Submission to the Child and Youth Wellbeing Strategy for 0-25 year-olds Tasmania Government Discussion Paper

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March 2021

Introduction

I have been honoured to serve the Tasmanian Child & Youth Wellbeing sector through my expertise in Family Nursing and Child & Family Health for over 20 years. This has been expressed through:

- Collaboration with The Australian Research Alliance for Children & Youth (ARACY) to help introduce the Six Domains of the Nest to Tasmania, now reflected in the Tasmanian Child and Youth Wellbeing Framework as The Six Domains of Child and Youth Wellbeing;
- Member of the Cross-Sectoral Consultative Committee for Strong Families – Safe Kids, Communities Tasmania;
- Collaboration with the School Health Nurse Program and the 2018–2021 Child and Student Wellbeing Strategy, Department of Education;
- Collaboration with CU@Home Child Health and Parenting Service for young first-time parents 15-19 years of age;
- State, National and International research, program evaluation, presentations and publications. For example, 'Can a Scheduled 15-minute School Nurse Appointment Influence Youth Health? Evaluation from an Enhanced School Health Service', in *Developing practice: The child youth and family work Journal*, 42 pp. 55-65. ISSN 1445-6818 (2015) with Dr JuliaTaylor, an evaluation of a School Health Nurse program in NorthWest Tasmania; and
- Organising committee member for the Australian Conference for Neurodevelopmental Disorders, Launceston 2019 & 2021.

As a background to my engagement in the work of ARACY in Tasmania, and to avoid duplication, please find Appendix One *The Australian Research Alliance for Children and Youth (ARACY) submission to the Tasmanian Government's Healthy Tasmania Five Year Strategic Plan Community Consultation* 2016. This submission provides a background to ARACY and its flagship project, The Nest, foundational to the Six Domains of Child and Youth Wellbeing of the Tasmanian Child and Youth Wellbeing Framework. This work contains appropriate content to strengthen the current Tasmanian Child and Youth Wellbeing Strategy for 0-25 year-olds especially in response to the Being Healthy domain.

Recognising the Strengths of the Tasmanian approach to promoting Child & Youth Wellbeing

The Discussion paper powerfully articulates the extensive initiatives, programs and activities currently across Tasmania positively impacting multiple domains associated with child and

youth wellbeing. The Strong Families – Safe Kids response is an outstanding example of promoting a wellbeing approach.

The extension outlined in the Tasmanian Government Child and Youth Wellbeing Strategy for 0-25 year-olds builds on the successes of the collaborative Government and Non-government Services approach and moves towards a whole of community and whole of government approach. This is commendable and strongly supported. The success of the Child and Youth Wellbeing Strategy for 0-25 year-olds is dependent on the inclusivity of children, young people, families, the community and services, in the broadest notion, at all stages during development and implementation. Children have a right to participate in decision making concerning issues that affect them, and evidence shows "that the incorporation of children's views is beneficial to project outcomes and to children directly" (ARACY, 2019). This consultation process has demonstrated this principle well. Ongoing efforts to listen to the voice of children, young people and families are strongly recommended.

The broad, excellent and successful range of initiatives and programs offered in Tasmania, such as those that I have collaborated in—School Health Nurses Program, Child Health and Parenting Services (CHaPS), Child and Adolescent Mental Health Services (CAMHS), Child and Student Wellbeing Strategy, Strong Families – Safe Kids —have demonstrated positive outcomes that enhance the wellbeing of children. There remains, however, no clearly identified initiative or service that fully addresses wellbeing for all children and young people 0 – 25 years across the full scope of the six domains of wellbeing. Fragmentation of services targeted to narrow age ranges and family life cycle stages challenges children and families ability to effectively meet their expressed needs for support that is beyond diagnosable conditions and identifiable risks.

The Need to Strengthen a Holistic Upstream Coordinated Approach to Child & Youth Wellbeing

The current focus of programs and services, both across Tasmania and Australia, tend to be a response to different stages of identifiable needs, problems and high-risk context of life experiences. These can be considered as downstream to wellbeing and a context supporting a flourishing life journey and optimal outcomes. Services established to address specific identifiable needs, reduce risks and building strengths to address concerns of wellbeing are often empowered to respond in one or a few of the 6 domains of Child & Youth Wellbeing. Services with a downstream approach to wellbeing are essential to support and further strengthen families and children to meet their acute needs. The impact of any service, however, is enhanced by a multi-domain approach to resilience building. The importance

has been demonstrated when a child experiencing multidimensional-deprivation across the six domains of wellbeing, their outcomes are significantly enhanced by strengths found in one or more of the other six domains of child & youth wellbeing (Sollis, 2019).

The Tasmanian Child and Youth Wellbeing Strategy for 0-25-year-olds is unique in that it has a clear upstream focus on holistic wellbeing creating the context for children & young people to flourish across the six domains of child & youth wellbeing. The First 1000 days and CHaPS services are examples of a universal approach for a specific period in the family life cycle and resources to ensure they can continue to be holistic, universal and focused on promoting the context that helps promote wellbeing for all should be ensured.

Research strongly demonstrates that genetic makeup does not solely determine human behaviours and life outcomes. Enhancement of developmental outcomes requires positive and complementary relational and environmental experiences to support the translation of genotype to successful resilient phenotype (Bronfenbrenner & Ceci 1994).

> Human interactions are the primary mechanism through which human genetic potential is actualised (Bronfenbrenner 2001). Thus, development occurs through interactions between the individual and the interacting systems around them (Rutter 2006). These interactions, which become effective if occurring regularly over time, are bi-directional. The ecology changes the person and the person changes the ecology. Therefore, the individual is active in their own development through selective patterns of attention, action and responses with people, objects and symbols…The bioecological theory of human development proposes that, by enhancing human interactions and environments, it is possible to increase the extent of genetic potential realised into development (Bronfenbrenner 2001, Bronfenbrenner & Ceci 1994 p 568). The bioecological theory focuses on the mechanisms of development alongside the ecological context as equal determinants of development.
>
> Smith, 2013.

Understanding and supporting the bioecological determinants of wellbeing is essential in promoting an upstream, truly primary health care approach to facilitating child & youth wellbeing outcomes and reducing the pressure on downstream acute care biomedical services.

A universal, holistic supportive upstream wellbeing service for families, children and young people developed in collaboration with families, children and young people is required to help fulfil the vision of the Tasmania Government Child and Youth Wellbeing Strategy for 0-25

year-olds. The 6 domains of wellbeing challenges the current systems focus on the problematisation of childhood and the life journey. In the promotion of wellbeing a new approach that can provide a focus on strengths, relationships, wholeness and interconnectedness is required. The profession of nursing and the specialty area of Family Nursing is uniquely positioned to fulfil this need. Family Nursing in Australia is an emerging specialty however, Family Nursing is established globally (WHO, 2000). The International Family Nursing Association (IFNA) *Position Statement on Advanced Practice Competencies for Family Nursing* 2017 articulates the abilities of Family Nurses practising in Tasmania to promote child & youth wellbeing can bring. "Central to the role of the Family Nurse - Advanced Practice is the ability of the nurse to act within a collaborative, non-hierarchical relationship between families and nurses, to offer a focus on strengths rather than pathology" (IFNA, 2017, pg 2). Family Nursing with a focus on child & youth wellbeing aligns clearly to the aim of the Tasmania Government Child and Youth Wellbeing Strategy for 0-25 year-olds and could provide the leadership and management of a newly established holistic service for families, children and young people. Family Nursing could be embedded within current universal services such as Community Nursing and the School Health Nursing program.

Proposals to Enhance Child & Youth Wellbeing Outcomes in Tasmania

1. Establish the specialty area of Family Nursing with a focus on Child, Youth & Family Wellbeing to offer unique universal and inclusive upstream wellbeing care, strengthening families, children and young people with enhanced resilience with referral capacity to existing specialist services and programs.
2. ARACY collaboration has been successful in Tasmania and strengthening the collaborative relationship with ARACY should be explored to help meet the aim of the Child and Youth Wellbeing Strategy for 0-25 year-olds. Areas of collaboration include: developing an evaluation framework based on the Tasmanian Child and Youth Wellbeing Framework and the six domains of Child and Youth Wellbeing; and exploring the statewide implementation of the Common Approach with the inclusion of families, children and the wider community alongside multidiscipline professionals across the full scope of state and local government and non-government services. Effective evaluation strategies contextualised to the Tasmania context should contain the capacity for National comparison of child & youth wellbeing outcomes.
3. Build on the theoretical foundation articulated in the current Tasmanian Child and Youth Wellbeing Framework, The Ecological Model of Human Development (Bronfenbrenner, 1979), by incorporating the four elements of the Bioecological Model of Human Development (Bronfenbrenner, 2001) – Process, Person, Context and Time. These four elements complement the original ecological model by increasing the focus on the drivers of human development alongside creating the context for optimal development.

