%	538	96.8%	26	100.0%	37	100.0%
CALD	No	35	100.0%	51	91.1%	41	93.2%	136	58.4%	664	86.1%	33	97.1%	49	86.0%
	Yes	0	.0%	5	8.9%	3	6.8%	97	41.6%	107	13.9%	1	2.9%	8	14.0%
GOM status	No	32	100.0%	40	95.2%	39	92.9%	222	95.3%	564	99.1%	26	100.0%	37	100.0%
	Short Term	0	.0%	1	2.4%	3	7.1%	1	.4%	4	.7%	0	.0%	0	.0%
	Until 18	0	.0%	1	2.4%	0	.0%	10	4.3%	1	.2%	0	.0%	0	.0%
SEIFA	Most Disadvantaged	25	71.4%	20	35.7%	7	15.9%	118	50.6%	259	33.6%	3	8.8%	15	26.3%
	2	9	25.7%	10	17.9%	11	25.0%	56	24.0%	199	25.8%	5	14.7%	18	31.6%
	3	0	.0%	8	14.3%	7	15.9%	29	12.4%	143	18.5%	3	8.8%	12	21.1%
	4	1	2.9%	11	19.6%	19	43.2%	28	12.0%	109	14.1%	9	26.5%	4	7.0%
	Most Advantaged	0	.0%	7	12.5%	0	.0%	2	.9%	61	7.9%	14	41.2%	8	14.0%
Remoteness level	Major Cities of Australia	1	2.9%	36	64.3%	23	52.3%	188	80.7%	610	79.1%	32	94.1%	54	94.7%
	Inner Regional Australia	0	.0%	0	.0%	0	.0%	13	5.6%	4	.5%	0	.0%	3	5.3%
	Outer Regional Australia	0	.0%	10	17.9%	15	34.1%	4	1.7%	64	8.3%	2	5.9%	0	.0%
	Remote Australia	9	25.7%	0	.0%	6	13.6%	27	11.6%	55	7.1%	0	.0%	0	.0%
	Very Remote Australia	25	71.4%	10	17.9%	0	.0%	1	.4%	38	4.9%	0	.0%	0	.0%

To examine the extent to which pathways to additional services might differ in relation to the services families first used in Centres, child enrolment data was explored for each program type in relation to enrolment in each other program time. That is, for children attending one type of program or service, how many of those children also attended another program or service. For example, of the 2412 children who attended pre-school, 47 also attended a supported playgroup, 16 attended a regular playgroup, 11 attended occasional care, 11 attended a parenting support service but fewer than 10 children attended any other type of service. In examining Table 4.5-7, it is evident that although service usage was overall highest for preschool and occasional care, and few of these children utilised other services, children attending occasional care were more likely to also use additional services—specifically a supported playgroup. In fact, children attending a supported playgroup or a community playgroup (playgroup) were the most likely to also be using other services in Centres. Similarly, of the few families utilising Aboriginal-focussed supports, many of these children also utilised additional services. Families utilising targeted supports (e.g. parenting programs, targeted support group, and parenting support services) also tended to utilise additional services.

Table 4.5-7 The relationship between service usage across the range of program types

	N	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Preschool	2412	-													
2. Occasional Care	1032	11	-												
3. Playgroup	140	16	18	-											
4. Health	20	3	8	0	-										
5. Community Group	34	1	3	5	0	-									
6. Supported Playgroups	771	47	120	12	8	10	-								
7. Preschool Support Programs	198	2	0	0	0	0	5	-							
8. Targeted Support Group	57	7	3	0	0	0	11	0	-						
9. Parenting Program	56	6	5	2	0	4	20	0	0	-					
10. Parenting Support Services	44	11	3	4	1	3	10	0	2	10	-				
11. Aboriginal Focussed Support	35	7	11	1	6	2	12	3	0	2	0	-			
12. Targeted Playgroup	34	0	0	0	0	0	5	0	0	0	0	0	-		
13. Family Support	9	1	0	0	0	0	2	0	0	1	0	0	0	-	
14. Bus Service	8	0	0	0	0	0	0	0	0	0	0	0	0	0	-

Notes

[1] Universal programs in the top half of the table (1–5), targeted programs in the bottom half of the table (6–14).

[2] The following programs have been combined (Playgroup and Community/Parent Led Playgroup into Playgroup; Inclusive Preschool Program, Preschool Speech and Language, Preschool Support Program and Preschool Bilingual Program into Preschool Support Programs)

[3] A small number of children were enrolled into 'adult learning' programs, and these records were excluded from the table

[4] The Learning Together program has been excluded from this list

[5] This table is based on data from Term 2 (2016) from the EYS.

Adults

A small amount of data was collected and reported for adult services used in Children's Centres. Additionally, where data was collected for program enrolment, demographic data was often not collected for parents. This greatly limits the ability of the evaluation to comment on provision of services to families. Table 4.5-8 presents enrolments in each program type for the three collection terms and Table 4.5-9 presents this same data grouped by service provider. Inconsistent data collection and entry for services is likely to have impacted this data for some service providers more so than for others. Data was most frequently collected and entered for supported playgroup and for programs provided by DECD staff. This is likely to reflect data sharing issues in Centres—that is Centre staff have reported that external service providers have been unwilling to share service utilisation data with Centre staff. Given the data limitations, no other adult service usage analyses were able to be conducted.

Table 4.5-8 Number and proportion of program types offered across the three collection terms

	2015—Term 4		2016—Term 1		2016—Term 2	
	Count	Column N %	Count	Column N %	Count	Column N %
Health	0	.0%	18	2.4%	6	1.2%
Targeted Playgroup	7	1.3%	7	.9%	17	3.5%
Targeted Support Group	26	4.8%	19	2.5%	19	3.9%
Parenting Support Services	36	6.6%	13	1.7%	30	6.2%
Community Group	32	5.9%	38	5.1%	11	2.3%
Family Support	34	6.2%	36	4.8%	23	4.7%
Aboriginal Focussed Support	27	4.9%	37	5.0%	32	6.6%
Parenting Program	38	6.9%	45	6.0%	42	8.6%
Community/Parent Led Playgroup	41	7.5%	72	9.7%	63	12.9%
Supported Playgroup	306	55.9%	438	58.7%	243	49.9%

Notes

[1] Adults can be enrolled in multiple programs, so a total has not been provided.

[2] Adults can attend multiple different types of sessions within a specific program type (e.g. a total of 306 adults attended a Supported Playgroup in Term 4 of 2015 but some of these parents attended both a Universal Playgroup session and a Jump N Jive Playgroup session).

[3] Adults can also attend a supported playgroup session with more than one child but each adult has been counted once in the table above.

Table 4.5-9 Number and percentage of organisations working with Centres across the three collection terms

	2015 – Term 4		2016 – Term 1		2016 – Term 2	
	Count	Column N %	Count	Column N %	Count	Column N %
Anglicare	0	.0%	0	.0%	2	.4%
Families SA	1	.2%	1	.1%	0	.0%
Peer Support Group	1	.2%	0	.0%	1	.2%
Local Council	0	.0%	3	.4%	0	.0%
Lutheran Church of Australia	3	.5%	2	.3%	2	.4%
MyTime	0	.0%	4	.5%	4	.8%
Uniting Care Wesley Country SA	8	1.5%	0	.0%	0	.0%
Health SA	0	.0%	3	.4%	7	1.4%
Relationships Australia	0	.0%	0	.0%	11	2.3%
Multiple Births Association	7	1.3%	7	.9%	12	2.5%
Private providers	21	3.8%	21	2.8%	17	3.5%
Save the Children	20	3.7%	36	4.8%	28	5.7%
Allied Health	18	3.3%	118	15.8%	53	10.9%
Family Services Co-ordinator	109	19.9%	146	19.6%	124	25.5%
DECD	169	30.9%	184	24.7%	93	19.1%
Community Development	190	34.7%	193	25.9%	131	26.9%

Notes

[1] Adults can be enrolled in programs provided by multiple providers, so a total has not been provided.

[2] The Learning Together program has been excluded from this list

4.6. What impacts do utilising services and supports in a Children's Centre have on parents' parenting practices, wellbeing and social connectedness?

In focus groups and interviews, Children's Centres were identified as positively impacting on parents' wellbeing, parenting capacity and parenting practices. The positive impact of Children's Centres on family wellbeing was related to two key types of support. Firstly, families were better connected to other families and this worked to reduce social isolation. Secondly, Children's Centres better supported parents in their role through the provision of parenting supports and programs, and an increase in staff capacity to work in partnership with parents around the care of their children.

Within the survey, parents were asked a series of questions to examine the impact of utilising services and supports in a Children's Centre on parenting, parental wellbeing and social support.

Parental Wellbeing

Parental wellbeing is often defined as the absence of manifested psychiatric symptoms. To measure the wellbeing of parents utilising services in Children's Centres, the survey asked parents six questions about depressive and anxiety symptoms (Kessler Psychological Distress K6 scale). Parents were asked to indicate, how often during the past four weeks they felt the following:

1. Did you feel nervous?
2. Did you feel hopeless?
3. Did you feel restless or fidgety?
4. Did you feel that everything was an effort?
5. Did you feel so sad that nothing could cheer you up?
6. Did you feel worthless?

Response options ranged from 1 (*all of the time*) through to 5 (*none of the time*). On average, parents tended to score highly on this measure (*M* = 4.26), with most parents reporting that they only felt the depressive and anxiety symptoms 'a little of the time', reflecting good overall wellbeing.

Parents were asked three additional questions from the Australian Temperament Project to further examine how well they felt they were coping with life's challenges. As illustrated in Table 4.6-1, parents typically felt that their life was moderately difficult, coped relatively well and sometimes felt rushed or pressed for time.

Table 4.6-1 Parent responses to parental wellbeing questions from the Australian Temperament Project

	Mean	(Min-Max Value)
1. How difficult do you feel your life is at present?	2.55	(1.00-5.00)
2. How well do you think you are coping?	3.51	(1.00-5.00)
3. How often do you feel rushed or pressed for time?	2.42	(1.00-5.00)

Parenting

To measure parenting practices, parents were asked 30 questions, which examined five different aspects of parenting, including: self-reported parenting efficacy, parental warmth, inductive reasoning, hostile parenting, and consistent parenting. The parent survey was distributed to both families using Children's Centres and to families in neighbouring areas whose children attended reception in a school that did not have a Children's Centre attached to it. In this way, comparison data was sought to identify any potential parenting benefits associated with accessing services and supports through a Children's Centre.

Too few surveys were returned by parents who did not access a Children's Centre, thus comparisons were not able to be drawn. Instead, we present here the findings and as far as possible compare these to published Australian data. The scales employed in the survey are also used in the Longitudinal Study of Australian Children and also in the evaluation of the Tasmanian Child and Family Centres.

