Submission to Productivity Commission

Proposal for a Clinical Trial of a New Targeted Early Intervention Program for Vulnerable Families

3 December 2019

Summary

This submission proposes that

- **vulnerable families** be identified as one group of Australians who experience high levels of mental ill health and transmit mental illness between generations
- that targeted early intervention will markedly reduce the transmission of mental illness between generations, and
- vulnerable families are a group who warrant support services that are designed for their specific needs, and this can be achieved by relatively minor re-adjustments of existing services.

The concept of a vulnerable family was identified in the National Framework for Protecting Australia's Children that was adopted by COAG in 2009. The National Framework distinguished the concepts of **vulnerable family** and **at-risk** child.

An **at-risk child** is exposed to a risk of harm that is immediate and severe, and that warrants removal of the child from parental care into the care of the state. Examples of serious risk include exposure to sexual abuse, to severe physical abuse, and to chronic neglect due to parental substance abuse or severe parental mental illness.

A **vulnerable family** is one where a child is exposed to adverse parenting practices that produces cumulative harm to a child over time, and leads to the child developing long term mental health problems. Most parents in vulnerable families experience mental health conditions of anxiety and depression, and these conditions are passed on to their children unless effective family-oriented therapy is provided.

Vulnerable families can be helped if they receive appropriate early intervention that supports parents to replace targeted parenting practices that produce adverse experiences for their child with parenting practices that enhance their child's mental wellbeing. Targeted early intervention can be provided by suitably qualified clinicians who operate in a community setting.

The submission reviews research about vulnerable families and recommends that further research be conducted on the cost-effectiveness of interventions for this population group.

The submission reports on a program implemented in South Australia over a period of 6 years that provided targeted interventions that improved parenting skills in vulnerable families and that reduced the exposure of children to risk factors for developing mental illnesses.

The submission seeks support for a clinical trial of a clinician-led targeted early intervention program for vulnerable families that is evaluated according to criteria outlined in the Draft Mental Health Report of the Productivity Commission published in October 2019.

The submission is presented in 4 parts:

1. Research
2. Situation in South Australia
3. Proposed Targeted Early Intervention program for vulnerable families
4. Other issues.

Part 1 - RESEARCH

Current practice adopted by many child protection agencies in Australia is to remove children from vulnerable families as a first intervention rather than as a last resort. There is significant research showing that removing a child from the care of parents they have an attachment bond to creates mental health issues for the child. This submission proposes the delivery of targeted early intervention for vulnerable families to give these families an opportunity to benefit from skilled professional help and to improve their parenting practices in ways that minimise the risk of their children experiencing mental health issues in the future.

Research about the impact on the mental health of children of prolonged removal of a child from the care of a parent with whom they have a strong attachment bond is briefly summarised. Research on other topics is summarised.

Research about impact on child of prolonged separation from a parent

There is considerable research about the impact on a child of prolonged separation from a parent with whom the child has formed an attachment bond. McLean (2018) summarised evidence that a child's brain functioning changes when a child experiences severe trauma, interfering with the child's ability to process their emotions and to think clearly. McLean reviewed evidence that severe disruption to an established child-parent attachment bond can have an ongoing impact on a child's brain, leading to long term mental health difficulties.

Howard and colleagues (2011) recommend that if it is necessary to remove children from the care of a parent because of a risk of immediate and serious harm, then it is important to provide the child with trauma-focused therapy. Children who do not receive appropriate therapy develop a high rate of mental health conditions including an 'affectionless character' and later show an ongoing tendency towards emotional disturbance and aggressive tendencies (McLean 2016a, 2016b; Lamb 2012).

A study by Guy and colleagues (2016) found that disruption in a family during the early years of a child's life is both a risk factor for a child developing a mental illness later in their life, and an opportunity to provide therapy for the child.

A study by Golsis and colleagues (2016) found that children who maintain frequent contact with the birth parent after being removed from their parent at a young age have better long term mental health.

Overall the studies support a conclusion that it is important to teach children good mental health resilience skills during the time the child's brain is developing, from the ages of 4 to 12 years.

References:

- Golsis, A., Ozcan, B., & Sigle, W. 2016. Child outcomes after parental separation: variations by contact and court involvement. London: Ministry of Justice.
- Guy, S., Furber, G., Leach, M., & Segal, L. 2016. How many children in Australia are at risk of adult mental illness? Australia and new Zealand Journal of Psychiatry, 50, 1146-1160.
- Howard, K., Martin, A., Berlin, L., & Brooks-Gunn, J. 2011. Early mother-child separation, parenting and child well-being in Early Head Start families. Attachment and Human Development, 13, 5-26.
- Lamb, M. 2012. A wasted opportunity to engage with the literature on the implications of attachment research for family court professionals. Family Court Review, 50, 481-485.
- McLean, S. 2016a. Children's attachment needs in the context of out-of-home care. Australian Institute of Family Studies.
- McLean, S. 2016b. The effect of trauma on the brain development of children: Evidence-based principles supporting the recovery of children in care. Australian Institute of Family Studies.
- McLean, S. 2018. Developmental differences in children who have experienced adversity. Australian Institute of Family Studies.