In the knowledge of the existing domains of the Child and Youth Wellbeing Framework what should be our unifying vision for the Child and Youth Wellbeing Strategy?

Tasmania— our place that helps families create the context for child and youth wellbeing to thrive.

References

ARACY, Children's Voice Position Statement 2019

Bronfenbrenner U, 2001. The bioecological theory of human development. Article 1 in U Bronfenbrenner (ed.) 2005, *Making human beings human: biological perspectives on human development*. Sage, Thousand Oaks, California.

Bronfenbrenner U, Ceci S, 1994. Nature–nurture reconceptualized in developmental perspective: a bioecological model. *Psychological Review* 101(4):568–86.

International Family Nursing Association (IFNA), 2017. IFNA Position Statement on Advanced Practice Competencies for Family Nursing. https://internationalfamilynursing.org/2017/05/19/advanced-practice-competencies/

Rutter, M, 2006. *Genes and behavior: nature–nurture interplay explained*. Blackwell, Oxford, UK.

Smith L, 2013. 'The young person'. In Margaret Barnes & Jennifer Rowe (eds), *Child, Youth and Family Health: Strengthening Communities*, Elsevier, Chatswood, NSW, pp. 192-209. ISBN 9780729541558

Sollis, K, 2019. *Measuring Child Deprivation and Opportunity in Australia: Applying the Nest framework to develop a measure of deprivation and opportunity for children using the Longitudinal Study of Australian Children*. Canberra: ARACY

Taylor, J & Smith, L, 2015. 'Can a Scheduled 15-minute School Nurse Appointment Influence Youth Health? Evaluation from an Enhanced School Health Service', *Developing practice: The child youth and family work Journal*, 42 pp. 55-65. ISSN 1445-6818

World Health Organisation, 2000. *The family health nurse: context, conceptual framework and curriculum*. https://www.euro.who.int/en/health-topics/Health-systems/nursing-and-midwifery/publications/2000/the-family-health-nurse-context,-conceptual-framework-and-curriculum

Appendix One

The Australian Research Alliance for Children and Youth (ARACY) submission to the Tasmanian Government's Healthy Tasmania Five Year Strategic Plan Community Consultation 2016

Submission to the Healthy Tasmania Five Year Strategic Plan – Community Consultation

Prepared by Dr Lindsay Smith and the Australian Research Alliance for Children and Youth

February 2016

ARACY

Australian Research Alliance for Children & Youth

Collaboration • Evidence • Prevention

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Introduction

Dr Lindsay Smith, State Convenor Tasmania is pleased to make the following submission on behalf of The Australian Research Alliance for Children and Youth (ARACY) to the Tasmanian Government's Healthy Tasmania Five Year Strategic Plan Community Consultation draft. This submission provides a background to ARACY and its flagship project *The Nest*, while addressing specific questions posed in the Consultation Draft throughout the discussion.

About ARACY

ARACY is a national peak body for child and youth wellbeing. We focus on bringing researchers, policymakers and practitioners together to turn the best evidence on 'what works' for child and youth wellbeing into practical, preventive action to benefit all young Australians.

Established in 2001, ARACY continues to build on the founding idea that the complex issues affecting young Australians cannot be solved by one organisation or sector working in isolation. ARACY, along with its 4,000 members, is in the business of brokering practical and innovative strategies to improve child and youth wellbeing.

In 2013, ARACY launched *The Nest* Action Agenda at Parliament House, Canberra, with the support of all major parties. *The Nest* is a national plan for child and youth wellbeing. The action agenda was developed collaboratively with ARACY's partners and identifies key priorities and effective interventions for 'turning the curve' on child and youth wellbeing. *The Nest* provides a framework to mobilise, align and enable government, community and business efforts in order to improve outcomes for children and young people.

In Tasmania, ARACY is pleased to be sponsored by the Tasmanian Government to implement the right@home trial in Hobart, Burnie and Launceston. In addition, ARACY plays an active role supporting Tasmanian professionals and providers in the child and youth sector, including through its 255 individual members and 16 organisational members from the higher education, government and not for profit sectors.

About *The Nest*

Australia's current 'middle of the road' ranking on OECD indicators of child and youth wellbeing tell us that we need to do better across the areas of family, health, education, child poverty and deprivation and levels of youth participation.

The Nest is grounded in the voice of young people themselves about what matters for a happy and healthy life. It also reflects expert consensus about priorities for action in the country. The information was gathered through national consultations in 2012 involving more than 4,000 Australians, including children and youth, parents, leading thinkers and researchers, child advocates, policy makers, and service planners and providers across Australia.

The task of improving child and wellbeing at a population level is a national endeavour involving many sectors and a long timeframe. As a result, *The Nest* is an organising framework to mobilise, align end enable the efforts of multiple actors across diverse sectors who want to improve child and youth wellbeing in Australia.

It outlines six overarching outcomes, sets up some bold goals for action and includes a set of common national indicators that sectors can work towards. To support those goals, *The Nest* identifies some priority directions based on evidence, with a focus on prevention and early intervention. In this way, *The Nest* focuses efforts by identifying 'what's important' and guides the investment of time and resources by outlining 'what works'.

The Nest is led by ARACY, but is brought to life through the collective efforts of individuals, agencies, programs, government departments and policy makers, research institutions, advocacy groups and representative organisations. This means that on the ground, *The Nest* is made up of a huge array of activities across many sectors – all aligned to a set of six outcomes which, together, allow us to 'turn the curve' on child and youth wellbeing.

The six *Nest* outcomes are:

Being loved and safe	**Having material basics**
Being healthy	**Learning**
Participating	**Experiencing a positive sense of culture and identity**

The Nest encourages a **child-centred, holistic and early intervention perspective** so researchers, practitioners and policy makers can:

- see where their everyday works fits in to the big picture of child and youth wellbeing
- map the way their work contributes to multiple Nest outcomes, encouraging comprehensive responses and work across silos
- identify the way their work contributes to national outcomes

It embeds **outcomes thinking** in the way individuals and agencies work by:

- encouraging measurement to demonstrate their impact, improve their practice and continuously improve outcomes
- making contributions to the evidence base for what works to improve child and youth outcomes

It helps to **identify** and **articulate shared priorities for action** by:

- prompting conversations that start and sustain collaboration
- helping to establish common goals and priorities within geographic or practice communities
- building the momentum for change and providing an evidence-based platform for advocacy

It helps to get **evidence into practice** by:

- offering the priority directions which are based on evidence, with a focus on prevention and early intervention.

About ARACY and *The Nest* in Tasmania

ARACY is pleased to recognise the strong early adoption of *The Nest* by numerous organisations and practitioners across Tasmania. These include Anglicare Tasmania (Communities for Children Every Child Succeeds initiative www.community-it.org.au), St. Giles Society, and the Glenorchy Opportunity Child. State wide adoption of *The Nest* as an organising framework to child and youth wellbeing efforts would enhance the work of existing agencies and drive momentum around a shared framework and a common language. This creates efficiencies, amplifies efforts and provides a platform for shared measurement of outcomes at a state level.

It is pleasing to note the emphasis on a preventative health focus in the Draft Healthy Tasmania Five Year Strategic Plan. All too often, the general wellness of childhood can lead to a reticence in relation to preventative measures aimed at the early years of life and childhood, yet evidence shows these most effectively alter and enhance life course outcomes. This is not to downplay the importance of preventative health strategies implemented at later life stages. It is simply that real change in the distribution of negative population health indicators requires a focus on early years and childhood (alongside other strategies aimed at adult populations), and before pathways of illness and negative life outcomes are established.

ARACY therefore welcomes the fact that one of the four key strategies proposed in the Draft Healthy Tasmania Five Year Strategic Plan is to 'Concentrate on the early years'. We see this as an essential foundation for developing priorities and actions towards a Healthy Tasmania.

ARACY has a demonstrated track record of supporting the importance of the early years to healthy life course outcomes in Tasmania. In 2015 ARACY, in collaboration with the Tasmanian Early Years Foundation, were pleased to bring the inaugural biennial *Coming Together for Australia's Children* conference to Tasmania. One of the keynote addresses at this conference was given by Clair Rees, UK Parliamentary Early Years Advisor and Researcher. Ms Rees is advancing the UK's 1001 Critical Days campaign which outlines the importance of the period from conception to age two to child health outcomes, with a focus on the brain science of early development.

