CHILDREN'S CENTRE EVALUATION

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

A COLLABORATION BETWEEN

FRASER
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of South Australia
Department for Education

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Acronyms used in this report:

ACRONYM	MEANING
AEDC	AUSTRALIAN EARLY DEVELOPMENT CENSUS
DECD	DEPARTMENT OF EDUCATION AND CHILD DEVELOPMENT
FCP	FAMILY AND COMMUNITY PROGRAM
EYS	EARLY YEARS SYSTEM
CALD	CULTURALLY AND LINGUISTICALLY DIVERSE
ECEC	EARLY CHILDHOOD EDUCATION AND CARE
ECCE	EVALUATION OF CHILDREN'S CENTRES IN ENGLAND
TFD	TORONTO FIRST DUTY
BBBF	BETTER BEGINNINGS, BETTER FUTURES
EHS	EARLY HEAD START
CC	CHILDREN'S CENTRE
GOM	GUARDIANSHIP OF THE MINISTER
DOB	DATE OF BIRTH
EDID	EDUCATION ID
SRC	SOCIAL RESEARCH CENTRE
LBOTE	LANGUAGE BACKGROUND OTHER THAN ENGLISH
CAFHS	CHILD AND FAMILY HEALTH SERVICE
LOTE	LANGUAGE OTHER THAN ENGLISH
SEIFA	SOCIO-ECONOMIC INDEX FOR AREAS
ABS	AUSTRALIAN BUREAU OF STATISTICS
ARACY	AUSTRALIAN RESEARCH ALLIANCE FOR CHILDREN AND YOUTH
EYLF	EARLY YEARS LEARNING FRAMEWORK

1. Executive Summary

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

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

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

1.1. Background

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

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

(Department for Education and Child Development, 2011)

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

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

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

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

1.2. Method

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

1.2.1. Survey data

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

1.2.2. Family and Community Programs data

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

1.2.3. Linked 2015 AEDC and preschools data

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

1.3. Findings

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

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

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

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

b. What are the referral pathways to additional support?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.4. Recommendations

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

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

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

2. Introduction

2.1. Children’s Centres in South Australia

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

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

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

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

(Department for Education and Child Development, 2011).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 2.2-1 Comparison of literature results

CHILD OUTCOMES					
Paper/Report	Physical health and wellbeing	Social competence	Emotional maturity	Language and cognitive skills (school based)	Communication skills and general knowledge
Sure Start - Belsky et al. (2006) * 9-month-old and 36-month-old children	No change - both age groups	No change - age 9 months Poorer social functioning—children (36 months) of teenage mothers Greater social competence—children (36 months) of non-teenage mothers	Reduced behavioural problems—children (36 months) of non-teenage mothers	No change - age 9 months Lower tested verbal ability—children (36 months) from workless or lone parent households	
Sure Start - Melhuish et al. (2008) * 3-year old children (that were 9 months in first evaluation)	No change	Increased independence—*age 3*	Improved social behaviour—*age 3* Adverse effects on social behaviour - *black-Caribbean children age 3*	No change	
Sure Start - NESS (2010) *Follow-up evaluation when children were aged 5	Lower BMIs—*age 5* Better physical health—*age 5*	No change	No change	No change	
Sure Start - NESS (2012) *Follow-up	No change	No change	No change	No change	

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

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

Table 2.2-2 Comparison of literature results - parents

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

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

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

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

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

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

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

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

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

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

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

3. Method

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

3.1. Survey

3.1.1. Recruitment

Sampling

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

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

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

Method of approach

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

1. Parents and Carers at Children's Centres

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

Experience from focus groups and advice from Centres about recruitment highlighted that families who are typically difficult to engage in services were less likely to take part and provide feedback about their experiences. Importantly, Children's Centres work to engage these families with targeted supports, therefore it is important to know about the experiences of these families. For families who might not have responded to written invitations to take part it was more appropriate to speak to parents directly about the survey. This required the staff in Centres, who were familiar to families, to approach parents to explain the evaluation and invite them to take part in the survey. In these circumstances, staff presented information about the research, its aims, and what participation involved verbally rather than in a formal letter of invitation. Researchers discussed with staff appropriate recruitment strategies in order to ensure that ethical guidelines for recruitment were maintained and parents did not feel pressured or obliged to take part.

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

2. Parents and Carers Comparison Group

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

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

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

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

Invitations to complete the survey online were disseminated to Children's Centre staff and Service Providers via the Children's Centre Director. Directors sent an email invitation to complete the survey, which contained a link to the questionnaire. The text contained in the invitation is presented in Appendix A. Consent to take part was collected prior to completing the questionnaire. The online questionnaire began with a consent page that appeared before any questions. Text relating to consent is presented in Appendix B.

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

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

3.1.2. Participants

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

Parents and Carers at Children's Centres

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

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

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

Parents and Carers Comparison Group

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

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

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

	N	%

		N	%
AGE (YEARS)			
	18-22	0	0
	23-25	4	10.3
	26-30	10	25.6
	31-35	15	38.5
	36-40	5	12.8
	> 40	5	12.8
GENDER			
	Male	4	10.3
	Female	35	89.7
ABORIGINAL OR TORRES STRAIT ISLANDER			
	No	35	89.7
	Yes	4	10.3
	Unknown	0	0.0
LANGUAGE BACKGROUND OTHER THAN ENGLISH			
	Yes	4	10.3
	No	35	89.7
NUMBER OF CHILDREN			
	0	0	0.0
	1	6	15.4
	2	12	30.8
	3	10	25.6
	4	6	15.4
	≥ 5	5	12.8
CHILDREN WITH SPECIAL NEEDS			
	No	32	82.1
	Yes	7	17.9
HAVE YOU OR YOUR CHILD USED ANY SERVICES AT ANY OF THE CHILDREN'S CENTRES?			
	Yes	21	53.8
	No	18	46.2
FIRST SERVICE USED IN CHILDREN'S CENTRE			
	Preschool	15	71.4
	Long Day Care	2	9.5
	Occasional Care	0	0.0
	Play Group	2	9.5
	Parenting Program	1	4.8
	Parenting Support Services	0	0.0
	Specific Support	0	0.0
	Community Group	0	0.0
	Health or Food Course	0	0.0
	Aboriginal Program	0	0.0

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

Children's Centre Staff and Service Providers

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

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

Directors and Heads of School Early Years

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

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

3.1.3. Design and Analysis

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

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

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

3.2. Family and Community Programs data

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

3.2.1. EYS data extracted for the evaluation

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

Child level demographic information:

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

Adult level demographic information:

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

Program level information:

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

Enrolment and attendance:

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

Extracted data summary

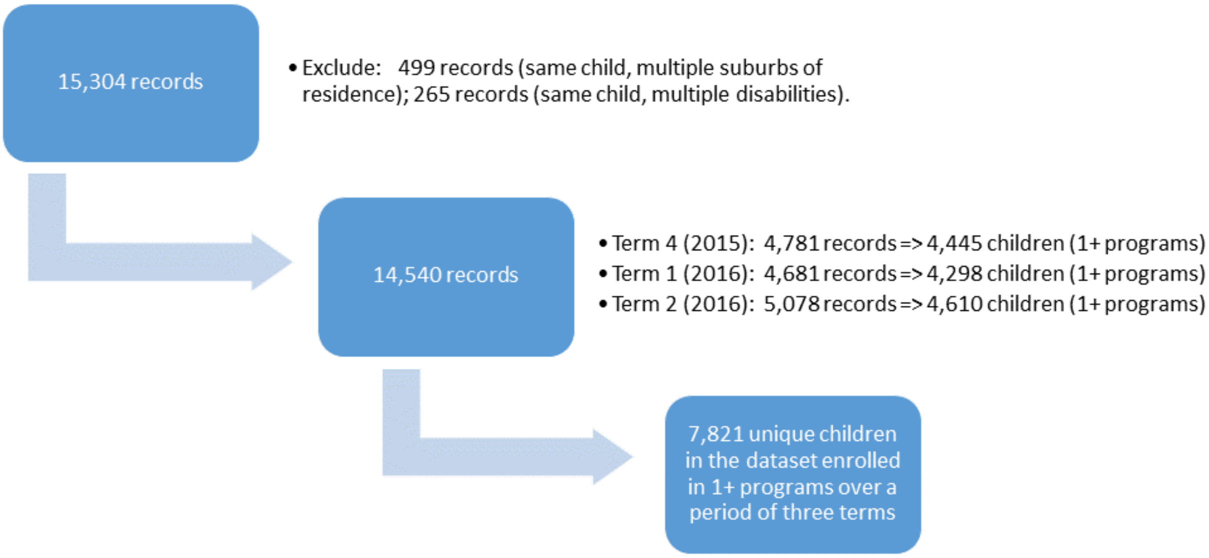

Figure 3.2-1and Figure 3.2-2 present the number of records extracted from the EYS for children and adults attending Children's Centres in Term 4 2015, Term 1 and Term 2 2016. The flow charts illustrate the number of service records and how many unique children and adults these relate to. The flow charts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

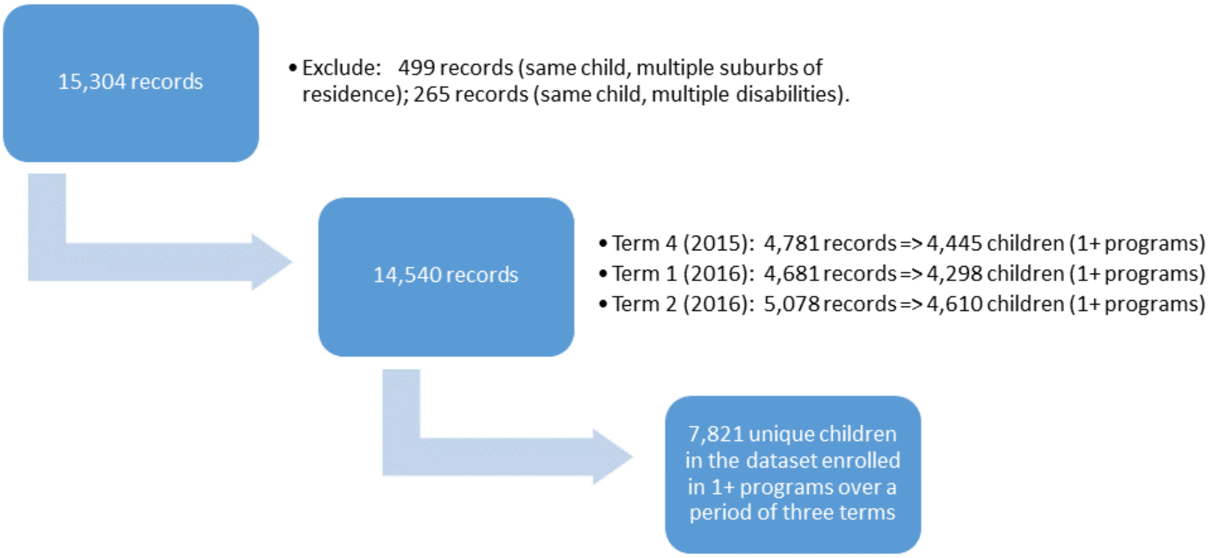

Figure 3.2-1 Child records extracted from the EYS

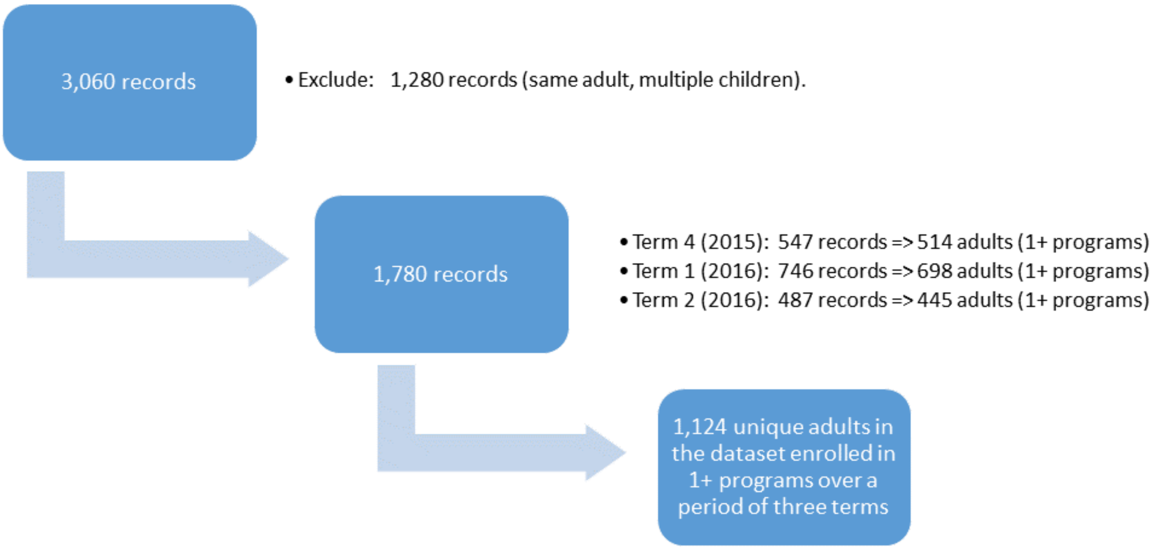

Figure 3.2-2 Adult records extracted from the EYS

3.2.2. Incomplete and missing data

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

Child level demographic information

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

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

Adult level demographic information

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

Program enrolment data for children and adults

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

Table 3.2-1 Child enrolment records by term

	TOTAL NUMBER OF PROGRAM TYPES WITH DATA ON CHILDREN'S ENROLMENT			TOTAL NUMBER OF RECORDS FOR CHILDREN ENROLLED IN PROGRAMS		
	TERM 4 (2015)	TERM 1 (2016)	TERM 2 (2016)	TERM 4 (2015)	TERM 1 (2016)	TERM 2 (2016)
CENTRE 19	5	5	6	241	247	284
CENTRE 32	2	4	5	203	202	281
CENTRE 41	4	4	4	273	263	263
CENTRE 40	6	5	5	181	194	211
CENTRE 24	7	6	6	206	175	191
CENTRE 29	7	8	8	189	201	188
CENTRE 18	7	7	7	166	153	176
CENTRE 3	2	3	3	163	161	168
CENTRE 20	4	5	6	147	159	162

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

Note

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

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

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

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

Table 3.2-2 Adult enrolment records by term

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

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

3.3. Linked 2015 AEDC and preschools data

3.3.1. Methodology – Data linkage of preschool and AEDC data

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

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

    a. Demographic information – child surname, first name and DOB - in the AEDC file was matched against records in the pre-population data file[2] provided to the Social Research Centre (SRC) prior to the 2015 census
    b. 97.9% were matched using this method (n = 13,527)
    c. 2.1% could not be identified in the pre-population data (n = 291)[3]
2) Preschool census data (2014) for government funded preschools (n = 20,986)
    a. These records were checked against the records in the AEDC dataset for matching EDIDs. For those children that did not "match" to any of the AEDC cases based on EDID, a second check of the records was conducted to see whether any cases matched based on child-level demographic information – child surname, first name and DOB. A total of 12,325 records[4] (58.7%) were matched using this method. Reasons for non-matching would include children who attended a government funded preschool but an Independent or Catholic primary school, children who moved interstate between preschool and reception, children who attended preschool for an additional year (2015), children whose parents opted out of the AEDC collection.

3.3.2. Analysis Sample

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

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

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

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

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

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

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

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

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

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

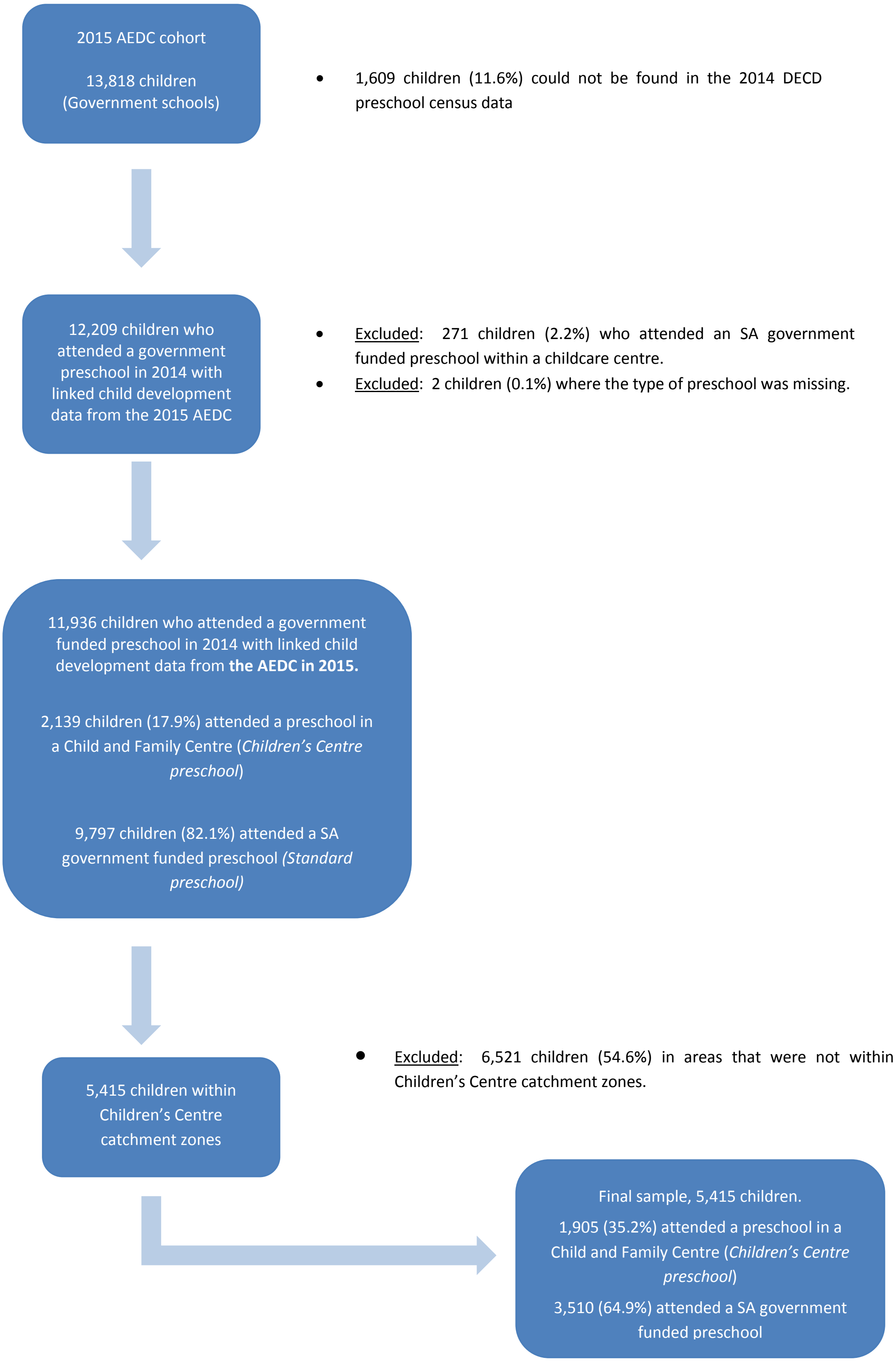
The other way to explore child development differences between children with different preschool experiences is to explore the geographical areas that form the catchment zone for the Children's Centres, and select a "matched" group of children who live in this same area but attended standard preschools.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

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

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

	STANDARD PRESCHOOL		CHILDREN'S CENTRE PRESCHOOL		TOTAL	
	N	%	N	%	N	%
ABERFOYLE PARK	101	100%	0	0%	101	100%
ADELAIDE	4	19%	17	81%	21	100%
ALBERT PARK	5	83%	1	17%	6	100%
ALBERTON/QUEENSTOWN/PORT ADELAIDE	24	100%	0	0%	24	100%
ALDGATE	29	97%	1	3%	30	100%
ALDINGA BEACH	75	74%	27	26%	102	100%
ALLENBY GARDENS/BEVERLEY	18	100%	0	0%	18	100%
ANDREWS FARM	77	68%	37	32%	114	100%
ANGASTON AND SURROUNDS	26	70%	11	30%	37	100%
ANGLE PARK	3	27%	8	73%	11	100%
ANGLE VALE	17	89%	2	11%	19	100%
ARDROSSAN/MAITLAND AND SURROUNDS	31	100%	0	0%	31	100%
ASCOT PARK	10	77%	3	23%	13	100%
ATHELSTONE	41	91%	4	9%	45	100%
ATHOL PARK	5	25%	15	75%	20	100%
BALAKLAVA	2	14%	12	86%	14	100%
BALHANNAH AND SURROUNDS	7	100%	0	0%	7	100%
BANKSIA PARK	28	97%	1	3%	29	100%
BARMERA	26	100%	0	0%	26	100%
BEAUMONT	16	100%	0	0%	16	100%
BELAIR	26	100%	0	0%	26	100%

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



- 1,609 children (11.6%) could not be found in the 2014 DECD preschool census data

- Excluded: 271 children (2.2%) who attended an SA government funded preschool within a childcare centre.
- Excluded: 2 children (0.1%) where the type of preschool was missing.

- Excluded: 6,521 children (54.6%) in areas that were not within Children's Centre catchment zones.