Australian Institute of Health and Welfare AIHW

The AIHW report Child Protection 2017-2018 states the following:

- 1 in 32 children aged under 18 in Australia or 2.87% of all children are referred to Child Protection services
- The rate of notification to Child Protection has increased by 25% in the last 5 years
- 63% of families where a notification is made to child protection services have previously been referred to a Child Protection agency
- 56% of notified children are removed from their homes while allegations are investigated and then returned to parental care as allegations are not substantiated. 82% of removed children remained out of parental care for at least a year while investigations are conducted, before being returned to parental care.
- Of children removed from parental care, 9 per 1000 are aged 1-4 years, and 8.4 per 1000 are aged 5-9 years.

- The types of substantiated abuse in notifications are: emotional abuse 48%, neglect 24%, physical abuse 16% and sexual abuse 12%.

Australian Department of Health

A report The Mental Health of Children and Adolescents (2015) by the Department of Health assessed the mental health of children in the Australian population using the Strengths and Difficulties Questionnaire SDQ.

The study reported the following prevalences of mental health disorders in children (Table A-1):

	Children aged 4-11 years	Children aged 12-17 years
Anxiety	6.9%	7.0%
Depression	1.1%	5.0%
ADHD	8.2%	6.3%
Conduct disorder	2.0%	2.1%

The study shows that the conditions of anxiety and ADHD are present in very young children aged 4-11 years. All four mental health conditions occur commonly in children aged 12-17 years.

Research in United Kingdom

Research in UK found that the rate of mental illnesses in children removed from parental care into state care was 5 times the level found in the general population (Ford et al, 2007; Tarren-Sweeney 2008; Sempic). In 2008 the UK Government required Local Councils that provided state care or out-of-home care for children to assess the mental health of each child in care on an annual basis using the Strengths and Difficulties Questionnaire (SDQ) and to forward data to a central authority.

Lok and Tzioumi (2015) studied this data set and reported that 60% of children in state care showed a mental health problem.

A further analysis of the UK data by Hillier and St Claire (2018) compared SDQ scores when children were admitted to state care and after 5 years of being in state care. The main results of the study are shown in Table 1.

Table 1: Changes in Children's Mental Health Status with Time in State Care

	On Admission	After 5 years
Level of mental health condition		
Normal range	55%	10%
Borderline range	15%	30%
Clinical range	30%	20%

The Hillier and St Claire study found deteriorations in the mental health status of children who remained in state care for 5 years. The percent of children in the normal range fell from 55% to 10%. The percent of children in the borderline range of having a mental health difficulty increased from 15% to 30%. The study found that 20% of children continued to exhibit mental health difficulties in

the clinical or severe range, showing that their mental health did not improve while they lived in state care.

Overall these statistics show that state care as provided in the UK is associated with deteriorations in children's mental health as measured by SDQ.

A further study by Baldwin and colleagues (2019) compared the mental health of 3 groups of children: children in state care, reunified children, and children who had never been in care. The study found that children in state care showed a higher rate of reactive attachment disorder, which is a condition where children do not form healthy attachment bonds.

References:

- Baldwin H., Biedal N., Cushworth L., Wade,J., Allgar V., & Vostanis P. 2019. Disentangling the effect of out-of-home care on child mental health. Child Abuse & Neglect, 88, 189-200.
- Ford, T., Vostanis, P., Meltzer, H., & Goodman, R. 2007. Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households. The British journal of psychiatry: the journal of mental science, 190, 319-325.
- Lok, L., & Tzioumi, D. (2015). Mental health needs of children in out-of-home-care. Journal of Paediatrics and Child Health, 51, 7-8.
- Sempic, J. Mental Health of Looked After Children in the UK: Summary. Centre for Child and Family Research, Loughborough University.
- Tarren-Sweeney, M., 2008. Retrospective and concurrent predictors of the mental health of children in care. Children and Youth Services Review, 30(1), 1-25.

Recommendation

It is recommended that the Productivity Commission identify the topic of effective interventions to reduce mental health conditions in children who experience prolonged separations from their birth parents is under-researched and warrants further research.

Part 2 – SITUATION IN SOUTH AUSTRALIA

This part reviews three initiatives that have been conducted in South Australia.

a - Establishment of Early Intervention Research Directorate

In April 2019 the South Australian Government announced the establishment of an Early Intervention Research Directorate(EIRD) within the Department for Human Services as part of the Government's response to the Nyland Royal Commission into the Child Protection System..

EIRD was established as the Nyland Royal Commission found that existing interventions were fragmented, poorly coordinated and not based on evidence.