In addition, many Tasmanian members and partners of ARACY played an active role in the national conference promoting some of the outcomes achieved in Tasmania through collaboration with ARACY. For example the presentation by M Gardiner DHHS Tasmania and Dr S Fox ARACY on the implementation of The Common Approach in Northern Tasmania http://www.togetherforchildren.net.au/program.php

The conference also provided an opportunity to showcase the Tasmanian Child and Family Centre's, too much acclaim, which included key note presentation from Mr P Prichard and parental engagement from numerous Child and Family Centre's during the conference. These centres illustrate the success that can be achieved through a targeted proportionate universalism approach (see Appendix One). This approach lies at the heart of the right@home trial being undertaken in Hobart, Burnie and Launceston with the support and sponsorship of the Tasmanian government.

right@home is a research collaboration between ARACY, the Centre for Community Child Health (CCCH) at the Murdoch Childrens Research Institute (MCRI), and the Translational Research and Social Innovation (TReSI) group at Western Sydney University. right@home is designed for the Australian context. It is based on the Maternal Early Childhood Sustained Home-visiting (MECSH) program and uses additional modules based on best evidence to help parents care for and respond to their children, and create a supportive home learning environment.

Visits commence in the antenatal period and continue until children turn two. right@home is delivered by highly trained child and family health nurses and is embedded in the universal system. All teams include a social worker who offers additional support to the nurses and families. The right@home trial intervention will conclude in September 2016 and data collection will conclude in early 2017 (Phase 1). Preliminary results on the primary outcome measures (when children are 2 years of age) will be available in early 2017. Results on secondary outcome measures, and an economic evaluation, will be available after June, 2017. Follow up research with families is planned until children turn five (Phase 2).

right@home demonstrates ARACY's contribution towards achieving better health and developmental outcomes for all infants in Tasmania. Support to align the state's CHaPS to this model is being discussed.

How could we measure what could be achieved?

ARACY would be please to collaborate with the Tasmanian government to implement state-wide initiatives which promote the use of *The Nest* as a shared framework and common language. The associated ARACY Report Card and new Nest Results Scorecard® provide the tools for a shared measurement framework, which could facilitate state-wide data collection.

High-level strategic plans and social health atlases have proved to be effective in communicating with diverse stakeholders about the nature of the issues and challenges, and in promoting a shared view about priorities for action.

There are numerous preventative health initiatives across Tasmania that achieve outcomes which often go unrecognised because their impact is not understood in light of the larger picture. We need to move beyond a disjointed individual service or program approach in preventative health and health promotion. A clear picture based on the available data of exactly how children and young people are faring across Tasmania, what strategies are being implemented and how they align to a state wide plan is needed.

Implementing a state-wide plan based on *The Nest* action agenda aligned to the strengths-based reporting system of the ARACY Report Card would be an effective enabler, bringing state wide leadership to the task of effective implementation of the proposed key strategy, 'Concentrating on the Early Years'.

ARACY proposes that the Healthy Tasmania initiative align its goals, targets and indicators for children and young people with those that appear in the ARACY Report Card: http://www.aracy.org.au/projects/report-card-the-wellbeing-of-young-australians.

ARACY would be pleased to discuss with the Tasmanian government how this alignment might be explored and/or achieved. The substantive Technical Report which sets out the evidence supporting the ARACY Report Card on the

wellbeing of young Australians can be found at: http://www.aracy.org.au/publications-resources/command/download_file/id/173/filename/Technical_Report_-_The_wellbeing_of_young_Australians.pdf

Consultation questions

In response to various specific consultation questions included in the Healthy Tasmania Five Year Strategic Plan Community Consultation draft, ARACY makes the following recommendations:

Where do you think the current actions we are taking on prevention and promotion have proven effective in improving the health of Tasmanians?

The Child and Family Centres have received **international acclaim for their collaborative impact on families and children**. Evaluation has demonstrated the positive success of these centres. Ongoing support for the Child and Family Centres will continue to enhance children's outcomes across a broad range of indicators including education and health.

The State Government's introduction of School Health Nurses across Tasmanian Government schools has the real potential to significantly enhance health, wellbeing and education outcomes for children and young people if adequately resourced and implemented **through a targeted proportionate universalism approach**. Long term support and evaluation of this nascent program will be essential to both identify strengths and achievements as well as areas of future need.

Where do you see the most effective changes could be made in terms of overall population health benefit?

A clear **whole of government priority on the early years of life** has been established to be the most cost effective means of achieving positive health outcomes across the life course. Such a position could be implemented through establishing an 'Early Years impact review' requirement for any proposed government policy or service provision change, to ensure policy settings contemplate the potential impact on the early years and on life course outcomes. See, for example, the same principle at work in respect of Black and Minority Ethnic (BME) populations using mental health services in the UK (www.jcpmh.info/wp-content/uploads/jcpmh-bme-guide.pdf).

Within that early years focus, **aligning efforts and resources around *The Nest*** outcome areas provides an evidence-based, early intervention platform from which to promote optimal developmental outcomes for children in Tasmania. There are significant population health efficiencies to be gained from an integrated approach that harmonises efforts, and focuses on 'what matters' and 'what works' to improve children's trajectories, from birth.

What evidence supports alternative government principles, strategies or enablers that would better support the shift to a more cost-effective model for preventative health in Tasmania?

A **targeted proportionate universalism approach**, as discussed in Appendix One, provides clear guidance on how to achieve cost effective health promotion in Tasmania.

In 2014, the NSW Department of Premier and Cabinet commissioned ARACY to write a Literature Review of evidence regarding the research and practice of prevention and early intervention. The report, *Better Systems, Better Chances*, was published in 2015 by the NSW Department of Families and Community Services, and includes consideration of the international evidence regarding service coordination. Extracts from this review pertinent to this

community consultation are included as Appendix One. The full report is available to download on ARACY's website and hard copies can be purchased: https://www.aracy.org.au/publications-resources/area?command=record&id=207.

Do you think targets would be effective in driving the change Tasmania needs to see in health outcomes?

Targets that align to effective plans are an **essential guide to the coordination of services and evaluation of progress**. ARACY commends the use of *The Nest* as an overarching framework within which to organise and focus the efforts of government and non-government service providers in Tasmania, and the use of the Nest Results Scorecard® as a shared measurement tool, to map progress against the population level indicators contained in ARACY's Report Card.

What indicators of health status provide the best picture of whether progress is being achieved and could monitored on HealthStats?

Evidence clearly demonstrates that healthy life outcomes are associated with **positive attributes and strengths embedded in the lives of individuals, families and communities**. This concept is captured in the Resilience Cycle (Smith 2013 pg. 198). (See diagram one).

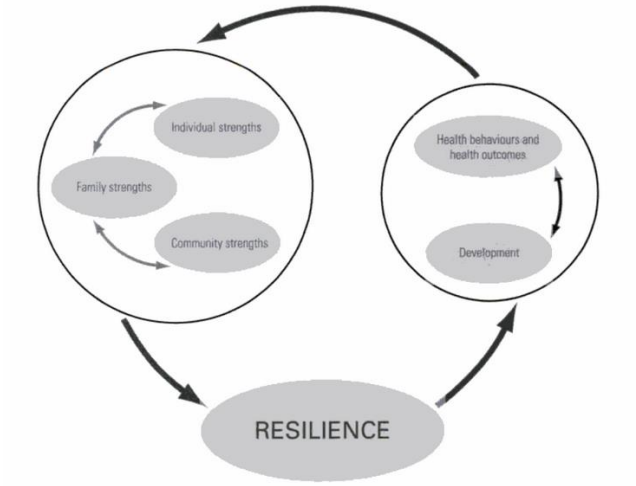


Diagram one: The Resilience Cycle

Any system attempting to provide a picture of progress towards healthy outcomes should **incorporate strengths in all domains**. The ARACY Report Card is based on a strengths approach to data collection, and references readily available national data sets.

In addition, ARACY is working with Opportunity Child and some of the other National Partner Organisations (Telethon Kids Institute, Centre for Community Child Health, Centre for Social Impact) to develop a systematic suite of program level measures for children aged 0 – 8 years. These will allow agencies **adopting *The Nest* as an organising framework** to their work to also contribute program level outcome data to a shared measurement framework, and to map their progress and contribution towards 'turning the curve' on population level indicators.

