

PART ONE: Background Information

Project Objectives and Methodology

The Nillumbik Health and Wellbeing Profile – Families 2009 aimed to identify and describe the factors that place a family at risk of experiencing disadvantage within the Shire of Nillumbik. ‘Family’ in the profile refers to families of children aged prenatal up to eight years.

Project Objectives

- 1 To identify and describe the current factors (2009), that place a family (with child aged prenatal to 8 years) at risk of disadvantage in the Shire of Nillumbik.
- 2 To explore the experience of families identified as at risk of, or experiencing, disadvantage.
- 3 To identify current gaps in service provision for families at risk of, or experiencing, disadvantage in the Shire of Nillumbik.

Output

“Nillumbik Health and Wellbeing Profile – Families 2009” data and report, disseminated through an online database/ web page; presentation at relevant local forums, such as early childhood network meetings and written document/profile available by email and hard copy (on request).

Methodology

The development of the “Nillumbik Health and Wellbeing Profile – Families 2009” was based on a combination of qualitative research (carried out between July and December 2009) and review of current local level data.

The Framework Analysis approach (as described by Ritchie and Spencer, 1994)² to project design and qualitative data analysis was selected as the most appropriate for this project. The Framework Analysis approach includes a flexible research/project design, where the data may be collected and analysed concurrently, with indexing or coding (identifying categories and connecting them) and analysis, which after coding, allows themes to be developed inductively from the data, and deductively from the project objectives.

The Framework Analysis approach met the needs of this project in allowing for the inclusion of pre-determined, as well as emergent themes in the data collection and coding, and analysis. This was important as the project had topics/themes for data collection determined at the planning stage (based on the literature review findings). The development of these themes in the planning stage, however, was not intended to exclude emerging presentations (from the research questions or narratives of participants) of patterns/themes in the data from consideration in directing the course of the study, or from inclusion in the analysis.

The process of interpretation added new themes to those that could be anticipated from the literature review, and systematically analysed the commonalities and contradictions reflected in the data. The parent case study interview data provided contextual information.

Sampling Frame

Purposive sampling was selected as the most appropriate strategy for the project. The rationale for this sampling frame was to obtain a full understanding of the features and experiences specific to a subset of the population (families at risk of, or experiencing disadvantage, with a child aged prenatal to eight years of age) in the local setting (Shire of Nillumbik). The collected data was then used comparatively within the data set, and also with the findings of past and current family/community health and wellbeing studies.

Effective purposive sampling involves considered selection and inclusion of participants that are thought to typify the characteristics and experiences of interest to the project. The following methods of purposive sampling were selected:

- Phase One: Intensity sampling: selecting participants to provide ‘information-rich’ data, to provide examples that are related to the phenomena under interest.
- Phase Two: Typical case sampling: selecting typical case participants, in order to act as a ‘qualitative profile’ to describe the features and experience of disadvantage.

The estimated number of participants required, to reach data saturation, was set at a minimum of 30 early childhood service agencies and 5 parent participants. This estimate was based on consideration of the following factors:

- The project involved significant use of ‘shadow data’ (i.e. early childhood workers describing the risk factors for families). This has been reported to be very important in providing “some idea of the range of experiences and the domain of the phenomena beyond the single participants experience” and “moving the analysis along more quickly” (p.4)³ which will assist in narrowing the reasonably broad scope of the project (i.e. ‘health and wellbeing’) to local issues.
- The nature of the topic was somewhat predetermined with the identification of some risk factors of family health and wellbeing in the planning stage. Consideration was given for the emergence of new themes, and the opportunity for this to influence further data collection, in terms of risk factors explored, and inclusion of new participants.
- The quality of the data, as determined by how rich and experiential the data is, may also be guided by the data obtained from early childhood professionals in data collection. Concurrent data collection and analysis was planned, as per thematic analysis approaches

Project Themes

Themes/topics in the project refer to the risk and protective factors that increase or decrease outcomes. The themes of interest (to meet the objectives of this project) were related to the health and wellbeing of the family (of relevance to the child health and wellbeing outcomes).

The initial themes were based on the combination of ‘family resource domain’ areas identified in the literature review as indicators of family functioning: Time, income, human, social and psychological capital and local data regarding risk factors for families (i.e. access to services). The development of these themes in the planning stage did not exclude presentation of emerging patterns in the data from consideration and reporting in the findings (as outlined above).