Self-reported parenting efficacy

Self-reported parenting efficacy, which refers to the belief that one can effectively perform or manage tasks related to parenting, was measured using items from the Early Childhood Longitudinal

Study. Parents respond on a 10-point Likert scale, with response options ranging from 1 (*not at all how I feel*) to 10 (*exactly how I feel*) to the following statements:

1. I feel that I am very good at keeping my child amused.
2. I feel that I am very good at calming my child when he or she is upset.
3. I feel that I am very good at keeping my child busy while I am doing house work.
4. I feel that I am very good at routine tasks of caring for my child (feeding him/her, changing his or her nappies and giving him/her a bath).

Parents using services in Children's Centres generally rated themselves as having high parenting efficacy (*M* = 8.05), out of a total possible score of 10.

Parents were asked an additional question that asked them to rate how they perceived themselves as a parent. Table 4.6-2 displays the response options and proportion of parents who answered in each category. Responses to this question were mostly positive, consistent with scores from the self-reported efficacy scale.

These findings are also consistent with findings from the Tasmania evaluation, where parents were asked the same question about their self-reported parenting efficacy. Specifically, the proportion of parents who felt they were 'an average parent' (approx. 31% in Tasmania study), 'a better than average parent' (approx. 25% in Tasmania study), and 'a very good parent' (approx. 38% in Tasmania study) were consistent across studies.

Table 4.6-2 Parent responses to how they feel they are as a parent overall

Response Options	N	%
Not very good at being a parent	1	0.5%
A person who has some trouble being a parent	14	7.3%
An average parent	60	31.3%
A better than average parent	56	29.2%
A very good parent	61	31.8%

Parental warmth

Parental warmth, which refers to how affectionate and accepting parents are towards their children, was measured through six questions from the Child Rearing Questionnaire. Using a 5-point Likert scale, with response options ranging from 1 (*never/almost never*) to 5 (*always/almost always*), parents were asked to indicate how often they did the following:

1. How often do you express affection by hugging, holding or kissing your child?
2. How often do you hug or hold your child for no reason?
3. How often do you tell your child how happy he or she makes you?
4. How often do you have warm close times together with your child?
5. How often do you enjoy listening to your child and doing things with your child?

6. How often do you feel close with your child both when he/she is happy and when he/she is upset?

On average, parents scored highly on this measure (*M* = 4.53), with most parents responding to the questions with 'often' or 'almost always', reflecting high levels of parental warmth.

Inductive reasoning

Inductive reasoning, which refers to how parents communicate with children about the rationality of their actions and the effects of their actions on others, was measured through five survey questions from the Child-Rearing Questionnaire. Parents were asked to indicate how often they do the following:

1. How often do you explain to this child why he or she is being corrected?
2. How often do you talk it over and reason with this child when he/she misbehaves?
3. How often do you give this child reasons why rules should be obeyed?
4. How often do you explain to this child the consequences of his/her behaviour?
5. How often do you emphasise to this child the reasons for rules?

Response options ranged from 1 (*never/almost never*) to 5 (*always/almost always*). On average, parents scored highly on this measure (*M* = 4.27) out of a total possible score of 5, reflecting high levels of inductive reasoning.

Hostile parenting

Hostile parenting, which refers to a general pattern of behaviour, manipulation, actions or decision-making that creates difficulties in the relationship with a child, was measured through seven survey questions from the National Longitudinal Survey of Children and Youth. Using a 5-point Likert scale, parents were asked to indicate how often the following statements occurred:

1. How often do you get annoyed with your child for saying or doing something he/she is not supposed to?
2. Of all the times you talk to your child about his/her behaviour, how often is this praise? (reversed)
3. Of all the times you talk to your child about his/her behaviour, how often is this disapproval?
4. How often are you angry when you punish your child?
5. How often do you feel you are having problems managing your child in general?
6. How often do you tell your child that he/she is bad or not as good as others?
7. How often do you think that the level of punishment you give your child depends on your mood?

On average, parents' responses were at the lower end of the continuum (*M* = 2.06), reflecting relatively low levels of hostile/angry parenting.

Consistent Parenting

Consistent parenting refers to when both parents are consistent with their approach from day to day and was measured through seven survey questions from the National Longitudinal Survey of

Children and Youth. Using a 5-point Likert scale, parents were asked to indicate how much of the time things turned out like this:

1. When you give your child an instruction or make a request to do something, how often do you make sure that he/she does it?
2. If you tell your child he/she will get punished if he/she doesn't stop doing something, but he/she keeps doing it, how often will you punish him/her?
3. How often does your child get away with things that you feel should have been punished? (Reversed)
4. How often is your child able to get out of punishment when he/she really sets his/her mind to it? (Reversed)
5. When you discipline your child, how often does he/she ignore the punishment? (Reversed)

On average, parents scored moderately highly (*M* = 3.48), with most parents reporting that the statements apply to them 'about half the time' or 'more than half the time', reflecting relatively moderate levels of parenting consistency.

Social Support

Social support refers to the various types of support that people receive from others and is generally examined through subdomains. Four types of support that were deemed important for parents were measured through 15 questions from the MOS Social Support Survey, including emotional/informational support (questions 1–4), tangible support (5–8), affectionate support (9–11) and positive social interaction (12–15). Parents were asked to indicate, using a 5-point Likert scale, how often each of the following kinds of support are available if they need it:

1. Someone you can count on to listen to you when you need to talk.
2. Someone to confide in or talk to about yourself or your problems.
3. Someone to share your most private worries and fears with.
4. Someone to turn to for suggestions about how to deal with a personal problem.
5. Someone to help you if you were confined to bed.
6. Someone to take you to the doctor if you needed it.
7. Someone to prepare your meals if you were unable to do it yourself.
8. Someone to help with daily chores if you were sick.
9. Someone who shows you love and affection.
10. Someone to love and make you feel wanted.
11. Someone who hugs you.
12. Someone to have a good time with.
13. Someone to get together with for relaxation.
14. Someone to do something enjoyable with.
15. Someone to do things with to help you get your mind off things.

Parents generally rated their levels of social support as high (*M* = 3.99), out of a possible score of 5, reflecting relatively high levels of social support in their lives.

Two additional questions examined parents' levels of social support—knowing where to find information about local services and supports and being well informed about local affairs. As shown in Figure 4.6-1 parents generally agreed that when they need information about local services, they knew where to find it. Families in Tasmania, reported slightly higher rates of knowing where to find services—with 37% reporting they knew where to find services 'most of the time' and 41% 'all of the time'.

Parents utilising Children's Centres in SA also tended to agree that they were well informed about local affairs (see Figure 4.6-2).

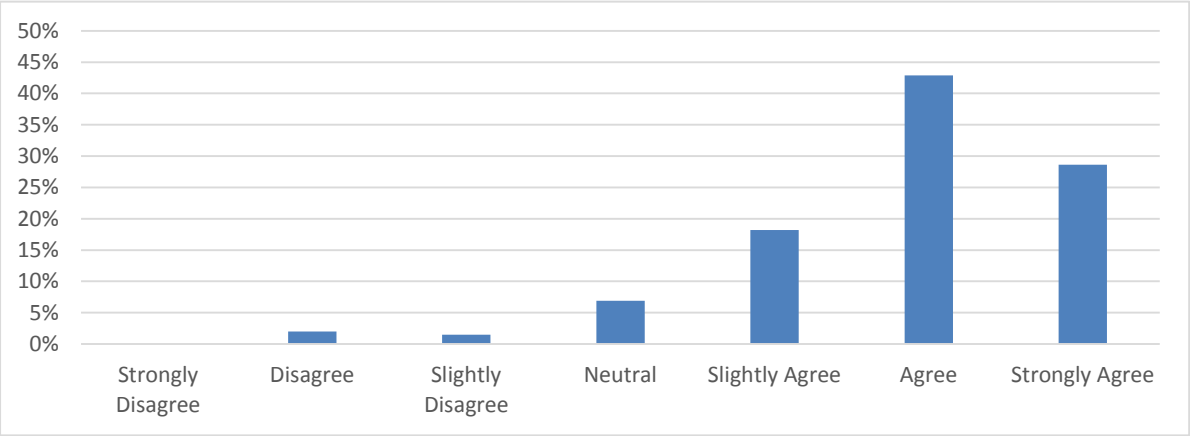

Figure 4.6-1 Parent responses to whether they knew where to find information about local services

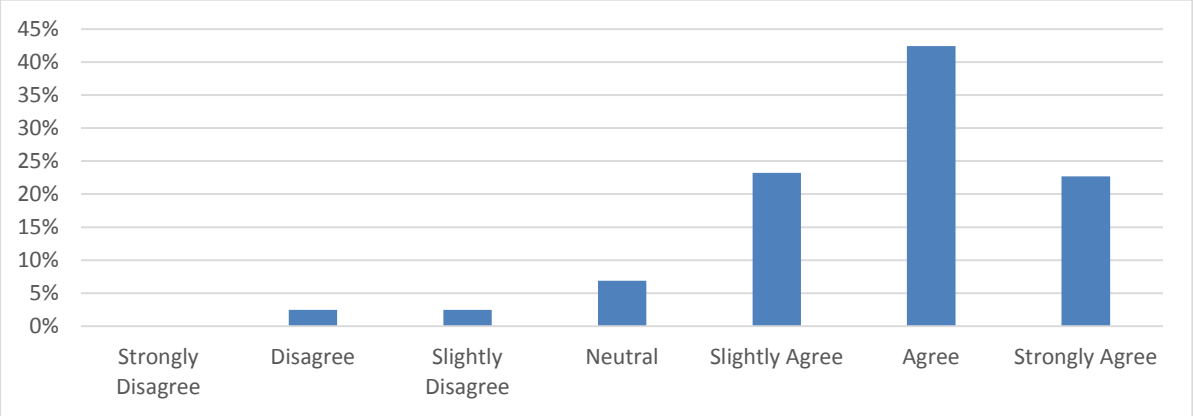

Figure 4.6-2 Parent responses to whether they were well informed about local affairs

Mann-Whitney U analyses were conducted to determine whether there were any significant differences in responses for groups with differing demographic characteristics. Differences were found for two demographic groups. Firstly, there was a statistically significant difference between household status (p = .010), with parents from single parent households reporting having more knowledge of where to find information and local services (M = 6.2, n = 31) compared to parents from two-parent households (M = 5.8, n = 163). Additionally, parents from single parent households reported that they were more informed about local affairs (M = 6.1, n = 93) compared to parents

from two-parent households (*M* = 5.6, *n* = 163) and this was a statistically significant difference (*p* = .010). Secondly, parents of children who only spoke English at home reported having more knowledge of where to find information and local services (*M* = 5.9, *n* = 172) compared to parents of non-English speaking children (*M* = 5.4, *n* = 31), and this difference was statistically significant (*p* = .015).