Conclusion

The aim of reform must be the development of infrastructure for an 'intelligent system' that collects and uses data to measure the outcomes it is achieving, and which has mechanisms for decision-making that are responsive to evidence, data and changing local contexts.

Effective systems are designed around the factors that promote the wellbeing of children and reflect the ways families work. They leverage trusted universal service platforms to promote the factors known to be important for child development and they respond early to emerging problems. ARACY is actively perusing collaboration in evidenced based practice and policy to enhance preventative health in Tasmania. ARACY is ready and available to assist the Tasmanian Government further through the initiatives suggested in this submission or in other proposals to help achieve its target of a healthy Tasmania.

Acknowledgment

The following ARACY documents have been used to inform this submission and Appendix One, and are acknowledged here:

- The Australian Research Alliance for Children and Youth (ARACY) submission to the NSW Legislative Council's Standing Committee on Social Issues in relation to the current inquiry into service coordination in communities with high social needs 2015, and
- The Australian Research Alliance for Children and Youth (ARACY) submission to the National Child and Youth Strategic Framework for Health 2014
- Fox, S., Southwell, A., Stafford, N., Goodhue, R., Jackson, D. And Smith, C. (2015). *Better Systems, Better Chances: A Review of Research and Practice for Prevention and Early Intervention*. Canberra; Australian Research Alliance for Children and Youth (ARACY).

References

Aked, J., Steuer, N., Lawlor, E. & Spratt, S. (2009). *Backing the future: Why investing in children is good for us all*. London: New Economics Foundation.

Allen, G., & Smith, I.D. (2008). Early intervention: *Good parents, great kids, better citizens*. London: The Centre for Social Justice and The Smith Institute.

ARACY. (2014). *The Nest action agenda: Improving the wellbeing of Australia's children and youth while growing our GDP by over 7 per cent*. Canberra: Author.

Australian National Preventive Health Agency (ANPHA) (2013). *State of Preventive Health 2013. Report to the Australian Government Minister for Health*. Canberra: Author.

Christie, C. (2011). *Commission on the future delivery of public services*. Glasgow: Scottish Government. Retrieved from http://www.gov.scot/resource/doc/352649/0118638.pdf.

Deloitte Access Economics. (2012). *The socio-economic benefits of investing in the prevention of early school leaving*. Deloitte.

Dowdy, E., Ritchey, K., & Kamphaus, R. W. (2010). *School-based screening: A Population- based approach to inform and monitor children's mental health needs*. School Mental Health, 2(4), 166-176. doi:10.1007/s12310-010-9036-3

Her Majesty's Government, Local Government Association. (2013). *Local public service transformation: A guide to whole place community budgets*. Essex, Greater Manchester, Tri-borough & West Cheshire: Her Majesty's Government, Local Government Association. Retrieved from http://communitybudgets.org.uk/wp-content/uploads/2013/03/Guide-to-Whole-Place-Community-Budgets.pdf

House of Commons. (2014). *Integration across government and Whole–Place Community Budgets: Fourteenth Report of Session 2013–14*. London: House of Commons. Retrieved from: http://www.publications.parliament.uk/pa/cm201314/cmselect/cmpubacc/472/472.pdf

Human Early Learning Partnership (HELP). (2011). *Policy Brief: Proportionate Universality*. British Columbia: University of British Columbia.

Kershaw, P., Warburton, B., Anderson, L., Hertzman, C., Irwin, L.G., & Forer, B. (2010). *The economic costs of early vulnerability in Canada*. Canadian Journal of Public Health, 101(3), S8-S12

Kilburn, M.R., and Karoly, L.A. (2008). *The economics of early childhood policy – what the dismal science has to say about investing in children*. Santa Monica: RAND Corporation.

Léveillé, S., & Chamberland, C. (2010). *Toward a general model for child welfare and protection services: A meta-evaluation of international experiences regarding the adoption of the Framework for the Assessment of Children in Need and Their Families (FACNF)*. Children and Youth Services Review, 32(7), 929-944. http://dx.doi.org/10.1016/j.childyouth.2010.03.009

Little, M., Bullock, R., Madge, J., & Arruabarrena, I. (2002) *How to develop needs-led, evidence-based services*. Journal of Integrated Care, 10(3), 28-32.

Marmot, M. (2010). *Fair society, healthy lives: The Marmot Review, Strategic Review of Health Inequalities in England post-2010*. London: Institute of Health Equity.

Moore, T.G. (2008). *Rethinking universal and targeted services*. Parkville, Victoria: Centre for Community Child Health (CCCH).

NAO. (2013). *Case study on integration: Measuring the costs and benefits of Whole-Place Community Budgets*. London: Department for Communities and Local Government. Retrieved from

http://www.nao.org.uk/wp-content/uploads/2013/03/10088-002_Whole-Place-Community-Budgets.pdf

National Audit Office (NAO). (2012). *Delivering the free entitlement to education for three- and four-year-olds*. London: The Stationery Office.

Sandford, M. (2014). *Community budgets and city deals*. London: Parliament and Constitution Centre, House of Commons Library.

Segal, L., Dalziel, K., & Papandrea, K. (2013). *Where to invest to reduce child maltreatment – a decision framework and evidence from the international literature*. In Queensland Child Protection Commission of Inquiry, Taking Responsibility: A Roadmap for Queensland Child Protection. Brisbane: State of Queensland. 619-642.

Siraj-Blatchford, I., & Siraj-Blatchford, J. (2009). *Improving development outcomes for children through effective practice in integrating early years services*. London: Centre for Excellence and Outcomes in Children and Young People's Services (C4EO).

Slee, P., Lawson, M., Russell, A., Askell-Williams, H., Dix, K., Owens, L., Spears, B. (2009). *KidsMatter primary evaluation: Final report*. Adelaide: Centre for Analysis of Educational Futures, Flinders University of South Australia.

Smith, L (2013). The Young Person. In Barnes, M & Rowe J (eds) 2013, *Child Youth & Family Health: Strengthening communities*, 2nd Edn. Churchill Livingstone, Sydney

Valentine, K., & Hilferty, F. (2011). *Why don't multi-agency child welfare initiatives deliver? A counterpoint to best practice literature. Prepared for NSW Ombudsman*. Sydney: Social Policy Research Centre, University of New South Wales.

Valentine, K., & Katz, I. (2007). *Cost effectiveness of early intervention programs for Queensland*. Brisbane: Queensland Council of Social Service.

Appendix One

Fox, S., Southwell, A., Stafford, N., Goodhue, R., Jackson, D. And Smith, C. (2015). *Better Systems, Better Chances: A Review of Research and Practice for Prevention and Early Intervention*. Canberra; Australian Research Alliance for Children and Youth (ARACY).

A proposed approach - coordinate for proportionate universalism

There is an ongoing debate regarding the relative cost effectiveness of universal and targeted services (Moore, 2008). Universal services tend to involve lower costs per-person but greater costs overall. They have the benefits of accessibility, being non-stigmatising, focusing on prevention and reaching the majority of children in need and therefore lifting wellbeing and outcomes at a population level. Targeted services often involve substantially higher costs per-person, with potentially lower costs overall (although often the administrative costs of determining eligibility make this approach more expensive). They may be the most appropriate response to emerging or established problems, but they may not reach all those who require them and are often difficult and stigmatising to access.

Further, while targeted interventions can shift the 'tail' end of the population distribution, because there are far greater numbers of children experiencing developmental difficulties across the rest of the population, universal interventions are much more likely to deliver large-scale, population-level change.

Heckman argues for the prioritisation of young children experiencing disadvantage, given the higher rate of return and the need to compensate for poorer rates of parental investment (although he defines disadvantage as poor parenting rather than simply economic or social disadvantage). For example, cost-benefit analysis of Nurse Family Partnerships shows a much higher benefit to cost ratio where it has been delivered to high risk families (5.70 : 1) compared with low risk (1.26 : 1), with higher risk families being the group for which the program could make more of a difference. That is to say, while "monetary payoffs may still be positive for universal programs, the rate of return may be higher when programs are targeted toward the groups

that are likely to benefit from them most" (Kilburn & Karoly, 2008, p. 17). Similar findings are noted in the cost-effectiveness assessments of Nurse Family Partnerships by Segal et al. (2013), with greater cost effectiveness of the programs that were engaged with higher risk families.