Figure 3.3-1. Participant flowchart

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

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

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

4. Findings

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

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

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

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

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

Range of services available in Children's Centres

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

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

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

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

	TERM 4-2015		TERM 1-2016		TERM 2-2016	
	SITES	PROGRAMS	SITES	PROGRAMS	SITES	PROGRAMS
ABORIGINAL FOCUSSED SUPPORT	13	36	15	49	14	41
COMMUNITY GROUP	28	64	34	92	30	76
COMMUNITY/PARENT LED PLAYGROUP	13	18	16	25	15	22
FAMILY SUPPORT	33	44	31	51	31	46
HEALTH	23	50	24	73	20	56
PARENTING PROGRAM	27	79	29	100	25	82
PARENTING SUPPORT SERVICES	40	206	40	244	40	218
SUPPORTED PLAYGROUP	36	102	37	138	36	118
TARGETED PLAYGROUP	7	11	10	16	10	15
TARGETED SUPPORT GROUP	27	83	30	101	29	92

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

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

Note

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

Definition of community

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

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

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

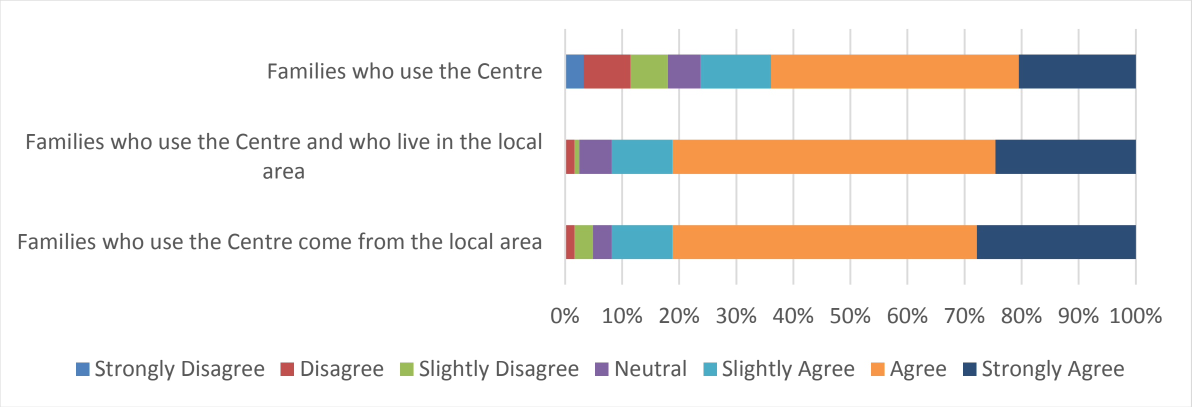


Figure 4.1-1 Staff and service provider perceptions of community

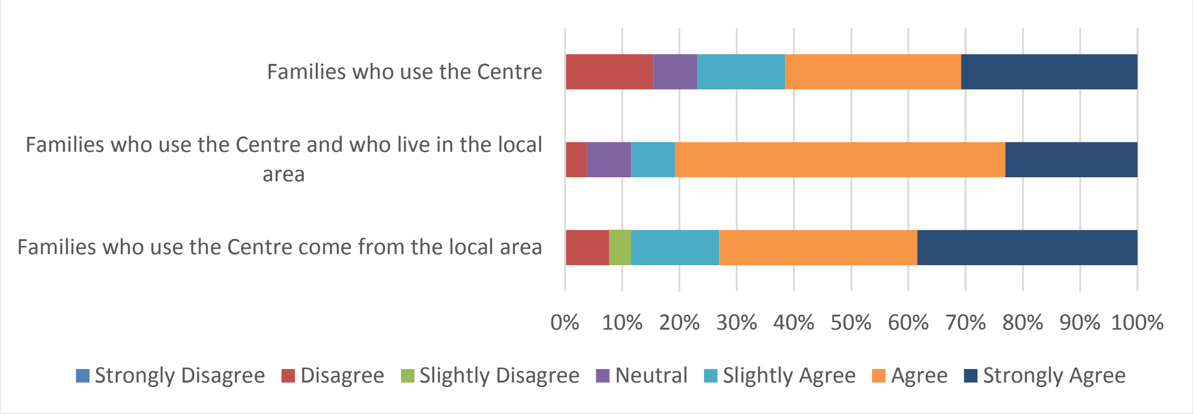


Figure 4.1-2 Director perceptions of community

Understanding the needs of community

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

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

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

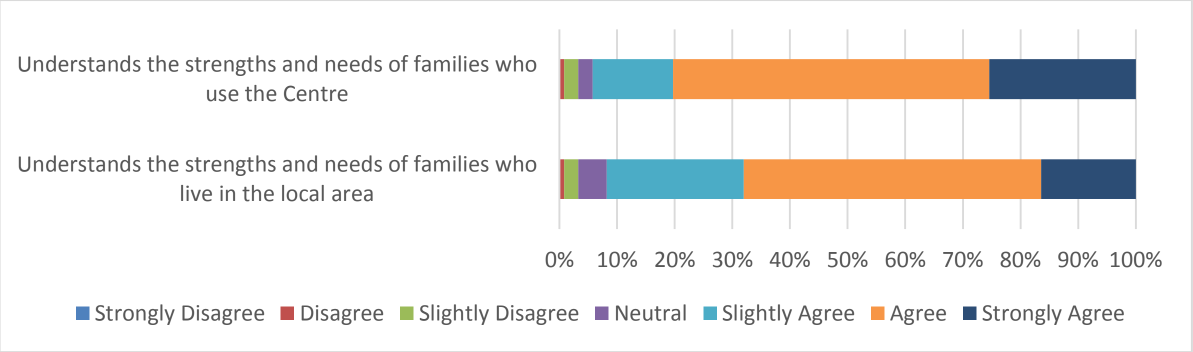


Figure 4.1-3 Staff and service provider's understanding of the strengths and needs of families

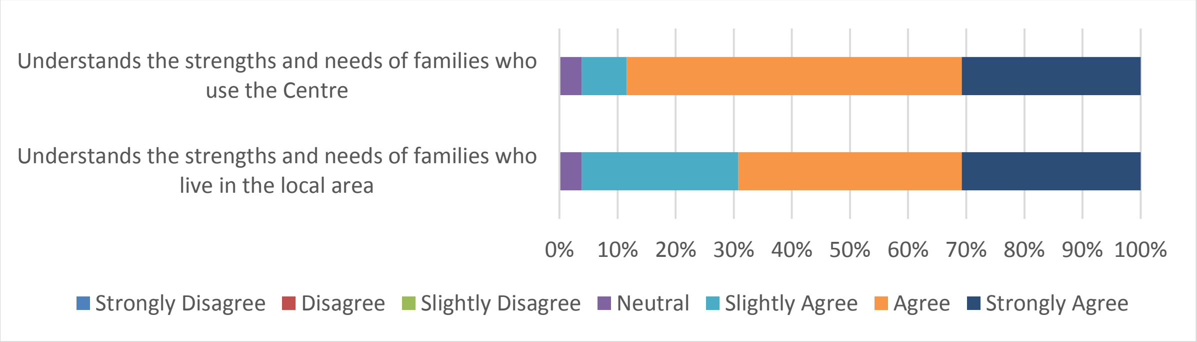


Figure 4.1-4 Director's understanding of the strengths and needs of families

Parent perceptions of influence in centres

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

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

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

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

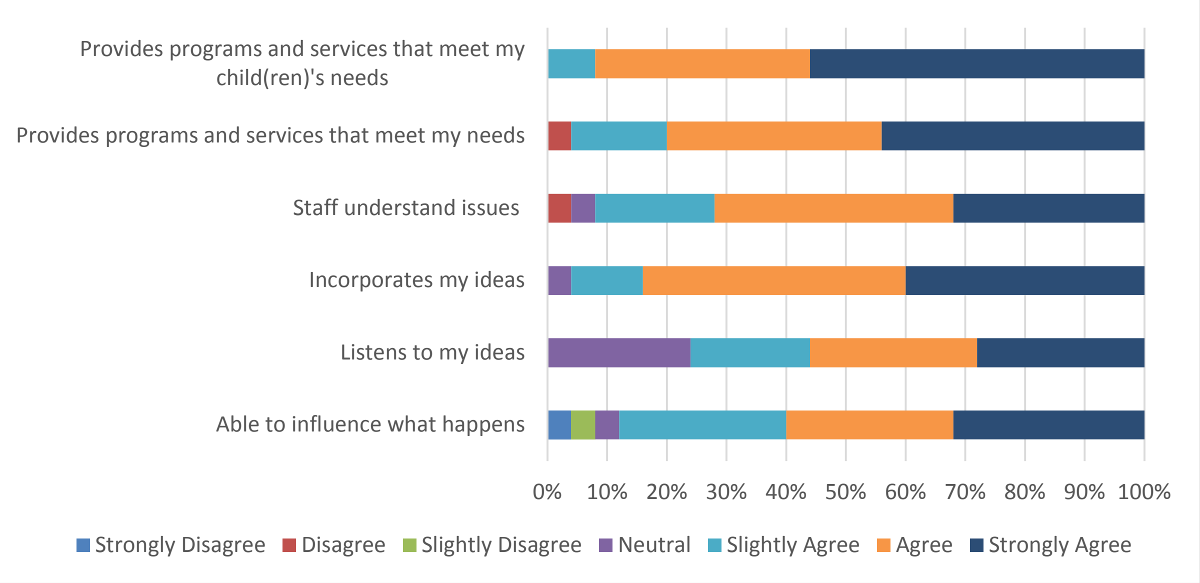


Figure 4.1-5 Parent perceptions of influence in Centres

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

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

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

Parents' experience of staff

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

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

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

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

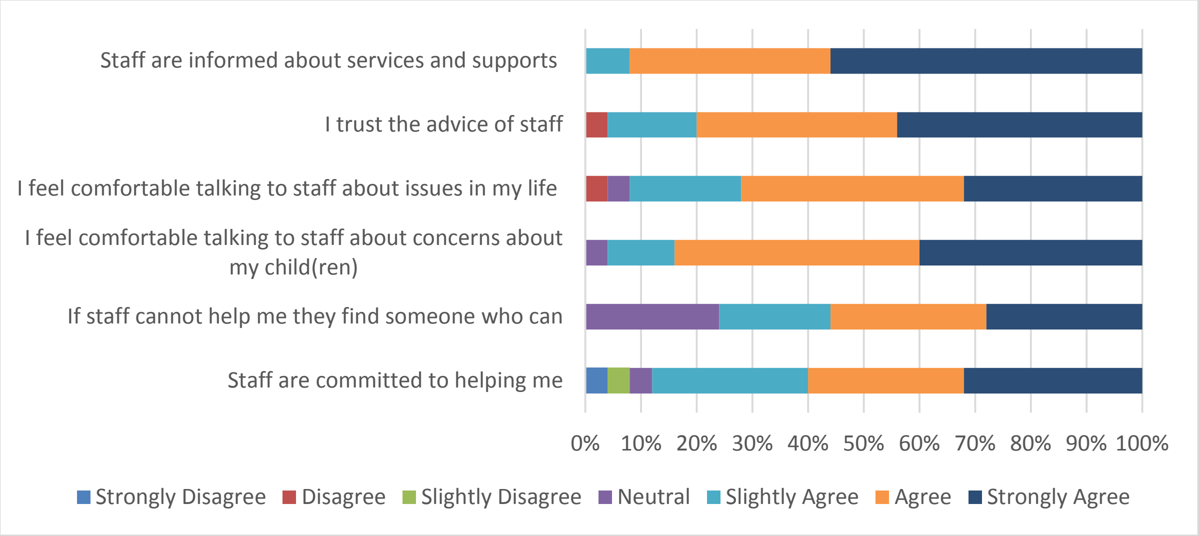


Figure 4.1-6 Parent perceptions of staff at Children's Centres

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

Although all groups of parents reported a generally high (a median score of six out of a possible score of seven) level of support, a non-parametric analysis of variance (Kruskal-Wallis) indicated that parents with lower education reported significantly more positive experiences of staff (p = .006) (high school or part high school education (M = 6.4, n = 43), TAFE (M = 6.2, n = 58) than those who had completed university (M = 5.9, n = 103)).

The length of time attending a Children's Centre was also significantly associated with differing perceptions (p = .009). Parents who had been attending a Children's Centre for more than three years reported Centres as the most friendly and trusted sources of advice (M = 6.4, n = 36), compared to those attending Centres for two to three years (M = 6.1, n = 40), one to two years (M = 6.4, n = 44), and less than one year (M = 5.9, n = 87). Although, respondents with an Aboriginal and Torres Strait Islander background tended to rate their experiences of Centres more highly than non-Indigenous respondents, too few survey responses were collected from families with an Aboriginal or Torres Strait Islander background to draw reliable comparisons.

Relationship between influence in Centre and experience of staff

Parent's experience of staff was significantly and positively associated with parents feeling like they were active partners in Centres (Spearman's rank-order correlation r = .509, p = .016). That is, parents who reported higher levels of involvement also tended to report more positive experiences of staff. To further examine this relationship, Centre level scores were created by aggregating respondent scores for each Centre. Aggregated scores for Centres were grouped into high and low categories, corresponding to the mean Centre rating falling above a score responding to 'agree' in the survey response options. As shown in Table 4.1-3, of the 22 Centres with parent responses, four Centres were consistently rated as having high parental involvement in the Centre. In contrast, 16

Centres were rated as having high experiences of staff. There was no relationship between parent reported involvement in Centres and their experience of staff ($\chi^2 = 1.83$, $p = .180$).

Table 4.1-3 Parent's experience of staff and whether they felt like active partners in the design and implementation of services by Children's Centres

			Experience of staff		
			Low	High	Total
Active partners in design	Low	Count	6	12	18
	High	Count	0	4	4

4.1.2. What are the referral pathways to additional support?

In focus groups and interviews, staff, service providers, and directors spoke about Children's Centres as service provision hubs in their communities. Participants also noted that Children's Centres were connecting service providers to each other and to families. However, discussions indicated that referral pathways were informal rather than formal, and relied upon relationships that were developed between individual staff within the Children's Centres and within service provider organisations. Surveys further explored these themes and asked staff, service providers, and directors to rate referral processes and pathways across Children's Centres and the factors that facilitate these.

Building service networks

Two survey questions explored staff, service provider's, and director's perception of the way in which Children's Centres support the building of local service provision networks. Staff, service providers, and directors were asked to rate the extent to which they agreed or disagreed that:

1. Children's Centres build positive relationships with external agencies
2. Children's Centres help improve relationships between government and non-government agencies

Figure 4.1-7 and Figure 4.1-8 below demonstrate that there was broad agreement that Children's Centres operated in a way that built positive working relationships in the community of service providers, although directors tended to rate this more highly than staff and service providers. These findings echo the themes that arose in focus groups and interviews.

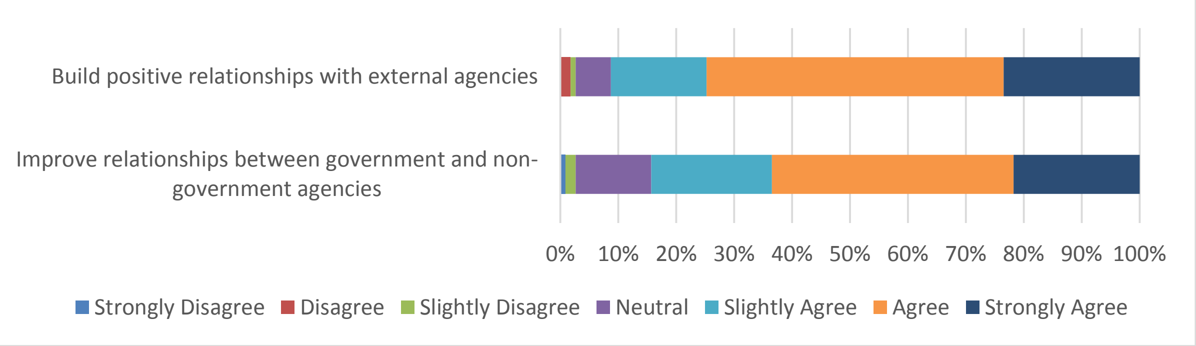


Figure 4.1-7 Staff and service provider perceptions of service networks

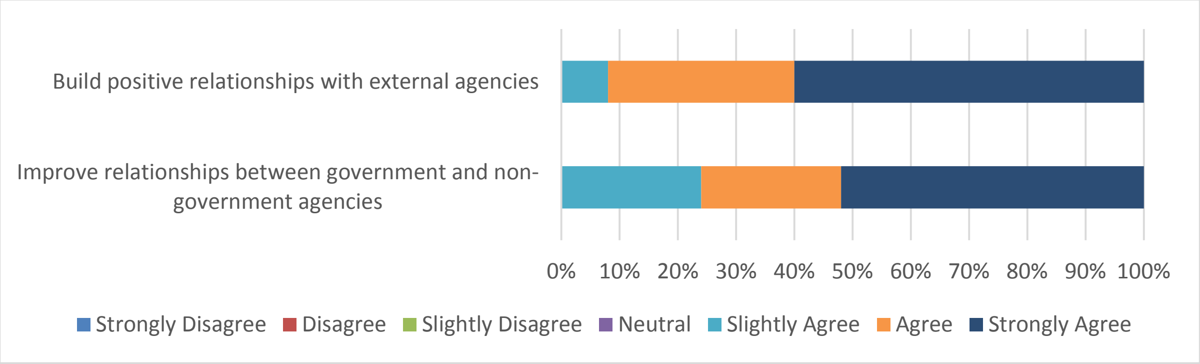


Figure 4.1-8 Director perceptions of service networks

When asked about the network groups and meetings that staff, service providers, and directors were currently involved in, 43% of staff and service providers and 76% of directors reported that they participated in a broad range of network groups and meetings. To examine whether network meetings were attended more by some staff in Centres than others, the frequency of meeting reports were explored for the range of staff groups. Most Community Development Coordinators (78%) and Family Services Coordinators (88%) reported attending a range of network meetings in addition to Governance Group meetings. In contrast, most Preschool Educators (74%) reported that they did not attend additional meetings.

Too few allied health, long day care occasional care, and school support staff took part to compare answers for these groups. Additional meetings included regional leadership meetings, school-based staff and team meetings and preschool director association meetings. The ability of additional staff to connect with local networks was similarly reported in focus groups and interviews. This demonstrates the importance of the community development and family service coordinator roles in Centres to facilitate the development of local professional networks.

Referral Pathways

Focus group and interview participants noted that enhanced service provider networks resulted in improved referral pathways for children and families in the community. To examine the extent to which referrals and pathways functioned in Children’s Centres, staff, service providers, and directors were asked to indicate if they were aware of various services in the area and whether there were referral pathways from the Children’s Centres to those services in place. As can be seen in

Table 4.1-4 and Table 4.1-5, staff, service providers, and directors were generally aware of services in the area and referral pathways to those services. While there was high awareness of some services, there were not, however, always referral pathways available. Staff, service providers and directors reported similar levels of awareness of services and referral pathways. Examination of how this differs across services in the community highlights areas where there is potential to improve local links for the benefits of families.

Table 4.1-4 Proportion of staff and service providers who were aware of various services and whether there were referral pathways available

REFERRAL PATHWAY	KNOW OF SERVICE (YES)	REFERRAL PATHWAY AVAILABLE (YES)
SPEECH PATHOLOGIST	98%	97%
MATERNAL AND CHILD HEALTH	93%	90%
MENTAL HEALTH	88%	78%
SEXUAL/REPRODUCTIVE HEALTH	58%	27%
GENERAL PRACTITIONERS	91%	63%
DISABILITY SERVICES	93%	84%
SOCIAL AND EMOTIONAL WELLBEING	94%	83%
LOCAL PRIMARY SCHOOLS FOR SCHOOL TRANSITION	96%	90%
PLAYGROUPS RUN BY FACILITATORS	95%	92%
LOCAL KINDERGARTENS	96%	89%
LOCAL CHILDCARE SERVICES	92%	79%
CHILD SAFETY	80%	62%
PARENT AND FAMILY SUPPORT	94%	91%
TRANSPORT	70%	55%
FINANCIAL ASSISTANCE FOR FAMILIES	80%	71%
HOUSING SERVICES	79%	62%
DRUG AND ALCOHOL SERVICES	73%	50%

Table 4.1-5 Proportion of directors who were aware of various services and whether there were referral pathways available

REFERRAL PATHWAY	KNOW OF SERVICE (YES)	REFERRAL PATHWAY AVAILABLE (YES)
SPEECH PATHOLOGIST	100%	92%
MATERNAL AND CHILD HEALTH	100%	92%
MENTAL HEALTH	100%	76%
SEXUAL/REPRODUCTIVE HEALTH	56%	28%
GENERAL PRACTITIONERS	96%	56%
DISABILITY SERVICES	96%	80%
SOCIAL AND EMOTIONAL WELLBEING	92%	76%
LOCAL PRIMARY SCHOOLS FOR SCHOOL TRANSITION	100%	92%
PLAYGROUPS RUN BY FACILITATORS	100%	88%
LOCAL KINDERGARTENS	100%	96%
LOCAL CHILDCARE SERVICES	100%	92%
CHILD SAFETY	88%	68%
PARENT AND FAMILY SUPPORT	96%	88%
TRANSPORT	84%	64%
FINANCIAL ASSISTANCE FOR FAMILIES	80%	68%
HOUSING SERVICES	88%	68%
DRUG AND ALCOHOL SERVICES	84%	64%

Connecting families to supports in their children’s early years

In focus groups and interviews, staff, service providers, and families noted the difficulties experienced by families seeking services and supports in the years before children commenced preschool. Families reported not knowing about what services and supports were available to them and had difficulty finding information when they were in need.

Antenatal and community maternal child health services (in South Australia the Child and Family Health Service (CaFHS)) provide universal health and support services for children and their families during pregnancy, infancy, and early childhood. Antenatal services focus on providing care during pregnancy, while the CaFHS focus on providing services for families and children from birth to school entry. By including such services within an early childhood and parenting setting (such as Children’s Centres), parents and their children can be supported to engage early with parenting support and their communities during children’s early years.

In focus groups participants noted that where good relationships existed between CaFHS nurses and Centres, families were connected to services and supports in Centres when their children were younger. Connections with maternal child health nurses were reported to be variable and not always systemically supported, but reliant on local relationships. In several sites, antenatal services and or CaFHS are delivered within the Children’s Centre. To examine whether this improved the uptake of services for younger children, the age profiles of children enrolled in Children’s Centres with and without antenatal services and/or a child health nurse were examined. Table 4.1-6 demonstrates that having antenatal and maternal child health services on site increased the proportion of younger children enrolled in Children’s Centres. Specifically, where these services were located in a Children’s Centre there was a higher proportion of children aged 0 to 2 years enrolled in the Centre compared to those Centres without either service. While both service types increased early enrolments, a CaFHS nurse on site had a larger impact on early enrolments than antenatal services.

Table 4.1-6 Number and proportion of children enrolled in Centres with a CaFHs service and/or antenatal service

		Does the Children’s Centre have a CaFHS service and/or antenatal services?							
		CaFHs (No), Antenatal services (No) 28 Centres		CaFHs (No), Antenatal services (Yes) 4 Centres		CaFHs (Yes), Antenatal services (No) 7 Centres		CaFHs (Yes), Antenatal services (Yes) 1 Centres	
		N	%	N	%	N	%	N	%
Child—Age group	0-2 years	974	59.2%	233	64.5%	635	74.7%	-	-
	3-4 years	609	37.0%	123	34.1%	206	24.2%	-	-
	> 5	61	3.7%	5	1.4%	9	1.1%	-	-
	Total	1644	100.0%	361	100.0%	850	100.0%	-	-

Note

[1] Child level data on all programs except Learning Together, preschool, preschool support programs and occasional care programs. N = 3,693 records from Term 4 (2015), Term 1 (2016) and Term 2 (2016) combined

[2] A single Children's Centre had both antenatal and CaFHs services and this centre had minimal data in the EYS, so data has been suppressed in this table.

[3] Two Children's Centres had no child-level information so they have been excluded from this table.

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

Focus groups and interview participants considered that two key system-level supports enhanced the capacity of the Children's Centres' leadership teams to work in an integrated service setting. The first was the professional development program, which was said to be helping people develop an understanding of working in partnership to meet community needs and develop a model of integrated practice. The second was the support provided by the Early Childhood Development Strategy Team, which was said to help staff from non-education backgrounds negotiate challenges they encountered in their work.

A number of challenges were also identified for the management of Children's Centres. Primarily these were related to governance structures around line management and workload of directors. In addition, the physical structures of Children's Centres were identified as either facilitating or hindering integrated service provision. Specifically, the layout of office space (staff teams together or separated) either brought staff together and encouraged incidental information sharing and discussion or made it difficult for staff to stay connected to activities and staff in other areas of the Centre—necessitating increased scheduled meetings and intentional connection with other staff. These factors were further explored in the survey of staff, service providers, and directors.

Professional development and central support

Four survey questions explored the extent to which directors agreed that professional development and central support from the Early Childhood Development Strategy Team facilitated the building of integrated services in centres. Directors were asked to rate the extent to which they agreed or disagreed with the following statements:

1. The professional development program provides training that is relevant to my work in developing integrated services
2. I attend professional development to increase my knowledge about providing integrated services
3. The Early Childhood Development Strategy team has skills and knowledge to help me develop integrated services in my site
4. When I need support in relation to establishing integrated services in my site, I contact someone from the Early Childhood Development Strategy team

Figure 4.1-9 below demonstrates that the majority of directors agreed or strongly agreed that the professional development program provided training that was relevant to work related to developing integrated services. Furthermore, most directors agreed or strongly agreed that they utilised professional development to increase their knowledge about providing integrated services. While most directors agreed or strongly agreed that the Early Childhood Development Strategy team had skills and knowledge to help them develop integrated services in their site, less than half reported that they utilised the team when they needed support in relation to establishing integrated services in their site.