Table 1: Broad Themes for Data Collection

The following were the initial broad themes identified for data collection in the project:

Broad Themes for Data Collection **Examples**

Time	Parent wellbeing: Time for own interests
	Time for fun individually and as a family
Income	Managing mortgage
Social Capital	Access to services
	Parent perception of supportive relationships outside the immediate family
Psychological Capital	Parents positive/negative feelings of parenting
	Parent wellbeing: Stress level
	Parent relationship with partner
	Parent wellbeing: Perception of shared parenting
Human Capital	Parenting skills & confidence
Gaps in Service	Access to services

Data collection Phase

Phase 1

The sample population for phase one of data collection constituted workers from relevant early childhood and family service agencies, operating within the Shire of Nillumbik. Refer to ‘Acknowledgements’ for a listing of agencies/services that elected to participate in the project.

Phase 2

The sample population for phase two of data collection constituted families identified (on basis of data collected in stage 1) as ‘at risk of, or experiencing, disadvantage.’ Specific sampling, using typical case sampling, of this subset of the population allowed for data associated with the ‘experience’ of disadvantage to be obtained. This provided this subset of the population with the opportunity to identify gaps in service provision, ensuring that a community voice was heard.

In addition data was sourced from recent, relevant projects and data bases already in existence (as listed under ‘Primary Data Sources’).

Data Collection Tools

A semi-structured interview format was selected for this study, using in depth interviewing and/or case study interviewing. This method allowed the project officer to follow the informant's lead, and aimed to gain rich, experiential data.

The project used two interview guides (piloted before implementation), as follows:

- Interview guide designed for early childhood and family services workers (see Appendix A). This guide was implemented in the individual interview format and in some group situations (i.e. kindergarten teachers meeting).
- Interview guide designed for parents (see Appendix B). This guide was implemented in the individual interview format. The parent interviews constitute 'case studies' in the final report.

The reliability and validity of the data was ensured through the use of a systematic approach (Framework Analysis), collaboration with the project supervisor and representatives from the Best Start Partnership (see Appendix C), purposive sampling and triangulation of data, which is gathering and analysing the data from more than one source to answer the project questions.

Ethical Considerations

The project met ethical considerations as per the Nillumbik Community Health Service policy: The project was deemed to be 'low risk' (i.e. non-interventional), as defined in the National Statement on Ethical Conduct in Human Research.⁴ The written information sheet (see Appendix D) and consent form (see Appendix E) included the following considerations:

- Possible risks: There was potential in the interview for participants to suffer emotional distress. Management of this included possible referral to a counselling service.
- Data use and confidentiality: Participant data was de-identified. Anonymity of responses was not assured in the group interview situations. The group interview, however, occurred with early childhood professionals only, who were bound by their own professional ethics.
- Participation was voluntary, and participants could withdraw from the project without ill effect.
- Provision of contact details of the project officer and supervisor to participants.

The information collected in the profile may be used to inform planning, partnering with stakeholders and community engagement for early childhood and family service agencies operating within the Shire of Nillumbik.

The profile has been structured into two main sections:

Part 1 Background: Provides an introduction to the project, definition of 'family health and wellbeing' and examines the existing local demographic data pertaining to families residing in the Shire of Nillumbik.

Part 2 Project Findings: Provides a description of the risk factors and gaps in local early childhood and family service delivery based on project data and case studies; provides case study experiences and a conclusion/discussion of the findings.

Project Funding

The project was commissioned through the Nillumbik Best Start Partnership. In 2006, the Shire of Nillumbik was awarded Best Start funds (through Victorian Government funds). The Nillumbik Best Start Partnership was made up of stakeholders from a number of local early childhood and family service agencies (see Appendix C).

The Best Start approach aimed to strengthen the local capacity of parents, families and early years services to better provide for the needs of all young children and their families. The cornerstone of the approach was the formation and work of collaborative local partnerships to meet the Best Start aims.⁵

The Nillumbik Best Start Action Plan 2008-2011⁶ provided detailed information regarding the aims and specific indicators of the partnership. The following four indicators were outlined:

Health and Wellbeing

1. Increased rate of children who participate in physical activity.

Learning and Development

2. Increased rate of parents reading to their children.
3. Improved reading, writing and numeracy.

Safety

4. Increased proportion of children whose parents report high levels of social support.

The development of the Nillumbik Health and Wellbeing Profile – Families 2009 was listed as Project 1, Indicator 4: 'Safety. Increase proportion of children whose parents report high levels of social support'.⁶

Understanding Family Health and Wellbeing

This brief introduction to family health and wellbeing outlines the results of a review of current Australian and International literature, incorporating specific local data.