However, families with the greatest levels of need or the greatest potential to benefit from targeted interventions are often the least likely to access them and the most difficult to retain in an intervention long enough to receive the 'dose' needed to change outcomes. Our systems are not consistently effective in identifying needs and vulnerability does not only cluster in specific geographic areas. Moreover, analysis from the UK draws on long-term modelling to argue that both universal and targeted investment is necessary to secure long- term change (AFC & NEF, 2008, p. 22). They argue for effective targeted investment to break the cycle of entrenched disadvantage and trauma, but suggest that to sustain the impact of targeted investments, high quality universal systems are essential:

Without investment in the universal services, we are unable to 'lock in' the gains made by investment in targeted services. We will have improved outcomes and life chances for today's most vulnerable and at-risk children but we will not have succeeded in preventing the same problems (i.e., poverty, inequality) from having an adverse effect on their younger siblings or their own children.

Importance of systems thinking and proportionate universalism

Designing systems that enable and promote evidence-based ways of working (evidenced- based programs as well as evidence-based practices) is a key priority for reform.

- Systems thinking involves holistic approaches to problems – understanding how the whole system works rather than merely 'joining up' services.

- Systems, structures and processes can be designed and used to drive service delivery that achieves outcomes and fosters innovation.
- Effective systems have a common vision, outcomes framework and monitoring systems to report progress, support evidenced based practice, meet the needs of service users and foster continuous improvement.
- Systems change involves consideration of ways of working (common assessments, joint commissioning, multidisciplinary approaches, collective impact models) which leverage and reflect the context and realities of child development in family and community life (reflecting an ecological model of child development).
- Implementation and program fidelity are as important as the interventions themselves – poor implementation of best practice approaches can result in negative outcomes.

"A system that incorporates the principle of proportionate universality for children in their early years would create and maintain a platform of universal services organized in a way that would eliminate the barriers to access that affect populations in the highest need" (Human Early Learning Partnership (HELP), 2011, p. 1).

The importance of 'systems thinking' for early intervention and prevention is emphasised most in the literature concerning a range of recent UK reforms, where it is argued that the key to success for early intervention is 'a reorientation of the system at all levels' (C4EO, 2010, p. 8). The role of universal services and, in particular schools, is underlined in these approaches. Change proponents argue for the systematic approach to achieving change that avoids 'cherry picking' from recommendations and instead draws on holistic suites of measures, considering the influences on outcomes that collectively will have most impact:

These golden threads [key factors] have to be taken together, applied universally and pursued relentlessly to achieve significant change. In other words, they are not a 'pick and mix' list but a recipe for whole system change. These are the keys to change, are of interest to everyone but in particular are essential reading for those responsible for leading and managing services, especially Directors of Children's Services (along with their partners…) and other leaders across the children's sector (C4EO, 2010, p. 17).

The principle of proportionate universalism (Marmot, 2010) underpins this paper's discussion of system design. The fundamental proposition of this approach is that: "focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage" (Marmot, 2010).

The rationale for this approach is the 'prevention paradox' – while poorer children are at greatest risk of vulnerability, a greater number of children across the population are vulnerable. As a result, the key to reducing vulnerability in the early years is a universal platform of supports and services available to all children. This platform needs to be accompanied by additional targeted services for highly vulnerable children and children in low SES ranges or geographical areas. Key also is the elimination, as far as possible, of barriers to access (HELP, 2011).

Proportionate universalism is a response to the limitations in investing in either universal or targeted services:

- "A universal approach has the potential to improve things for children in all SES ranges. But in practice, children in higher SES ranges tend to benefit more than those in lower SES ranges. This is because lower SES families are more likely to face obstacles to accessing services – these might be physical, cultural, or social. Using a universal approach without addressing barriers to access, one that

provides the same service to all, can actually steepen the gradient, and create greater differences in child outcomes between SES ranges" (HELP, 2011).

- "Targeting programs toward children who are most vulnerable has the potential to reach children in the greatest need. But targeting also has substantial challenges. First, targeted solutions can reach the most vulnerable children in low SES ranges in a more intensive way, and so possibly improve outcomes for these children. However, as the largest number of vulnerable children are in the middle class, the majority of vulnerable children are missed. Second, targeting programs in itself does not eliminate barriers to access – barriers such as the stigma associated with some programs continue to affect families. Targeting alone then, does not flatten the social gradient overall and improve child outcomes across the whole population" (HELP, 2011).

There are clear indications that, currently, the families that most need assistance are the least likely to access help and that secondary services are overwhelmed and failing to cope with demand, even though they are not close to reaching all those who need help (Moore, 2006). All levels of the service system appear to struggle to engage and retain vulnerable families. Moore identifies four major themes from his review of current system limitations:

- the need to shift from treatment and targeted services to a universal prevention approach;
- the need to develop an integrated tiered system of universal, targeted and specialist services;
- the need to shift from a risk-based approach to targeting children and families in need to a response-based approach; and
- the need to develop better ways of engaging and retaining the most vulnerable families (Moore, 2008, p. 8).

The potential for proportionate universalism to reduce costs

The appeal of the proportionate universalism (Marmot, 2010) is that it combines the strengths of both universal and targeted approaches. However, in order to be effective, proportionate universalism requires universal systems that are primed and capable of accurately identifying needs, and early intervention and tertiary services (of the right duration and intensity) need to be available. Sayal (2006) outlines a common pathway to need identification and service response for children with emerging emotional and behavioural difficulties:

- **Parental perception of problems.** Following parental awareness of child symptoms, parental perception of problems is the key initial step in the help-seeking process.
- **Use of primary care services.** Although children with mental health problems or disorders are regular attenders within primary care and most parents acknowledge that it is appropriate to discuss concerns about psychosocial issues in this setting, few children are presented for treatment of mental health symptoms even if their parents have such concerns.
- **Recognition within primary care.** Subsequently, less than half of children with disorders are recognised in primary care.
- **Referral to or use of specialist health services.** Amongst recognised children, about half are referred to specialist services (Sayal, 2006 in Moore, 2008, p. 3).

In this pathway, the potential for additional and unnecessary costs is significant: if parents had knowledge of evidence-based child development and parenting practice information, their ability to recognise and respond to emerging issues would be strengthened; if primary care services were better able to identify potential issues, engage with parents and provide appropriate support and referral (including in areas outside their direct area of expertise); and if alternative, community-based early intervention was available, the pressure on expensive one-on-one consultation with specialists would be reduced.

It is clear that continuing with existing models of delivery is fundamentally unsustainable, and will continue to accrue enormous costs:

Targeted policies and services to meet the special needs of children with chronic problems, or who face difficult circumstances, will always be required. However, such services will continue to consume an ever-increasing proportion of public expenditure on social and other human services unless there is a substantial repositioning of policy from its current focus on remedial and treatment services towards increased investment in universal prevention for all children, particularly in the early years. (Richardson and Prior, in Moore, 2008)

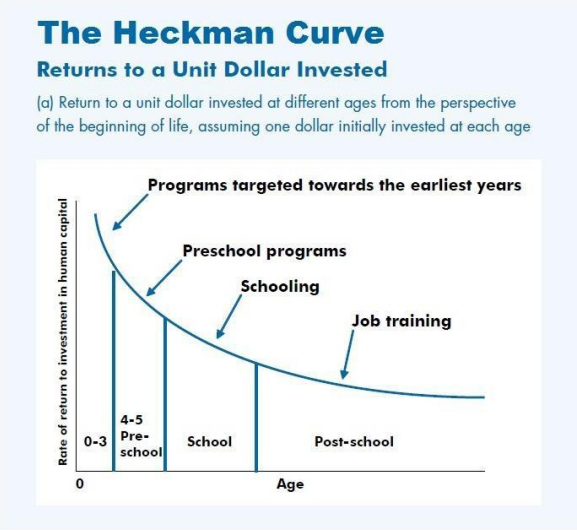
Coordinate to intervene early

The evidence from the child development sciences (including neuroscience, psychology, genetics and numerous longitudinal studies from multiple countries) is clear that early childhood and early adolescence offer crucial windows of opportunity to build strong cognitive and social and emotional foundations, which in turn equip children and young people to cope with adversity and optimises their life chances. The theoretical rationale for prevention and early intervention, and for prioritising investment in the early years, is incontrovertible.

In addition to being crucial to children's developmental trajectories, it is clear that investments in the early years and in prevention and early intervention more broadly yield significant financial returns. The return on investment for prevention and early intervention is consistently greater than costly remedial responses; preventative investment reduces downstream expenditure on remedial education, school failure, poor health, mental illness, welfare recipiency, substance misuse and criminal justice. Expenditure on evidence-based prevention initiatives reduces incidence and prevalence at a population level. It is most cost effective to invest in early intervention that resolves issues as they emerge and are malleable, rather than responding to crisis,

toxic stress and trauma, which is both more challenging and more expensive to resolve.