EIRD plans to identify vulnerable families based on notifications to the Child Protection Department (DCP) that are deemed not sufficiently serious for DCP to take on a case. As parents have received one notification to DCP, these parents are likely to show greater motivation to respond to accept offers of assistance than occurs under other approaches, provided services are not delivered in ways that stigmatise parents and families.

The EIRD program aims to be child centred, outcome focused, collaborative, evidence-based, transparent, and achievable but ambitious.

EIRD aims to maximise the benefit of government expenditure.

b – Australian Centre for Child Protection

The Australian Centre for Child Protection is located in Adelaide, based at the University of South Australia. The Centre is dedicated to researching practical tools and techniques that will assist front-line staff who work with children in vulnerable families and family protective services.

c - Adaire Model of Early Intervention for Vulnerable Families

Between 1996 and 2006 the writer was team leader of the Community Mental Health team of the South Australian Mental Health Service for Adults, located at Adaire Clinic, Noarlunga. At that time 30% of adult clients registered with the Noarlunga Community Mental Health team were custodial parents of dependent children, and half of these clients were single parents. This is a high proportion of vulnerable families for a community mental health in Australia. The team decided to introduce an early intervention program to provide targeted support for vulnerable families in the Noarlunga region.

The Adaire early intervention program was designed to assist vulnerable families where parents used adverse parenting practices associated with their mental health condition. The Adaire program aimed to help parents to change their adverse parenting practices. The Adaire program was not designed for at-risk families where there was a significant risk of children being exposed to harm that was serious and immediate.

Adaire Clinic is located in the Noarlunga Health Village where health and welfare services are co-located. Other services in the local area were an office of the Department of Child Protection (then FamiliesSA) and a Womens' Health Centre.

i - Risk Factors

The Adaire program was designed to address five over-riding risk factors for mistreatment of children and subsequent development of mental health problems in children. The risk factors are: parental mental illness, parental misuse of substances, domestic violence, behavioural difficulties of children, and social isolation.

The program was designed to support parents who either had been hospitalised due to an episode of mental illness or were assessed as being at high risk of needing hospitalisation. Triggers for hospitalisation were identified. Two common triggers were: a parent's difficulty in managing the behaviour of their child, and distress due to ongoing disputes between separated parents or other family members about care of their child.

ii - Staffing

The Adaire program was implemented by a multi-disciplinary group of clinicians comprising clinical psychologists, mental health social workers, and mental health nurses. Each clinician functioned as a clinical case manager for allocated clients. Clinicians provided therapy on core topics and when further assistance was required the clinical case manager referred a client to an external service.

Clinicians aimed to contact clients initially on a weekly basis and then on a fortnightly basis. Contact was made both in a client's home and at the clinic. Typically clients were followed up for a period of 2 years while targeted interventions were implemented and outcomes monitored.

iii – Court orders

Some clients were on a mental health Community Treatment Order CTO issued by a Mental Health Tribunal or Guardianship Board. If a CTO was required then clinicians provided a treatment report to the Tribunal to justify an order or to request an extension of an existing order. While orders were often in place, most parents viewed the Adaire program as being helpful rather than oppressive and they and their families did not object to a CTO being in place. Perhaps because CTOs were in place, the Department of Child Protection (DCP) applied for fewer orders from the Youth Court to place children into the care of the Minister.

iv - Involvement of Department for Child Protection

Most cases were over-sighted by both a mental health clinician and the Department of Child Protection (DCP).

If a parent was hospitalised and the parent did not have sufficient family support then their children would be placed into the care of DCP. After the parent recovered from an episode of mental illness and was discharged from hospital and referred to the Community Team, the parent would apply to DCP to have their child returned to their parental care.

The Adaire program adopted an approach of making a further notification to DCP only if a parent displayed new adverse practices, but not to make further notifications about a known adverse parenting practice that the program was addressing.

v – Psycho-social in-home support

The Adaire community team was allocated limited funds by the Commonwealth Government to employ psycho-social support workers to prevent clients from being hospitalised. These funds were used to employ psycho-social support workers who had practical parenting skills and who were willing to work with a referred parent in the client's own home. The practical workers addressed issues that were identified by the parent and clinician as requiring assistance over and above therapy. The provision of psycho-social support was called a Parent Assist sub-program. Priority topics for clients were decided on an individual basis to suit the needs of each family. The support

worker was accountable to the clinician for topics addressed and for progress made, giving a clinician-led approach.

The Parent Assist sub-program was provided to about one quarter of parents in the overall Adaire program.