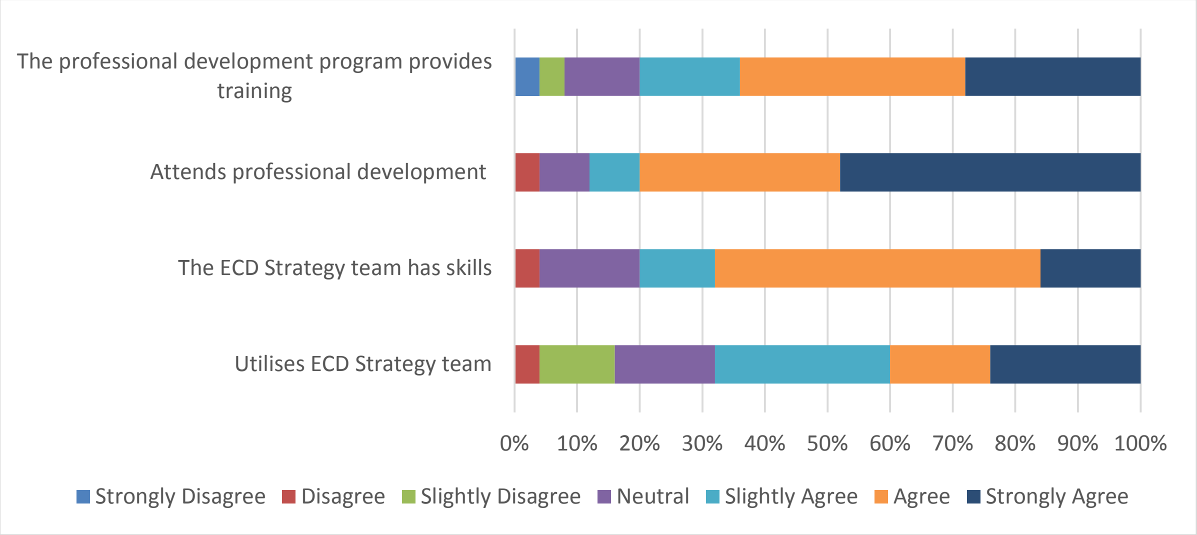


Figure 4.1-9 Director perceptions of the professional development program and the Early Childhood Development Strategy team

Impact of the physical space on integrated service provision

To explore the impact of physical space, one survey question asked staff, service providers, and directors to rate the extent to which the physical space in Centres supported integrated service provision. As shown in Figure 4.1-10, most respondents agreed that the physical space in Centres promoted integrated service provision. Although physical space was extensively discussed by focus group and interview participants, this did not appear to be a substantial issue.

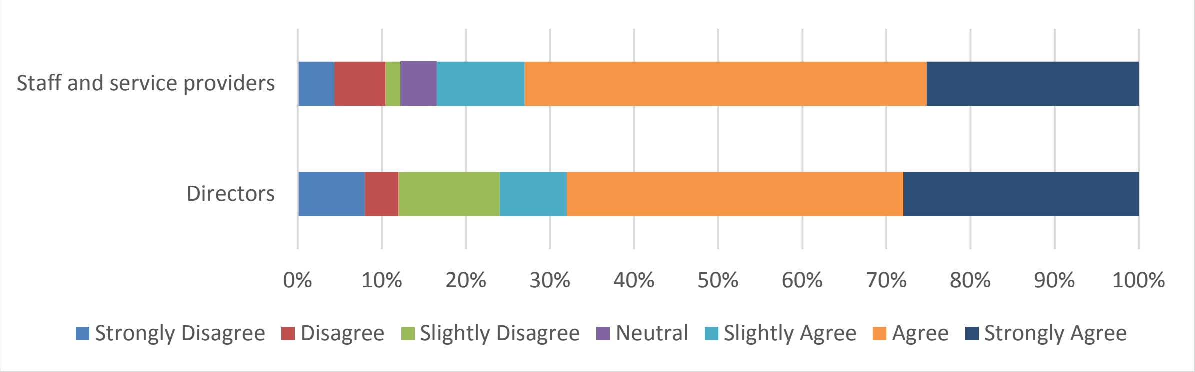


Figure 4.1-10 Staff, service provider and director perceptions of whether the physical space promotes integrated support to families

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

In focus groups and interviews, parents reported that referral pathways were functioning better in Children’s Centres than in standalone preschool or child care settings. However, not all parents identified improved access to services through referral pathways. Staff, service providers, and directors noted that once families were using the Children’s Centre, the capacity of staff and the quality of relationships between service providers and the Centre were important for improving referral pathways. Additionally, the increased capacity of staff to work with vulnerable children and their families, resulting from working in an integrated setting, was said to increase the rate of identification of families needing support.

Eight survey questions explored the extent to which staff, service providers, and directors agreed that Children’s Centres help achieve the following outcomes:

1. Earlier identification of vulnerable children and families
2. New knowledge or skills for team members
3. Improved capacity to reach more children and families
4. A clearer pathway for families to the supports they need
5. Improved access to specialist services
6. Improved access to preschool programs
7. Reduced duplication of services in our area
8. The provision of the right service at the right time

Figure 4.1-11 and Figure 4.1-12 below indicate that the majority of staff, service providers, and directors agreed or strongly agreed that Centres were improving the way in which families were supported and connected to relevant services. Staff, service providers, and directors also tended to agree or strongly agree that Children’s Centres helped to achieve earlier identification of vulnerable children and families, provided new knowledge or skills for team members, improved the capacity to reach more children and families, provided a clearer pathway for families to the supports and services, and improved access to specialist services and preschool programs.

While most staff and service providers agreed or strongly agreed that Centres supported families to connect with the right service at the right time, directors did not agree to the same extent. Fewer staff, service providers, and directors agreed or strongly agreed that Children’s Centres reduced duplication of services in the area. For most of the eight outcomes, directors reported higher levels of agreement than staff and service directors.

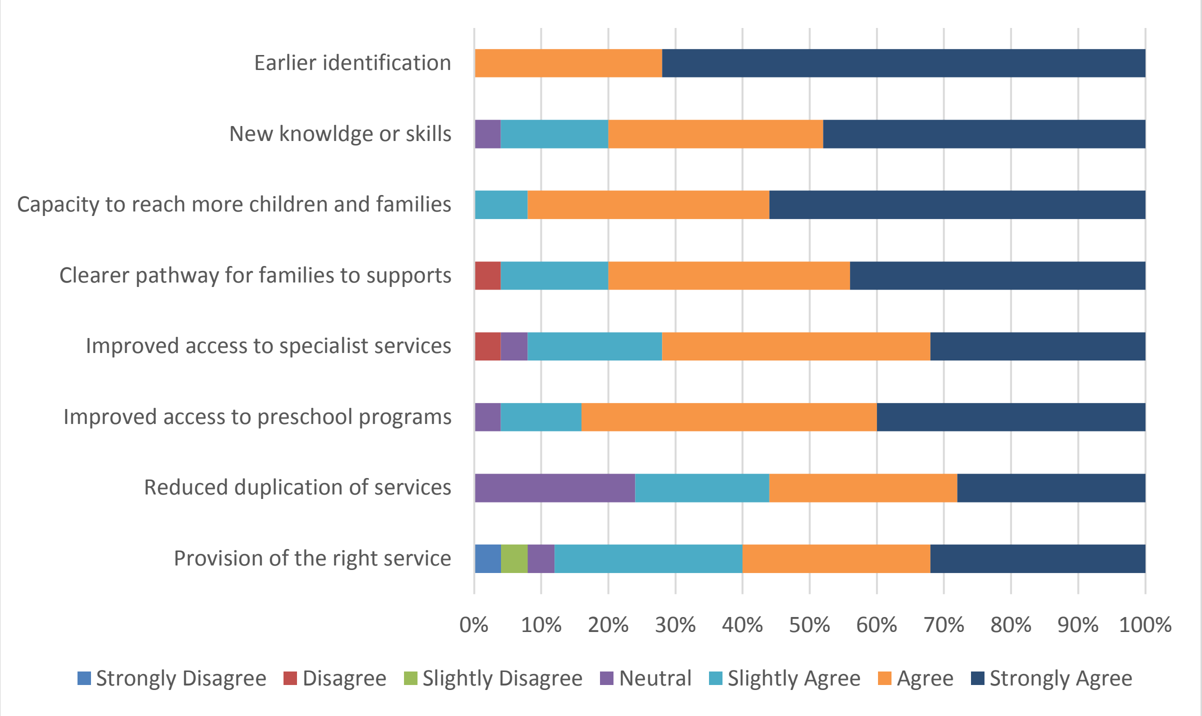


Figure 4.1-11 Staff and service provider perceptions of referral processes and pathways

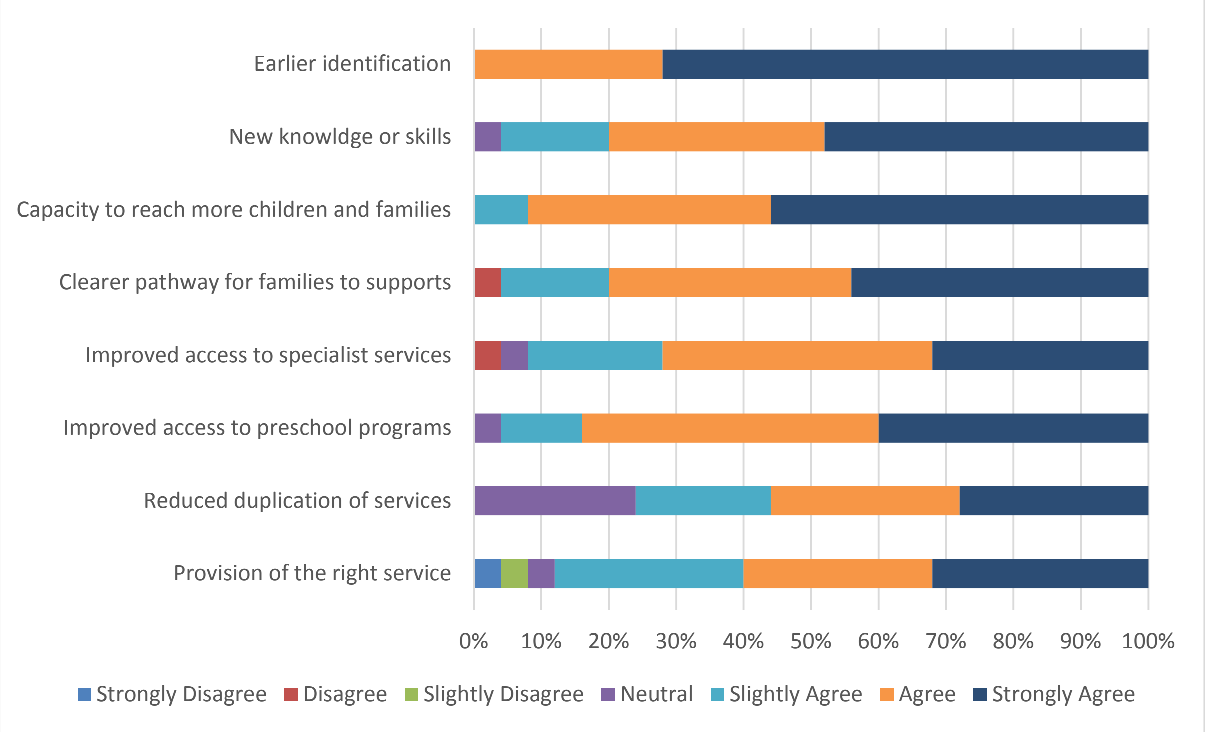


Figure 4.1-12 Director perceptions of referral processes and pathways

Improving access to services

To examine which services families were able to access and which were needed but could not be accessed, parents were asked to select from two different lists of services. One was a list of services they used for their children in the past 12 months, and the other was a list of services with a focus on families that they accessed for themselves. Parents were also asked to select the services that they needed for their children or themselves but were not able to access.

As illustrated in Table 4.1-7 and

Table 4.1-8, parents generally reported higher usage of universal services for both their children (e.g. playgroup or parent–child group and general practitioner or other health centre services) and for themselves (such as bulk-billing GP services and Centrelink or the Family Assistance Office). Universal services are those that are available to all children and families in the population.

In contrast, targeted services were reported to be used less frequently. These are services that are available to groups within the population that meet specific criteria, be they cultural, issue specific or demographic specific. Targeted services included services such as Aboriginal and language support for children and drug or alcohol services. Overall, few parents reported that there were services they were not able to access.

Table 4.1-7 Proportion of services used for children and services needed but not accessible

	SERVICES USED	SERVICES NEEDED BUT NOT ACCESSIBLE
PLAYGROUP OR PARENT-CHILD GROUP	51%	3%
MATERNAL & CHILD HEALTH CENTRE/PHONE HELP	17%	1%
MATERNAL AND CHILD HEALTH NURSE VISITS	18%	1%
PAEDIATRICIAN	23%	3%
HOSPITAL EMERGENCY DEPARTMENT	32%	1%
HOSPITAL OUTPATIENTS CLINIC	12%	1%
GENERAL PRACTITIONER OR OTHER HEALTH CENTRE	63%	2%
EARLY EDUCATION SERVICES	15%	1%
ABORIGINAL SERVICES	1%	0%
FAMILY SUPPORT SERVICES	5%	1%
LANGUAGE SUPPORT SERVICES	2%	1%
DISABILITY SERVICES	4%	1%
THERAPY/COUNSELLING SERVICES	7%	1%
OTHER MENTAL HEALTH OR BEHAVIOURAL SERVICES	5%	2%
DENTAL SERVICES	34%	2%
OTHER MEDICAL SPECIALISTS	11%	1%
SPEECH THERAPY	16%	3%
OTHER SPECIALIST	13%	4%
OTHER CHILD SPECIFIC SERVICES	10%	3%
NONE OF THE ABOVE	9%	77%

Table 4.1-8 Proportion of services used for families and services needed but not accessible

	SERVICES USED	SERVICES NEEDED BUT NOT ACCESSIBLE
PARENT LINE/HELP LINE	18%	1%
PARENTING EDUCATION COURSES OR PROGRAMS	19%	1%
RELATIONSHIPS AUSTRALIA	4%	1%
OTHER COUNSELLING SERVICES	10%	1%
PARENT SUPPORT GROUPS	7%	1%
BULK-BILLING GP SERVICES	70%	2%
ANTENATAL CLASSES OR HEALTH SERVICES	9%	1%
DRUG OR ALCOHOL SERVICES	0%	0%
ADULT MENTAL HEALTH SERVICES	8%	1%
MIGRANT OR ETHNIC RESOURCES	1%	1%
HOUSING SERVICES	2%	1%
EMPLOYMENT SERVICES	3%	1%
DISABILITY SERVICES	3%	2%
CHARITIES	5%	1%
AUSTRALIAN BREASTFEEDING ASSOCIATION	9%	1%
CHURCH OR RELIGIOUS GROUP	14%	0%
OTHER MEDICAL OR DENTAL SERVICES	26%	2%
CENTRELINK OR THE FAMILY ASSISTANCE OFFICE	56%	1%
OTHER FAMILY SUPPORT SERVICES	2%	1%
RELATIONSHIP EDUCATION SERVICE	1%	0%
RELATIONSHIP COUNSELLING	3%	1%
PARENTING INFORMATION	26%	1%
NONE OF THE ABOVE	8%	82%

Barriers to access

To examine the barriers that prevented parents from accessing the services they needed for their children, parents were asked to select any barriers from a list of 12 (illustrated in Figure 4.1-13). Parents reported that the main reasons they were unable to access services for their children included having to wait too long for appointments, the services required were too expensive, and the services were not available. Parents were also asked to select the reasons that they could not access services for themselves (see Figure 4.1-14), and the barriers were the same as those for child services.

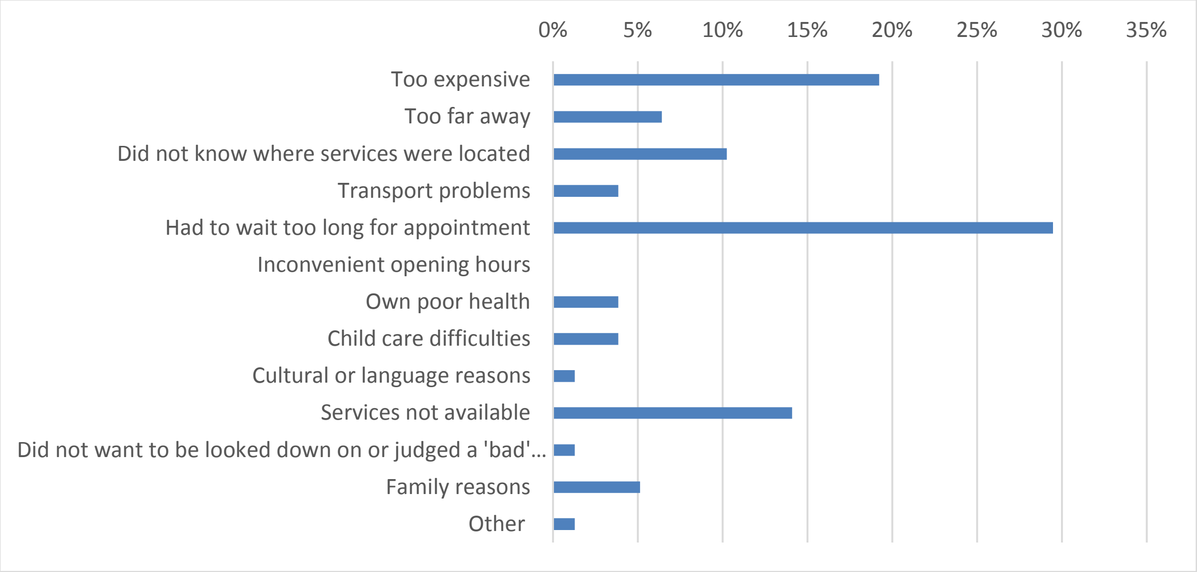


Figure 4.1-13 Reasons parents could not access child services and percentage of parents who responded in each category

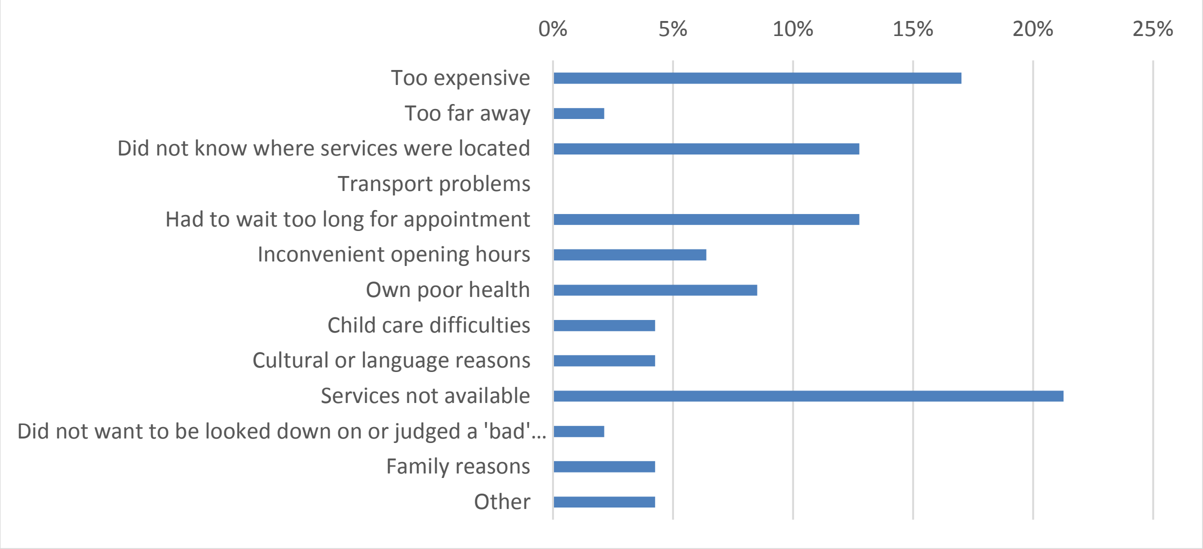


Figure 4.1-14 Reasons parents could not access family services and percentage of parents who responded in each category

Table 4.1-9, whether parents or children identified as Aboriginal appeared to somewhat increase the likelihood of not being able to access child (but not family) services. Additionally, families where parents or children identified as having a medical condition or disability appeared to have more difficulty accessing both child and family services. Similarly, families in which the child spoke a language other than English at home appeared to have a slightly increased likelihood of not being able to access child or family services. Whether the current household situation consisted of a single or two-parent structure and parent education did not appear to have much influence on being able to access child and family services. However, caution must be taken when interpreting these findings due to the small number of families in these samples.

Chi-Square Tests of Independence were conducted to determine whether there were any significant associations between service use and differing demographic characteristics. Differences were found for both use of services and access to services for two demographic groups—children with a disability and children who spoke English as a second language. In relation to service usage, children who had a disability ($p < .001$) tended to use more services and children who spoke a language other than English at home tended to use fewer services ($p = .019$).

Access to services was reported to be more difficult for families in which parents reported having a disability ($p = .002$). In families in which no parent had a disability, 2.3% reported not being able to access two or more services. In comparison, 17.2% of families where a parent had a disability reported not being able to access two or more services.

Table 4.1-9 Number and proportion of families who could and could not access child and family services across demographic characteristics

	Child Services				Family Services			
	Can access all services		Cannot access one or more		Can access all services		Cannot access one or more	
	N	%	N	%	N	%	N	%
Parent identifies as Aboriginal								
Yes	2	66.7%	1	33.3%	3	100%	0	0.0%
No	163	81.5%	37	18.5%	173	86.5%	27	13.5%
Parent has a medical condition[1]								
Yes	21	72.4%	8	27.6%	22	75.9%	7	24.1%
No	145	82.9%	30	17.1%	155	88.6%	20	11.4%
Current household situation								
Single parent	26	83.9%	5	16.1%	28	90.3%	3	9.7%
Two-parent	134	81.7%	30	18.3%	142	86.6%	22	13.4%
Parent education								
University completed	82	80.4%	20	19.6%	87	85.3%	15	14.7%
Technical, Trade, TAFE or some Uni.	48	82.8%	10	17.2%	51	87.9%	7	12.1%
Partial or completed High School	34	82.9%	7	17.1%	37	90.2%	4	9.8%
Child has a medical condition[1]								
Yes	26	76.5%	8	23.5%	25	73.5%	9	26.5%
No	139	82.2%	30	17.8%	151	89.3%	18	10.7%
Child speaks other LOTE								
Yes	24	77.4%	7	22.6%	24	77.4%	7	22.6%
No	142	82.1%	31	17.9%	153	88.4%	20	11.6%
Child identifies as Aboriginal								
Yes	5	71.4%	2	28.6%	7	100%	0	0.0%
No	160	81.6%	36	18.4%	169	86.2%	2	13.8%

Note

[1] medical condition or disability of 6 or more months

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

In focus groups and interviews, several factors, related to the way in which staff work together, were said to be facilitating or impeding integrated service provision. The way in which site leadership supported staff to work together, and also the relationships between staff that enabled information sharing and working together toward a common goal were said to be factors. Where integration was said to be working well, staff were reported to: share professional knowledge; engage in shared curriculum planning; and work collaboratively to holistically support children and families. These themes were explored further in the survey of staff, service providers, and directors.