Figure 1: The Heckman Curve



The costs of late intervention and responding to symptoms rather than causes

There is a strong argument that expenditure on late intervention and crisis responses is becoming unsustainable – rising demand and increasing complexity is creating significant long-term challenges for government budgets. National and state budgets consistently favour reactive tertiary responses over proactive preventive investment: Michael Marmot found that only 4 per cent of health funding in the UK was targeted at prevention (Marmot, 2010, 26), while a Scottish parliamentary inquiry cited evidence that 40-45 per cent of their total public spending was on short-term responses to social problems (Christie, 2011), and it is estimated that only 1.6 per cent of all health spending in Australia is on prevention- focused public health (Australian National Preventive Health Agency [ANPHA], 2013, p. 32).

The pressure on public expenditure from addressing dysfunction is one driving force behind moves toward prevention and early intervention internationally. A UK think-tank estimated that at current levels, spending on social issues will amount to £4 trillion over a 20 year period (AFC [Action for Children] and the

New Economics Foundation (NEF), 2009). Allen and Smith (2008, pp. 33-34) estimate that current annual expenditure on the impacts of social issues is over £140 billion on social welfare, £20 billion incurred from the costs of violence, £2 billion on children in care and £1 billion spent on the costs arising from child abuse. Canadian research estimates that reducing early childhood vulnerability (as measured by the Early Development Index) by nine per cent by 2020 would result in an increase in GDP of more than 20 per cent over the life course of those children (Kershaw et al., 2010).

In Australia, a number of studies have sought to establish the costs arising from aspects of vulnerability and dysfunction, including the remedial interventions instigated in relation to these. ARACY extrapolated the Canadian research cited above and determined that reducing rates of childhood vulnerability as measured by AEDI could result in a 7.35 per cent increase in GDP over 60 years (ARACY, 2014). valentine and Katz calculated the long-term annual human and social costs of child abuse and neglect in Australia, which in 2003 were estimated to be close to $2 billion (2007, pp. 5-6) (valentine and Katz, 2007). Almost half of this cost was accounted for by adult criminality arising later in life.

Estimating cost savings from reducing vulnerability and dysfunction

Data analysis and modelling from Deloitte Access Economics (2012) demonstrates potential cost savings from reducing the incidence of a range of modifiable outcomes. The analysis estimates the net present value (NPV) of the cost of a range of scenarios accumulated between the period 2008-2050 if the patterns for these scenarios continue on current trajectories. This forms the basis for modelling potential cost savings that would arise from a 25, 50 or 75 per cent linear reduction in the rate at which a set of problems occurs (for example, if obesity rates were to reduce by 50 per cent between 2008-2050, it would result in $21,310 million dollars being saved over this time) (Table 1).

Table 1: Financial cost and potential savings for scenarios between 2008-2050 in Australia (Deloitte Access Economics, 2012)

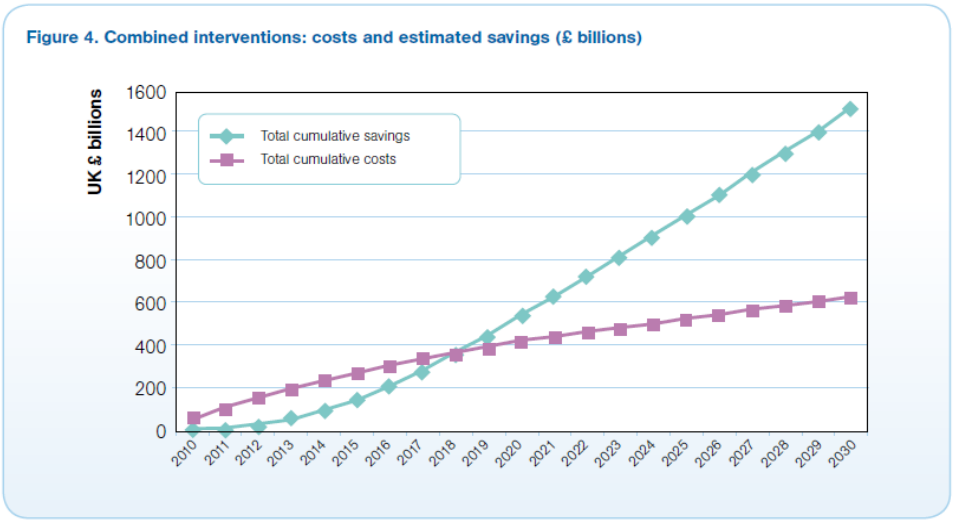
	Financial cost 2008-2050	Cost saving with 50 per cent reduction 2008-2050
Child abuse and neglect	$25,494m	$5,460m
Obesity	$98,948m	$21,310m
Mental illness	$59,312m	$12,379m
(Unrealised) human capital	$418,070m	$87,324m
Crime and delinquency	$1,380m	$289m
Bullying	$46m	$9.7m
Adolescent pregnancy	$4,130m	$868m
Binge drinking	$5,816m	$1,219m

Due to inter-relationships between scenarios, the potential cost-savings established in this analysis are not cumulative; however, this modelling does indicate that substantial savings would be made from a reduction of 50 per cent in each of the scenarios. Savings would also begin to emerge after five years and increase exponentially over the longer term (Deloitte Access Economics, 2009, p. 70). Even with the conservative estimate of 25 per cent, the modelling suggests that within five years, child protection costs could reduce by $52m, obesity by $185m and mental illness by $120m (Deloitte Access Economics, 2009, p. 70).

Similarly, in the UK, Action for Children and the New Economics Foundation have estimated the cost to the UK economy of continuing (and rising)

dysfunction in society and calculated the cost for introducing and running a suite of evidence-based targeted and universal interventions to address levels of dysfunction emerging through childhood. Utilising conservative effect size data and delivery costs, the analysis estimates that with an investment of £620 billion over 20 years, a saving of £1.5 trillion could be anticipated (equating to a net saving of £880 billion) (Figure 2). Savings would begin to outweigh investment within eight years. Interestingly, it is investment in targeted interventions that would yield the quickest return – breaking even in five years, compared to twelve years for universal interventions (Aked, Steuer, Lawlor & Spratt, 2009).

Figure 2: Long-term impact of systems reform to improve universal and targeted interventions



Beyond the clear financial and social benefits of prevention, there is also an ethical argument to be made for investments that optimise children's life chances and that actively seek to prevent their chances of experiencing abuse, neglect, ill-health, poor achievement, psychological distress and diminished opportunity. Prevention and early intervention approaches build personal capability and responsibility, and avoid the state exercising coercive and/or intrusive powers into the lives of individuals and families due to issues which they would have more willingly accepted assistance on earlier (for example child protection, mental health and justice responses).

Analysis of what works for coordination

The strategies and initiatives with evidence of effectiveness represent a 'new generation' of coordinated working strategies. They go beyond earlier 'place-based' and systems change initiatives in that they are explicitly focused on realigning system-level levers and involve formal processes, governance and/or budgetary arrangements for making investment and service delivery decisions based on evidence. There is mixed evidence for less structured 'place-based' approaches (valentine & Hilferty, 2009; House of Commons, 2013). For instance, the National Audit Office in the UK found limited evidence that various integration initiatives and reform efforts improved outcomes. They reviewed 181 publications related to place-based collaborative planning and delivery models and found that "only ten past evaluations had assessed impact on service-user outcomes. Seven of the ten reported a lack of robust evidence that joint or collaborative working improved outcomes" (NAO, 2012, p.8), while "the remaining three referred to tentative evidence of some impact, but all raised methodological issues that weakened the reliability of results" (NAO, 2012, p. 16).

The modest impact of earlier multi-agency or collaboration initiatives may be due to the fact that they were working against entrenched structural barriers and were often reliant on goodwill and the commitment of individuals and organisations willing and able to work beyond their core business. These more informal approaches may work when local conditions and circumstances are conducive – where there are champions on the ground, histories of collaboration or working in the way intended by the reform process, and a shared underpinning philosophy – but if they do not alter the way the system works, they are vulnerable to key staff leaving, to a loss of momentum if new ways of working do not become part of routine business practice, and may not be sustainable in the long-term.