The support worker typically attended the parent's home weekly for 2 hours for 12 sessions. The clinician made risk assessments to ensure that practical workers operated in safe environments. The worker met with the clinician on a monthly basis to report progress and coordinate plans. The support workers were willing to work hours that suited the needs of each family. For example a worker might arrive at a home at 8.30am to help get children to school, or after 5.00pm to help a parent implement an evening routine.

vi - Assessment tools

The Adaire program developed or used 4 assessment screening tools that guided the work of clinicians. The screening tools are:

- Screen for **Parenting Capacity** that listed common risk issues or topics of concern that warranted intervention.
- Assessment of **child-parent attachment** for children aged 3-10 years based on observations made during a one hour period, similar to the Strange Situation procedure
- Assessment of **child's mental health** or **temperament** using the Strengths and Difficulties Questionnaire
- Assessment of **Parenting Style** that recorded strengths and shortcomings in parenting practices associated with the mental disorders of anxiety, depression and personality disorder.

The Parenting Capacity screen identified topics of concern for each individual parent. The other screens were used when further information and intervention was required on a specific topic.

vii – Content of psycho-education

The Parenting Capacity screen comprises a set of 35 items. Each item identifies specific educational content that needs to be provided to a parent. The parent's individual profile determined which educational modules were provided to each parent.

Psycho-education material has been prepared for all items in the Parenting Capacity screen and other screens before and after 2006.

viii - Evaluation of outcomes of Parent Assist sub-program

A brief evaluation of outcomes was conducted for clients of the Parent Assist sub-program. The majority of parents were diagnosed with depression or anxiety and traits of personality disorder, with a few having a diagnosis of psychosis.

Parent Assist was provided for a minimum of 3 months. Therapy was usually provided for a period of one year to parents who received the Parent Assist input, with some parents receiving a second year of therapy and over-sight. A follow-up was conducted one year after the parent was discharged

from receiving regular therapy. Parents were contacted in the follow-up and data was reviewed about any further admissions to emergency services.

The Parent-Assist sub-program was provided to 64 parents over a period of 6 years. Of parents who received Parent Assist support, 84% of parents (54 parents) were assessed as maintaining a standard of providing adequate care for their children during the intervention and follow-up period of one year. The children of 10 parents (16%) were permanently removed from the care of their parents as DCP applied for an order to place the child into the care of the Minister until the child was aged 18 years.

ix - Level of intensity of service

The level of intensity of services provided in the Adaire program could be classified as moderate using a scale proposed in the Stepped Care model of care.

Part 3 – PROPOSED TARGETED EARLY INTERVENTION PROGRAMME

This submission recommends three proposals to the Productivity Commission:

- That the Productivity Commission identify vulnerable families as being a group of Australians who require special consideration as these families transmit mental disorders between generations. Effective early intervention strategies are available. An effective early intervention service model can be introduced by re-organising existing services.
- The Productivity Commission recommend that a clinical trial of service delivery for vulnerable families be implemented in a state such as South Australia.
- The Productivity Commission identify the population group of vulnerable families as warranting further research.

South Australia is identified as a suitable site for a clinical trial for delivery of targeted early intervention services for four reasons:

- South Australia has conducted 3 Royal Commissions into the Child Protection system, and officials in South Australia hold a higher level of knowledge about the needs of vulnerable families than officials in other states
- The South Australian Government has recognized the importance of providing early targeted intervention for vulnerable families and in April 2019 announced the establishment of an Early Intervention Research Directorate (EIRD) located in the Department of Human Services that is mandated to re-organize existing childhood services.
- The Australian Centre for Child Protection is located in Adelaide.
- An Adaire program was implemented in South Australia, and some key personnel who are knowledgeable about the Adaire program hold key positions in South Australia.

EIRD Project

The EIRD project is commissioned to provide targeted early intervention for vulnerable families who are notified to the Department for Child Protection but where DCP has not taken up case

management. There is scope to conduct a clinical trial involving vulnerable families who are referred to the EIRD service.

Further detail is provided below about a proposed early intervention service for vulnerable families that addresses topics and standards identified by the Productivity Commission and by EIRD.

Details of Proposed Intervention

Details of a proposed clinical trial are summarised using headings that refer to topics identified as important by the Productivity Commission and EIRD.

1 - Target group

It is recommended that a clinical trial be implemented that delivers individually targeted early intervention to vulnerable families with an aim of encouraging parents in vulnerable families to improve their parenting practices by implementing identified parenting practices that are supportive of their individual child's mental wellbeing and ceasing adverse parenting practices.

2 - Gap in services

It is recommended that the Productivity Commission identify vulnerable families as being an important group in Australia that contributes to increasing rates of mental illness in parents and children, and that contributes to the preventable transmission of mental illness from generation to generation.

It is recommended that the Productivity Commission identify vulnerable families as a group where service delivery could be improved markedly within 2 years in a selected state.

3 - Aims of intervention

The aim of early targeted intervention is to assist parents in vulnerable families to improve their parenting practices, to provide parenting that is appropriate for the assessed temperament and mental health status of their individual children, and to achieve standards of being a competent parent within a reasonable amount of time such as two years from referral to the program.

The program aims to maintain the good mental health of parents, to support parents through a period of heightened stress and through brief crises that are likely to trigger an episode of mental illness, and to assist parents to continue to make a constructive contribution in raising their children. The program will aim to keep vulnerable families intact and functioning at a good standard that meets the needs of individual children in the family, including the safety of children. The program will deliver family-oriented therapy, practical supports and monitoring.