Children's Centre team functioning

Four survey questions explored staff, service providers', and directors' perceptions of team functioning. Staff, service providers, and directors were asked to rate the extent to which they agreed or disagreed that:

1. The whole team works together toward a commonly understood goal.
2. Team members readily share information to help in the support of clients.
3. There is a high level of trust between team members.
4. There is policy and procedure in place to support the sharing and exchange of client information.

Additionally, staff and service providers were asked to rate the extent to which they agreed or disagreed that:

5. My role is understood and valued by my team mates.
6. Children's Centre team members have planned for how the roles work together.

Figure 4.2-1 and Figure 4.2-2 illustrate that the majority of respondents believed that integration was working well in Children's Centres. That is, staff shared information to support families and that they worked together toward a common goal.

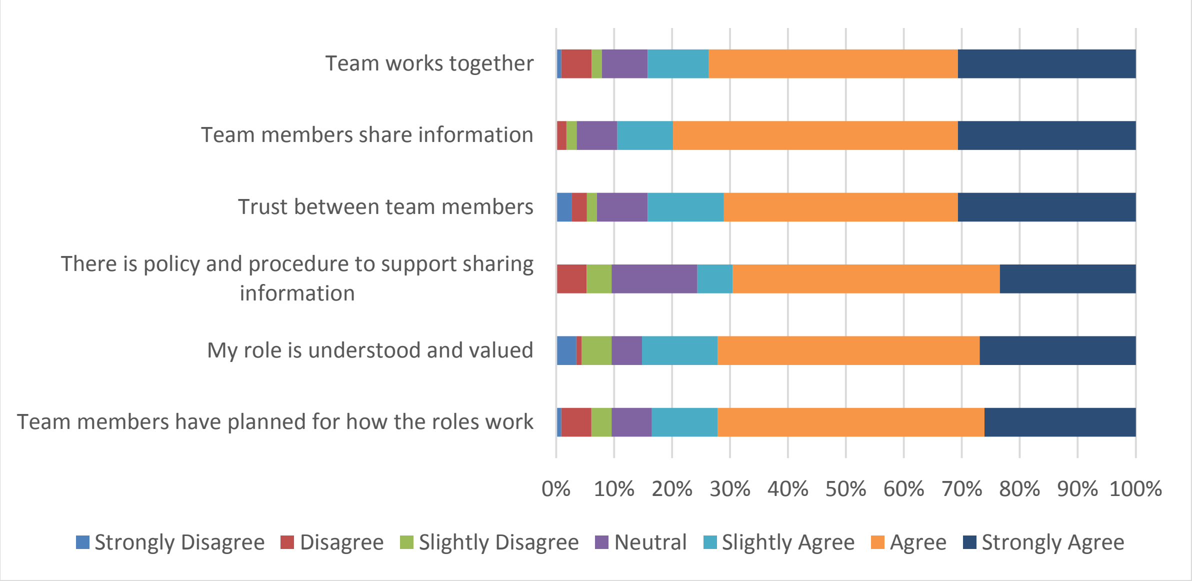


Figure 4.2-1 Staff and service provider perceptions of integration

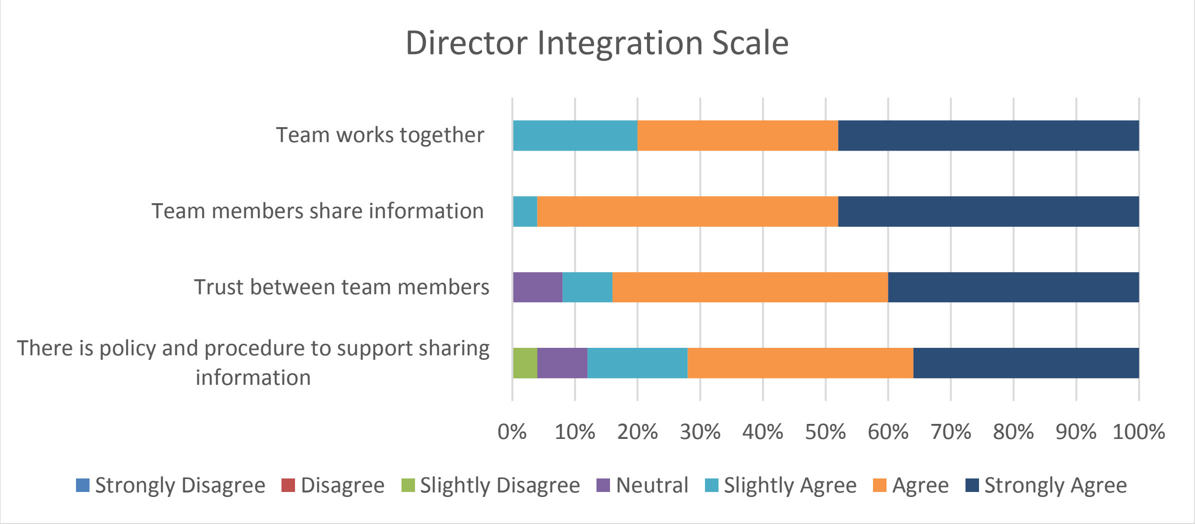


Figure 4.2-2 Director perceptions of integration

Leadership in Children's Centres

Six questions explored staff and service providers' perceptions of leadership at Children's Centres. Staff and service providers were asked to rate the extent to which they agreed or disagreed that:

1. The Children's Centre Director is accountable for how well the team works together at the Centre.
2. The Children's Centre Director has a clear vision for integrated service provision at the Centre.
3. I have a say in how I deliver services in the Centre.
4. I feel encouraged to contribute to planning activities in the Children's Centre.
5. My ideas and knowledge are valued.
6. I feel confident in sharing my professional opinions.

As illustrated in Figure 4.2-3, around four in five staff and service providers agreed or strongly agreed that the Children's Centre director was accountable for how well the team works together at the Centre and had a clear vision for integrated service provision. Staff and service providers also tended to agree or strongly agree that they had a say in how they delivered services in the Centre, that they felt encouraged to contribute to planning activities, that their ideas and knowledge were valued and that they felt confident in sharing their professional opinions.

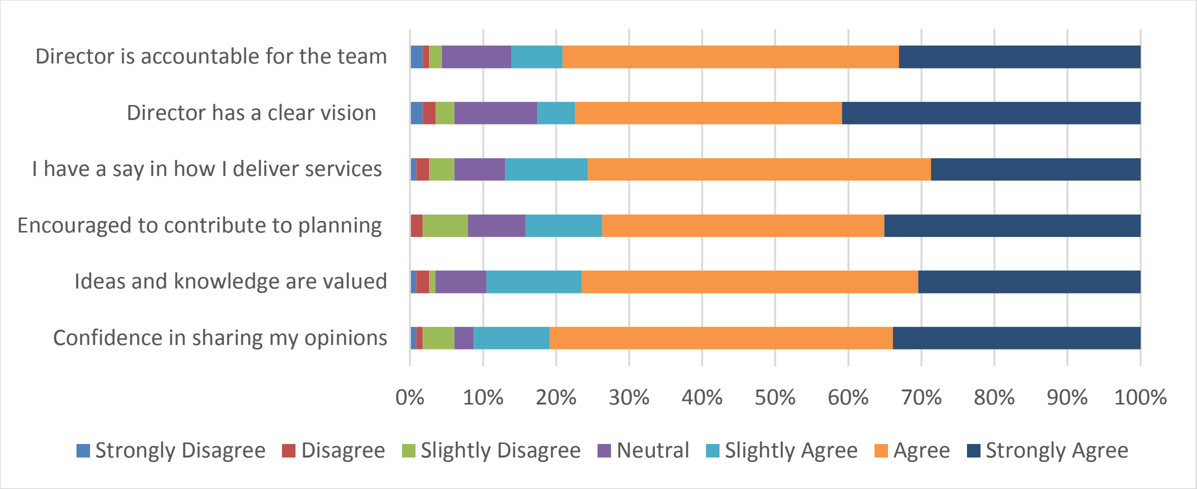


Figure 4.2-3 Staff and service provider perceptions of leadership

Three survey questions explored directors' perceptions of leadership at Children's Centres. Specifically, directors were asked to rate the extent to which they agreed or disagreed with the following:

1. My current level of authority over staff across the site is adequate for managing a multi-disciplinary team.
2. If there is a problem in the staff team at my site, I have adequate authority to impact staff behaviour.
3. I have adequate input into staffing at my site to enable me to develop a cohesive staff team.

Figure 4.2-4 indicates that the majority of directors agreed or strongly agreed that their level of authority over staff across the site was adequate for managing a multi-disciplinary team, that they had adequate authority to impact staff behaviour, and that they had adequate input into staffing at their site to enable them to develop a cohesive staff team. These findings suggest that leadership issues related to control over staffing in sites raised in focus groups and interviews are not overly pervasive.

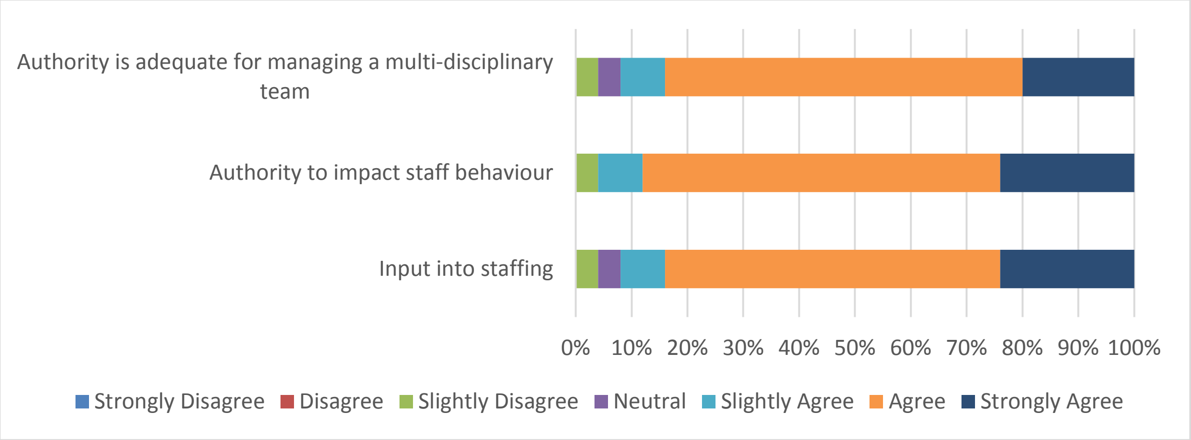


Figure 4.2-4 Director perceptions of leadership

Four questions examined directors' roles in Children's Centres. Specifically, directors were asked to report on the extent to which they agreed or disagreed with the following:

1. I was aware of the demands of the role before becoming a Director or Head of School Early Years in the Children's Centre.
2. Being a Director or Head of School Early Years in the Children's Centre is professionally rewarding.
3. The role of Director or Head of School Early Years in the Children's Centre is sufficiently resourced.
4. The role of Director or Head of School Early Years in the Children's Centre model is well understood.

Echoing the themes raised in focus groups that directors felt they had become a director of a Children's Centre before learning what that entailed, only around half of the directors surveyed agreed or strongly agreed that they were aware of the demands of the role before taking on the role (see Figure 4.2-5). Fewer still agreed that the role was sufficiently resourced. In contrast, almost all directors agreed or strongly agreed that being a Director or Head of School Early Years in the Children's Centre was professionally rewarding. While most directors agreed or strongly agreed that the role of Director or Head of School Early Years was well understood, there was less consensus that this was the case. Overall these findings suggest that opportunities exist to develop the parameters of the leadership role and purposeful recruitment of staff.

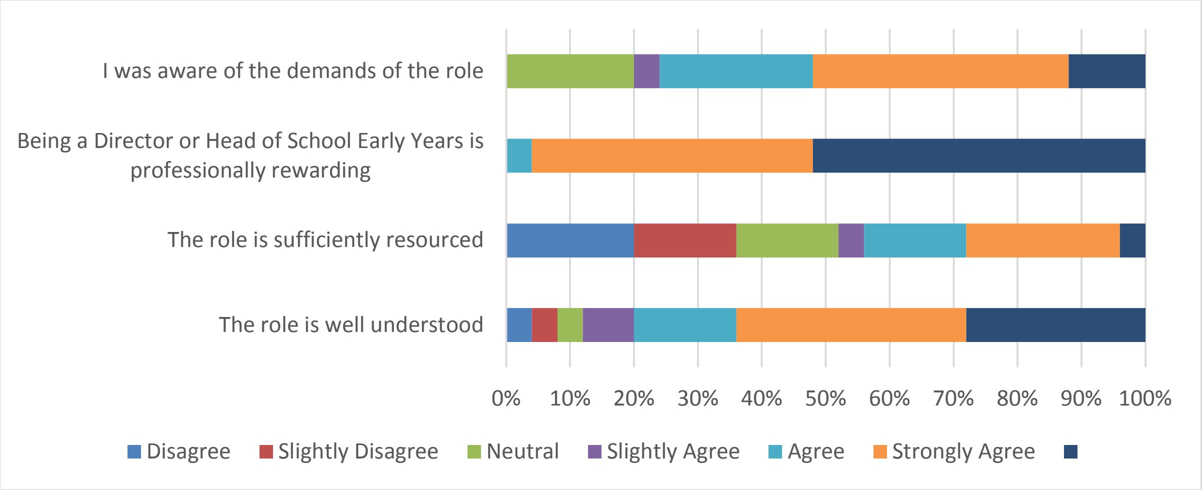


Figure 4.2-5 Director perceptions of their role in Children's Centres

Relationship between leadership and integration functioning

To explore the relationship between leadership and how well integration was working in centres, aggregated leadership and integration scores were generated for each centre. Staff and service provider rankings of how well integration was working in Centres was positively correlated to the ratings of directors (r = .430, p = .041).

Based on aggregated ratings, Centres were grouped into high or low leadership and integration groups based on the overall ratings they received from staff and service providers. Staff and service providers tended to rate how well integration was functioning in sites similarly to the directors of those sites, (r = .430, p = .041). A Chi-Square test was conducted to examine the extent to which Centre leadership ratings were related to ratings of how well integration was working at the site.

As shown in Table 4.2-1, of the 33 sites for which responses were received by staff and service providers, 13 were rated as having low leadership and 20 as having high leadership scores. Similarly, staff and service providers rated 14 Centres as having low integration and 19 as Centres where integration was working well. The majority of Centres fell in either the low-low or high-high groups, with only seven Centres being rated as high on one dimension and low on another ($\chi^2 = 10.45$, $p < .001$). The same analysis conducted from the responses of directors (see Table 4.2-2), showed a similar relationship between perception and how well integration was working ($\chi^2 = 12.89$, $p < .001$).

These findings indicate that leadership at a Centre level plays an integral role in the functioning of integrated sites and echoes the themes raised in focus groups. With both leadership and integration being rated as low in around one third of Centres, the opportunity to make further improvements in this area is highlighted

Table 4.2-1 Staff and service provider perceptions of leadership and integration by Children's Centres

			Integration		
			Low	High	Total
Leadership	Low	Count	10	3	13
	High	Count	4	16	20
Total			14	19	33

Table 4.2-2 Director perceptions of leadership and integration by Children's Centres

			Integration		
			Low	High	Total
Leadership	Low	Count	6	2	8
	High	Count	1	16	17
Total			7	18	25

Furthermore, as demonstrated in Table 4.2-3, where directors felt they had less control over staff, staff and service providers also tended to rate the quality of leadership less favourably. Conversely, where leadership was rated high, directors also tended to rate the adequacy of their level of control highly ($\chi^2 = 5.96$, $p = .015$).

Table 4.2-3 Director and staff and service provider perceptions of leadership by Children's Centres

			Staff and Service Provider Leadership		
			Low	High	Total
Director Leadership	Low	Count	5	2	7
	High	Count	3	13	16
Total			8	15	23

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

The Interim report of the focus group and interview findings highlighted that there was a great deal of disparity in the functioning of governance groups in Centres and that their value and the rate at which they were considered relevant to the functioning of the sites varied. Specifically, partnership, leadership, and governance groups were not identified as being operational in each site. Where groups were operational, the composition, the role and the function of the groups was said to vary across sites. Some groups were said to work well if the members of the group saw the benefits of working in partnership. In other instances, partnership groups were said to be unproductive due to: inconsistent attendance; lack of interest from partners; or comprising partners who were not authorised to make decisions. In some sites, it seemed as though partnership groups had low levels of participation from partners, which was limited to information sharing or consultation. In other sites, partnership groups appeared to have higher levels of participation from partners, whereby partners were engaged in shared planning, discussed data sources, shared knowledge of the community, set goals, distributed tasks, and implemented plans.

In order for the evaluation to comment on the processes that enable partnership and governance groups to meet community needs, it was necessary to first understand the extent to which these groups existed and their perceived role in the planning of services. Surveys of directors and service providers included items to measure and quantify the magnitude of these factors.

Figure 4.3-1 and Figure 4.3-2 highlight the diversity of staff, service providers' and directors' experience of governance groups. Parent engagement groups were reported most frequently as either not existing, or if they did exist, not functioning well. The findings indicate that there is opportunity to adjust the governance structures of Centres to make these both relevant and pragmatic. In focus groups and interviews the less than optimal functioning of governance groups was attributed to several issues. These included the time commitment required from group members, understandings of the function of the groups, and the value placed on the group at a Centre level. Below, we explore the extent to which the functions of the groups, as these were conceptualised for the Children's Centre model, were perceived by survey respondents.

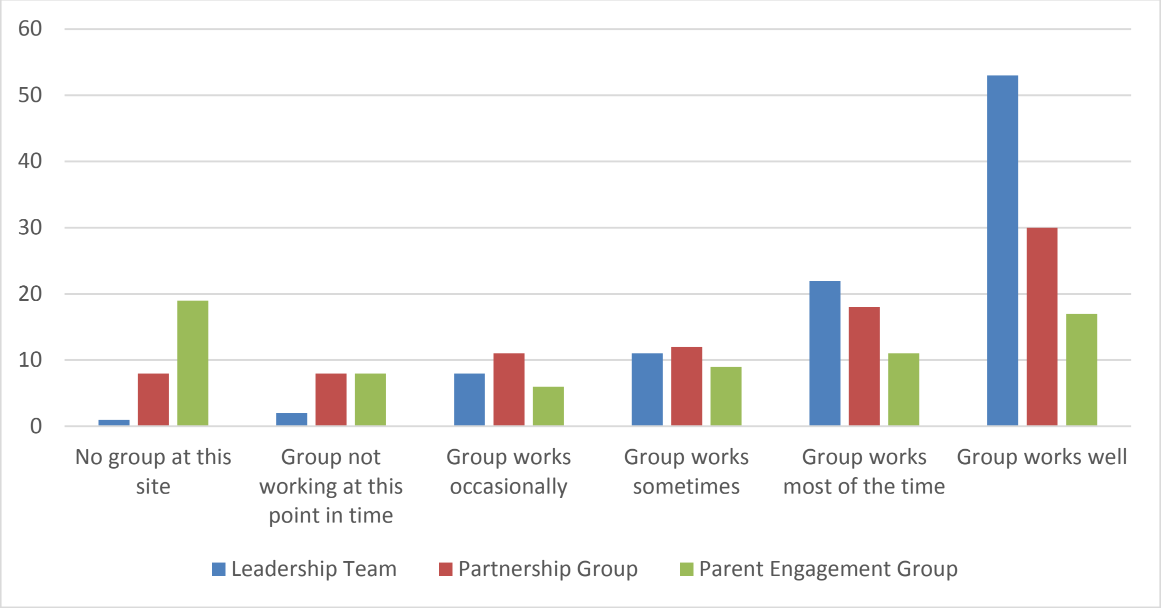


Figure 4.3-1 Staff and service provider perceptions of how well governance group work at Children's Centres

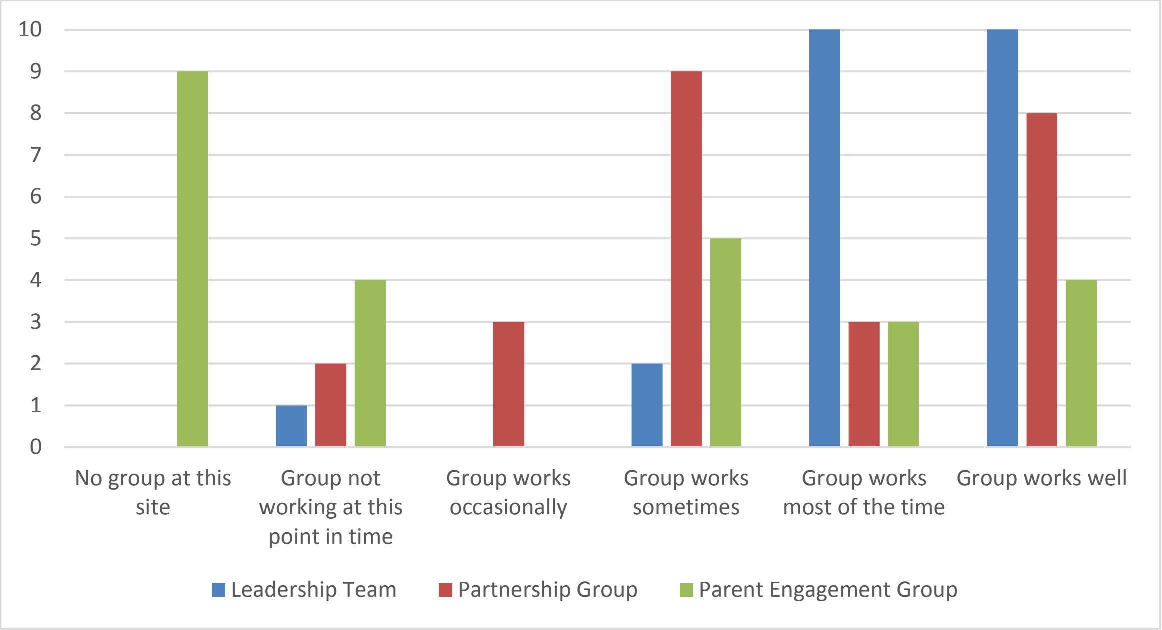


Figure 4.3-2 Director perceptions of how well governance groups work at Children's Centres

Parent engagement groups

Seven questions asked staff, service providers, and directors to report on the extent to which they agreed about the functions of the parent engagement group. These are separated in this report into ‘influencing the Centre’, ‘engaging the community’, and ‘volunteering and training’.

Influencing Centre activities and directions

The parent engagement group’s influence over the Centre was asked about through three survey questions. Staff, service providers, and directors were asked to indicate the extent to which they agreed or disagreed with the following functions of the parent engagement group:

1. Connects with families and the community to obtain their views.
2. Contributes to the development of the Centre’s vision and values.
3. Provides advice on programs and services needed.

Overall, there was not strong agreement that the parent engagement group should help set the directions of the Centre. Figure 4.3-3 shows that just under half of staff, service providers, and directors agreed or strongly agreed that parent engagement groups should be used to connect with families and the community to obtain their views to contribute to the development of the Centre’s visions and values (see Figure 4.3-4). Moreover, just over half of the staff and service providers and just under half of directors agreed or strongly agreed that parent engagement groups should be utilised to gather advice from parents about the range of services and supports that families need. However, there was a considerable degree of uncertainty for all three questions, with a large proportion of respondents neither agreeing nor disagreeing.