Further analyses were conducted to examine whether there were differences in parental wellbeing and self-reported parenting among demographic groups. Significant differences emerged for five demographic groups. A Mann-Whitney U analysis revealed that parents with a medical condition or disability had less favourable outcomes across a range of measures (see Table 4.6-3). Specifically, parents with a medical condition or disability reported poorer wellbeing, had lower self-reported parenting efficacy, had higher scores on the hostile parenting scale, felt that life was more difficult, had poorer coping, and felt more rushed and pressed for time compared to parents without a medical condition or disability.

Table 4.6-3 Parenting scales mean scores and whether there was a significant difference for parents with a medical condition or disability

Parenting Scales	Parent has a medical condition or disability (6 months or more)				
	Yes		No		
	M	N	M	N	p
Kessler K6	3.59	28	4.37	171	.001*
MOS Social Support Scale	3.70	29	4.04	170	.079
Self-Reported Parenting Efficacy	7.22	26	8.18	167	.017*
Parental Warmth	4.34	26	4.57	166	.090
Inductive Reasoning	4.02	26	4.32	165	.092
Hostile Parenting	2.33	25	2.02	167	.040*
Consistent Parenting	3.52	25	3.47	166	.989
Overall as a parent…	3.52	27	3.90	165	.051
How difficult do you feel life is at present?	3.14	29	2.46	171	.000*
How well do you think you are coping?	3.14	29	3.57	171	.014*
How often do you feel rushed or pressed for time?	2.07	29	2.49	171	.020*

*$p < .05$

Similarly, as demonstrated in

Table 4.6-4, a Mann-Whitney U analysis revealed that parents who had a child with a medical condition or disability also had less favourable outcomes across a range of measures. Specifically, they reported having poorer wellbeing, lower levels of social support, lower self-reported efficacy, higher scores on the hostile parenting scale, rated themselves lower as a parent overall, reported having a more difficult life, and were more rushed and pressed for time compared to parents without a child with a medical condition or disability.

Table 4.6-4 Parenting scales mean scores and whether there was a significant difference for parents with a child with a medical condition or disability

Parenting Scales	Parent has a child with a medical condition or disability (6months or more)				
	Yes		No		
	M	N	M	N	p
Kessler K6	4.00	34	4.31	164	.046*
MOS Social Support Scale	3.58	34	4.09	164	.004*
Self-Reported Parenting Efficacy	7.53	33	8.18	159	.025*
Parental Warmth	4.43	33	4.56	158	.150
Inductive Reasoning	4.13	33	4.31	157	.193
Hostile Parenting	2.28	33	2.01	158	.033*
Consistent Parenting	3.50	33	3.48	157	.909
Overall as a parent…	3.42	33	3.94	158	.008*
How difficult do you feel life is at present?	3.15	34	2.42	165	.000*
How well do you think you are coping?	3.32	34	3.55	165	.147
How often do you feel rushed or pressed for time?	2.09	34	2.50	165	.011*

*$p < .05$

As shown in Table 4.6-5, a Kruskal-Wallis analysis revealed a significant association between the number of children a parent had and how they rated themselves as a parent, with parents with five or more children scoring themselves the lowest. Additionally, there was a significant association between the number of children a parent had and if they felt rushed or pressured for time. Specifically, parents with five or more children felt the most rushed and pressed for time, with parents of one child feeling the least time pressure.

Table 4.6-5 Parenting scales mean scores and whether there was a significant difference depending on how many children the parent has

Parenting Scales	Number of Children												
	0		1		2		3		4		≥ 5		
	M	N	M	N	M	N	M	N	M	N	M	N	p
Kessler K6	2.00	1	4.32	66	4.23	88	4.27	32	4.26	9	4.44	3	.536
MOS Social Support Scale	3.53	1	4.11	67	4.01	87	3.91	32	3.52	9	3.40	3	.324
Self-Reported Parenting Efficacy	10.00	1	8.20	65	7.86	84	8.13	31	8.50	9	7.67	3	.465
Parental Warmth	5.00	1	4.65	64	4.46	84	4.45	31	4.57	9	4.61	3	.241
Inductive Reasoning	5.00	1	4.31	63	4.24	84	4.23	31	4.38	9	4.53	3	.591
Hostile Parenting	3.00	1	1.95	64	2.15	84	2.01	31	2.24	9	2.04	3	.266
Consistent Parenting	3.00	1	3.36	63	3.52	84	3.64	31	3.50	9	3.40	3	.192
Overall as a parent…	3.00	1	3.91	65	3.98	83	3.55	31	3.67	9	2.67	3	.044*
How difficult do you feel life is at present?	3.00	1	2.46	67	2.61	88	2.50	32	2.78	9	2.67	3	.879
How well do you think you are coping?	3.00	1	3.63	67	3.47	88	3.53	32	3.00	9	3.33	3	.509
How often do you feel rushed or pressed for time?	1.00	1	2.63	67	2.42	88	2.22	32	2.22	9	1.33	3	.030*

*$p < .05$

Additionally, a Kruskal-Wallis analysis revealed that there was a significant difference in how parents rated themselves on self-efficacy and the age of a parent. As illustrated in Table 4.6-6, parents aged 18–22 years had the highest self-reported efficacy, with adults 40 years and above having the next highest self-reported efficacy. Parents aged 23–25 years had the lowest self-reported efficacy scores. Furthermore, there was also a significant difference in how well parents thought they were coping and age of parent, with parents aged 18–22 reporting coping the best and parents aged 23–25 reporting coping the worst.

Table 4.6-6 Parenting scales mean scores and whether there was a significant difference depending on age of parent

Parenting Scales	Age of Parent												
	18–22		23–25		26–30		31–35		36–40		> 40		
	M	N	M	N	M	N	M	N	M	N	M	N	p
Kessler K6	4.06	8	3.92	8	4.13	30	4.33	67	4.35	55	4.20	31	.253
MOS Social Support Scale	4.17	8	3.60	9	4.06	29	4.08	67	4.00	55	3.80	31	.654
Self-Reported Parenting Efficacy	8.94	9	6.44	8	7.67	29	8.03	65	8.16	52	8.45	30	.006*
Parental Warmth	4.85	8	4.48	8	4.53	29	4.53	65	4.54	52	4.48	30	.689
Inductive Reasoning	4.73	8	4.35	8	4.25	28	4.30	65	4.16	52	4.30	30	.279
Hostile Parenting	2.00	9	2.37	8	2.04	29	2.16	64	2.03	52	1.89	30	.126
Consistent Parenting	3.27	9	3.45	8	3.45	28	3.48	64	3.52	52	3.54	30	.986
Overall as a parent…	3.88	8	3.00	9	3.71	28	3.92	65	3.83	52	4.07	30	.129
How difficult do you feel life is at present?	2.63	8	2.89	9	2.63	30	2.48	67	2.51	55	2.61	31	.817
How well do you think you are coping?	3.63	8	2.78	9	3.20	30	3.61	67	3.60	55	3.59	31	.029*
How often do you feel rushed or pressed for time?	2.75	8	2.44	9	2.57	30	2.43	67	2.27	55	2.45	31	.538

*$p < .05$

Finally, a Mann-Whitney U test revealed a significant difference between household status and the amount of social support parents reported to have. As shown in Table 4.6-7, parents living in a single parent household reported having lower levels of social support compared to parents in a two-parent household. Interestingly, no significant differences emerged between any demographic characteristics and parental warmth.

Table 4.6-7 Parenting scales mean scores and whether there was a significant difference for parents with a medical condition or disability

Parenting Scales	Household Status				
	Single Parent		Two-Parent		
	M	N	M	N	p
Kessler K6	3.94	28	4.34	162	.078
MOS Social Support Scale*	3.51	29	4.10	161	.001
Self-Reported Parenting Efficacy	8.25	28	8.06	157	.725
Parental Warmth	4.65	28	4.54	156	.669
Inductive Reasoning	4.45	28	4.28	156	.293
Hostile Parenting	2.22	27	2.03	157	.087
Consistent Parenting	3.56	27	3.49	157	.547
Overall as a parent…	3.69	29	3.92	155	.194
How difficult do you feel life is at present?	2.90	29	2.49	162	.066
How well do you think you are coping?	3.41	29	3.53	162	.515
How often do you feel rushed or pressed for time?	2.45	29	2.42	162	.915

*$p < 0.05$

4.7. What difference does attending an integrated service setting make to children's development at the start of the school year?

4.7.1. Do children who attend preschool in a Children's Centre have better child development outcomes in their reception year than (comparable) children who attend other types of government funded preschools?

Matched data from the Preschool Census (2014) and the AEDC (2015) were analysed to answer the question of whether children who attend preschool within a Children's Centre have better development at school entry than children who attend a standard preschool? Descriptive information on the two groups is presented first (percentage of children vulnerable on each developmental domain and summary indicators), followed by logistic regression analyses to test whether these differences between groups were statistically significant. Overall, the findings, presented in Table 4.7-1 suggest that there were very few differences in the development of children who attended preschool in a Children's Centre compared to those who attend a standard preschool.

Table 4.7-1. 2015 AEDC results for children attending different types of preschools

	Standard Preschool (n = 3,510)		Children's Centre Preschool (n = 1,905)	
	N	%	N	%
Developmental domains				
Physical Health and Wellbeing	409	12.6%	226	12.7%
Social Competence	375	11.5%	225	12.7%
Emotional Maturity	344	10.6%	189	10.7%
Language and Cognitive Skills	269	8.3%	151	8.5%
Communication skills and General Knowledge	305	9.4%	158	8.9%
Summary Indicators				
Vulnerable on ≥ 1 domain	851	26.2%	462	26.1%
Vulnerable on ≥ 2 or more domains	442	13.6%	254	14.3%

Logistic regression analyses confirmed that there was no difference in the probability of being developmentally vulnerable on one or more AEDC domains between children who attended a Children's Centre preschool and those who attended a standard preschool. Once we adjusted for differences in gender, Aboriginality, language background, and socio-economic status, children who attended a Children's Centre preschool had slightly lower odds of being vulnerable (OR = 0.94, 95% CI 0.82-1.08) than children attending a standard preschool. However, this difference was not

statistically significant and, as such, these analyses suggest there is no significant difference in the odds of being developmentally vulnerable at school entry between children attending different types of preschools. Table 4.7-2 presents these results.