The social, emotional, physical and economic wellbeing of families, and the strength of communities in which they live are risk and protective factors for children's outcomes.¹

A social model of health is based on the concept that individual and community health is socially shaped and collectively experienced, and that factors external to the biological system are crucial in determining health. Generally, there are evolving pressures on Australian families, due to issues including changing employment and earning patterns, technological advances, climate change and open trade. Zubrick (2000) highlighted that as a result of these pressures there is a:

“...perceived decline in social cohesion which has placed stress on family and social functioning. Rapid economic and social change can manifest as serious problems in the developmental health and well-being of children, young people and their families...” (p.ix)⁷

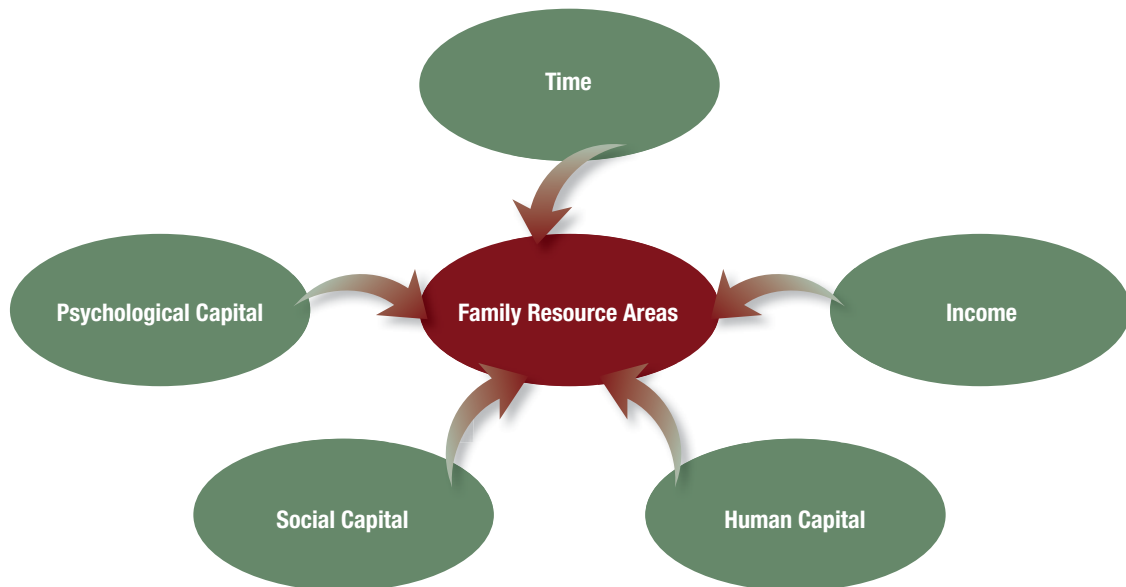
Family 'health and wellbeing' needs to be understood within the personal, social and cultural context specific to the local setting.⁸ Research has found that family health and wellbeing, determined through the social determinants of health (i.e. factors such as living and working conditions that are determined socially), is crucial as a protective factor in a child's developmental trajectory. The recent Australian Institute of Health and Welfare (2009) summary report, however, noted that “we don't know how many children live in healthy functioning families.”(p. ix)⁹ There is no national data available on family 'functioning' in families with children aged 0 -14 years.⁹

For most children, families are the fundamental social and protective unit. It is now well recognised that the early years of a child's life are a time of rapid brain development. To illustrate, Perry (1997) reported that exposure to trauma (e.g. domestic violence) between birth and three years changes the organisation of an infant's brain, resulting in a lowered immune system, difficulties coping with stress throughout life and disruption of progression through age appropriate developmental tasks.¹⁰ There are critical periods (i.e. between birth and three years) when a child requires appropriate stimulation to establish neural pathways in the brain for optimum development. Many of these critical periods are waning by the time the child is six years old. (p.6)¹¹

Risk and protective factors are characteristics or variables that if present for an individual will make it more or less likely that the individual will or will not develop a disorder or experience an adverse outcome. Zubrick et al (2000)⁷ identified the main factors that increase or decrease outcomes for families and children which can be used to help a community track trends in local wellbeing over time.

Zubrick et al (2000)⁷ identified the following factors as resource areas of risk/benefit for a family. At any given time families may have access to one (more than another) of these areas. Children in families without consistent access to many, or any, of these areas would be deemed at risk of poorer developmental, learning, social and psychological outcomes.

- Time: Including the time that caregivers have available for themselves and other members of the family.
- Income: Income available to support the family (including food security)
- Human capital: Referred to resources that the family may be able to use on behalf of their children such as caregivers educational level and employment status, and knowledge and skills of parenting (e.g. setting boundaries, positive reinforcement, problem solving).
- Social capital: Including the quality and depth or relationships between people in a family or community; trust in relationships; community engagement; neighbourhood support and volunteerism.
- Psychological capital: Including parents' mental health, the level of family cohesion, the perceived level of family support and the level of stress and conflict within the family.