4 - Cost savings

It is recommended that the Productivity Commission identify the provision of targeted early intervention for vulnerable families, where service delivery is led by a skilled clinician, as holding a high prospect of producing savings for the community. Savings occur as unnecessary removal of young children from parental care and placement into the care of the state for prolonged periods of time is avoided. The program aims to provide effective treatment for parents to ensure the parent resumes the role of providing an adequate standard of parenting within a short period of time, and continues to be a contributing parent in their community while ensuring the child is safe.

5 - Referral pathway

Many mental health clinicians in private practice have suitable skills to deliver early intervention therapy for vulnerable families. These private practitioners can be motivated to provide family-oriented therapy and clinician-led case management for vulnerable families if a suitable system is introduced by Medicare and State services.

It is proposed that a vulnerable family can be referred for an initial 6 sessions to a qualified clinician by the client's GP or by a staff of the Child Protection Department or by EIRD.

It is proposed that the clinician can apply for further sessions that are funded by either Medicare or the State by submitting an assessment report that identifies precise issues that will receive targeted therapy that is provided by the clinician. It is proposed that the clinician be required to provide reportable therapy in this program according to agreed standards.

6 - Single care plan

The Productivity Commission recommends use of a single care plan for people with complex mental health needs. A single care plan for vulnerable families can be based on a Parenting Capacity Screen that identifies topics of concern that warrant intervention. The Parenting Capacity Screen can be filled out by an administrative case manager in EIRD. A single care plan is then developed by the clinician and is used to coordinate interventions provided by the lead clinician and by other participating service providers. The clinician provides a clinical case management service to the client that is clinician-led.

It is recommended that a standardised Parenting Capacity Screen be adopted and routinely administered to vulnerable families referred to the early intervention program. A suitable Parenting Capacity screen identifies risk factors for each individual family from a list of common risk factors. One screen is used to ensure that all identified risk factors are addressed by an appropriate provider who is asked to provide therapy and to produce a focused treatment report that describes progress made on each specific topic where intervention has been provided. The use of one screen and one care plan will ensure that interventions are targeted and comprehensive.

The Parenting Capacity Screen that was designed for vulnerable families in the Adaire program can be made available for a clinical trial.

7 - Service delivery

It is recommended that vulnerable families be supported by both an administrative case manager and a clinical case manager. The roles of the two case managers need to be clarified.

An **administrative case manager** located in EIRD oversees all service delivery. The EIRD case manager:

- uses a Parenting Capacity screen to assess the level of intervention required for each family - either self-management by the client, or intervention led by a clinician with suitable skills.
- identifies a clinical case manager who has suitable skills to address the family's needs, or allows the parent to select a clinical case manager.
- passes on the completed Parenting Capacity Screen to the clinician so that there is agreement about the needs of each family

- allocates an initial 6 sessions to the clinical case manager so that therapy can commence promptly.

A **clinical case manager** is responsible for:

- personal delivery of clinical services
- conducting ongoing assessments of the needs of the family and informing the administrative case manager about any additional needs that are identified
- recommending need for psycho-social support services and supervising work by an allocated worker
- making referrals to external services as required by the family and coordinating input from other professionals to ensure that all important needs of a family are met
- providing treatment reports as required.

8 - Referral pathway

It is important to establish a clear referral pathway for clients who have multiple and complex needs especially if a client needs both skilled therapy and practical supports.

The following steps are recommended:

- a vulnerable family is referred by the Department of Child Protection to EIRD where an administrative case manager is appointed
- a clinical case manager is appointed and service delivery commences.

The clinical case management role might be provided either by an employee in State services or by a private clinician who is funded by Medicare.

The following is recommended:

- that EIRD or the state Child Protection Department be authorized to allocate an initial 6 sessions to a private clinician based on notification of concern by DCP, or by a client's GP. The initial allocation of services will provide funds for a clinician to provide introductory therapy, to read documents provided by DCP, and to prepare a treatment plan that is submitted to EIRD based on information provided in the Parenting Capacity Screen.
- That the client's GP be involved in authorizing funding for further sessions conducted by a private clinician.
- That EIRD be authorized to fund allocation of a psycho-social worker to provide in-home support when recommended by a clinician, where the work performed by the psycho-social worker is directed by the clinician.
- That a maximum of 30-40 sessions be allocated to a clinician in the year following referral.

9 - Coordination of care

Coordination of care is an important topic when a client displays several risk factors, or has co-morbidities, or has many and complex needs. Coordination of care is more complex when a client requires a combination of both health services and social support services.

It is recommended that care of a vulnerable family be based on a coordinated approach between an administrative case manager (located in EIRD) and a clinical case manager (located in the community).