Table 4.7-2. Logistic regression analyses – % of children vulnerable on 1 or more domains for children attending different types of preschools

		Unadjusted			Adjusted		
		N	OR (95% CI)	p	N	OR (95% CI)	p
Preschool type	Standard	3,244	ref	-	3,243	ref	-
	Children's Centre	1,767	0.99 (0.87,1.14)	.95	1,766	0.94 (0.82,1.08)	.36
Sex of child	Female				2,498	ref	-
	Male				2,511	2.40 (2.10,2.74)	<.001
Aboriginal status	No				4,674	ref	-
	Yes				355	2.13 (1.68,2.70)	<.001
Language Background other than English	English only				4,059	ref	-
	LBOTE				950	1.01 (0.86,1.19)	.90
Socio-economic status of the community where the child lives	Quintile 1 (most disadvantaged)				1,801	ref	-
	Quintile 2				1,432	0.78 (0.67,0.92)	<.01
	Quintile 3				936	0.65 (0.54,0.78)	<.001
	Quintile 4				602	0.37 (0.29,0.48)	<.001
	Quintile 5 (least disadvantaged				238	0.52 (0.37,0.74)	<.001

4.7.1. Were children who attended preschool in a Children's Centre less likely to be identified by their reception teacher as having additional/undiagnosed special needs?

Children's Centres bring together a range of different service providers to help support children and families. This integrated service model should support the early identification of children's needs before they commence school and support families with children who have special needs – speech, language, developmental, behavioural, emotional problems – to access relevant services and supports. Within the AEDC data collection, teachers are asked two questions; (1) whether children have any diagnosed special needs (*special needs*), and (2) whether children have additional needs that need further assessment (*additional needs*). Thus, as a result of the integrated service provision model, it is hypothesised that children who attend Children's Centres would be less likely to start school with undiagnosed special needs and that this would be reflected in teachers' responses to the question about children's additional needs that need further assessment.

To examine the extent to which this is the case, two comparisons were conducted. The first to examine whether there was a higher incidence of children with diagnosed additional needs and the second to examine whether there were differences in the proportion of children starting school who required further assessment. Table 4.7-3 shows the percentage of children in each of these groups based on their preschool experience. The percentage of children with special needs status was a little lower for children who attended a Children's Centre. There was, however, no evidence that children who attended a Children's Centre were less likely to have additional (undiagnosed) needs than children who attended a standard preschool.

Table 4.7-3. Special and additional needs for children attending different preschools (n = 5,415)

		Standard Preschool (n = 3,510)		Children's Centre Preschool (n = 1,905)	
		N	%	N	%
Special needs	Yes	252	7.2	127	6.7
	No	3,258	92.8	1,778	93.3
Additional needs	Yes	449	13.3	269	14.6
	No	2,928	86.7	1,570	85.7

5. Discussion

This evaluation report has presented findings as they relate to eight evaluation questions. Three sets of quantitative data were analysed, including: state-wide survey of staff, service providers and families; Early Years System (EYS) administrative data collected in Children's Centres about the range of services offered to children and their families and use of these services; and SA Government

preschool data linked to 2015 AEDC data. Analyses of these data sets, sought to further develop understandings of the factors affecting integration in centres and the impacts that Centres have on children and their parents. These analyses built upon the themes reported in the Interim report; exploring quantitatively the extent to which the factors reported in focus groups and interviews were impacting integrated service delivery across the state.

5.1. Evaluation Questions

5.1.1. Do Children's Centres provide families with effective pathways that assist families to access the range of services and support that they need? How does this happen?

What services and supports are available in Children's Centres and do these meet community needs?

To better inform planning for the needs of children and families, an opportunity exists for Children's Centres to use population data for communities to identify and quantify level of need. This is particularly important for determining the required scale and intensity of any response. Issues identified using population data should then be combined with community and service provider consultation to understand: factors contributing to issues and assets available in the community that can be utilised to respond to the needs of children and families. That is ensuring these are:

- culturally appropriate
- cognisant of barriers to access
- acceptable to target group
- implementable with scale and intensity needed to shift issue
- amenable to change.

The Early Years System data examined for the evaluation demonstrated that a broad range of services were available across Centres, with some being far more prevalent than others. The evaluation was not able to determine whether this mix of services was appropriate to need. However, the evaluation did examine the extent to which staff, service providers, and directors reported understanding the needs of the community. Additionally, parents reported the extent to which services met the needs of families.

In planning services and supports, Centres reported having a better understanding of the needs of families using Centres than they did of families living in the local area. In focus groups and interviews, staff and directors reported that one way in which they came to know what supports families needed was by listening to families when they spoke about their challenges. In contrast, population data such as the AEDC and ABS data was spoken about as having limited utility for understanding community need. From the evaluation, it is unclear how extensively population data sources are used to support service planning. Considered alongside focus group and interview data, the survey findings illustrate that there is an opportunity to improve utilisation of population data for mapping community needs as well as resources available in communities.

While the majority of families reported that Centres understood their needs and provided services and supports that met their needs and the needs of their children, they did not feel like active partners in the design of services. Nevertheless, most families reported feeling supported by

Children's Centre staff. Moreover, families reported feeling comfortable seeking advice and support from staff when they were in need. Fewer parents felt that staff were committed to helping them or that they would find someone that could help them.

On the whole, survey data illustrated the diversity in the ways in which Children's Centres operate across the state; some resembling service provision hubs that are acceptable to the community and others resembling community spaces that are owned by the community and run in partnership with the community. Although this diversity in engagement may be an appropriate reflection of the needs of the community, it may also reflect that an opportunity exists for some centres to improve their capacity to engage the community and work in true partnership with community. The evaluation has highlighted opportunities to develop and improve the way in which Children's Centres operate within the community and the extent to which they involve the community in the design and implementation of services and supports for families.

Recommendations:

1. Opportunities exist for Children's Centres to use population data at the community level to assess and monitor changes in child and family needs over time, and the extent to which current strategies are working to address needs.
2. Develop the vision of Children's Centres to include a clear model for how these work with or service communities. This must include: intended outcomes, means to achieve these outcomes, and supporting structures that enable implementation.

What are the referral pathways to additional support?

The Royal Commission into the Child Protection System noted a confusing early intervention support system for families in South Australia, with a dearth of information about the services and supports available to them. Families who took part in this evaluation similarly reported finding it difficult to find services before they found the Children's Centre.

In focus groups and interviews, staff, service providers, and directors spoke about Children's Centres as service provision hubs in their communities. Participants also noted that Children's Centres were connecting service providers to each other and to families. Discussions indicated that referral pathways were informal rather than formal, and relied upon relationships that were developed between individual staff within the Children's Centres and within service provider organisations.

Surveys further explored these themes and asked staff, service providers, and directors to rate referral processes and pathways across Children's Centres and the factors that facilitated these. Survey respondents tended to agree that Centres were supporting the building of local networks, and improving relationships between government and non-government agencies. Availability of additional staff (i.e. Community Development Coordinators and Family Service Coordinators) enabled Centres to attend local network meetings and connect with other service providers in the community. Staff, service provider and director survey responses about their knowledge of services in the community and the extent to which referral pathways to these services existed, highlighted an opportunity to continue to build connections to health and adult support services.

At the same time, most families reported accessing community based health services. The importance of connecting with health services to support families in children's formative years was demonstrated by improved early uptake of services in Centres with antenatal and maternal child health services on site. Better connections with health services in the community should equally support the referral to Children's Centres of families needing support.

An opportunity exists for Children's Centres to become more visible as a place for families to seek support. The Community Development role in centres should routinely map all available supports and services in the community, noting restrictions on these (criteria for eligibility). At a local level this information should be routinely distributed to families through communication local services (e.g. maternal child health, general practitioners, Centrelink offices, child care centres, playgroups, and so forth).

Recommendations:

3. Promote Children's Centres to families by strategically identifying and building referral pathways to and from agencies that are connected to families, from conception through to school age. Agencies may include: community health, hospital antenatal and paediatric services, housing services, child protection agencies, and social services.
4. At the executive level, continue to strengthen cross-agency partnerships and negotiate agreements that facilitate the strengthening or establishment of local partnerships. Cross-agency agreements should seek to address challenges to working in partnership; how information and data is shared to support the identification of the needs of families; formal referral processes; and reduction of duplication for families (e.g. reducing the need to fill in multiple enrolment forms to access a range of services at a single site).

What system level changes/supports/challenges are there to support Children's Centres?

In focus groups and interviews, two key system level supports were reported to be enhancing the capacity of the leadership team within Children's Centres to work in an integrated service setting. The first was the professional development program, which was said to be helping people develop an understanding of working in partnership to meet community needs. The second was the support provided by the Early Childhood Development Strategy Team, which was said to help staff from non-education backgrounds negotiate challenges they encountered in their work.

Two challenges were identified for the management of Children's Centres. Primarily these were related to governance structures around line management and workload of directors. Surveys of staff, service providers and directors sought to quantify the extent to which these facilitators and challenges were impacting integrated service provision in Centres. Directors reported that the professional development program was a useful source of support—they both valued this and utilised what was offered. In contrast, although directors reported that the Early Childhood Development Strategy team had skills and knowledge to help them develop integrated services in their site, less than half reported that they utilised the team when they needed support in relation to establishing integrated services in their site.

An additional challenge to providing integrated services in Centres was said to be the physical structures themselves. The size and layout of buildings were spoken about frequently as either facilitating or hindering integrated service provision. This was not borne out as having an extensive negative impact; most survey respondents reported that the physical space in Children's Centres promoted the provision of integrated support to families.

Recommendations:

5. Continue to provide professional support and training opportunities aligned to the vision of Children's Centres.

How do these referral processes and pathways differ to those in the broader community?

In focus groups and interviews, parents reported that referral pathways were functioning better in Children's Centres than in standalone preschool or child care settings. However, not all parents identified improved access to services through referral pathways.

Staff, service providers, and directors noted that once families were using the Children's Centre, the capacity of staff and the quality of relationships between service providers and the Centre were important for improving referral pathways. Additionally, the increased capacity of staff to work with vulnerable children and their families, resulting from working in an integrated setting, was said to increase the rate of identification of families needing support.

Survey findings illustrated that although Children's Centres were improving referral pathways for families, there were still opportunities to make this consistent across the state. Centres were said to be supporting the early identification of children and families in need of additional supports, and the connection of families to the right service at the right time. Additionally, respondents agreed that Centres were helping to reduce duplication of services in the community, although this was not consistently reported. Three in four families reported they were able to access services and supports. Those families who reported not being able to access services they needed for themselves or for their children, tended to report difficulties in accessing both universal services and targeted supports. Barriers to accessing services tended to be cost, knowing about services, and long wait times. Families who faced additional challenges (parent or child having a disability or speaking English as a second language) reported more difficulty accessing services.