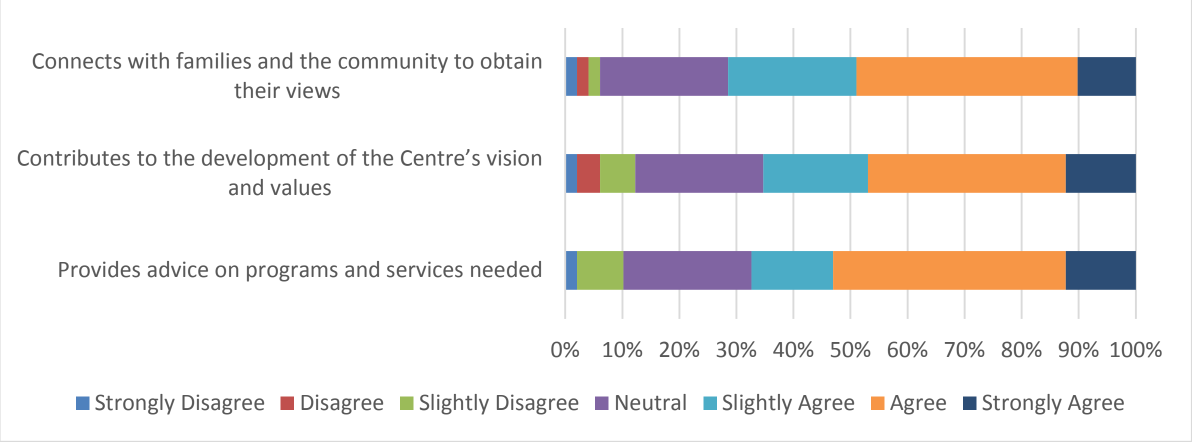


Figure 4.3-3 Staff and service provider perceptions of parent engagement groups' influence over Centres

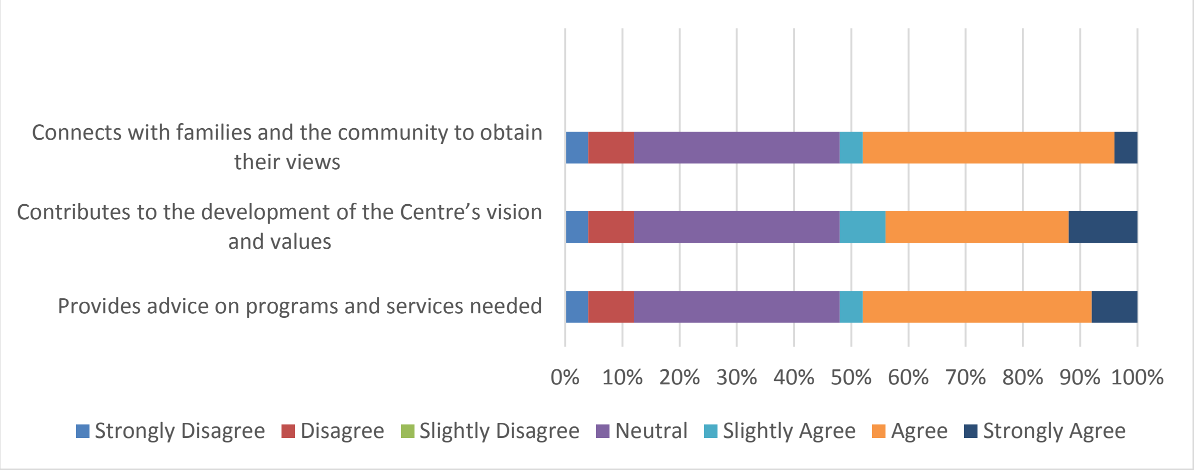


Figure 4.3-4 Director perceptions of parent engagement groups' influence over Centres

Engaging the community

Engaging the community through the parent engagement group was asked about in two ways. Firstly, staff, service providers, and directors were asked to report on the extent to which they agreed that the parent engagement group could advise on how to encourage families and communities to participate and engage in the Centre. The second question asked about the extent to which respondents agreed that the parent engagement group could be used to promote the Centre in the community.

Figure 4.3-5 and Figure 4.3-6 indicate that less than half of the staff, service providers, and directors agreed that a function of the parent engagement group was to provide advice around encouraging family and community participation. In contrast, over half of staff and service providers agreed or strongly agreed that a function of the group was to promote the Centre within the community. Similarly, directors also tended to report more agreement with this function.

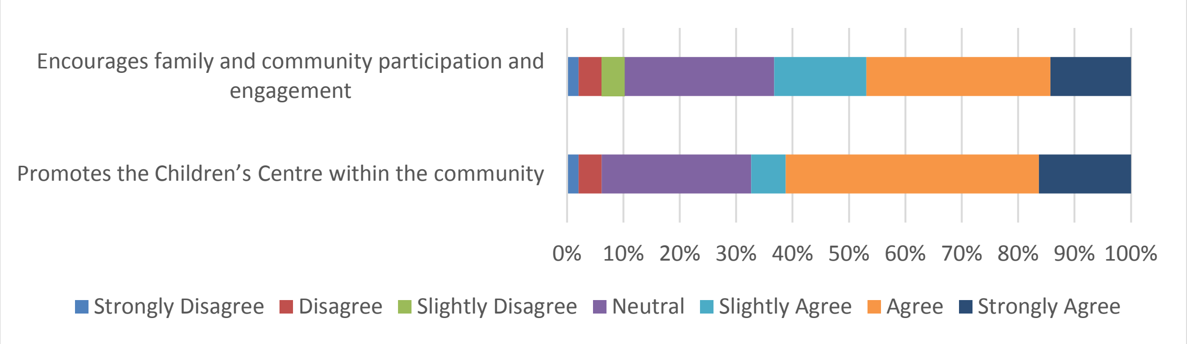


Figure 4.3-5 Staff and service provider perceptions of engaging the community through parent engagement groups

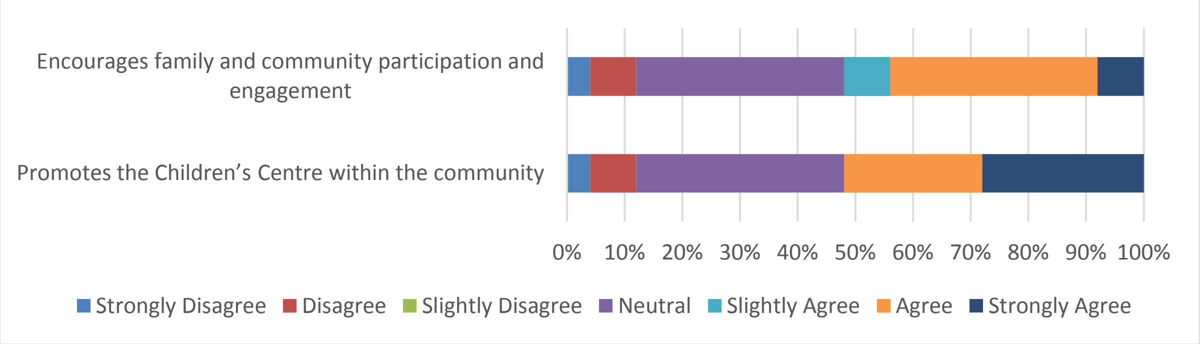


Figure 4.3-6 Director perceptions of engaging the community through parent engagement groups

Volunteering and training

The two final functions of the parent engagement group explored in the survey were volunteering and participating in training opportunities. Both these functions are ways in which Centres can contribute to capacity building in the community—that is, providing parents with opportunities to develop skills that can enhance their employment opportunities. Responses are presented in Figure 4.3-7 and Figure 4.3-8.

Overall, a minority of staff, service providers, and directors agreed that this was a function of the parent engagement group. Staff and service providers tended to agree more strongly than directors that undertaking volunteer work in Centres was a function of the parent engagement group. Similarly, few service providers, and directors agreed that participating in training opportunities was a function of the parent engagement group.

Staff, service providers, and directors were asked to rate the extent to which they agreed or disagreed about the following functions of the Parent Engagement group:

1. Undertakes volunteer work within the Centre.
2. Participates in training opportunities.

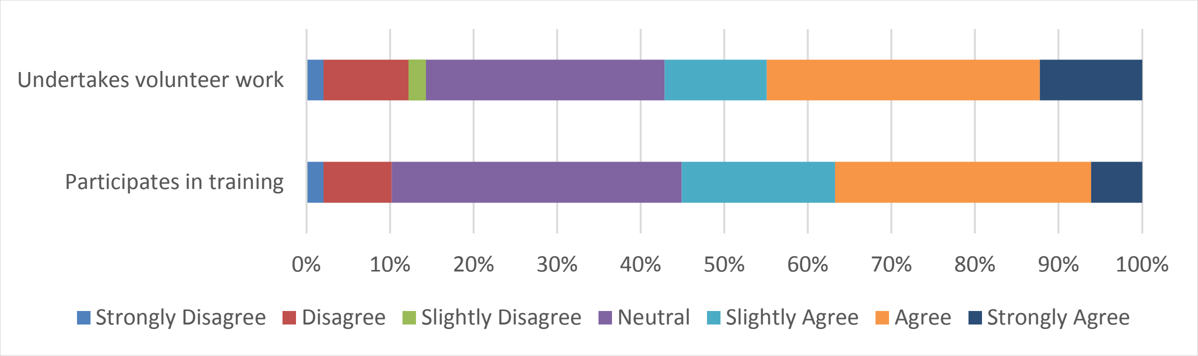


Figure 4.3-7 Staff and service provider perceptions of volunteering and training through parent engagement groups

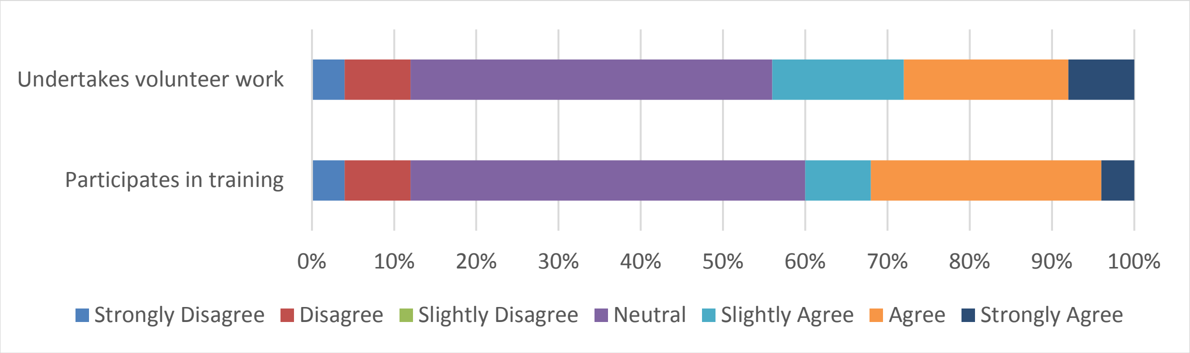


Figure 4.3-8 Director perceptions of volunteering and training through parent engagement groups

Leadership groups

Seventeen survey questions asked staff, service providers, and directors to report on the extent to which they agreed about the functions of the leadership group. These are separated in this report into ‘influencing Centre activities and directions’, ‘operational functions’, ‘evaluation and monitoring’ and ‘information sharing’.

Influencing Centre Activities and Directions

Influencing Centre activities and directions through the leadership group was asked about through seven questions. Overall there was strong agreement that influencing Centre activities and directions was the function of the leadership group. Figure 4.3-9 and Figure 4.3-10 below present staff, service providers’, and directors’ responses.

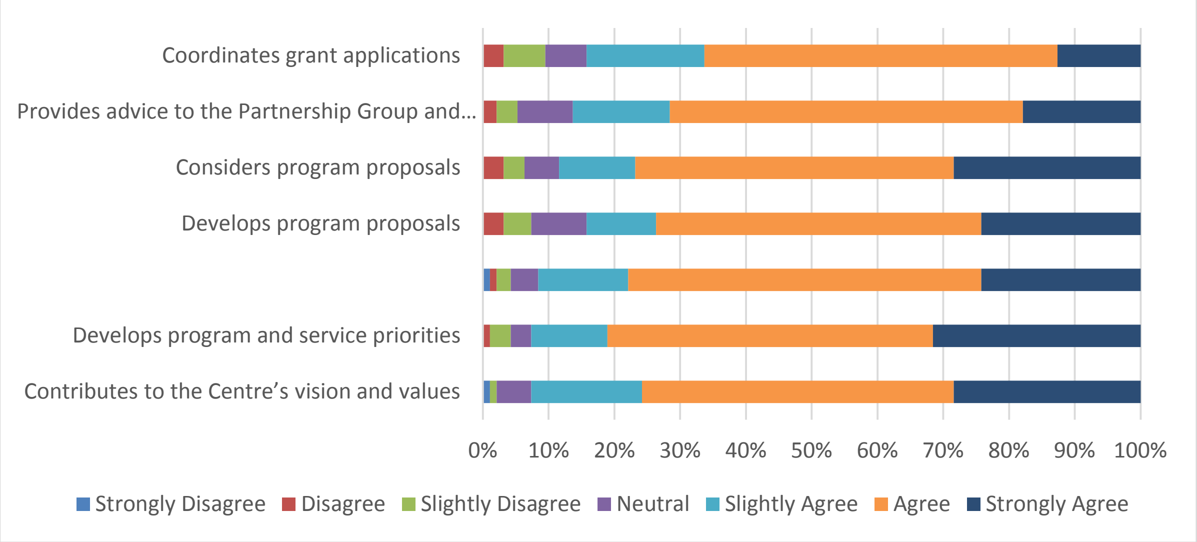


Figure 4.3-9 Staff and service provider perceptions of leadership groups’ influence over Centres

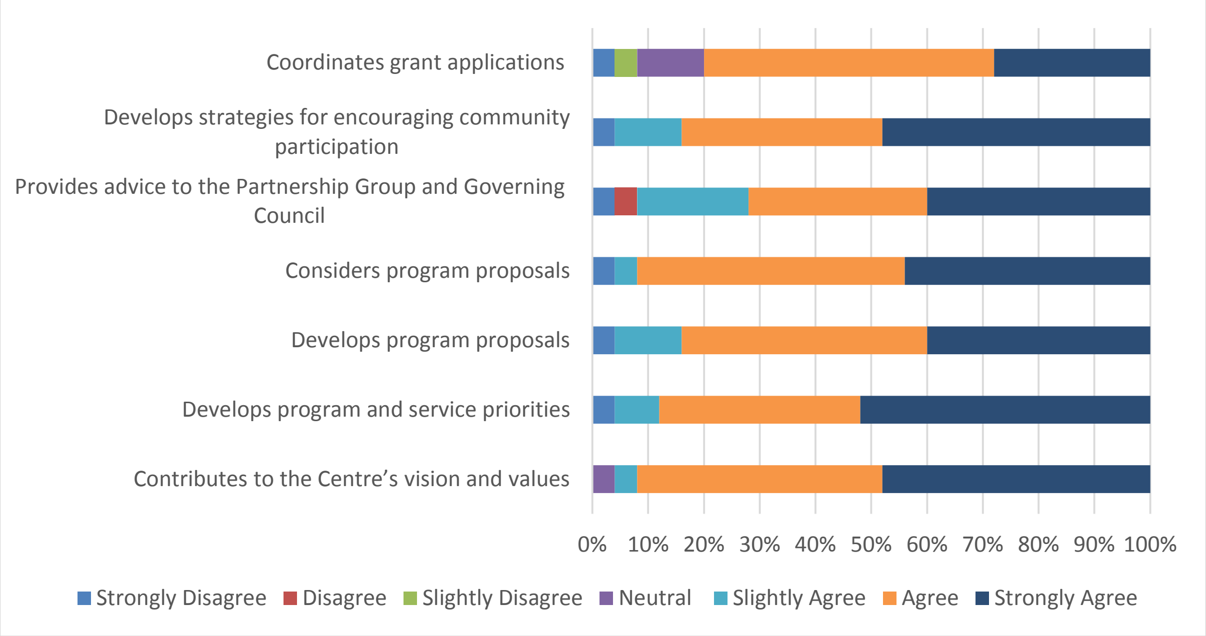


Figure 4.3-10 Director perceptions of leadership groups’ influence over Centres

Operational Functions

The operational functions of the leadership team were examined through five survey questions. Figure 4.3-11 and Figure 4.3-12 present the findings. Overall, there was agreement among staff, service providers and directors with the operational functions of the leadership group.

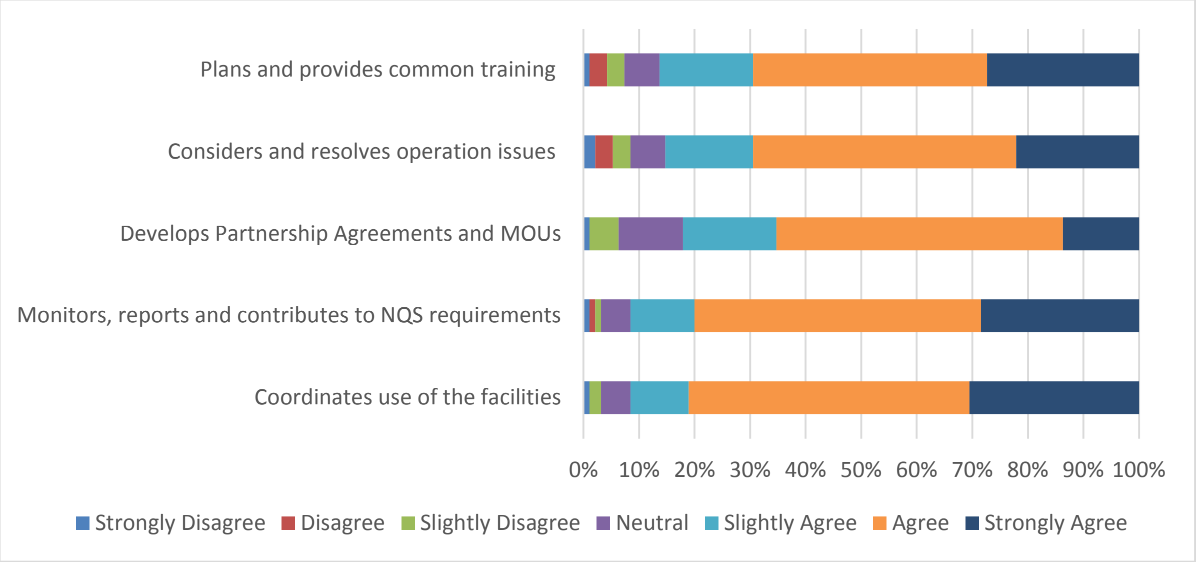


Figure 4.3-11 Staff and service provider perceptions of the operational functions of leadership groups

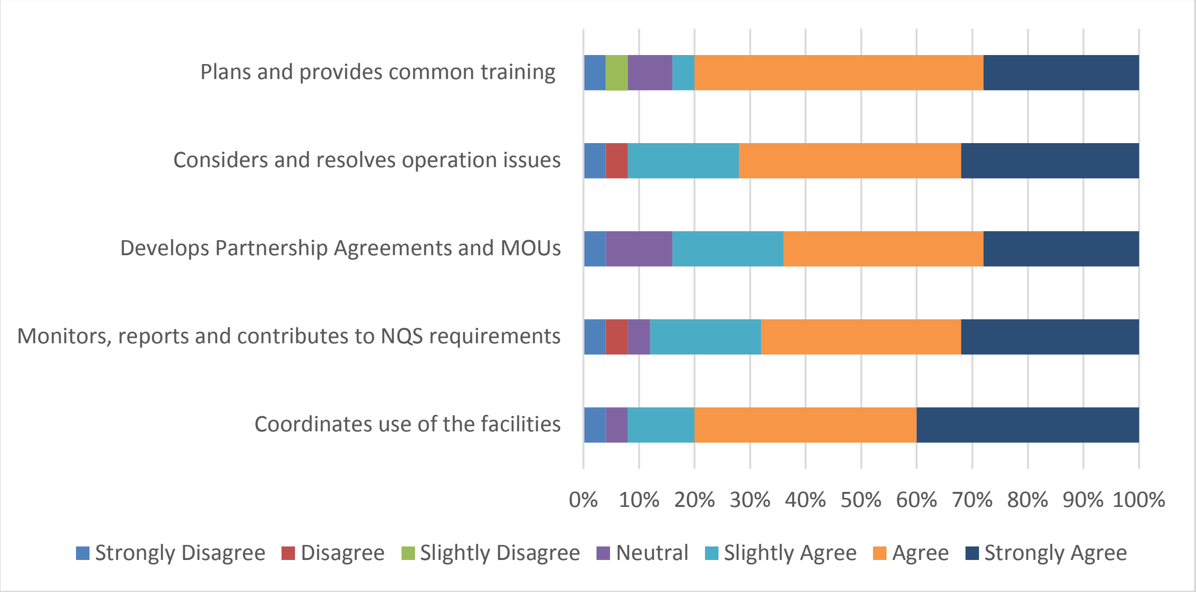


Figure 4.3-12 Director perceptions of the operational functions of leadership groups

Evaluation and monitoring

Evaluation and monitoring were asked about in three ways. Figure 4.3-13 and Figure 4.3-14 indicate that most staff service providers and directors agreed that sharing and analysing relevant data and research, monitoring service outcomes, and undertaking data collection, monitoring and reporting against agreed outcomes were functions of the leadership group.

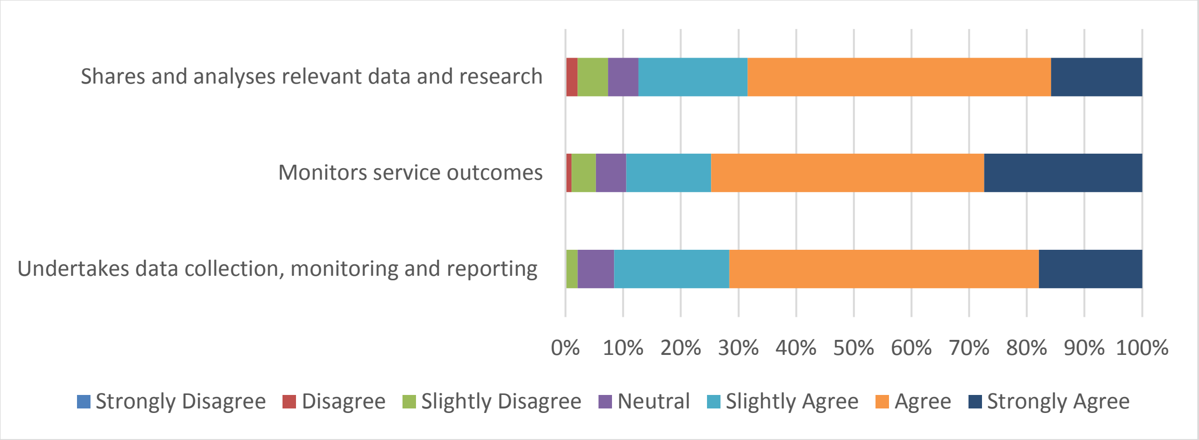


Figure 4.3-13 Staff and service provider perceptions of evaluation and monitoring through leadership groups

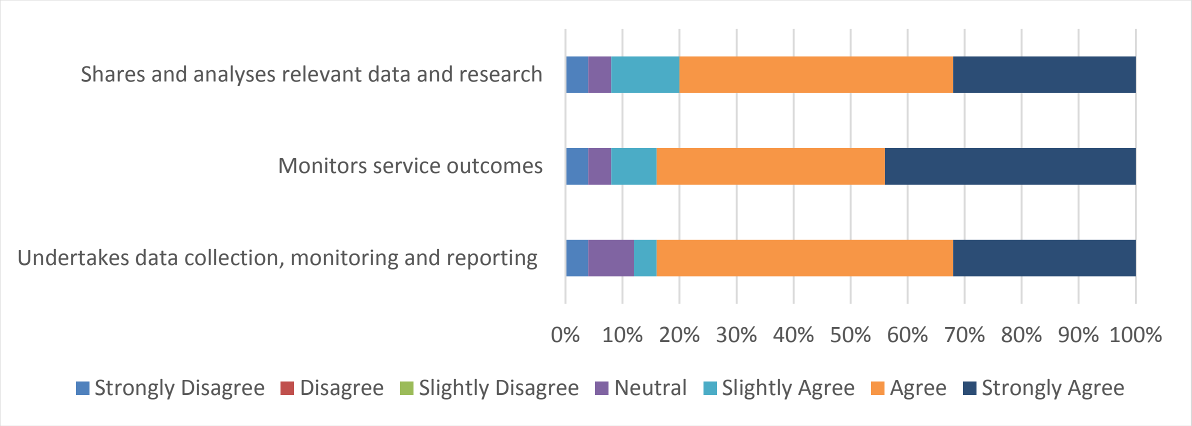


Figure 4.3-14 Director perceptions of evaluation and monitoring through leadership groups

Information Sharing

The final function of the leadership group was information sharing, which was asked about in two ways. Firstly, staff, service providers and directors were asked to report on the extent to which they agreed that the leadership team shares information about programs and practices. The second question asked about the extent to which the leadership team shares strategies and responses for individual children and families.