The role of an administrative case manager is to identify a referred client as eligible for the early intervention service, to register the client and complete a Parenting Capacity Screen, to identify a suitable clinician, to approve recommended psycho-social supports, and to receive treatment reports from the clinician.

The administrative case manager can also adopt a role of receiving objections if a family disagrees with recommendations made by the clinician about the provision of services from other members of the multi-disciplinary support team.

10 – Benefits of clinician-led service delivery

Having services delivered to a vulnerable family with complex needs by a clinical case manager has the following benefits:

1. provision of all necessary supports is coordinated by one responsible professional who has expertise on topics that are most important for the family
2. there is markedly reduced need for the client to see many providers and to repeat their story to several providers
3. service delivery is flexible and meets the individual needs of families, based on assessment tools and the clinical judgment of the lead clinician
4. there is continuity of care as the client does not have to wait to make appointments with a large range of different therapists
5. a suitable allocation of sessions can be made for therapy involving the parent, the child, and for dyadic therapy
6. service delivery is seamless and client-centred, with minimal need to refer to multiple agencies
7. interventions meet established clinical standards of care
8. the role of an administrative case manager is clarified to support service delivery that is recommended by the lead clinician
9. the need for multi-disciplinary case conferences is minimized as one lead clinician is responsible for decisions
10. involving several clinical providers ensures that service delivery is not dominated by a single philosophy of care provided by one agency that holds a monopoly in providing services
11. the clinician can ensure that interventions empower a parent who demonstrates change and reaches the standard of providing competent parenting for their individual child, encouraging a safe level of self management
12. use of group therapy for parents or children can be provided at the discretion of the clinician
13. children who become child-carers or are parentified can be identified and provided with individualised support
14. one professional accepts responsibility for the safe and effective delivery of care
15. services can be provided using a system where the clinician is reimbursed on a fee-for-service model within set limits.

11 – Benefits of using a single tool to assess Parenting Capacity

Benefits arise if all clinicians use the same screen to assess Parenting Capacity, as follows:

1. using one standardised assessment instrument to measure Parenting Capacity ensures a uniform approach to service delivery for clients who have multiple and differing needs
2. a standardised Parenting Capacity screen ensures that some important needs are not over-looked while other needs are over-emphasised
3. use of a standardised Parenting Capacity screen makes it easier for clinicians to provide treatment reports that are brief and focused on targeted topics
4. use of a standardised screen allows summary treatment or progress reports to be made available to all participating services ensuring sharing of critical information
5. the basic Parenting Capacity Screen can refer a clinician to use a more specific screen to address specific topics such as chid-parent attachment, the child's current mental health status, and the parenting style used by the parent.
6. use of standard tools enables an assessment to be made of when a parent meets the standard of competent parenting on specific topics, rather than waiting until an holistic assessment shows that the parent has achieved this standard on a large number of topics
7. a single tool facilitates communication between all service providers, and facilitates analyses of the adequacy of assessment tools and interventions.

12 – Additional screens

Experience gained during the Adaire program identified a need for 3 screens that are commonly required with vulnerable families, in addition to the Parenting Capacity Screen.

The three extra screens are:

- a screen to assess **child-parent attachment**
- a screen to assess a **child's mental health functioning** and temperament of children, such as the Strengths and Difficulties Questionnaire SDQ. The SDQ can be used as an outcome measure by repeating the measure over time.
- a screen to identify the **Parenting Style** used predominantly by a parent, and changes in parenting style over time.

Each screen provides an individualised assessment and recommends specific interventions.

If screens provide quantified scores then the screen can also be used as an outcome measure by administering the screen later on and observing whether there is an improvement in scores of over. Researchers can identify cut-off scores that indicate a parent shows the standard of a competent parent.

Having several assessment screen means there are many components in the overall program. Screens and associated interventions that have been developed during and after the Adaire program was implemented can be made available in a clinical trial.

13 – Assessment of Parenting Style

Work that commenced during the Adaire program focused on parenting styles that were commonly used by parents who experienced different mental health conditions including anxiety, depression, and traits of personality disorders. Experience showed that it is more efficient to develop scales that

describe **parenting styles** rather than checklists of adverse parenting practices that are linked to specific mental health conditions of parents.

Experience from the Adaire project, and review of literature, led to the production of an assessment tool for Parenting Style that is relevant to vulnerable families where a parent has a mental health condition, misuses substances, a family has been exposed to domestic violence, and a child has a distinct temperament. This Parenting Style Screen produces quantified scores and can be made available in a clinician trial conducted in Australia.