Recommendations:

6. Community Development Coordinators in Children's Centres should seek to identify gaps in services relative to population needs. These opportunities may involve addressing a lack of services or insufficient services to address the scale of the need. Mapping gaps in services must happen in all communities, irrespective of the level of disadvantage of an area.
7. At a whole of state planning level, an opportunity exists for the Department for Education and Child Development to refine the mix of universal services and targeted supports to ensure all communities have appropriate services available to them.

8. An opportunity exists to ensure that universal services to support parents are available in all communities and that these services have sufficient capacity to support the number of resident families. Further, there is an opportunity to ensure that targeted supports are matched to the scale of an issue, and resourcing reviewed with an emphasis on meeting existing need and bolstering early intervention resources that can help mitigate future need for high-cost intensive services.

5.1.2. What are the facilitators and challenges for Children's Centre staff working together collectively for the benefit of children? Where do staff see their work along the integration continuum?

Children's Centre's in South Australia are run on a model of distributed leadership. Whilst there have been extensive studies on the concepts and functioning of distributed leadership within schools Gronn and Hamilton (2004); Harris and Allen (2009); MacBeath (2005); Tian, Risku, and Collin (2016), there is far less work in early childhood with these studies having been carried out in an early years education environment. Distributed leadership requires that staff from diverse disciplines work together to create a holistic service with a joint vision.

In focus groups and interviews several factors related to the way in which staff work together were said to be facilitating or impeding integrated service provision. Where integration was said to be working well, staff were said to share professional knowledge; engage in shared curriculum planning; and work collaboratively to holistically support children and families. These qualities of integrated service provision were quantified in the survey of staff, service providers and directors.

Importantly, site leadership was said to be critical to the functioning of integrated teams. Specifically, the way leaders facilitated staff to work together toward a common goal. The introduction of Children's Centres in South Australia has meant the creation of a new role, that of a Children's Centre Director.

Centre directors had all previously managed a team of educators. Expansion of the staff team at sites to include staff from diverse disciplines brought with it challenges for leadership, such as the extent to which leaders felt that they had adequate control over staffing issues, when these arose. Centre Directors are required to engage with a variety of stakeholder groups (families, governing bodies, service providers), whilst ensuring quality service delivery, managing staff and resources, and completing administration and reporting obligations.

The leadership role is complex, and has been recognised as such in the literature. Leaders of multidisciplinary teams in early years settings need to be "change managers, proactive and solution focused, […] with a high degree of emotional intelligence, able to form strong relationships and work in partnership to make a difference for children and families" (Sharp et al., 2012, p. 19). To explore the extent to which Children's Centre directors worked in this way staff and service providers were asked to rate their experience of Centre leadership. Also, directors were asked to rate the extent that they felt they had the authority and capacity to manage a diverse team. This included having authority to manage staff from diverse disciplines, ability to impact on staff behaviour, and adequate

input in staffing decisions to enable them to develop a cohesive team. These questions were asked to explore themes related specifically to the model of Centre leadership in the South Australian context.

Overall, respondents tended to rate both integration and leadership as working well. To examine the extent to which this differed across Centres, individual responses were combined for each Centre. This generated a site-specific rating for how well integration and leadership was working. These Centre ratings were then explored to examine the degree to which leadership was impacting integrated service delivery at sites. Leadership was rated highly in around two thirds of sites. Where leadership was not rated highly, integrated service delivery was also rated as less functional. Staff and service provider experience of leadership was related to directors' ratings of their level of control in sites. That is, where staff and service providers rated leadership highly, directors also reported feeling that they had control over the way the staff team functioned at the site.

A growing body of research suggests that effective leaders in early childhood settings positively impact on both the developmental outcomes of children and the quality of the centre as a workplace (Bloom & Sheerer, 1992; Lower & Cassidy, 2007; Rodd, 2006; Sylva, Melhuish, Sammons, Siraj-Blatchford, & Taggart, 2004; Waniganayake, Cheeseman, Fenech, Hadley, & Shepherd, 2012). Nevertheless, it is common for leaders in early childhood to have come to the position by accident or default, and are subsequently under-prepared for the role (Ebbeck & Waniganayake, 2003; Sims, Forrest, Semann, & Slattery, 2015), with many viewing themselves as practitioners rather than leaders (Moyles, 2006). In this evaluation, leaders highlighted the enormity of the workload associated with running a high-quality education site whilst also managing a multidisciplinary staff team.

Although leadership issues identified in this evaluation are not unique to South Australian Children's Centres, it is imperative that the leadership structure is further developed with a view to identifying mechanisms that support or detract from the vision of Children's Centres being realised. Leadership roles and responsibilities, along with the associated skills required and performance indicators should be created to reflect the intentions of the role. Leadership positions should be primarily linked to the management of a multi-disciplinary team rather than the management of an education site. In addition, organisational accountability of the role should be reviewed and further developed to ensure this aligns with the aims of Centres.

In South Australia, Children's Centre leadership is line-managed through regional education management structures. That is, Education Directors are responsible for line management of preschool, primary school, and secondary school sites. It would be fair to say that most Education Directors, having themselves come from a school management role (e.g. school principal), may not have an in-depth understanding of the leadership required in Children's Centres to achieve South Australia's vision for integrated service provision in the early years. Indeed, in focus groups and interviews, staff and service providers noted that when the Children's Centre leadership was not functioning well systemic supports to hold them accountable were not in place. Specifically, management by education staff who may be unfamiliar with aims and vision of Children's Centres reduces the adherence to a model of integrated service provision to meet the needs of communities.

Leadership is integral to the way in which services and supports are planned and how the staff team works together. This has flow on effects for how the community is engaged with the Centre and the extent to which Centres meet the needs of families. Management of the education program should be one facet of the leadership team, as are family support, allied health and community development.

Recommendations:

9. Further develop the leadership model for Children's Centres and consider broadening the role to recruit staff from a range of disciplines.
10. Further develop the line management model of Children's Centre leadership.
11. For new sites, recruit leaders based on capacity to manage a multidisciplinary team rather than education management experience.
12. Role descriptions for all staff should be developed to reflect key outcomes of the roles specified along with the skills required to work effectively in the role.

5.1.3. What are the processes that enable partnerships and governance groups (parent advisory, leadership group and partnership groups) to respond to community needs effectively?

The Interim report of the focus group and interview findings highlighted that there was an opportunity to improve the functioning of governance groups in centres as their value and the rate at which they were considered relevant to the functioning of the sites varied. The governance structure developed for centres specifies the role of three governance groups—parent engagement, partnership, and leadership. The parent engagement group is described as a formal mechanism that enables the community to have a say in the centre. The parent engagement group was envisaged as giving parents the opportunity to participate in setting the agenda of the centre, the services and supports that are offered, and the strategies used to work with the community. The partnership group is specified as the formal mechanism that brings together service providers in the community to share information and engage in shared planning at a community level. The leadership group, is intended to be made up of staff representing each of the disciplines in the Centre. It was intended that this group work together to set Centre priorities, manage operational concerns, establish a shared vision, and share information to support children and families.

Findings from both the qualitative and quantitative components of the evaluation highlighted an opportunity for this governance structure to be further developed. On the whole, parent engagement and partnership groups were reported either as not operational, or functioning at a below optimal level. The extent to which other mechanisms were used to engage families and service providers in the community was not able to be determined from this evaluation. Nevertheless, agreement with the intended functions of these groups tended to be low. The ability of Centres to work with the community to plan in partnership is hampered when structures to support this are not in place or not utilised as intended. In contrast, leadership groups tended to be reported as functioning well and their envisaged functions agreed upon. These findings highlight the

opportunity to further develop parental engagement, and in doing so make further gains towards achieving their goal of working inclusively and in partnership with community.

Working in partnership with the community presents challenges for government services. There is a distinction between government organisations working with community in a model of community development and government agencies engaging communities. Community engagement operates from the premise that change initiatives will have the greatest impact in communities where citizens feel part of the process, are empowered to create change and have ownership over the process. There is no consensus on how community engagement should be conducted. An extensive review of community engagement for reducing health inequalities reported on a range of community engagement models. In these, the extent of engagement ranged from limited amounts such as providing information and consulting community to more intensive engagement involving shared development of and participation in initiatives and community empowerment (O'Mara-Eves et al., 2013). Table 5.1-1 outlines the potential variation in collaboration based on whether professionals act independently or with community members to deliver services (Bovaird, 2007).

Table 5.1-1 Range of Professional-Community member relationships (Adapted from Bovaird, 2007)

		Planning involvement		
		Professionals as sole service planners	Community members as co-planners	No professional input into service planning
Service delivery involvement	Professionals as sole service deliverer	Traditional professional service provision	Traditional professional service provision with community members involved in planning and design	N/A
	Professionals and community members as co-deliverers	Community members' co-delivery of professionally designed services	Community member/professional coproduction	Community member co-delivery of services with professionals, with little formal planning or design
	Community members as sole deliverers	Community members' delivery of professionally planned services	Community member delivery of co-planned or co-designed services	Traditional self-organised community provision

The National Institute for Health and Care Excellence in the UK published NICE guidelines for community engagement in March 2016. The guidelines present the most recent review of community engagement and outline best practice principles to reduce health inequalities and ensure that health and wellbeing initiatives are effective. The guidelines were specifically developed for public health practitioners in local authorities, and translate well to the settings of Children's Centres in South Australia. Key recommendations of the guidelines include:

1. Ensure local communities, community and voluntary sector organisations and statutory services work together to plan, design, develop, deliver and evaluate health and wellbeing initiatives, by:
    - using evidence-based approaches to community engagement
    - being clear about which decisions people in local communities can influence and how this will happen
    - recognising, valuing and sharing the knowledge, skills and experiences of all partners, particularly those from the local community
    - making each partner's goals for community engagement clear
    - respecting the rights of local communities to get involved as much or as little as they are able or wish to
    - establishing and promoting social networks and the exchange of information and ideas (on issues such as different cultural priorities and values)
2. Recognise that building relationships, trust, commitment, leadership and capacity across local communities and statutory organisations needs time and:
    - plan to provide sufficient resources (see identifying the resources needed)
    - start community engagement early enough to shape the proposed initiative
    - establish clear ways of working for all those involved
    - start evaluating community engagement activities early enough to capture all relevant outcomes
3. Support and promote sustainable community engagement by encouraging local communities to get involved in all stages of a health and wellbeing initiative. Do this by:
    - identifying and working with community networks and organisations, particularly those reaching vulnerable groups or recently established communities
    - involving communities in setting priorities
4. Ensure decision-making groups include members of the local community who reflect the diversity of that community. Encourage individual members to share the views of their wider networks and others in the community.
5. Feed the results of engagement back to the local communities concerned, as well as other partners. This could be communicated in a range of ways, for example, via the local newspaper or community website, via community groups or via public events in community venues or other widely accessible places.