Family Resource Areas: Figure 2

The area of 'psychological capital' is increasing in importance, as The World Health Organisation (WHO) predicts that mental health problems will be one of the dominating conditions impacting on the burden of disease in the future decades.¹² Specific indicators of wellbeing are linked to mental health functioning in terms of being protective factors (e.g. patterns of connectedness that link individuals to each other, to a group and community settings). The mental health of parents has been found to impact significantly on the health and welfare of their children, and that social and health systems need to address the mental health needs of the parents to ensure the health and well being of their children. (p.23)⁸

In the area of 'human capital', Sanders (1999) reported that parents of children at risk of developing emotional and behavioural problems were less confident in their parenting role, found parenting to be stressful, demanding and depressing and experienced more conflict with relationship partners over parenting issues.¹³ Sanders (2002) argued that the quality of parenting and family relationships acted as significant risk or protective factors.¹⁴

In terms of 'social capital', protective attributes included social networks and access to local community resources.¹⁵ The Vic Health Burden of Disease data supported that social isolation and exclusion have been found to influence health.¹⁶

Crucially, research has shown that it is the accumulation and interaction of risk factors that determines overall level of risk for poor outcomes.^{8,17} It was reported that exposure to six risk factors increased a child's odds of poor outcomes by twenty fold.⁸

In brief, the evidence suggests:

- All developmental outcomes have their origins in risk and protective factors.
- Children who are exposed to risk factors at an early age can be predisposed to problems later in life.
- Children who are exposed to protective factors are better equipped to deal with subsequent risk factors and life's challenges.
- Protective factors in the lives of young children need to be promoted, with a focus on prevention and minimisation of the known risk factors.

Families in the Shire of Nillumbik: Demographic overview

The Shire of Nillumbik is located less than twenty five kilometres north east of Melbourne, Victoria. Nillumbik is one of nine interface councils on Melbourne's edge, meaning that it shares aspects of both urban and rural community life. The Nillumbik Shire incorporates 23 suburbs, with two main urban centres (Eltham, Diamond Creek) and a population of approximately 62,310 people (figure based on 2006 Census data). Eighty percent of Nillumbik Shire lies outside these urban centres. The population is concentrated around the main urban centres, with a quarter of the population living in the outer lying rural areas.⁵

The 2006 Australian Bureau of Statistics (ABS)¹⁸ and the 2007 Community Indicators Victoria (CIV) Survey¹⁹ findings indicated that residents in the Shire of Nillumbik were relatively advantaged.

The ABS calculated a Socio-Economic Index for Areas (SEIFA) which provided an index of relative disadvantage for local government areas (incorporating factors such as income, educational levels, and unemployment rates, types of occupations and variables that reflect disadvantage). According to the SEIFA, Nillumbik was ranked fourth least disadvantaged of the 31 municipalities located within the Melbourne Statistical Division.⁶

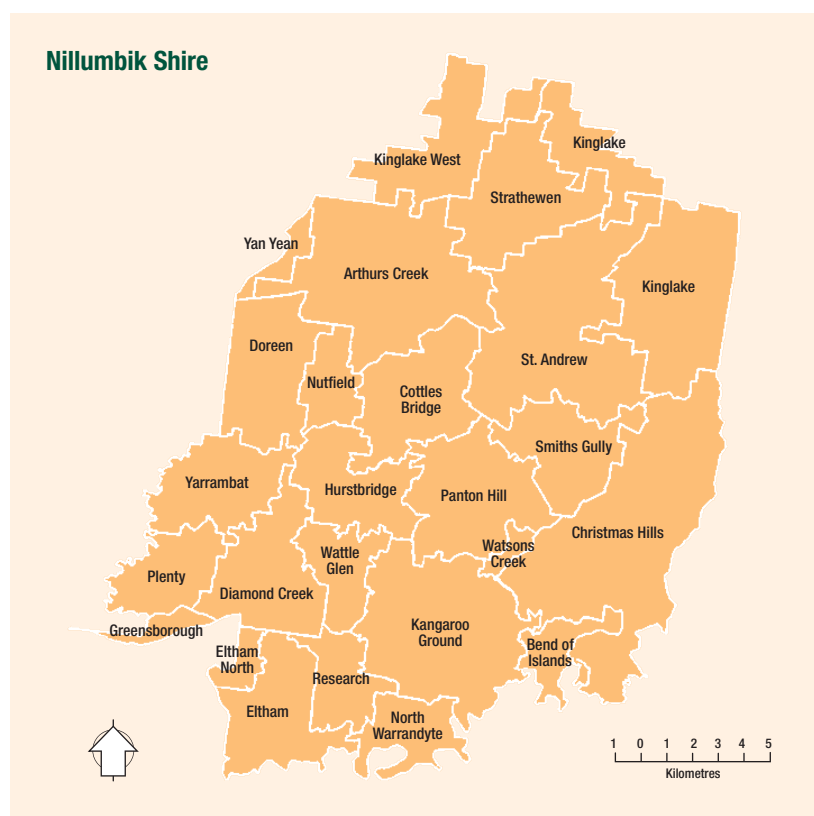
The CIV 2007 Survey reported that across all indicators (including areas such as self reported health, subjective wellbeing, feeling part of the community, social support, volunteering, child health assessments, perceptions of safety, work-life balance, water conservation and household recycling) the Nillumbik Shire data was positive in either meeting or exceeding the percentage levels reported in the Northern and Western Metropolitan Region and the Victorian State average.²⁰