14 - Services usually provided by clinicians

Skilled clinicians in the Adaire program were able to provide the following services to at least a moderate level:

1. Provide psycho-education about common impacts of mental illnesses on parenting styles , and monitor specific impacts on a child
2. Help parents to recognise signs of mental health struggles in their child, and the need to adjust parenting to suit their child's temperament
3. Provide psycho-education about the adverse effects of illicit substances on parenting, and monitor the specific impacts of parental substance use on a child
4. Manage situations where a parent is exposed to domestic violence, and monitor specific impacts on a child
5. Support a parent during stressful times that increase the risk of an episode of mental ill health
6. Recognise the emotional needs of young child and be able to provide child-oriented therapy on identified topics, including parent-child or dyadic therapy
7. Monitor that children aged 8-13 years do not provide excessive support to their parent with a mental illness, and refer child-carers to available COPMI services (Children of Parents with a Mental Illness)
8. Be familiar with child-parent attachment bonds and know how to repair insecure attachments
9. Recognise signs of separation anxiety, and be able to counsel separated parents about steps to manage their child's separation anxiety
10. Assist parents to recognise adult disputes that are not suitable to discuss with children, and to not use their child as a confidante
11. Encourage co-parenting with a separated partner or other carer as ordered by a Family Law Court
12. Give advice about complex family situations and encourage a parent to accept reasonable support from members of their extended family, and to reduce tensions in a client's extended family
13. Advise family carers, with the consent of the parent who is the primary client
14. Help family members to deal with community stigma
15. Follow the principles of providing services that are in the best interests of a child, and ensuring safety of the child
16. Arrange admissions to a mental health unit if a parent experienced a relapse of severe mental illness

17. Be able to provide focused treatment reports to a legal body when required that describe issues addressed, therapy provided, and progress made by the client.

Clinicians who lead therapy for vulnerable families need a number of skills that have arisen from different disciplines, so clinicians need to adopt a healthy inter-disciplinary attitude.

As clinicians require a high level of skill on many topics, the level of remuneration for clinicians needs to be at a suitably high level.

15 - Services commonly outsourced

Services that were commonly outsourced by allied health and nursing clinicians in the Adaire program are:

1. Budget management for parents who had difficulty living within their income
2. Ensure clients receive appropriate funding supports
3. Referral to specialist Drug and Alcohol Services for parents who showed a very high commitment to use of substances that leads to a heightened risk of neglect of their children
4. Encourage a parent who is subject to domestic violence to go to Police
5. Arrange a review of medication by a psychiatrist if required
6. Approach accommodation services if a parent is at risk of becoming homeless
7. Approach Women's Services for gender specific matters
8. Couple therapy especially for separated parents who persistently dispute arrangements for their child
9. Refer families to DCP if a parent either displays new risk factors or fails to make adequate progress in achieving the standard of a competent parent after participating in interventions
10. Recognition of the role of the Child Protection Court if there is a need for a child at-risk of serious harm to be removed from parental care.

16 - Online delivery of psycho-education services

While the Adaire program was operating and subsequently, work was carried out to produce psycho-education material that is designed to improve the parenting skills of parents who display each shortcoming identified in the Parenting Capacity screen and other screens.

At present, psycho-education and interventions are recorded on paper. Steps are being taken to transcribe interventions into a format that can be delivered directly to families using an online App. This work is being commissioned by a private company Adelaide Psychological Services through an existing program called WeParent.

Delivering targeted psycho-education directly to parents through an App has several benefits:

1. consistency in psycho-education is ensured
2. parents who have a smart phone or computer can access the psycho-education material promptly in their own time and they can work through modules at their own pace
3. modules are delivered that address specific issues according to the assessed individual needs of each family

4. parents who are able to self-manage do not feel stigmatised when they access material using an App, and parental apprehensions about being judged by a service provider are avoided
5. parents are able to re-read content they struggle with, minimising the need for professionals to repeat basic points
6. a confidentiality arrangement can be made that allows clinicians and practical workers to access the same material that is provided to a parent from the individualised assessment
7. an App can be designed to record a parent's progress and to provide progress reports to the parent and to participating professionals
8. an App can facilitate use of further assessment screens, such as an assessment of child-parent attachment, and measures of a child's mental health or temperament
9. an App can deliver the same content to parents who are not registered in a monitored early intervention program, normalising the program
10. delivering content through an App facilitates research on the efficacy of each component in the overall program as data is held in the App.

No other online program is known that provides specific online education for vulnerable families.

17 - Use of psycho-social support workers

It is proposed that an early intervention program for vulnerable families encourage the use of psycho-social practical support workers who act as an in-home coach for a parent on targeted topics, when in-home assistance is requested by a client.

It is proposed that availability of in-home workers be approved by the EIRD administrative case manager based on a recommendation by the clinical case manager. The psycho-social worker is accountable to the lead-clinician both for identifying topics to address in each individual family and for providing progress reports.

It is proposed that in-home workers operate within a funding budget that is managed by EIRD.

Eligibility of a family for practical in-home support is recommended by the family's lead clinician, based on established guidelines.

Psycho-social support workers might be employed by a current non-government agency that provides overall support including insurance.

18 - Accountability

Having a standardized Parenting Capacity Screen facilitates accountability as the screen identifies risk issues in an individual family that need to be addressed. Each clinician is responsible either for providing therapy to address each need, or for referring a family to an appropriate service provider.