Recommendations:

13. Further develop the governance structure of Children's Centres and align this to the vision for Centres' work with communities.

5.1.4. How does the mix of services and programs available to families differ across Children's Centres?

The Children's Centre Outcomes Framework provides a guide to Centres to help them align their work to the overall aims of Children's Centres. Specifically, Children's Centres are tasked to provide universal services with targeted support in order to effect population outcomes in four areas:

1. Children have optimal health, development and learning

2. Parents provide strong foundations for their children's healthy development and wellbeing

3. Communities are child and family friendly

4. Aboriginal children are safe, healthy, culturally strong and confident (Department for Education and Child Development, 2011)

As a result of the Children's Centres mandate to be responsive to community need, it is expected to find variation in the range of services and supports available to families. For example, in communities where there is dearth of high quality child care available, Centres may run long day care services on site. In regional communities facing service shortages Centres may seek to address gaps in service provision. In communities that accommodate large numbers of newly arrived refugee families, Centres may establish support groups and services to meet the needs of these families. In this way, service provision across Centres will vary dependent on community context. However, it is also expected that there will be overlap in service provision, and this will be especially prominent for the types of services all families can benefit from. For instance, playgroup, parenting supports, and allied health services should be available in all Centres. This is because these types of services are general supports that are valuable to all families, no matter their context.

To examine the extent to which services across Centres varied in South Australia, administrative data from the Early Years System detailing available programs was interrogated. The data demonstrated that some Centres provided a large range of program types while others provided fewer program types. Correspondingly, some Centres ran 30 or more programs each term while others ran 10 or fewer programs. As discussed earlier in this report, the types of programs offered varied in the extent to which they were offered across sites. Parenting support services, family support, and supported playgroups were most frequently offered across Centres, followed by community groups and health services. Given that these types of programs are relevant to most communities, it is encouraging that this is reflected in the data. However, the evaluation is not able to determine with any certainty whether variation in Centres is due to community level variation or some other driver related to the capacity of Centres to deliver services.

The evaluation did not quantitatively measure the extent to which the Outcomes Framework was being utilised in Centres. In focus groups and interviews, the Outcomes Framework was discussed, with participants mentioning their uncertainty of how it should be used. Anecdotally, there have also been changes in the way this is communicated to Centres. Analyses presented earlier in this report related to families' access to services, suggests that there is an opportunity for improvement to

ensure that services are appropriate to need and that all families have access to services and supports in the community. The way in which Centres work toward this should be documented and monitored at the local level and form part of any performance indicators for Centres. Specifically, to ensure that the needs of communities are met and that service provision is context dependent, Centres should document the planning process, including: identified needs, available resources, planned response, intended reach (who is the support aiming to reach), and envisioned outcomes. This will better enable Centres to monitor the extent to which services and supports meet the needs of communities.

There is potential for the Outcomes Framework to provide a template for planning and monitoring if Centres value the Outcomes Framework. It is important that Department also consider the Children's Centre Outcomes Framework within the broader array of frameworks for children. That is, any further development of the Children's Centre Outcomes Framework should be conducted alongside existing frameworks. There are a number of national frameworks for supporting children's development. Two prominent frameworks used in the early years include ARACY's Nest (Australian Research Alliance for Children and Youth, 2014) and the Early Years Learning Framework (EYLF, Australian Government, 2009). Although these documents differ in their intents and audience, both outline areas in which children's development is to be supported. A recent addition to this space is the National Interdisciplinary Education Framework for Professionals working in the Early Years (Grant, Parry, & Gregoric, 2016). This framework sets out a shared approach to supporting children and families from birth to five years. The framework also includes a statement of outcomes across five domains. Outcome areas across all frameworks align, to some extent, with outcome areas in the Children's Centre Outcomes Framework. Moreover, early years education and care programs in Children's Centres already work within Early Years Learning Framework (EYLF). Drawing this information together in a coherent way can provide Centres with a consistent approach and set of expectations to support their planning for children and families.

Recommendations:

14. An opportunity exists to develop a reporting plan and reporting framework for Children's Centres. In doing this, consider the Children's Centres Outcome Framework and how this is currently being used.

5.1.5. Who is accessing services and supports in Children's Centres (reach) and how much support are they receiving (dose)?

Data available for the evaluation was not sufficient to determine reach or dose for children and families. Determining reach and dose of Centres is critical and should be prioritised. At the outset of the evaluation, a data gap analysis was conducted to determine what data was being collected in Children's Centres. The data gap analysis also sought to inform what data should be collected administratively to report on the ongoing value of Children's Centres in the South Australian service mix. This data gap analysis identified that only Preschool, Occasional Care, and Long Day Care enrolment information was being routinely collected in Children's Centres. Enrolment and attendance data for the additional services and supports that were part of the Children's Centre

mandate (e.g. community and target playgroups, parenting programs and individual parenting support), was not being collected routinely and what was being collected was stored in a range of ways at sites with no central database. The exception being the Family Service Providers, who were regularly reporting data on their activities in a spreadsheet to line management in the (then) Office for Children and Young People.

Following this data gap analysis, a proposal to extend data collection in Children's Centres to capture Family and Community Programs (FCP) use was developed in conjunction with the Office for Education and Early Childhood (then the Office for Children and Young People). The proposal was progressed and the Early Years System (capturing preschool and occasional care information for SA government preschools) was expanded to enable the capture of FCP utilisation data. In 2014, quantitative evaluation works were put on hold to enable the evaluation to utilise EYS data once this was collected. At this time, it became clear that initial ideas about how the evaluation might measure impact of Children's Centres (presented in the Three Year Evaluation Plan – see, Brinkman & Harman-Smith (2013) were not feasible within the timeframe of the data collection enhancements. An alternative set of analyses to report on the range of services available in centres and who was accessing these services, and the impact of attending preschool in a Children's Centre site was developed.

Five pilot sites tested the data collection enhancements in Term 1 2015. After this time, the system was progressively rolled out to support centres to begin to enter data. By Term 4 2015 all sites had been supported by the EYS staff to set up information about the programs and services available in their sites. This initial set up was undertaken to enable sites to then enter information about children and families accessing these services. Three terms of data were made available to the evaluation team by late August 2016. It was not possible for the evaluation team to assess the completeness of this data, thus limiting the extent it could be utilised to report on FCP utilisation in Children's Centres.

Where data was entered, it was evident that the vast majority of children were enrolled for a single service during a term in a Children's Centre, with few children making use of multiple services. Although reach and dose could not be determined, the limited service provision data that was reported was analysed to examine whether particular population groups had better access to services in Children's Centres than did others. Demographic distributions for children using Centres were compared to the South Australian demographic distributions to examine the extent to which children attending Centres are representative of all children in SA. These findings should be considered preliminary until more comprehensive data is available.

Compared to SA population distributions, children attending Centres tended to live in more disadvantaged areas, come from an Aboriginal background, and live in remote areas of the state. Children from CALD backgrounds appeared to be under-represented in the group of children attending a Children's Centre. There were also demographic differences in the extent to which families used universal and targeted services. Children with an Aboriginal background had higher rates of preschool and health service usage when compared to the composition of the population. Families living in areas with high socio-demographic disadvantage were more highly represented in

universal service usage data for all program types except for playgroup. In contrast, targeted supports tended to be more heavily utilised by families living in more socio-economically advantaged suburbs, and families who are from English speaking backgrounds. There was mixed representation in service usage data for families living in regional and remote regions, with some services more heavily utilised and others underutilised. No population comparisons could be drawn for children under the Guardianship of the Minister (GOM). However, overall these children tended to have low reported universal service use—with most children enrolled only in preschool and several of these receiving preschool supports.

These preliminary findings indicate that although Children's Centres are located in areas of higher need, and thus attract families from suburbs with greater socio-economic disadvantage, additional supports in Children's Centres tended to be utilised more heavily by families from less disadvantaged communities. In the first national evaluation of Sure Start, adverse effects of the program were reported for the three of the 14 outcome variables for the most vulnerable populations when compared with those families in communities with no Sure Start centre (Belsky et al., 2006). It was postulated that this finding may have resulted from a paucity of service use in Sure Start Centres by families in the community facing the greatest barriers to service access—with services being primarily utilised by families facing fewer barriers.

Although a paucity of service use data limits the ability of the evaluation to definitively determine reach of services, the evaluation highlights the importance of administrative data collected in centres being used to monitor the effectiveness of any targeting strategies. That is, examining whether the program or service is reaching the people who need support. It must be noted that it is not sufficient to target programs based solely on demographic characteristics of families. Instead, Children's Centres should continue the work they already do to build trusting professional relationships with families that enable them to feel comfortable to share information about challenges they are facing. Referral pathways into the targeted services provided through Children's Centres should be investigated to understand why higher need families are not accessing the services. To enable those families who may not feel as comfortable talking to staff about their challenges, Centres should consider using intake forms and routine assessments of support needs. Intake procedures for targeted programs should assess child and family challenges so that these can be best fitted to available programs or supports.

Recommendation:

15. Investigate barriers impacting on the collection and entering of enrolment and attendance information for Family and Community Programs.
16. An opportunity exists to respond to identified challenges and enablers by consulting with Children's Centre staff to design and implement a strategy to improve the capacity of sites to collect and enter data.
17. Mandate administrative data collection in the same way it is mandated for other government provided services.

18. Consider implications of mandating data collection for service provision partners and what data sharing agreements will need to be negotiated at an agency level to best support planning and program monitoring.
19. Refine assessment and intake criteria and associated processes for the additional targeted support services.
20. An opportunity exists to design intake assessments in such a way that specific needs of families are matched to available services and that these are delivered as locally as possible.
21. Continue to engage all families in the community in universal services. Where universal services in Children's Centres are at capacity, connect families to similar services in the community.
22. Geographical boundaries for services should only exist for services that are available in each community to ensure that the capacity of each service point is utilised.
23. Opportunities exist for Children's Centres to create strong links between all Early Childhood Education and Care services (government and private long day care and preschool providers) and community health across suburbs to ensure all families have access to additional services and supports that have been located in Children's Centres for the benefit of the whole community (rather than solely the children attending ECEC services in a Children's Centre).

An additional recommendation is made in light of the findings of the Child Protection Systems Royal Commission Report. This recommendation is made along with three points for consideration.

24. Consider the role Children's Centres might play in the prevention/early intervention arm of a reformed child protection system in SA.

5.1.6. What impacts does utilising services and supports in a Children's Centre have on parents' parenting practices, wellbeing and social connectedness?