Staff, service provider and director responses are presented in Figure 4.3-15 and Figure 4.3-16. Again, there was agreement amongst staff and service providers, and amongst directors that information sharing was a function of the leadership group.

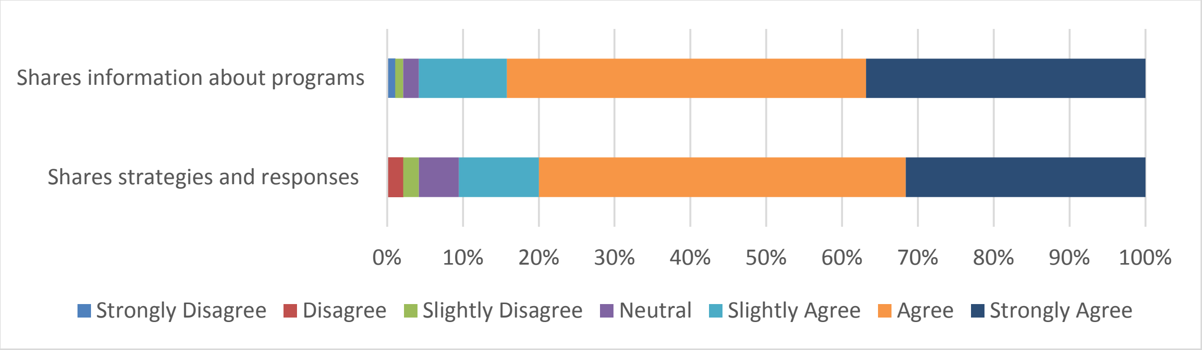


Figure 4.3-15 Staff and service provider perceptions of information sharing through leadership groups

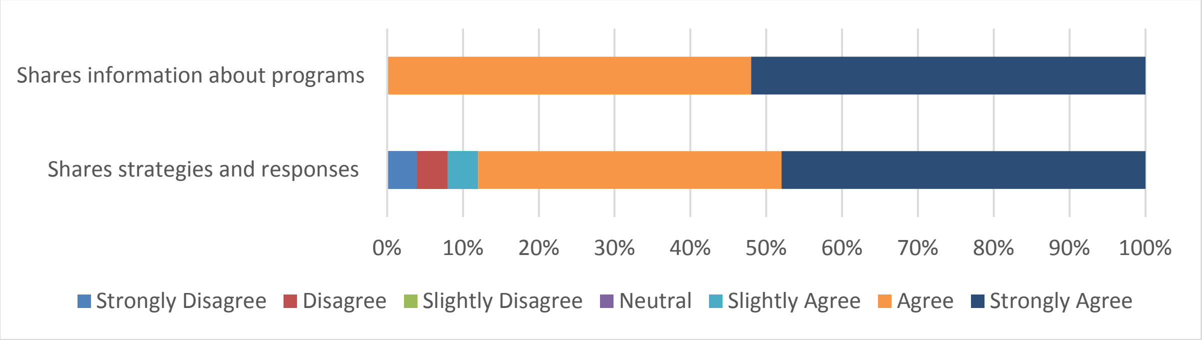


Figure 4.3-16 Director perceptions of information sharing through leadership groups

Partnership groups

Seven questions asked staff, service providers and directors to report on the extent to which they agreed about the functions of the partnership group. These are separated in this report into ‘influencing centre activities and directions’, ‘engaging the community’ and ‘evaluation and monitoring’.

Influencing Centre Activities and Directions

Influencing Centre activities and directions through the partnership group was asked about through four survey questions. Staff, service providers, and directors were asked to rate the extent to which they agreed the following statements were functions of the partnership group:

1. Contributing to Centre planning.
2. Ensuring research and best practice underpin advice and directions.
3. Coordinating agency activities and services in response to community needs.
4. Developing Children’s Centre visions and values.

Figure 4.3-17 and Figure 4.3-18 indicate that there were staff, service providers and directors who did not consistently agree that influencing Centre activities and direction was a function of the partnership group.

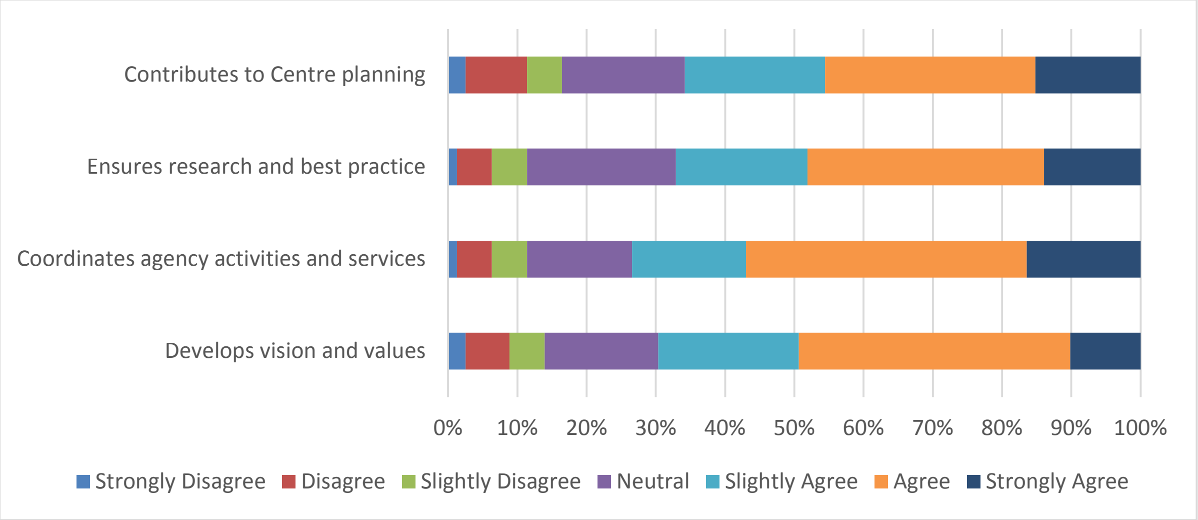


Figure 4.3-17 Staff and service provider perceptions of partnership groups' influence over Centres

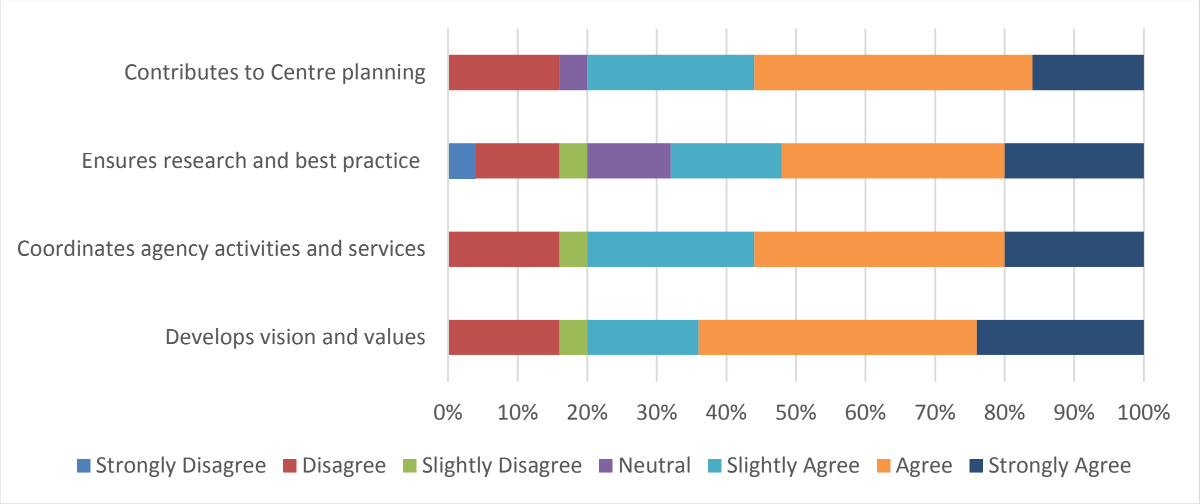


Figure 4.3-18 Director perceptions of partnership groups' influence over Centres

Engaging the Community

Engaging the community was asked about in two ways. Firstly, staff, service providers and directors were asked to report on the extent to which they agreed or disagreed that the partnership group identifies opportunities for collaborative action. The second question asked about the extent to which respondents agreed or disagreed that the partnership group establishes and monitors community consultation in the Centre. Figure 4.3-19 and Figure 4.3-20 indicate that there was not a consistent view that engaging the community was a function of the partnership group.

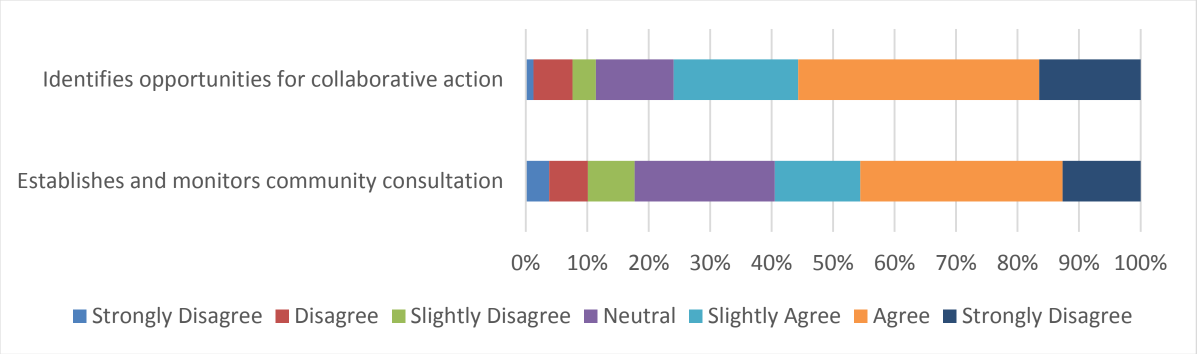


Figure 4.3-19 Staff and service provider perceptions of engaging the community through partnership groups

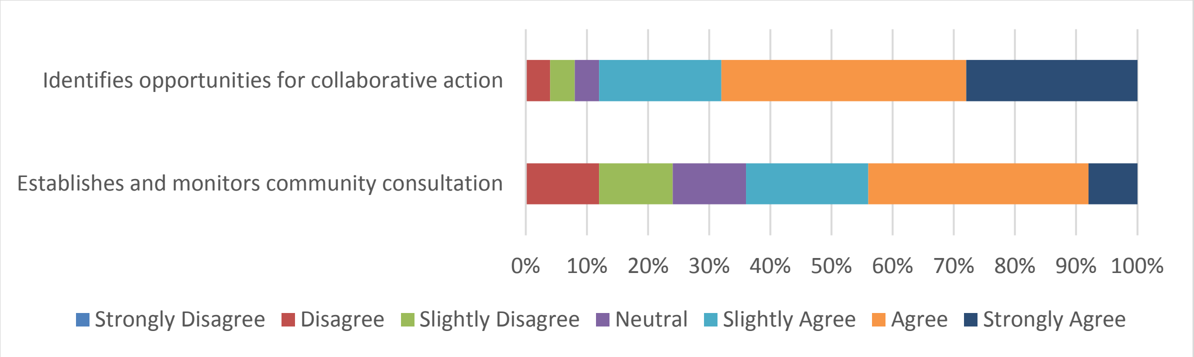


Figure 4.3-20 Director perceptions of engaging the community through partnership groups

Evaluation and Monitoring

The final function of the partnership group, evaluation and monitoring, was asked about through one question. Staff, service providers and directors were asked to report on the extent to which they agreed or disagreed that considering reports on programs and monitoring outcomes was the function of the partnership group. Figure 4.3-21 and Figure 4.3-22 indicate that staff, service providers and directors did not consistently agree that partnership groups should be involved in evaluation and monitoring.

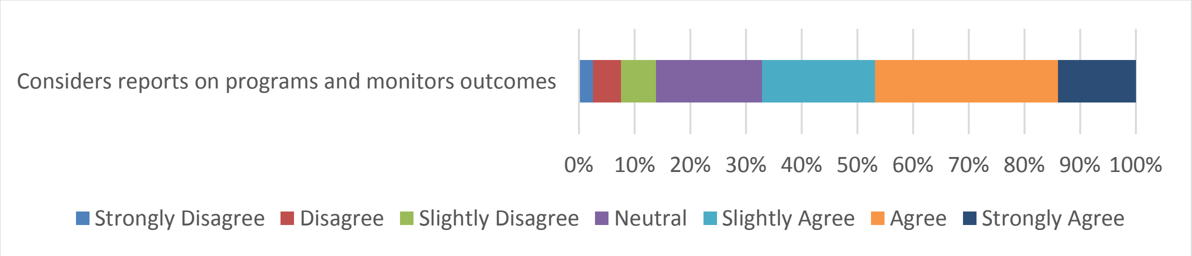


Figure 4.3-21 Staff and service provider perceptions of evaluation and monitoring through partnership groups

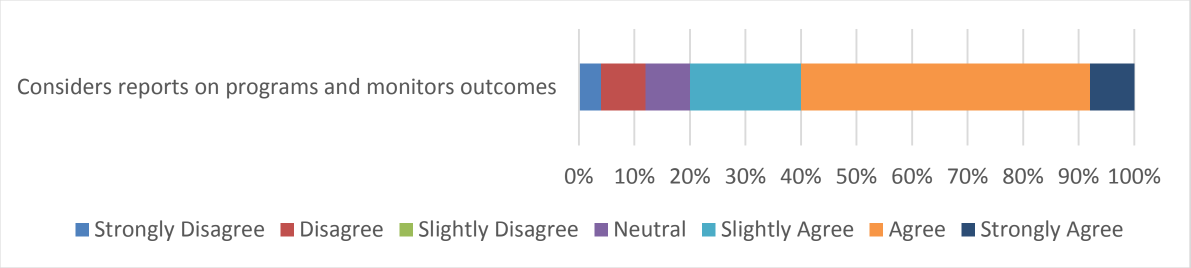


Figure 4.3-22 Director perceptions of evaluation and monitoring through partnership groups

Summary of governance group findings

Taken together, these findings indicate that an opportunity exists to further develop the functions of governance groups and negotiate a governance structure that can operationalise the vision of Children's Centres.

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

In 4.1 we presented the EYS data that showed the range of services available through Children's Centres. Here we present the extent to which service availability varied across sites.

Figure 4.4-1 and Figure 4.4-2 illustrate variation in the number and range of programs at the centre level; the first for the number of programs available and the second for the number of program types available. A great deal of variation is evident, with some centres offering both a large range of service types and many programs, while others offered few programs and/or a small range of program types.

Analyses of the EYS data demonstrated that overall there was little variation from term to term in both the range and number of programs offered in Children's Centres. Nevertheless, for a few Centres there was large variation over time. For example, centres at John Hartley and Gawler offered far more programs in Term 1 2016 than in either Term 4 2015 or Term 2 2016. For both these Centres, the range of program types remained steady across two terms, with the number of programs offered spiking only in Term 1 2016. Similar, but smaller spikes in number of programs were evident for several other centres. This may have been related to a hive of activity at the start of a new school year. Table 4.1-1 shows that a greater number of programs across all program types were available in Term 1 (refer to 4th column in the table).

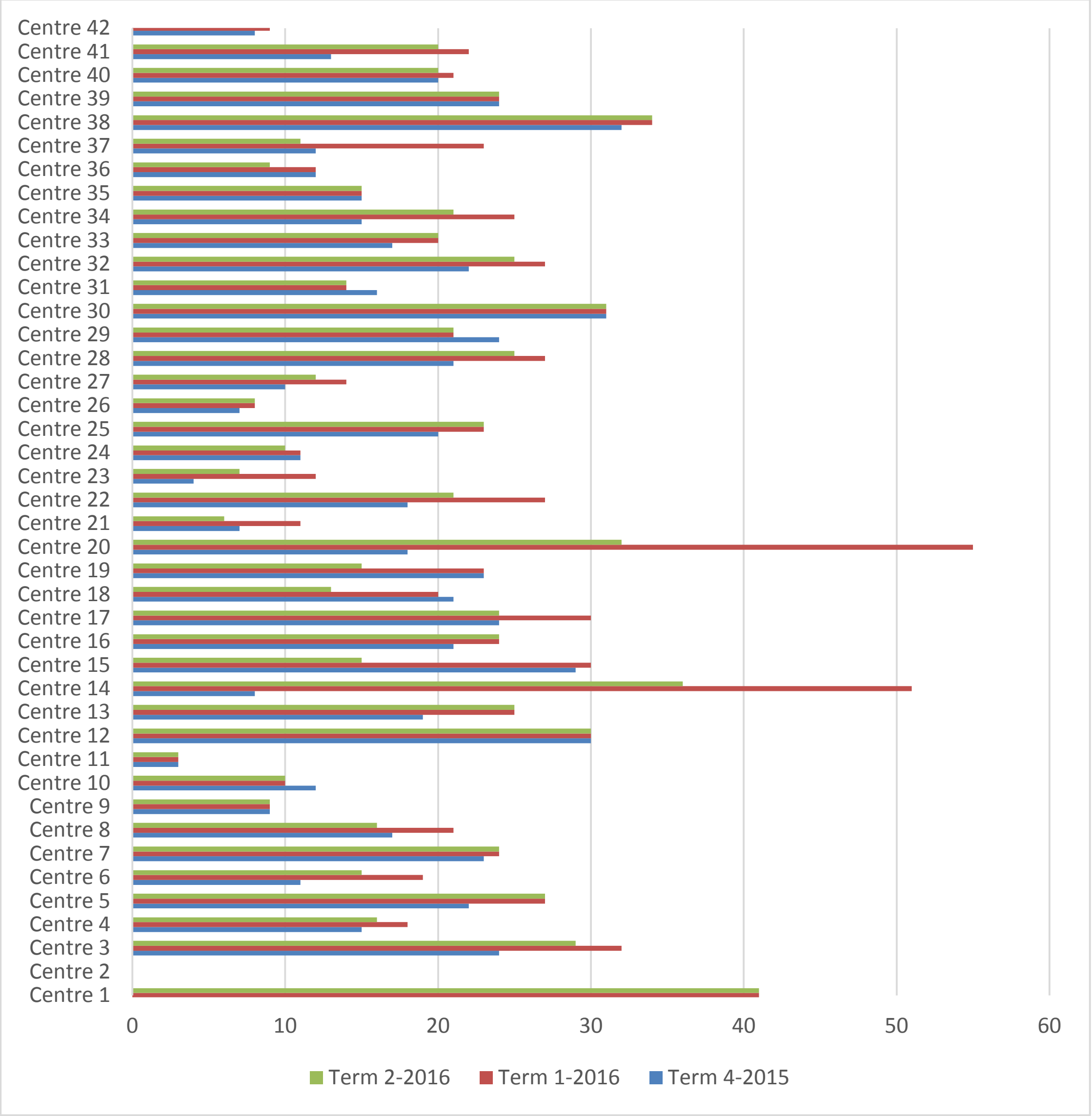


Figure 4.4-1 Number of programs offered in each Children's Centre taken from three terms of EYS administrative data

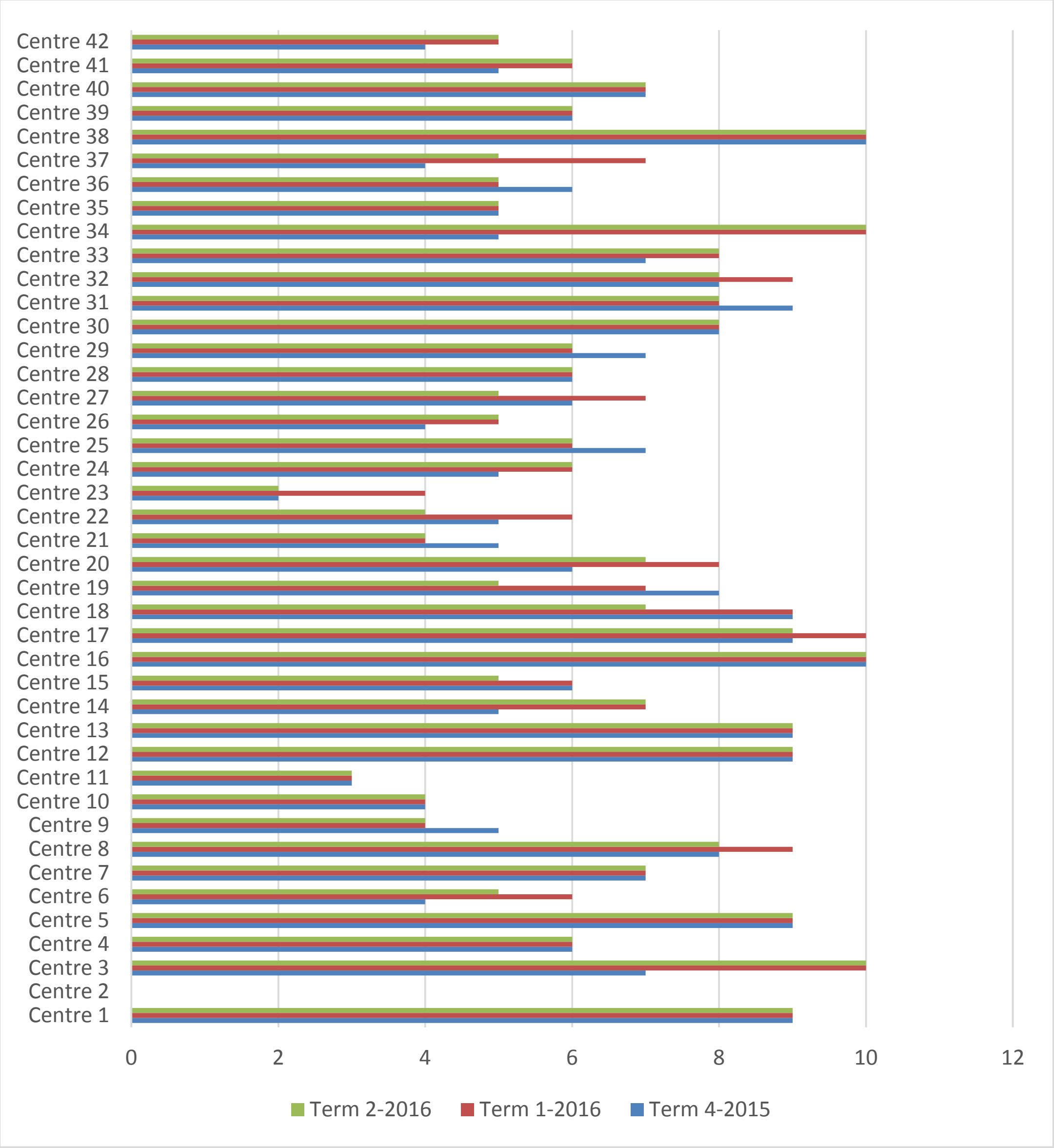


Figure 4.4-2 Number of program types offered in each Children's Centres taken from three terms of EYS administrative data

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

Survey data from parent report and the EYS administrative data were utilised to examine service usage in Children’s Centres. In the present evaluation, neither data set could be used to accurately assess reach and dose—administrative data was not consistently collected and entered into the EYS and the survey was not designed to measure reach or dose. Instead, data are presented here to examine service usage patterns and differential service use for population groups. Analyses are presented separately for children and parent service use. With sufficient data collection, service usage data will be able to be linked to other education, health and child protection data to measure the impact of dose on children’s outcomes. Moreover, more reliable data collection will enable

Centres to determine whether there are groups in the community who may be under-represented in Children's Centre service use.