Newer bottom-up change models – such as Communities that Care or Collective Impact – do involve formal structure and mechanisms to structure collaborative effort and some ability to shift structural factors. They are likely to be highly effective in some communities, but there are few examples of these approaches being scaled-up across social policy sectors and at national or state levels. The UK's efforts at national whole-of-system reform show variable patterns of impact. Roughly a third of areas appear to be highly

effective adaptors of reform, another third appear to adopt and systematise some elements of the reform or in some parts of the system, while reform appears to have limited impact on the final third.

Where there are histories of poor relationships between organisations, where there is limited history or experience of collaboration or disproportionate power relationships between actors in the system, a bottom-up approach is unlikely to sufficient to deliver significant change.

The UK National Audit Office highlighted the importance of a data-driven approach to new reform initiatives, the need to begin with a strong understanding of baseline costs and the importance of central-government technical expertise, especially for consistent use of robust costing methodology (NAO, 2013). Similarly, a recent review of the mechanisms that promote effective collaborative governance identified the following factors as critical:

- **Using what works, developing evidence-based delivery models:** real transformation needs to take local partners beyond broad 'in principle' agreement on vision and priorities, and use evidence as the basis for new business plans and models of delivery, which can be jointly funded through new investment agreements.
- **Evaluating the effectiveness of new service models and using this to drive re-investment of resources so that successful projects can be scaled-up and sustained:** there are no 'quick fixes' to deep-seated complex problems, but tracking financial and social benefits over the medium- to long-term is vital to securing continued involvement and investment from partners.
- **Commitment to share data and information:** the delivery of integrated services will only be achieved if local public services agree to allow access to and share data about service users, recognising the need to meet their legal obligations, whilst developing a more systematic and timely approach to the use of data between partners.

- **Joint commissioning and performance frameworks:** create joint-commissioning arrangements and single-performance frameworks that span across public sector agencies to avoid silo thinking and cultures.
- **Scale is important for significant savings and outcomes:** while significant improvement in targeting and outcomes for customers can be achieved locally, delivery at a different scale is required to realise substantial savings to the taxpayer (Her Majesty's Government and Local Government Association, 2012, p. 8).

Key conclusions that emerge from these examples of effective practice include:

- The central importance of establishing the infrastructure for an 'intelligent system', especially by measuring common outcomes, improving collection and use of data (including cost-benefit analysis), developing data analysis capacity and embedding a data-driven approach at all levels of the system.
- The benefit of a shared and consistent practice model and guide to identifying areas of strength and need, grounded in an ecological approach to child and family wellbeing and informing practice across universal, secondary and tertiary sectors.

Governance approaches that strike a balance between tailoring to local needs and local decision-making with the important role of central leadership in maintaining momentum – recognising that the right balance is likely to differ between areas (due to different starting points and capacity) and across time (at different stages of implementation).

- An approach that recognises and builds on existing good practice and builds the mechanisms that enable a focus on continuous quality improvement rather than a pre-determined ideal end-state – aiming for iterative rather than transformational change.
- Governance models that contain authority and capability to address system barriers at the local level.

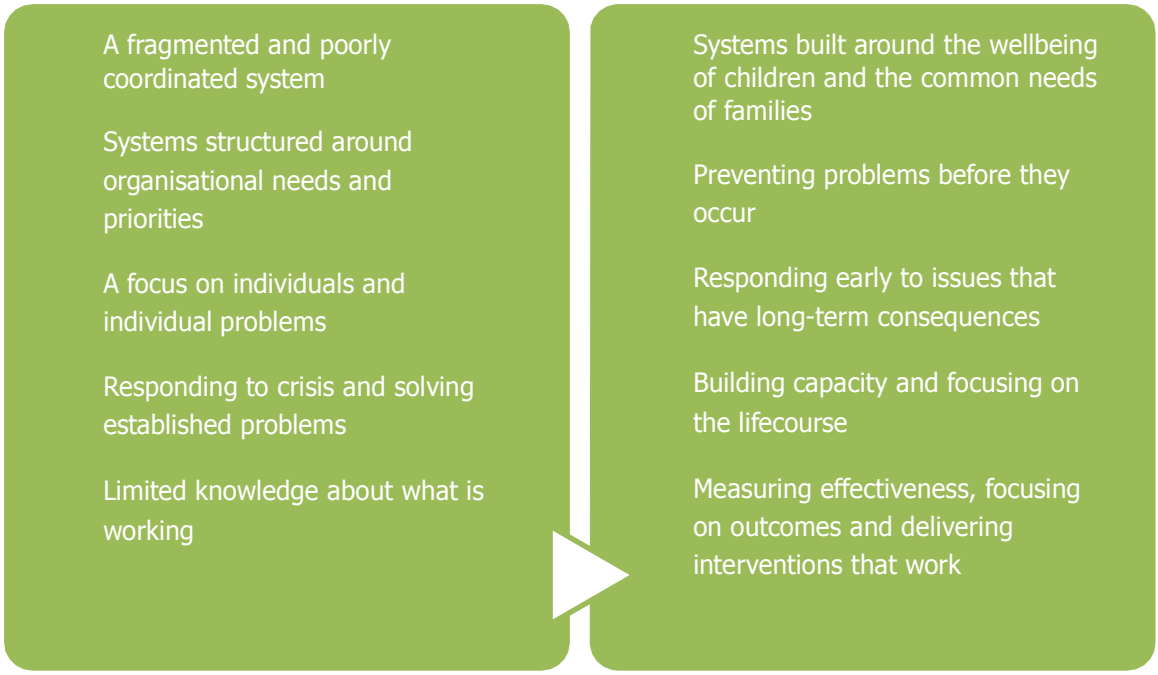
- Utilising implementation science approaches that engage with explicit and implicit elements of the system, including building capacity and adopting common principles and processes.
- The importance of building the capacity of systems, organisations and practitioners to implement evidence-based interventions at scale.

Critical coordination components for improving outcomes

Our current service systems have been shaped by history, but are no longer serving people or communities well. Service system fragmentation leaves clients without timely or coordinated responses to interrelated concerns, even where it is likely those concerns will lead to long-term consequences and costs. Services often respond to the current crisis without working to prevent the next crisis and avoid welfare dependence. This occurs in the context of siloed service investments that are overwhelmingly skewed towards reacting to established problems; concentrating on the intensive/high-cost end rather than on prevention.

ARACY has used available research to highlight factors that enable effective prevention and early intervention at a system-wide level. This has included service-system design approaches which are informed by the evidence and, because of this, are consistent with current reform directions in Australia and internationally.

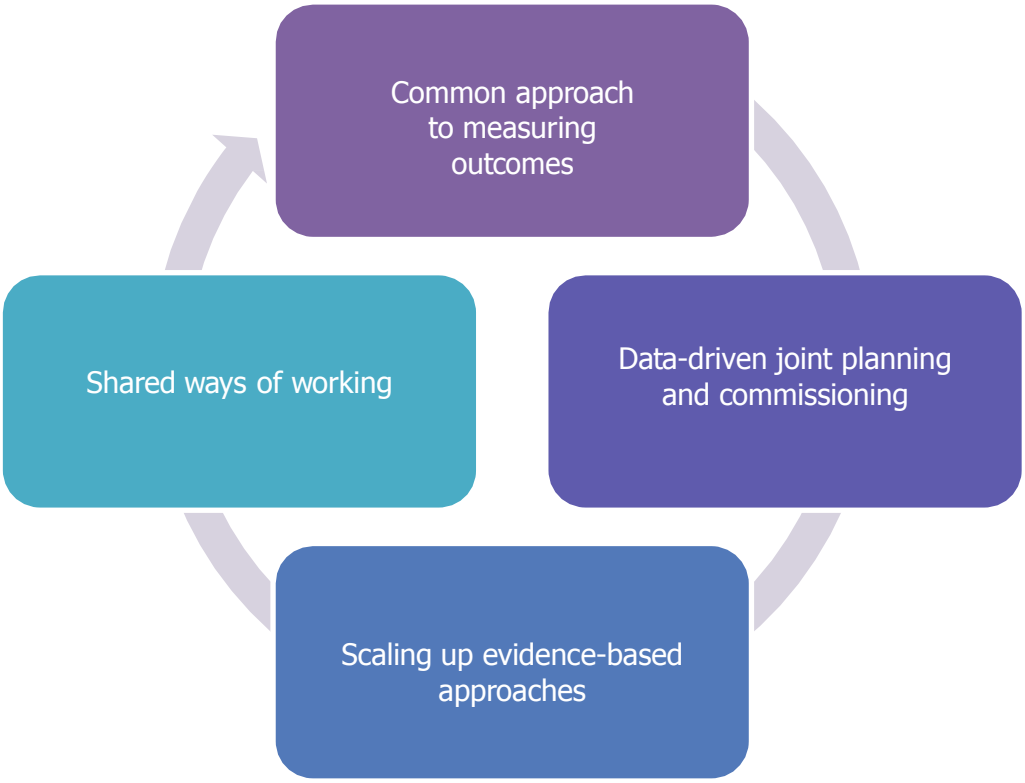
The evidence provides strong theoretical underpinnings and directions for systems reform, although the balance of evidence would suggest that there is no single model or 'silver bullet'. Instead any system should establish the capacity for continual measurement and improvement. The 'ideal system' is not a rigid or static model but is an agile and responsive system comprised of cultures, structures and processes that are flexible and responsive. It is underpinned by robust accountability and governance mechanisms and thereby enables adaptation and problem-solving.