In focus groups, Children's Centres were spoken about as positively impacting on parents' wellbeing, parenting capacity and parenting practices. Support for parents and parenting happened through the provision of programs, but also through interaction with the Children's Centre staff, who were said to be supportive, understanding, and to have a greater capacity to promote positive parenting practices. Parents said that they were able to talk to staff about any parenting challenges because they knew staff were on the same page as them and could offer helpful ideas about things to try. Parents felt supported in their role through interactions with staff.

Additionally, parenting programs were spoken about as improving the way parents interacted with their children and with their partners. Parents also reported that attending Centres connected them to other parents in the community and in this way built peer-support networks. To explore quantitatively the impact of attending a Children's Centre on parental wellbeing, parenting practices and social connectedness, the parent survey included a number of validated parenting and wellbeing scales.

Parents using services in Children's Centres reported good overall wellbeing and rated themselves positively as parents. Parents also reported engaging in parenting practices that reflected high

parental warmth and low levels of hostile parenting. Parents reported that they frequently spoke to their children about their behaviour, the consequences of behaviours, how behaviours impact on others, and the need for rules. In comparison to the favourable responses for other scales, parents reported less consistency in their parenting behaviours. Parents also reported having high levels of social support. Additional analyses were conducted to examine the extent to which this varied across demographic groups, with differences noted for a number of groups of parents. Specifically, parents with a health condition or disability, parents of children with a health condition or disability, parents with more children, parents in their early 20s, and single parents reporting less favourable outcomes. Parenting, wellbeing and social connectedness did not differ uniformly across these groups of parents. Instead, these appeared to be related to the unique challenges faced by each group. For example, single parents reported less social support and parents with five or more children reported feeling greater time pressures.

Although the evaluation sought to compare the parenting outcomes of families using Children's Centres to those not utilising Centres, insufficient survey responses were received from families not using Centres. A similar survey of families using an integrated service or those not using such services was conducted as part of the evaluation of Tasmanian Child and Family Centres (Taylor et al., 2015). The Tasmanian evaluation reported similar levels of parenting self-efficacy ratings and social supports as reported here irrespective for both service users and those families not using services.

Self-report parenting measures provide some insight into the mechanisms that may be supporting children's development. Instead of providing a decisive conclusion about the impact of Centres, these measures are better used to differentially identify needs of families and whether these are being met for all families using Centres. Moreover, findings derived from self-report measures should not be considered definitive, but rather should be viewed alongside other outcomes data. In this way, a more complete story can be told about the ways in which Children's Centres enhance the outcomes of children.

The evaluation did not seek to measure the specific impact of the various range of parenting supports and programs available in Centres. Instead, this type of evaluation should be routinely conducted at the Centre or program (where it is being delivered across a number of sites) level. Collecting information about the impact of specific parenting supports on parents can also help to evaluate the appropriateness of these programs for addressing identified needs. Although Centres usually select evidence-based programs when seeking to implement supports for parents, there is little information about the extent to which these are implemented with fidelity and whether desired impacts are achieved. For such evaluation at the local level, it is important that measures are selected that are aligned with the desired outcomes. For instance, a parenting program that seeks to improve parent-child attachment should seek to collect information about parent-child attachment pre and post program. Measures should be selected that have been validated and found reliable and sensitive to change.

Recommendations:

25. Opportunities exist to measure and evaluate the impact of targeted supports, such as parenting programs or supported playgroups, to ensure these are having the desired effect for the target issue they seek to improve.

5.1.7. What difference does attending an integrated service setting make to children's development at the start of the school year?

Earlier identification of children's needs

The model of integrated care in a preschool setting is intended to support families to connect to services and supports early. Children's Centres bring together a range of education, health and family support staff. These staff offer a range of 'soft touch' supports (such as playgroups, community groups, and information provision) alongside targeted supports for children and families with complex needs. Bringing together diverse staff and services is intended to improve service coordination and referral process as well as enhance the capacity of staff to identify the needs of children and families. In focus groups and interviews, staff, service providers, Centre Directors, and families identified this as a key benefit of Children's Centres. Although this was reported anecdotally, this was not reflected in the linked AEDC and preschool data. While it is possible that Children's Centres are not systematically supporting early identification of children's additional needs, there are a number of possible explanations for this finding. The data included in the analyses utilised preschool enrolment data which is unlikely to accurately reflect the earlier use of Children's Centres. That is, not all of the children who attended preschool in a Children's Centre will have used additional services within the Centre. In the data presently available, there is no way to identify who has used services before preschool and who has only attended preschool. It is also not possible to identify children who may have utilised services in a Children's Centre but attended a standalone preschool. Another explanation is that a single year of preschool does not provide enough contact with non-education staff who work in Children's Centres that this is sufficient in and of itself to enable earlier identification of additional needs. At this stage, available data does not permit direct analysis of the benefits of integrated services before preschool. Enrolment and attendance data for all services offered in Children's Centres is required to comment on the extent to which these services are enabling early identification of children's needs.

Improved child development outcomes

Through early identification of children's needs and timely referrals to appropriate services and supports Children's Centres are thought to have the potential to improve the developmental outcomes of children. In addition to the benefits of early intervention, the parenting support provided within Children's Centres has the potential to improve the children's early experiences in the home environment, thus lead to improved developmental outcomes for children. Anecdotally, focus group and interview participants highlighted this as a key benefit of Children's Centres. In the present study, analyses of the linked AEDC and preschool administrative data were conducted to explore the developmental outcomes of children who attended either a standard or Children's Centre preschool. The AEDC provides a holistic snapshot of children's development across five domains (physical health and wellbeing, social competence, emotional maturity, communication skills and general knowledge, and language and cognitive skills). No differences between children

who attended a standard or Children's Centre preschool were found on any of these AEDC domains. Again, limitations in presently available data about the services children accessed in Children's Centres before school, may make it difficult to detect any impacts Children's Centres are having. What is clear is that attending preschool in either a standard or Children's Centre preschool is likely to be equally beneficial. Who is accessing earlier services, what services they are accessing, and how this supports children's development will be able to be explored as data collections in Children's Centres improve.

Recommendations:

No additional recommendations are made. Recommendations 17 and 25 are further supported by the findings of these analyses.

6. Conclusion

It is important to note that the initial aims and scope of the evaluation were developed in 2012. Since that time there have been a number of changes in the South Australian service provision landscape for children and their families, hence, it is important to consider the findings of this evaluation in light of these changes. Here we consider the service system in South Australia, recent changes, and the potential role for Children's Centres in the changing service provision landscape.

At the commencement of this evaluation in 2012, Children's Centres were considered a pilot project. The first two centres in South Australia were established in 2005. By 2009 an initial nine centres were operational. In 2010 a report published about the characteristics of families attending the first seven Children's Centres (Luddy, Lynch, & Sawyer, 2010) noted that limited data was available to assess what services and supports were available in sites and who was accessing the available services. A further 18 centres were progressively opened during 2010–2012, and a further 15 centres have been opened since the commencement of this evaluation in mid-2012.

In addition to the growth of the Children's Centre program, there have also been some changes to the range of services offered in Children's Centres—specifically the addition of the provision of community based antenatal services in five sites. This has provided families with connections to support in their community within a routine care environment, which can help support them beyond the birth of their child. Arguably this has been an important addition in improving the potential to provide early intervention and supports at a time that is critical for children's development. Indeed, there is a dramatically increasing body of evidence showing that the pathways to some adult diseases start in utero and early childhood. Whilst there may still be some residual tension with the 'traditional' public health groups who believe that the most important pathways involve adult lifestyle exposures (i.e. lifestyle health choices that are made by adults that can be impacted through public health campaigns and so forth) there is increasing realisation that the opportunities for prevention and public health interventions may be expanded by better understanding how the early pathways to disease start (Lynch & Davey-Smith, 2005). There is now clear evidence that a combination of exposures and social circumstances during childhood crucially influences health inequalities across the whole life course (Marmot, 2010).

Globally, an increasing investment in early years services have stemmed from a growth in the understanding of the importance of these early years, not only for later health outcomes but also as a critically important time in brain development (Gable & Hunting, 2000). Early childhood experiences have a decisive impact on the architecture of the brain, and on the nature and extent of adult capacities (Shore, 1997). The environment that shapes child development includes family and the immediate neighbourhood as well as the socio-economic, political, and cultural context. Children who have endured negative early life experiences are more likely to suffer mental and physical health problems, participate in delinquent activities, drop out of school and face prolonged unemployment (Hertzman & Wiens, 1996; Kuh & Ben-Shlomo, 1997; Robins & Rutter, 1990; Willms, 2002; Zubrick, Williams, Silburn, & Vimpani, 2000). For service systems aimed at supporting families, it is therefore critical that we examine the extent to which we reach families during this critical time.

Amid this expansion of the Children's Centres program, there have also been a number of important investigations of the functioning of the South Australian Child Protection System (Child Protection Systems Royal Commission, 2016; State Coroner, 2015) and subsequent revisions to thinking about how vulnerable children and families are supported in South Australia. The Child Protection Systems Royal Commission Report made a case for the importance of intervening early by presenting three arguments for the evidence for early intervention:

1. Early intervention offers an opportunity to interrupt painful, adverse experiences for children that can damage their later development and opportunities.
2. Damage caused by abuse and neglect is difficult to reverse.
3. It is costly to try to solve these problems in adulthood and early interventions are often a more cost-effective use of public resources.

Early intervention (in the primary and secondary services space) must consider the role of both universal services and targeted supports. A contraction of the universal service base in the interests of providing greater targeted supports is likely to have adverse impacts for large numbers of children. This is because, in the absence of a strong universal service base that is available to provide light touch supports to all families, children and families' needs will go unidentified until these become critical.

Light touch supports during children's formative years, when all families face some challenges, can help keep children and families on track and prevent them from needing more intensive supports. Indeed, the National Framework for Protecting Australia's Children (2009–2020) (Council of Australian Governments, 2009) called for the provision of both universal and targeted supports to families early to reduce the risk of children and families entering the statutory child protection system. Among a range of services for vulnerable families in South Australia, Children's Centres were noted in the mix of services as a place where families could access universal supports in a non-stigmatising space and be supported to access targeted supports where additional needs become evident.