Nillumbik residents have been found to have a high level of tertiary and educational qualifications, earn higher incomes and fewer are unemployed than those who live in other interface municipalities or in the Melbourne Statistical Division.¹⁸

Nevertheless, previous community consultation reports have identified lack of public transport, lack of local work opportunities (and consequent impact of long commute times), lack of public services and the divide in levels of advantage/disadvantage between the urban and rural areas as issues impacting on residents.²¹

In 2006 'Growing Communities, Thriving Children' funding was allocated to the Shire of Nillumbik, as the result of joint submissions by the nine interface councils.

Map of Shire of Nillumbik: Figure 3



The funds were allocated to address the “critical shortage of locally available family services” (p.16)⁵, tackle specific interface issues (of which the Best Start program was a part) and support the strategic directions identified in the Municipal Early Years Plan 2009 -2013.⁵

In terms of family composition, Nillumbik Shire has a:

- Younger population than the Melbourne Statistical Division (MSD): Higher proportion in the family formation and young family age groups. The mean age being 34 which is lower than the Australian mean age of 36.²²
- Fertility rate comparable to the national rate.²²
- Projected population growth of 3.7% by 2020, which is lower than the rate of growth projected for Victoria (14.4%) over the same time period.²²
- In 2007-2008 Nillumbik registered 714 births with 272 first time mothers.²³

Families in the Shire of Nillumbik: Areas of Strength

Families in the Shire of Nillumbik demonstrated the following areas of strength (in family functioning and decision making) that are of significant importance for children’s health and wellbeing:

- 73.7% of babies were breastfed (figure includes both partially and fully breastfed rates) at three months, compared to a state average of 61.2%, according to the 2007-2008 Maternal & Child Health annual report.²³
- 70.3% of parents were involved in their child’s school in a voluntary capacity.²⁴
- By six years, 93.5% of Nillumbik children were fully immunised.²² The current Victorian average rate for immunisation by six years approximates 90%.²⁵

The Shire of Nillumbik had a comparatively low rate of child protection report substantiations (i.e. a report is substantiated when it is concluded that the child/ young person is in need of protection). Data provided by Central Department of Human Services (DHS) Family Services 2009, as follows:

Area	No. of Substantiations	Year	Approximate Population
Nillumbik	19	2008/09	62,000
Whittlesea	170	2008/09	130,000
Banyule	121	2008/09	120,000

The Nillumbik community performed relatively well on the **2009 Australian Early Development Index²⁶** (AEDI) measures. The AEDI is a 2009 population measure of how young children are developing in Australian communities. The AEDI involved collecting information through a teacher completed checklist for children in their first year of full time school.

The following data had been released at the time of writing: The AEDI provided percentages of children as “on track” (in the top 75% of the national population) and “developmentally vulnerable” (much lower than average ability) in the five measured areas of childhood development. The sample size for the Nillumbik community was 883.

	% of children “on track”	% of children “developmentally vulnerable”
Physical health and wellbeing	89.0%	4.0%
Social competence	86.9%	3.5%
Emotional maturity	83.9%	4.6%
Language and cognitive skills (school based)	88.7%	3.67%
Communication skills and general knowledge	88.8%	2.6%

Overall, 11.3% of children were reported as developmentally vulnerable in one or more areas and 4% in two or more areas. This compared well with the national figures of 23.4% developmentally vulnerable in one or more areas and 11.8% in two or more areas.²⁶

	Overall % of children developmentally vulnerable in 1 or more areas	Overall % of children developmentally vulnerable in 2 or more areas
Nillumbik	11.3%	4%
Australia	23.4%	11.8%