The use of a standard Parenting Capacity screen promotes accountability as the screen can be used to identify who is responsible for providing each service. This format will identify any gaps between services in demand and services that are available in a local community.

The clinician identifies topics of concern based both on information received and on their own assessments. The clinician is responsible for recording when a parent's functioning reaches the standard of a competent parent, based on agreed standards of care.

A standard screen for Parenting Capacity both ensures that interventions are targeted to identified concerns or that the right service is provided for the right family, and improves accountability. When no screening tool is used, service delivery tends to be holistic with a risk that some topics are over-serviced while other topics are over-looked.

A standard screen allows both the administrative case manager and the clinical case manager to monitor progress on each topic of concern.

De-identified data collected using the Parenting Capacity Screen can be made available to EIRD and to researchers to facilitate assessments of the cost-effectiveness of each component of the overall program.

19 - Outcome measures

A range of outcome measures can be used to monitor the effectiveness of early intervention therapy for vulnerable families. The overall program includes a number of components and the efficacy of each component can be assessed.

If screens provide quantified scores then screens can double as outcome measures.

If data is recorded using a computerised system, then data can easily be collated and analysed at both an individual level and an aggregate level.

Progress can be measured on each specific topic for each family if an online or App system of recording is used. Measures of progress in an individual case that can be recorded using an App that guides interventions for individual families are:

- A parent achieves the standard of being a competent parent on an increased number of topics of concern as identified using a Parenting Capacity screen.
- Improved scores on a quantified measure of a child's mental health, such as the Strengths and Difficulties Questionnaire
- Improved scores on a quantified scale that assesses child-parent attachment bond
- Improved scores of a quantified scale that assesses supportive and adverse parenting styles.

Administrative measures of overall progress that could be recorded externally from the App include:

- fewer notifications to DCP and fewer substantiated notifications in a case
- fewer presentations of parents to Emergency Departments of hospitals, and fewer hospital admissions
- adequate attendance at school by a child.

PART 4 - OTHER ISSUES

This section addresses other issues that arise when a clinician works with vulnerable families.

1 - Adjustments to Medicare

The current Medicare Better Access scheme would need to be adjusted to fund the level of intervention recommended above as follows:

- Provide additional therapy sessions to provide family-oriented therapy, allowing a clinician to use about 30-40 sessions per year for 2 years with any member of a vulnerable family
- Extra sessions to allow a clinician to perform administrative tasks including reading documents provided by a Department of Child Protection or similar agencies, and liaising with other service providers
- Time to oversight input by any practical worker allocated to a family
- Additional time if treatment reports are required by a Child Protection Court
- A higher level of remuneration to a clinician who holds the high level of skill required for this work. A suitable level of remuneration would be equivalent to Level 3 in the Psychology awards in State services.

2 – Coordinate input from Commonwealth and State Governments

A targeted early intervention program for vulnerable families is best:

- Located in the community and over-sighted by a client's GP, so linked to the Commonwealth primary health care system, and
- Linked to State welfare systems.

It is important for the early intervention program to be linked to the primary health care if the aim is to keep family members out of more intensive emergency services and hospitals.

3 – Coordinate parenting standards between State and Commonwealth agencies

Vulnerable families and treating clinicians can be referred to four legal bodies that monitor human rights:

- Family Law Courts operated by the Commonwealth when separated parents dispute access to their child
- State Child Protection Courts if an allegation is made that a child is being abused or neglected
- Mental Health Tribunals if there is an allegation that inadequate parenting is due to a parent's mental health condition and the parent needs to participate in compulsory treatment
- Bodies that register health professionals to ensure that professionals provide interventions that are suitably targeted while respecting the rights of clients.

There is a need to ensure that the four legal bodies have similar powers to issue orders, and that all legal bodies set similar standards of adequate parenting and appropriate care by professionals.

It is beneficial if all four legal bodies publish rulings that address specific issues that arise with vulnerable families.

4 - Evidence base

There is a need for further research about the needs of vulnerable families, and effective interventions that respect the rights of children and adults.

5 - Workforce development

Clinicians who provide and lead services for vulnerable families require a set of skills as outlined above.

At present, many clinicians have specialised skills in some important areas but they might have doubts about their ability and confidence in providing a high level of skill in addressing some issues that are needed by vulnerable families.

Some workforce development will likely be required both to commence the innovative service system in a state and to maintain the service.

It is proposed that the Commonwealth or State Government sponsor a series of workshops for clinicians who express an interest in working with vulnerable families. It is proposed that each workshop be devoted to a topic that is important when assessing and treating vulnerable families. It is proposed that some workshops include a presentation from a human rights perspective to ensure that clinicians are informed about significant rulings made by Australia's legal bodies.

It is recommended that similar workshops be organised for psycho-social workers who provide services in the homes of vulnerable families.