Certainly, in its assessment of the functioning of the child protection system in South Australia, the Royal Commission Report (Child Protection Systems Royal Commission, 2016) stated the importance of universal and targeted support mapping at a community level. The Royal Commission's review of the early intervention service system in South Australia found a difficult to navigate mix of services with unclear referral pathways and stated that:

"Effective prevention and early intervention require an integrated system of primary, secondary and tertiary interventions (whether delivered by government, not-for-profit or community organisations) to identify and respond to the needs of vulnerable and at-risk families and their children. A public health approach, as advocated in the National Framework, involves more than providing generic services that fit the intensity level of universal, secondary and tertiary responses. It requires identifying and addressing the risk factors that compromise the safety of children in families, and delivering services that respond to those needs." (Child Protection Systems Royal Commission, 2016)

The extent to which Children's Centres have a role in or the capacity to undertake such community mapping of need should be further explored. A recent review of the role of Community Development Coordinators in Children's Centres (Harman-Smith & Brinkman, 2016) highlighted the opportunity to utilise this resource more effectively to support a greater number of children and families across the State. In Justice Nyland's call for reform of early intervention and service coordination, she stated that effective prevention and early intervention relies on:

- selecting and funding appropriate, evidence-based service models;
- robustly identifying vulnerable families, assessing their needs and referring them to evidence-based services; and
- coordinating support services with coherent referral pathways, and committing to share information and promote collaborative practice.

Given the range of services and supports available in Children's Centres, their capacity to support families holistically, and their child development expertise, the Department must consider the role Centres play within an effective early intervention and service coordination system. Children's Centres represent a large investment, but more importantly they are uniquely places that are for children and their families. Therefore, it is vital that Centres operate on a premise of using the best available data to understand the needs of the whole community; develop processes for effectively and efficiently identifying families who may need additional supports; and providing timely referrals to evidence based programs that address identified needs.

Children's Centres must do more than provide evidenced-based programs alone and to fill these with families who may be attending centres. Key to providing an equitable service system is identifying who may be missing out on services, what barriers are preventing those families from accessing appropriate and timely supports, and what needs to change to support the families who are falling through the gaps. This is a task that Children's Centres cannot undertake on their own. Fraser Mustard (Mustard, 2008) identified this need for joined up services in 2008 and there is still a way to go to realise this vision for all families.

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8. Appendices

Appendix A—Invitation letters

Appendix B—Consent text

Appendix A—Invitation letters

- Director Invitation Letter
- Parent Invitation Letter (parents who had used services in a Children's Centre)
- Parent Invitation Letter
- School Principal Invitation Letter
- Staff and Service Provider Information Letter

Information letter – Director and Heads of School Early Years

Children's Centre - Survey

Children's Centres bring together a range of services for children, families and communities in South Australia. We are investigating how these services work together and what benefits there might be for children, families and communities. As a Director or Head of School Early Years of a Children's Centre, we invite you to complete a questionnaire that asks you about your experiences of Children's Centres.

Participation

Participation will involve completing an online questionnaire that will take about 20 minutes. We will ask you questions about your experience of managing integrated service provision in a Children's Centres and impacts of this model of service that you see for children, families and communities.

Risks

There are no known or anticipated risks to you from participation in this research.

Confidentiality

All information you provide will be kept confidential and grouped with responses from other participants. The information you provide will be treated with strict confidence and kept secure. Although there is no intent to identify individuals, from the information you provide, it may be possible for the researchers to identify you. We need to collect this information to be able to match the perceptions of staff as to how the Children's Centres are working, to the perception of families attending the same service, however, all information collected will be stored securely and access to this information will be limited to members of the research team only and no names of participants or organisations will appear in any reports.
The information collected will be kept in a physically and digitally secure environment for a period of seven years at the Telethon Institute for Child Health Research.

Right to withdraw

You can choose to withdraw from this research at any time. However, once you have completed and submitted the questionnaire we won't be able to withdraw your responses, because all responses become anonymous once they are submitted.

If you have any questions about participation in this research, please feel free to contact Dr Yasmin Harman-Smith on 0438 112 418.

If you are interested in receiving a copy of the report of these research findings, please contact Dr Yasmin Harman-Smith at yasminh@ichr.uwa.edu.au.

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

Should you have comments or concerns resulting from your participation in this study, please contact Dr David Filby (8226 6367, SA Health Human Research Ethics).

Information letter - Parent

Children's Centre - Survey

Children's Centres bring together a range of services for children, families and communities in South Australia. We are investigating how these services work together and what benefits there might be for children, families and communities.

As a parent who has used a service in a Children's Centre, we invite you to complete a questionnaire that asks you about your experiences of Children's Centres. The questionnaire also asks you about your experience of being a parent.

Participation

Participation will involve completing a questionnaire that will take about 20 minutes. We will ask you questions about your experience with Children's Centres, parenting and your wellbeing. You can complete the questionnaire online or in paper copy. Paper copies are available in the Children's Centre and can be returned to a sealed box in the Children's Centre.

Risks

There are no known or anticipated risks to you from participation in this research.

Confidentiality

All information you provide will be kept confidential and grouped with responses from other participants. The information collected will be kept in a physically and digitally secure environment for a period of seven years at the Telethon Kids Institute.

Right to withdraw

You can choose to withdraw from this research at any time. However, if you complete the questionnaire online we won't be able to withdraw your responses once you have completed and submitted the questionnaire, because all responses become anonymous once they are submitted.

If you have any questions about participation in this research, please feel free to contact Dr Yasmin Harman-Smith on 0438 112 418.

If you are interested in receiving a copy of the report of these research findings, please contact Dr Yasmin Harman-Smith at yasmin.harman-smith@telethonkids.org.au.

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

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

Information letter - Parent

Children's Centre - Survey

Children's Centres bring together a range of services for children, families and communities in South Australia. We are investigating how these services work together and what benefits there might be for children, families and communities.

As a parent of a child who has recently started school, we invite you to complete a questionnaire that asks you about your experiences of accessing services before your child started school. The questionnaire also asks you about your experience of being a parent.

Participation

Participation will involve completing a questionnaire that will take about 20 minutes. We will ask you questions about your experience of accessing services, parenting and your wellbeing. You can complete the questionnaire online or in paper copy. Paper copies are available in your school and can be returned to a collection envelop at the school.

Risks

There are no known or anticipated risks to you from participation in this research.

Confidentiality

All information you provide will be kept confidential and grouped with responses from other participants. The information collected will be kept in a physically and digitally secure environment for a period of seven years at the Telethon Kids Institute.

Right to withdraw

You can choose to withdraw from this research at any time. However, if you complete the questionnaire online we won't be able to withdraw your responses once you have completed and submitted the questionnaire, because all responses become anonymous once they are submitted.

If you have any questions about participation in this research, please feel free to contact Dr Yasmin Harman-Smith on 0438 112 418.

If you are interested in receiving a copy of the report of these research findings, please contact Dr Yasmin Harman-Smith at yasmin.harman-smith@telethonkids.org.au.

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

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

Information letter – School Principals

Children's Centre - Survey

Children's Centres bring together a range of services for children, families and communities in South Australia. We are investigating how these services work together and what benefits there might be for children, families and communities. As a School Principal in a region that has a Children's Centre, we ask for your support to recruit the parents of children who have commenced in reception in your school this year.

Parents who volunteer to take part will be asked to complete a brief survey, either online or in hard copy, that asks about their experiences of accessing services and supports for their child in the year before commencing school. The survey also asks some questions about people's experience of being a parent.

Risks
There are no known or anticipated risks to parents from participation in this research.

Confidentiality
All information parents provide will be kept confidential and grouped with responses from other participants. The information collected will be kept in a physically and digitally secure environment for a period of seven years at the Telethon Institute for Child Health Research.

Right to withdraw
Parents can choose to withdraw from this research at any time. However, once they have completed and submitted the online questionnaire we won't be able to withdraw their responses, because all responses become anonymous once they are submitted.

A researcher from the Fraser Mustard Centre, Telethon Kids Institute will contact you in the coming weeks to discuss recruitment of families through your school. If you would prefer not to be contacted, please email yasmin.harman-smith@telethonkids.org.au.

In the meantime, if you have any questions about this research, please feel free to contact Dr Yasmin Harman-Smith on 0438 112 418.

If you are interested in receiving a copy of the report of these research findings, please contact Dr Yasmin Harman-Smith at yasmin.harman-smith@telethonkids.org.au.

Ethics approval for this study has been granted by SA Health Human Research Ethics Committee and approval to recruit parents through DECD school sites has been granted by DECD.

Should you have comments or concerns about this study, please contact Dr David Filby (8226 6367, SA Health Human Research Ethics).

Information letter – Staff and Service Providers

Children's Centre - Survey

Children's Centres bring together a range of services for children, families and communities in South Australia. We are investigating how these services work together and what benefits there might be for children, families and communities.

As a person working in or working with a Children's Centre, we invite you to complete a questionnaire that asks you about your experiences of Children's Centres.

Participation

Participation will involve completing an online questionnaire that will take about 20 minutes. We will ask you questions about your experience of working in or with Children's Centres and impacts that you see for children, families and communities.

Risks

There are no known or anticipated risks to you from participation in this research.

Confidentiality

All information you provide will be kept confidential and grouped with responses from other participants. The information collected will be kept in a physically and digitally secure environment for a period of seven years at the Telethon Institute for Child Health Research.

Right to withdraw

You can choose to withdraw from this research at any time. However, once you have completed and submitted the questionnaire we won't be able to withdraw your responses, because all responses become anonymous once they are submitted.

If you have any questions about participation in this research, please feel free to contact Dr Yasmin Harman-Smith on 0438 112 418.

If you are interested in receiving a copy of the report of these research findings, please contact Dr Yasmin Harman-Smith at yasmin.harman-smith@telethonkids.org.au.

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

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

Appendix B—Consent text

Consent to take part in online Questionnaire

All participant groups

Thank you for taking part in this study being undertaken by the Fraser Mustard Centre, the Telethon Institute for Child Health Research.

The information you provide will help build a better understanding of the facilitators and barriers for providing integrated services for children and families in Children's Centres, and the impact of Children's Centres on children, families and communities.

The anonymous questionnaire takes about 20 minutes to complete. By completing it, you will be indicating your consent to participate. It will not be possible to withdraw your consent after finishing and submitting your answers, because individual responses won't be identifiable. However, if you do decide to participate but then change your mind before finishing the questionnaire, simply close your web browser.

The information you provide will be treated with strict confidence and kept secure. Access to study information will be limited to members of the research team and no names of participants or organisations will appear in any reports.

The research has been approved by the SA Health Human Research Ethics Committee. If you have any questions about the study, feel free to contact Yasmin Harman-Smith by phoning 8207 2089 or emailing Yasmin.harman-smith@telethonkids.org.au

ABOUT THE FRASER MUSTARD CENTRE

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

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

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

A COLLABORATION BETWEEN

FRASER MUSTARD CENTRE

Government of South Australia
Department for Education

TELETHON KIDS INSTITUTE
Discover. Prevent. Cure.

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