Service utilisation—parent report

Parents who completed the survey were asked what services they first used in a Children's Centre. This information was gathered to gain a better understanding of the way in which parents came to utilise Centres. Parents were also asked what additional services they had used in Centres. Figure 4.5-1 shows that parents most frequently reported utilising universal services, such as preschool, long day care, playgroup, and occasional care first, but also subsequently.

Targeted supports such as parenting programs, family services, and allied health were less frequently reported and were very rarely reported as the first service families used. Child youth health nurse was also infrequently reported as a service used first or subsequently. Just over one in four respondents reported using no other services in a Children's Centre.

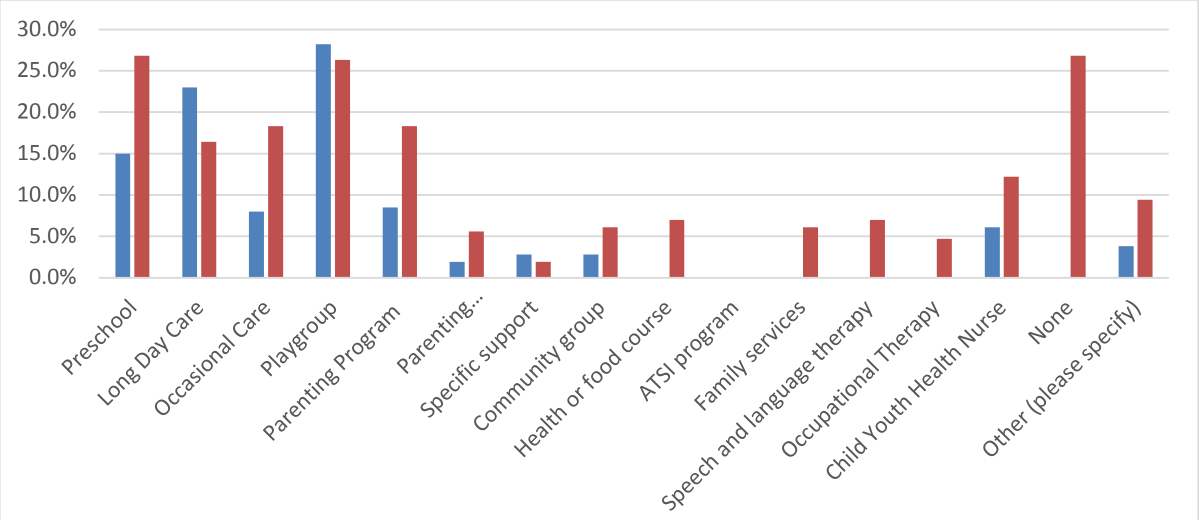


Figure 4.5-1 Parent reports of services used in Children's Centres

Children

The EYS administrative data was used to explore services accessed by children, how this differed across demographic groups, ages of children attending programs, and the extent to which children were enrolled in multiple programs. Caution should be taken in drawing conclusions from this early administrative data, given the amount of missing data and resultant small sample sizes in some population groups.

Table 4.5-1 presents enrolment data for children for each of the three data collection terms and in relation to the program type. Education and care services were most heavily recorded. Additional FCP data suggests other services were used by fewer than 15% of children enrolled in Centres. This figure does not correspond with survey data where parents reported much higher use of FCPs in Centres. This discrepancy is likely to have resulted from a dearth of data being collected and entered about FCP use. Another possible, but less likely explanation is that survey respondents were over representative of families using FCP programs (i.e. families only using education and care services were under-represented among survey respondents).

Table 4.5-1 Number and percentage of children enrolled in programs for each of the three data collection terms

	2015 - TERM 4		2016 - TERM 1		2016 - TERM 2	
	N	%	N	%	N	%
PRESCHOOL	2533	53.9%	2352	51.4%	2412	49.4%
OCCASIONAL CARE	1177	25.0%	1010	22.1%	1032	21.1%
SUPPORTED PLAYGROUP	365	7.8%	608	13.3%	771	15.8%
PRESCHOOL SUPPORT PROGRAMS	310	6.6%	218	4.8%	233	4.8%
PLAYGROUP	54	1.1%	93	2.0%	140	2.9%
PARENTING PROGRAM	60	1.3%	69	1.5%	56	1.1%
TARGETED SUPPORT GROUP	48	1.0%	65	1.4%	57	1.2%
PARENTING SUPPORT SERVICES	42	.9%	39	.9%	44	.9%
ABORIGINAL FOCUSSED SUPPORT	30	.6%	34	.7%	35	.7%
TARGETED PLAYGROUP	20	.4%	25	.5%	34	.7%
COMMUNITY GROUP	17	.4%	24	.5%	34	.7%
BUS SERVICE	32	.7%	8	.2%	8	.2%
HEALTH	9	.2%	15	.3%	20	.4%
FAMILY SUPPORT	4	.1%	20	.4%	9	.2%

Notes

[1] Children can be enrolled in multiple programs, so a total has not been provided

[2] The following programs have been combined (Playgroup and Community/Parent Led Playgroup into Playgroup; Inclusive Preschool Program, Preschool Speech and Language, Preschool Support Program and Preschool Bilingual Program into Preschool Support Programs)

[3] A small number of children were enrolled into “adult learning” programs, and these records were excluded from the table

[4] The Learning Together program has been excluded from this list

To examine the range of FCPs utilised for children based on their age, three age groups were created—0–2 years, 3–4 years, and 5+ years. As shown in Table 4.2-2, children aged 0–2 years tended to be enrolled most frequently in occasional care and supported playgroups. The pattern of enrolment varied only in that supported playgroup attendance appeared to reduce for the 3–4-year-old group. Again, a dearth of data collected about children’s FCP use means that this data should be considered preliminary and interpreted with caution.

Table 4.5-2 Number of children of different ages enrolled in programs

	CHILD—AGE GROUP		
	0-2 years	3-4 years	≥ 5
FAMILY SUPPORT	5	4	0
HEALTH	11	9	0
BUS SERVICE	0	7	1
COMMUNITY GROUP	17	17	0
TARGETED PLAYGROUP	21	11	2
ABORIGINAL FOCUSSED SUPPORT	20	15	0
PARENTING SUPPORT SERVICES	20	21	1
TARGETED SUPPORT GROUP	32	18	3
PARENTING PROGRAM	38	18	0
PLAYGROUP	72	68	0
PRESCHOOL SUPPORT PROGRAMS	0	224	9
SUPPORTED PLAYGROUP	540	228	1
OCCASIONAL CARE	519	512	1
PRESCHOOL	27	2338	47

Notes

1 Children can attend multiple programs

2 The Learning Together program has been excluded from this list

3 The following programs have been combined (Playgroup and Community/Parent Led Playgroup into Playgroup; Inclusive Preschool Program, Preschool Speech and Language, Preschool Support Program and Preschool Bilingual Program into Preschool Support Programs)

Additional analyses were conducted to explore the demographic characteristics of children utilising programs in Centres. Demographic distributions in Centres were compared to the South Australian distributions to examine the extent to which children attending Centres are representative of all children in SA. Compared to SA population distributions, children attending Centres tended to live in more disadvantaged areas, come from an Aboriginal background, and live in remote areas of the state (see Table 4.5-3). Children from culturally and linguistically diverse (CALD) backgrounds appeared to be under represented in the group of children attending a Children's Centre.

Table 4.5-3 Number and proportion of child characteristics in the EYS system over three terms

		N	%	SA %*
CHILD—AGE GROUP	0-2 years	3655	25.2%	-
	3- 4 years	9520	65.6%	-
	> 5	1345	9.3%	-
CHILD—GENDER	F	6916	47.6%	48.6%
	M	7624	52.4%	51.4%
CHILD—ABORIGINAL STATUS	Yes	1774	13.2%	5.3%
	No	11648	86.8%	94.7%
CHILD—CULTURALLY AND LINGUISTICALLY DIVERSE (CALD)	No	12148	83.5%	80.9%

		N	%	SA %*
	Yes	2392	16.5%	19.1%
CHILD—GUARDIAN OF THE MINISTER (GOM) STATUS	No	13399	98.4%	-
	Short Term	87	0.6%	-
	Until 18	137	1.0%	-
SEIFA IRSAD QUINTILE WITHIN AUSTRALIA	Most Disadvantaged	5660	38.9%	24.5%
	2	4526	31.1%	23.7%
	3	2478	17.0%	18.7%
	4	1456	10.0%	18.8%
	Most Advantaged	417	2.9%	13.9%
REMOTENESS LEVEL—BASED ON POSTCODE	Major Cities of Australia	11138	76.6%	72.1%
	Inner Regional Australia	726	5.0%	10.3%
	Outer Regional Australia	1518	10.4%	13.4%
	Remote Australia	576	4.0%	3.1%
	Very Remote Australia	582	4.0%	1.2%

Notes

[1] Characteristics of the 7,821 children in the EYS system over the three terms.

*SA population distributions were generated from the 2015 Australian Early Development Census data. Data not captured in the Census is indicated with a -.

Focus group and interview participants reported that once families were engaged with a Children's Centre, staff sought to support them to connect with a range of services. Analyses of the EYS data were conducted to examine the extent to which children were connected to multiple supports and services. Table 4.5-4 illustrates that the vast majority of children were enrolled for a single service during a term in a Children's Centre, with few children making use of multiple services.

Table 4.5-4 Number of children attending one or multiple programs across the three term collection times

		N	%
2015—TERM 4	1 program	4148	93.3
	2 programs	259	5.8
	3–5 programs	38	.9
	Total	4445	100.0
2016—TERM 1	1 program	3967	92.3
	2 programs	284	6.6
	3–5 programs	47	1.1
	Total	4298	100.0
2016—TERM 2	1 program	4196	91.0
	2 programs	369	8.0
	3-5 programs	45	1.0
	Total	4610	100.0

To examine the extent to which service usage differed for population groups, demographic characteristics of children attending programs were further explored in relation to whether the program was a universal service or targeted support. Table 4.5-5 and Table 4.5-6 present this data with cases of over representation highlighted in grey and cases of under representation highlighted in yellow.

Caution should be taken in drawing conclusion from this data, especially where there were small numbers of children recorded as using services. For universal services, boys tended to be over represented in health service utilisation in Children's Centres. Aboriginal children had higher rates of preschool and health service usage when compared to the composition of the population. With the exception of playgroup, families living in areas with high socio-demographic disadvantage were more highly represented in universal service usage data.

Targeted supports tended to be more heavily utilised by parents of girls, families living in less socio-economically disadvantaged suburbs, and families who are from English speaking backgrounds. There was mixed representation in service usage data for families living in regional and remote regions, with some services more heavily utilised and others underutilised.

No population comparisons could be drawn for children under the Guardianship of the Minister (GOM). However, overall these children tended to have low reported universal service use—most children enrolled only in preschool with several of these receiving preschool supports.

Although caution should be taken in drawing conclusions from this data—given small numbers of cases in some instances—it appears that some groups in the community are less likely to access both universal services and targeted supports.

Table 4.5-5 Characteristics of children who attend different types of universal programs

		Community Group		Health		Occasional Care		Playgroup		Preschool		
		N	%	N	%	-	%	N	%	N	%	SA %*
Child - Age group	0-2 years	17	50.0%	11	55.0%	519	50.3%	72	51.4%	27	1.1%	-
	3-4 years	17	50.0%	9	45.0%	512	49.6%	68	48.6%	2338	96.9%	-
	> 5	0	.0%	0	.0%	1	.1%	0	.0%	47	1.9%	-
Child - Gender	F	17	50.0%	8	40.0%	472	45.7%	64	45.7%	1162	48.2%	48.6%
	M	17	50.0%	12	60.0%	560	54.3%	76	54.3%	1250	51.8%	51.4%
Child - Aboriginal status	Yes	0	.0%	9	56.3%	65	6.6%	2	2.1%	419	17.7%	5.3%
	No	22	100.0%	7	43.8%	927	93.4%	95	97.9%	1947	82.3%	94.7%
Child - Culturally and Linguistically Diverse (CALD)	No	22	64.7%	20	100.0%	798	77.3%	122	87.1%	2071	85.9%	80.9%
	Yes	12	35.3%	0	.0%	234	22.7%	18	12.9%	341	14.1%	19.1%
Child - Guardian of the Minister (GOM) status	No	22	100.0%	16	100.0%	1004	99.5%	97	100.0%	2361	98.0%	-
	Short Term	0	.0%	0	.0%	4	.4%	0	.0%	19	.8%	-
	Until 18	0	.0%	0	.0%	1	.1%	0	.0%	29	1.2%	-
SEIFA IRSAD Quintile within State or Territory	Most Disadvantaged	4	11.8%	16	80.0%	413	40.0%	16	11.4%	953	39.5%	24.5%
	2	10	29.4%	2	10.0%	268	26.0%	9	6.4%	614	25.5%	23.7%
	3	3	8.8%	0	.0%	105	10.2%	13	9.3%	264	10.9%	18.7%
	4	16	47.1%	2	10.0%	181	17.5%	75	53.6%	489	20.3%	18.8%
	Most Advantaged	1	2.9%	0	.0%	65	6.3%	27	19.3%	92	3.8%	13.9%
Remoteness level - based on postcode	Major Cities of Australia	29	85.3%	4	20.0%	821	79.6%	117	83.6%	1866	77.4%	72.1%
	Inner Regional Australia	1	2.9%	0	.0%	56	5.4%	0	.0%	162	6.7%	10.3%
	Outer Regional Australia	2	5.9%	10	50.0%	72	7.0%	22	15.7%	269	11.2%	13.4%
	Remote Australia	0	.0%	0	.0%	54	5.2%	0	.0%	40	1.7%	3.1%
	Very Remote Australia	2	5.9%	6	30.0%	29	2.8%	1	.7%	75	3.1%	1.2%

Note *Census data collected in the AEDC

Table 4.5-6 Characteristics of children who attend different types of targeted programs

		ABORIGINAL FOCUSSED SUPPORT		PARENTING PROGRAM		PARENTING SUPPORT SERVICES		PRESCHOOL SUPPORT PROGRAMS		SUPPORTED PLAYGROUP		TARGETED PLAYGROUP		TARGETED SUPPORT GROUP	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%
AGE GROUP	0-2 years	20	57.1%	38	67.9%	20	47.6%	0	.0%	540	70.2%	21	61.8%	32	60.4%
	3-4 years	15	42.9%	18	32.1%	21	50.0%	224	96.1%	228	29.6%	11	32.4%	18	34.0%
	> 5	0	.0%	0	.0%	1	2.4%	9	3.9%	1	.1%	2	5.9%	3	5.7%
GENDER	F	18	51.4%	34	60.7%	25	56.8%	100	42.9%	393	51.0%	17	50.0%	24	42.1%
	M	17	48.6%	22	39.3%	19	43.2%	133	57.1%	378	49.0%	17	50.0%	33	57.9%
ABORIGINAL STATUS	Yes	20	62.5%	0	.0%	3	7.3%	43	18.5%	18	3.2%	0	.0%	0	.0%
	No	12	37.5%	42	100.0%	38	92.7%	189	81.5%	538	96.8%	26	100.0%	37	100.0%
CALD	No	35	100.0%	51	91.1%	41	93.2%	136	58.4%	664	86.1%	33	97.1%	49	86.0%
	Yes	0	.0%	5	8.9%	3	6.8%	97	41.6%	107	13.9%	1	2.9%	8	14.0%
GOM STATUS	No	32	100.0%	40	95.2%	39	92.9%	222	95.3%	564	99.1%	26	100.0%	37	100.0%
	Short Term	0	.0%	1	2.4%	3	7.1%	1	.4%	4	.7%	0	.0%	0	.0%
	Until 18	0	.0%	1	2.4%	0	.0%	10	4.3%	1	.2%	0	.0%	0	.0%
SEIFA	Most Disadvantaged	25	71.4%	20	35.7%	7	15.9%	118	50.6%	259	33.6%	3	8.8%	15	26.3%
	2	9	25.7%	10	17.9%	11	25.0%	56	24.0%	199	25.8%	5	14.7%	18	31.6%
	3	0	.0%	8	14.3%	7	15.9%	29	12.4%	143	18.5%	3	8.8%	12	21.1%
	4	1	2.9%	11	19.6%	19	43.2%	28	12.0%	109	14.1%	9	26.5%	4	7.0%
	Most Advantaged	0	.0%	7	12.5%	0	.0%	2	.9%	61	7.9%	14	41.2%	8	14.0%
REMOTENESS LEVEL	Major Cities of Australia	1	2.9%	36	64.3%	23	52.3%	188	80.7%	610	79.1%	32	94.1%	54	94.7%
	Inner Regional Australia	0	.0%	0	.0%	0	.0%	13	5.6%	4	.5%	0	.0%	3	5.3%
	Outer Regional Australia	0	.0%	10	17.9%	15	34.1%	4	1.7%	64	8.3%	2	5.9%	0	.0%
	Remote Australia	9	25.7%	0	.0%	6	13.6%	27	11.6%	55	7.1%	0	.0%	0	.0%
	Very Remote Australia	25	71.4%	10	17.9%	0	.0%	1	.4%	38	4.9%	0	.0%	0	.0%

To examine the extent to which pathways to additional services might differ in relation to the services families first used in Centres, child enrolment data was explored for each program type in relation to enrolment in each other program time. That is, for children attending one type of program or service, how many of those children also attended another program or service. For example, of the 2412 children who attended pre-school, 47 also attended a supported playgroup, 16 attended a regular playgroup, 11 attended occasional care, 11 attended a parenting support service but fewer than 10 children attended any other type of service. In examining Table 4.5-7, it is evident that although service usage was overall highest for preschool and occasional care, and few of these children utilised other services, children attending occasional care were more likely to also use additional services—specifically a supported playgroup. In fact, children attending a supported playgroup or a community playgroup (playgroup) were the most likely to also be using other services in Centres. Similarly, of the few families utilising Aboriginal-focussed supports, many of these children also utilised additional services. Families utilising targeted supports (e.g. parenting programs, targeted support group, and parenting support services) also tended to utilise additional services.

Table 4.5-7 The relationship between service usage across the range of program types

	N	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Preschool	2412	-													
2. Occasional Care	1032	11	-												
3. Playgroup	140	16	18	-											
4. Health	20	3	8	0	-										
5. Community Group	34	1	3	5	0	-									
6. Supported Playgroups	771	47	120	12	8	10	-								
7. Preschool Support Programs	198	2	0	0	0	0	5	-							
8. Targeted Support Group	57	7	3	0	0	0	11	0	-						
9. Parenting Program	56	6	5	2	0	4	20	0	0	-					
10. Parenting Support Services	44	11	3	4	1	3	10	0	2	10	-				
11. Aboriginal Focussed Support	35	7	11	1	6	2	12	3	0	2	0	-			
12. Targeted Playgroup	34	0	0	0	0	0	5	0	0	0	0	0	-		
13. Family Support	9	1	0	0	0	0	2	0	0	1	0	0	0	-	
14. Bus Service	8	0	0	0	0	0	0	0	0	0	0	0	0	0	-

Notes

[1] Universal programs in the top half of the table (1–5), targeted programs in the bottom half of the table (6–14).

[2] The following programs have been combined (Playgroup and Community/Parent Led Playgroup into Playgroup; Inclusive Preschool Program, Preschool Speech and Language, Preschool Support Program and Preschool Bilingual Program into Preschool Support Programs)

[3] A small number of children were enrolled into 'adult learning' programs, and these records were excluded from the table

[4] The Learning Together program has been excluded from this list

[5] This table is based on data from Term 2 (2016) from the EYS.

Adults

A small amount of data was collected and reported for adult services used in Children's Centres. Additionally, where data was collected for program enrolment, demographic data was often not collected for parents. This greatly limits the ability of the evaluation to comment on provision of services to families. Table 4.5-8 presents enrolments in each program type for the three collection terms and Table 4.5-9 presents this same data grouped by service provider. Inconsistent data collection and entry for services is likely to have impacted this data for some service providers more so than for others. Data was most frequently collected and entered for supported playgroup and for programs provided by DECD staff. This is likely to reflect data sharing issues in Centres—that is Centre staff have reported that external service providers have been unwilling to share service utilisation data with Centre staff. Given the data limitations, no other adult service usage analyses were able to be conducted.

Table 4.5-8 Number and proportion of program types offered across the three collection terms

	2015—TERM 4		2016—TERM 1		2016—TERM 2	
	Count	Column N %	Count	Column N %	Count	Column N %
HEALTH	0	.0%	18	2.4%	6	1.2%
TARGETED PLAYGROUP	7	1.3%	7	.9%	17	3.5%
TARGETED SUPPORT GROUP	26	4.8%	19	2.5%	19	3.9%
PARENTING SUPPORT SERVICES	36	6.6%	13	1.7%	30	6.2%
COMMUNITY GROUP	32	5.9%	38	5.1%	11	2.3%
FAMILY SUPPORT	34	6.2%	36	4.8%	23	4.7%
ABORIGINAL FOCUSSED SUPPORT	27	4.9%	37	5.0%	32	6.6%
PARENTING PROGRAM	38	6.9%	45	6.0%	42	8.6%
COMMUNITY/PARENT LED PLAYGROUP	41	7.5%	72	9.7%	63	12.9%
SUPPORTED PLAYGROUP	306	55.9%	438	58.7%	243	49.9%

Notes

[1] Adults can be enrolled in multiple programs, so a total has not been provided.

[2] Adults can attend multiple different types of sessions within a specific program type (e.g. a total of 306 adults attended a Supported Playgroup in Term 4 of 2015 but some of these parents attended both a Universal Playgroup session and a Jump N Jive Playgroup session).

[3] Adults can also attend a supported playgroup session with more than one child but each adult has been counted once in the table above.