To achieve this transformation, key service system elements that emerge from international research include:

- A common approach to measuring outcomes: to embed accountability, the measurement of effectiveness, and the building of evidence at all levels of the system.
- Data-driven local planning and commissioning: local approaches to needs assessment, service planning and resourcing.
- Scale-up of evidence-based practice: building 'evidence ready' systems and using evidence to guide investment decisions and service provision.
- Shared ways of working: systems, structures, tools and mindsets that enable and promote shared ways of working.

- Commitment to implementation: establishing processes and structures that reflect the lessons of implementation science and enable the objectives of system change to be embedded in practice.
- Governance and accountability mechanisms: with a focus on addressing system-level barriers and facilitating improved practice on the ground.



These elements are mutually reinforcing and together form the core infrastructure of an agile and responsive service system.

Enabling proportionate, coordinated, person centred service delivery

ARACY has analysed what works to engage vulnerable families and achieve improved outcomes to outline the kind of service delivery the next generation of service system needs to support.

Current research regarding service systems that enable prevention, early intervention and person-centred service delivery highlight those systems which have increased the level of integration across the system to achieve coordinated and proportionate responses from a universal base. These systems have innovative governance approaches that enable the local co-design of service systems around local needs through collaborative decision-making.

The primary findings from a number of studies of these models are:

- the central importance of implementation, change management and continuous quality improvement processes;
- the clear link between evidence-based interventions and system-wide effectiveness. Underpinning the effectiveness of these approaches is a common set of structures:
- the use of an outcomes framework to provide accountability and embed the measurement of effectiveness and building of evidence at all levels of the system;
- local approaches to needs assessment, service planning and resourcing;
- building 'evidence ready' systems and using evidence to guide investment decisions and service provision; and
- systems and structures that enable and promote shared ways of working.

Local actions to promote system sustainability are often not sufficient. Central leadership, resources and governance contribute critically to effective

implementation and the long-term survival of re-shaped service systems. (Peterson et al., 2013, p. 8)

Collecting and using outcomes for collaborative data-driven decision making

High quality data is central to the effective planning of prevention and early intervention strategies, and is a key means for mobilising collaborative approaches to service planning and delivery. Systematic collection of common outcomes data across-sector is important for accountability, and can maintain commitment to reform and continuous improvement processes. It also facilitates the development of shared goals; the identification of particular strengths, priorities and pressures at regional levels; and enables collective impact.

Little identifies the key information sources required for an 'intelligent system' as:

- Epidemiology to formulate priorities for intervention, estimate likely impact on child well-being, and monitor trends.
- Systematic reviews and databases of proven models with clear standards of evidence.
- Economic analysis that predicts the costs and cashable benefits of introducing various evidence-based programs into local systems.
- Experimental evaluation to estimate the impact of locally implemented programmes on child outcomes, and the actual costs and cashable benefits.
- High quality dissemination.
- Quality assurance procedures (Little, 2010, p.43).

To collect and draw meaningful conclusions about child, youth and family wellbeing, a much stronger emphasis on the collection of outcomes data is required at all levels of the system (service, region and state). There are a number of strategies needed to shift social policy systems to a culture of

measurement, including building workforce capacity, linking data and enabling collaborative governance which uses data to shape and steer.

Local data-driven planning and commissioning

Local approaches to identifying community needs and priorities, and planning and funding services accordingly, have emerged as key strategies for driving re-alignment of system elements around shared goals and outcomes. This re-alignment is central to achieving a more cohesive local service platform and for reshaping investment to achieve prevention (Sandford, 2014).

Data driven planning and commissioning breaks down barriers to reprioritising funding for prevention and early intervention through better intelligence on the drivers of demand for secondary and tertiary services. This intelligence enables: a clearer picture of how investment in one area of the system can reduce pressure on other parts of the system; better targeted investment in prevention and early intervention; and more direct opportunities to realise the economic benefits of prevention and re-invest in local services.

Data-driven planning and commissioning relies on devolved decision-making and local co- design across sectors. Innovative local governance has been shown to benefit from the support of central leadership, governance and systems to overcome well-documented implementation challenges and maintain momentum across diverse stakeholders.

Using evidence to guide investment decisions and service provision

Systems improvements are intrinsically tied to service improvements – without attention to both the effectiveness of either is limited. There are several key factors that influence the extent to which systems are able to adopt and scale-up evidence-based interventions: knowledge and access to information, capacity and readiness, and incentives to utilise evidence-based interventions. Sound implementation of evidence based services and systems is best supported with implementation science approaches, including capacity building and common principles and processes.

Shared practice frameworks

Shared practice frameworks enable coordinated and proportionate service delivery at a client level, and continual improvement at a system level. Shared practice frameworks have proved an important starting point for systems change and for shifting the implicit elements of a system - the knowledge, attitudes and beliefs that influence and shape practice on-the- ground. They also play an important role in strengthening connections between universal and secondary services regarding effective prevention and early intervention.

The core principles that apply across sectors and define a common way of working must be grounded in the science of child and youth development and the evidence that supports an ecological approach to child and family wellbeing. To be effective, shared practice frameworks require a parallel commitment to changing the structural elements of the system.

Identifying strengths, needs and intervention thresholds

One priority of a prevention and early intervention focused system is the early identification of needs and the ability to link children and families to appropriate and timely support.

Systems also work to ensure that limited resources are used in the most efficient and effective manner.

To support these goals, flexible practice frameworks which emphasise strengths as well as needs have been developed in response to the benefits and limitations of structured assessment approaches (Léveillé & Chamberland, 2010). These models tend to be:

- Focused on building the capacity of practitioners to identify a broad range of strengths and needs, based on evidence-based risk and protective factors, an ecological model of child and family wellbeing, and/or priority outcomes;
- Designed to guide shared practice and cross-sector collaboration; and
- Embedded and integrated within agency or systems around assessment, planning and referral.

Alongside wellbeing-focused practice frameworks that guide the identification of needs, validated instruments provide a useful and robust mechanism for consistently quantifying areas of need and for tailoring appropriate prevention strategies (Dowdy et al., 2010; Slee et al., 2009). In order to be effective, however, screening processes must lead to appropriate and accessible service responses.

Matching needs and services

Equally important as needs assessment, but less well understood, are the decisions about appropriate and proportionate service responses that flow from those assessments.

Flexible service threshold guides have been developed in some jurisdictions to assist practitioners undertake appropriate assessment, planning and intervention for children and families from birth to adolescence. Used well, these guides may support proportionate universalism with a strategic approach to risks, prospective outcomes and likely lifetime costs. Service threshold guides are yet to generate demonstrable results. In the meantime it is important for service systems to collect client-level outcomes data that, over time, will enable an analysis of aggregate data on service type, dose, intensity and sequencing.

Case coordination and management is a broadly used strategy, often delivered with different levels of intensity and with different conceptualisations of what it means (Rapp et al., 2014). Given the importance of a relationship-based worker-client partnership for matching service responses to needs, case coordination is a key strategy. Gronda outlines the potential benefits of effective case coordination and management:

- Cost containment: efficiency, effectiveness, reduced duplication;
- Accountability: single point for coordination and follow-through;
- Therapeutic outcomes : personal development – assisting people toward higher levels of self-care, self-responsibility, independence and productivity;

- Better project management: better planning, coordination, appropriation, and outcome achievement through a structured process resource;
- System improvement : compensating for fragmentation and gaps in the service system; and/or
- Improved bureaucratic control of resource allocation: a service that is documented, monitored and evaluated (Gronda, 2009, p. 24).

Co-designing service responses and system structures with families and communities is emerging as a crucial component of impact.