Table 4.5-9 Number and percentage of organisations working with Centres across the three collection terms

	2015 – TERM 4		2016 – TERM 1		2016 – TERM 2	
	Count	Column N %	Count	Column N %	Count	Column N %
ANGLICARE	0	.0%	0	.0%	2	.4%
FAMILIES SA	1	.2%	1	.1%	0	.0%
PEER SUPPORT GROUP	1	.2%	0	.0%	1	.2%
LOCAL COUNCIL	0	.0%	3	.4%	0	.0%
LUTHERAN CHURCH OF AUSTRALIA	3	.5%	2	.3%	2	.4%
MYTIME	0	.0%	4	.5%	4	.8%
UNITING CARE WESLEY COUNTRY SA	8	1.5%	0	.0%	0	.0%
HEALTH SA	0	.0%	3	.4%	7	1.4%
RELATIONSHIPS AUSTRALIA	0	.0%	0	.0%	11	2.3%
MULTIPLE BIRTHS ASSOCIATION	7	1.3%	7	.9%	12	2.5%
PRIVATE PROVIDERS	21	3.8%	21	2.8%	17	3.5%
SAVE THE CHILDREN	20	3.7%	36	4.8%	28	5.7%
ALLIED HEALTH	18	3.3%	118	15.8%	53	10.9%
FAMILY SERVICES CO-ORDINATOR	109	19.9%	146	19.6%	124	25.5%
DECD	169	30.9%	184	24.7%	93	19.1%
COMMUNITY DEVELOPMENT	190	34.7%	193	25.9%	131	26.9%

Notes

[1] Adults can be enrolled in programs provided by multiple providers, so a total has not been provided.

[2] The Learning Together program has been excluded from this list

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

In focus groups and interviews, Children's Centres were identified as positively impacting on parents' wellbeing, parenting capacity and parenting practices. The positive impact of Children's Centres on family wellbeing was related to two key types of support. Firstly, families were better connected to other families and this worked to reduce social isolation. Secondly, Children's Centres better supported parents in their role through the provision of parenting supports and programs, and an increase in staff capacity to work in partnership with parents around the care of their children.

Within the survey, parents were asked a series of questions to examine the impact of utilising services and supports in a Children's Centre on parenting, parental wellbeing and social support.

Parental Wellbeing

Parental wellbeing is often defined as the absence of manifested psychiatric symptoms. To measure the wellbeing of parents utilising services in Children's Centres, the survey asked parents six questions about depressive and anxiety symptoms (Kessler Psychological Distress K6 scale). Parents were asked to indicate, how often during the past four weeks they felt the following:

1. Did you feel nervous?
2. Did you feel hopeless?
3. Did you feel restless or fidgety?
4. Did you feel that everything was an effort?
5. Did you feel so sad that nothing could cheer you up?
6. Did you feel worthless?

Response options ranged from 1 (*all of the time*) through to 5 (*none of the time*). On average, parents tended to score highly on this measure (*M* = 4.26), with most parents reporting that they only felt the depressive and anxiety symptoms ‘a little of the time’, reflecting good overall wellbeing.

Parents were asked three additional questions from the Australian Temperament Project to further examine how well they felt they were coping with life’s challenges. As illustrated in Table 4.6-1, parents typically felt that their life was moderately difficult, coped relatively well and sometimes felt rushed or pressed for time.

Table 4.6-1 Parent responses to parental wellbeing questions from the Australian Temperament Project

	MEAN	(MIN-MAX VALUE)
1. HOW DIFFICULT DO YOU FEEL YOUR LIFE IS AT PRESENT?	2.55	(1.00-5.00)
2. HOW WELL DO YOU THINK YOU ARE COPING?	3.51	(1.00-5.00)
3. HOW OFTEN DO YOU FEEL RUSHED OR PRESSED FOR TIME?	2.42	(1.00-5.00)

Parenting

To measure parenting practices, parents were asked 30 questions, which examined five different aspects of parenting, including: self-reported parenting efficacy, parental warmth, inductive reasoning, hostile parenting, and consistent parenting. The parent survey was distributed to both families using Children’s Centres and to families in neighbouring areas whose children attended reception in a school that did not have a Children’s Centre attached to it. In this way, comparison data was sought to identify any potential parenting benefits associated with accessing services and supports through a Children’s Centre.

Too few surveys were returned by parents who did not access a Children’s Centre, thus comparisons were not able to be drawn. Instead, we present here the findings and as far as possible compare these to published Australian data. The scales employed in the survey are also used in the Longitudinal Study of Australian Children and also in the evaluation of the Tasmanian Child and Family Centres.

Self-reported parenting efficacy

Self-reported parenting efficacy, which refers to the belief that one can effectively perform or manage tasks related to parenting, was measured using items from the Early Childhood Longitudinal

Study. Parents respond on a 10-point Likert scale, with response options ranging from 1 (*not at all how I feel*) to 10 (*exactly how I feel*) to the following statements:

1. I feel that I am very good at keeping my child amused.
2. I feel that I am very good at calming my child when he or she is upset.
3. I feel that I am very good at keeping my child busy while I am doing house work.
4. I feel that I am very good at routine tasks of caring for my child (feeding him/her, changing his or her nappies and giving him/her a bath).

Parents using services in Children's Centres generally rated themselves as having high parenting efficacy (*M* = 8.05), out of a total possible score of 10.

Parents were asked an additional question that asked them to rate how they perceived themselves as a parent. Table 4.6-2 displays the response options and proportion of parents who answered in each category. Responses to this question were mostly positive, consistent with scores from the self-reported efficacy scale.

These findings are also consistent with findings from the Tasmania evaluation, where parents were asked the same question about their self-reported parenting efficacy. Specifically, the proportion of parents who felt they were 'an average parent' (approx. 31% in Tasmania study), 'a better than average parent' (approx. 25% in Tasmania study), and 'a very good parent' (approx. 38% in Tasmania study) were consistent across studies.

Table 4.6-2 Parent responses to how they feel they are as a parent overall

RESPONSE OPTIONS	N	%
NOT VERY GOOD AT BEING A PARENT	1	0.5%
A PERSON WHO HAS SOME TROUBLE BEING A PARENT	14	7.3%
AN AVERAGE PARENT	60	31.3%
A BETTER THAN AVERAGE PARENT	56	29.2%
A VERY GOOD PARENT	61	31.8%

Parental warmth

Parental warmth, which refers to how affectionate and accepting parents are towards their children, was measured through six questions from the Child Rearing Questionnaire. Using a 5-point Likert scale, with response options ranging from 1 (*never/almost never*) to 5 (*always/almost always*), parents were asked to indicate how often they did the following:

1. How often do you express affection by hugging, holding or kissing your child?
2. How often do you hug or hold your child for no reason?
3. How often do you tell your child how happy he or she makes you?
4. How often do you have warm close times together with your child?
5. How often do you enjoy listening to your child and doing things with your child?

6. How often do you feel close with your child both when he/she is happy and when he/she is upset?

On average, parents scored highly on this measure (*M* = 4.53), with most parents responding to the questions with ‘often’ or ‘almost always’, reflecting high levels of parental warmth.

Inductive reasoning

Inductive reasoning, which refers to how parents communicate with children about the rationality of their actions and the effects of their actions on others, was measured through five survey questions from the Child-Rearing Questionnaire. Parents were asked to indicate how often they do the following:

1. How often do you explain to this child why he or she is being corrected?
2. How often do you talk it over and reason with this child when he/she misbehaves?
3. How often do you give this child reasons why rules should be obeyed?
4. How often do you explain to this child the consequences of his/her behaviour?
5. How often do you emphasise to this child the reasons for rules?

Response options ranged from 1 (*never/almost never*) to 5 (*always/almost always*). On average, parents scored highly on this measure (*M* = 4.27) out of a total possible score of 5, reflecting high levels of inductive reasoning.

Hostile parenting

Hostile parenting, which refers to a general pattern of behaviour, manipulation, actions or decision-making that creates difficulties in the relationship with a child, was measured through seven survey questions from the National Longitudinal Survey of Children and Youth. Using a 5-point Likert scale, parents were asked to indicate how often the following statements occurred:

1. How often do you get annoyed with your child for saying or doing something he/she is not supposed to?
2. Of all the times you talk to your child about his/her behaviour, how often is this praise? (reversed)
3. Of all the times you talk to your child about his/her behaviour, how often is this disapproval?
4. How often are you angry when you punish your child?
5. How often do you feel you are having problems managing your child in general?
6. How often do you tell your child that he/she is bad or not as good as others?
7. How often do you think that the level of punishment you give your child depends on your mood?

On average, parents’ responses were at the lower end of the continuum (*M* = 2.06), reflecting relatively low levels of hostile/angry parenting.

Consistent Parenting

Consistent parenting refers to when both parents are consistent with their approach from day to day and was measured through seven survey questions from the National Longitudinal Survey of

Children and Youth. Using a 5-point Likert scale, parents were asked to indicate how much of the time things turned out like this:

1. When you give your child an instruction or make a request to do something, how often do you make sure that he/she does it?
2. If you tell your child he/she will get punished if he/she doesn't stop doing something, but he/she keeps doing it, how often will you punish him/her?
3. How often does your child get away with things that you feel should have been punished? (Reversed)
4. How often is your child able to get out of punishment when he/she really sets his/her mind to it? (Reversed)
5. When you discipline your child, how often does he/she ignore the punishment? (Reversed)

On average, parents scored moderately highly (*M* = 3.48), with most parents reporting that the statements apply to them 'about half the time' or 'more than half the time', reflecting relatively moderate levels of parenting consistency.

Social Support

Social support refers to the various types of support that people receive from others and is generally examined through subdomains. Four types of support that were deemed important for parents were measured through 15 questions from the MOS Social Support Survey, including emotional/informational support (questions 1–4), tangible support (5–8), affectionate support (9–11) and positive social interaction (12–15). Parents were asked to indicate, using a 5-point Likert scale, how often each of the following kinds of support are available if they need it:

1. Someone you can count on to listen to you when you need to talk.
2. Someone to confide in or talk to about yourself or your problems.
3. Someone to share your most private worries and fears with.
4. Someone to turn to for suggestions about how to deal with a personal problem.
5. Someone to help you if you were confined to bed.
6. Someone to take you to the doctor if you needed it.
7. Someone to prepare your meals if you were unable to do it yourself.
8. Someone to help with daily chores if you were sick.
9. Someone who shows you love and affection.
10. Someone to love and make you feel wanted.
11. Someone who hugs you.
12. Someone to have a good time with.
13. Someone to get together with for relaxation.
14. Someone to do something enjoyable with.
15. Someone to do things with to help you get your mind off things.

Parents generally rated their levels of social support as high (*M* = 3.99), out of a possible score of 5, reflecting relatively high levels of social support in their lives.

Two additional questions examined parents' levels of social support—knowing where to find information about local services and supports and being well informed about local affairs. As shown in Figure 4.6-1 parents generally agreed that when they need information about local services, they knew where to find it. Families in Tasmania, reported slightly higher rates of knowing where to find services—with 37% reporting they knew where to find services 'most of the time' and 41% 'all of the time'.

Parents utilising Children's Centres in SA also tended to agree that they were well informed about local affairs (see Figure 4.6-2).

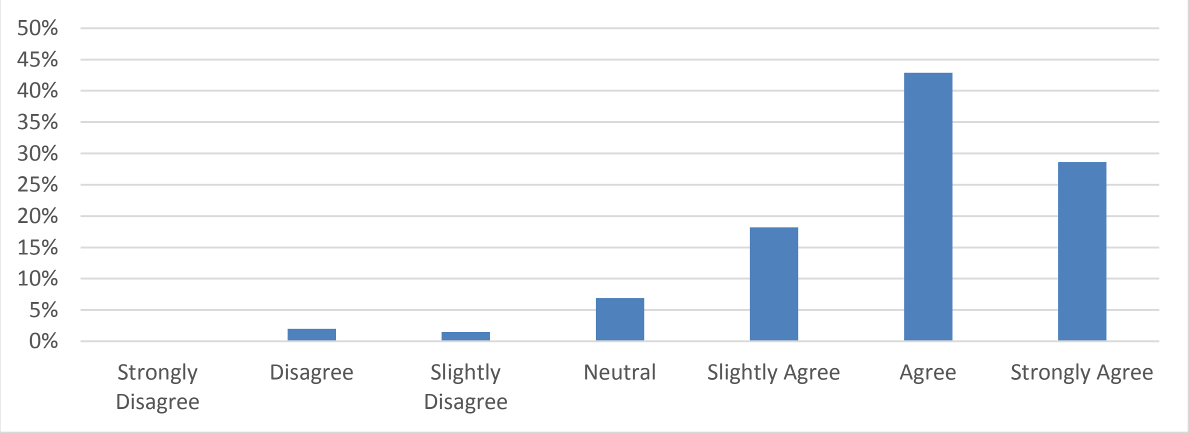


Figure 4.6-1 Parent responses to whether they knew where to find information about local services

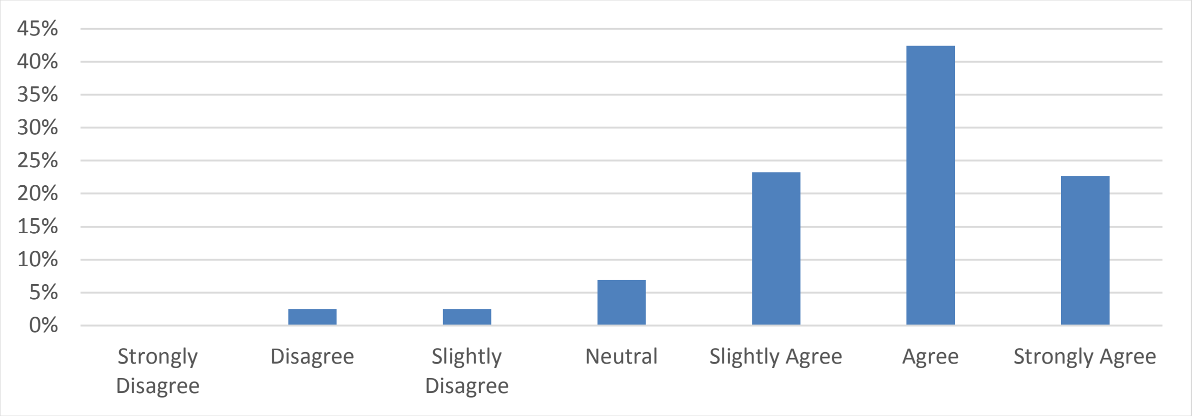


Figure 4.6-2 Parent responses to whether they were well informed about local affairs

Mann-Whitney U analyses were conducted to determine whether there were any significant differences in responses for groups with differing demographic characteristics. Differences were found for two demographic groups. Firstly, there was a statistically significant difference between household status (p = .010), with parents from single parent households reporting having more knowledge of where to find information and local services (M = 6.2, n = 31) compared to parents from two-parent households (M = 5.8, n = 163). Additionally, parents from single parent households reported that they were more informed about local affairs (M = 6.1, n = 93) compared to parents from two-parent households (*M* = 5.6, *n* = 163) and this was a statistically significant difference (*p* = .010). Secondly, parents of children who only spoke English at home reported having more knowledge of where to find information and local services (*M* = 5.9, *n* = 172) compared to parents of non-English speaking children (*M* = 5.4, *n* = 31), and this difference was statistically significant (*p* = .015).

Further analyses were conducted to examine whether there were differences in parental wellbeing and self-reported parenting among demographic groups. Significant differences emerged for five demographic groups. A Mann-Whitney U analysis revealed that parents with a medical condition or disability had less favourable outcomes across a range of measures (see Table 4.6-3). Specifically, parents with a medical condition or disability reported poorer wellbeing, had lower self-reported parenting efficacy, had higher scores on the hostile parenting scale, felt that life was more difficult, had poorer coping, and felt more rushed and pressed for time compared to parents without a medical condition or disability.

Table 4.6-3 Parenting scales mean scores and whether there was a significant difference for parents with a medical condition or disability

Parenting Scales	Parent has a medical condition or disability (6 months or more)				
	Yes		No		
	M	N	M	N	p
Kessler K6	3.59	28	4.37	171	.001*
MOS Social Support Scale	3.70	29	4.04	170	.079
Self-Reported Parenting Efficacy	7.22	26	8.18	167	.017*
Parental Warmth	4.34	26	4.57	166	.090
Inductive Reasoning	4.02	26	4.32	165	.092
Hostile Parenting	2.33	25	2.02	167	.040*
Consistent Parenting	3.52	25	3.47	166	.989
Overall as a parent…	3.52	27	3.90	165	.051
How difficult do you feel life is at present?	3.14	29	2.46	171	.000*
How well do you think you are coping?	3.14	29	3.57	171	.014*
How often do you feel rushed or pressed for time?	2.07	29	2.49	171	.020*

**p* < .05

Similarly, as demonstrated in

Table 4.6-4, a Mann-Whitney U analysis revealed that parents who had a child with a medical condition or disability also had less favourable outcomes across a range of measures. Specifically, they reported having poorer wellbeing, lower levels of social support, lower self-reported efficacy, higher scores on the hostile parenting scale, rated themselves lower as a parent overall, reported having a more difficult life, and were more rushed and pressed for time compared to parents without a child with a medical condition or disability.

Table 4.6-4 Parenting scales mean scores and whether there was a significant difference for parents with a child with a medical condition or disability

Parenting Scales	Parent has a child with a medical condition or disability (6months or more)				
	Yes		No		
	M	N	M	N	p
Kessler K6	4.00	34	4.31	164	.046*
MOS Social Support Scale	3.58	34	4.09	164	.004*
Self-Reported Parenting Efficacy	7.53	33	8.18	159	.025*
Parental Warmth	4.43	33	4.56	158	.150
Inductive Reasoning	4.13	33	4.31	157	.193
Hostile Parenting	2.28	33	2.01	158	.033*
Consistent Parenting	3.50	33	3.48	157	.909
Overall as a parent…	3.42	33	3.94	158	.008*
How difficult do you feel life is at present?	3.15	34	2.42	165	.000*
How well do you think you are coping?	3.32	34	3.55	165	.147
How often do you feel rushed or pressed for time?	2.09	34	2.50	165	.011*

*$p < .05$

As shown in Table 4.6-5, a Kruskal-Wallis analysis revealed a significant association between the number of children a parent had and how they rated themselves as a parent, with parents with five or more children scoring themselves the lowest. Additionally, there was a significant association between the number of children a parent had and if they felt rushed or pressured for time. Specifically, parents with five or more children felt the most rushed and pressed for time, with parents of one child feeling the least time pressure.

Table 4.6-5 Parenting scales mean scores and whether there was a significant difference depending on how many children the parent has

Parenting Scales	Number of Children												
	0		1		2		3		4		≥ 5		
	M	N	M	N	M	N	M	N	M	N	M	N	p
Kessler K6	2.00	1	4.32	66	4.23	88	4.27	32	4.26	9	4.44	3	.536
MOS Social Support Scale	3.53	1	4.11	67	4.01	87	3.91	32	3.52	9	3.40	3	.324
Self-Reported Parenting Efficacy	10.00	1	8.20	65	7.86	84	8.13	31	8.50	9	7.67	3	.465
Parental Warmth	5.00	1	4.65	64	4.46	84	4.45	31	4.57	9	4.61	3	.241
Inductive Reasoning	5.00	1	4.31	63	4.24	84	4.23	31	4.38	9	4.53	3	.591
Hostile Parenting	3.00	1	1.95	64	2.15	84	2.01	31	2.24	9	2.04	3	.266
Consistent Parenting	3.00	1	3.36	63	3.52	84	3.64	31	3.50	9	3.40	3	.192
Overall as a parent…	3.00	1	3.91	65	3.98	83	3.55	31	3.67	9	2.67	3	.044*
How difficult do you feel life is at present?	3.00	1	2.46	67	2.61	88	2.50	32	2.78	9	2.67	3	.879
How well do you think you are coping?	3.00	1	3.63	67	3.47	88	3.53	32	3.00	9	3.33	3	.509
How often do you feel rushed or pressed for time?	1.00	1	2.63	67	2.42	88	2.22	32	2.22	9	1.33	3	.030*

*$p < .05$

Additionally, a Kruskal-Wallis analysis revealed that there was a significant difference in how parents rated themselves on self-efficacy and the age of a parent. As illustrated in Table 4.6-6, parents aged 18–22 years had the highest self-reported efficacy, with adults 40 years and above having the next highest self-reported efficacy. Parents aged 23–25 years had the lowest self-reported efficacy scores. Furthermore, there was also a significant difference in how well parents thought they were coping and age of parent, with parents aged 18–22 reporting coping the best and parents aged 23–25 reporting coping the worst.

Table 4.6-6 Parenting scales mean scores and whether there was a significant difference depending on age of parent

	Age of Parent												
Parenting Scales	18–22		23–25		26–30		31–35		36–40		> 40		
	M	N	M	N	M	N	M	N	M	N	M	N	p
Kessler K6	4.06	8	3.92	8	4.13	30	4.33	67	4.35	55	4.20	31	.253
MOS Social Support Scale	4.17	8	3.60	9	4.06	29	4.08	67	4.00	55	3.80	31	.654
Self-Reported Parenting Efficacy	8.94	9	6.44	8	7.67	29	8.03	65	8.16	52	8.45	30	.006*
Parental Warmth	4.85	8	4.48	8	4.53	29	4.53	65	4.54	52	4.48	30	.689
Inductive Reasoning	4.73	8	4.35	8	4.25	28	4.30	65	4.16	52	4.30	30	.279
Hostile Parenting	2.00	9	2.37	8	2.04	29	2.16	64	2.03	52	1.89	30	.126
Consistent Parenting	3.27	9	3.45	8	3.45	28	3.48	64	3.52	52	3.54	30	.986
Overall as a parent…	3.88	8	3.00	9	3.71	28	3.92	65	3.83	52	4.07	30	.129
How difficult do you feel life is at present?	2.63	8	2.89	9	2.63	30	2.48	67	2.51	55	2.61	31	.817
How well do you think you are coping?	3.63	8	2.78	9	3.20	30	3.61	67	3.60	55	3.59	31	.029*
How often do you feel rushed or pressed for time?	2.75	8	2.44	9	2.57	30	2.43	67	2.27	55	2.45	31	.538

*$p < .05$

Finally, a Mann-Whitney U test revealed a significant difference between household status and the amount of social support parents reported to have. As shown in Table 4.6-7, parents living in a single parent household reported having lower levels of social support compared to parents in a two-parent household. Interestingly, no significant differences emerged between any demographic characteristics and parental warmth.

Table 4.6-7 Parenting scales mean scores and whether there was a significant difference for parents with a medical condition or disability

Parenting Scales	Household Status				
	Single Parent		Two-Parent		
	M	N	M	N	p
Kessler K6	3.94	28	4.34	162	.078
MOS Social Support Scale*	3.51	29	4.10	161	.001
Self-Reported Parenting Efficacy	8.25	28	8.06	157	.725
Parental Warmth	4.65	28	4.54	156	.669
Inductive Reasoning	4.45	28	4.28	156	.293
Hostile Parenting	2.22	27	2.03	157	.087
Consistent Parenting	3.56	27	3.49	157	.547
Overall as a parent…	3.69	29	3.92	155	.194
How difficult do you feel life is at present?	2.90	29	2.49	162	.066
How well do you think you are coping?	3.41	29	3.53	162	.515
How often do you feel rushed or pressed for time?	2.45	29	2.42	162	.915

*$p < 0.05$

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

4.7.1. Do children who attend preschool in a Children's Centre have better child development outcomes in their reception year than (comparable) children who attend other types of government funded preschools?

Matched data from the Preschool Census (2014) and the AEDC (2015) were analysed to answer the question of whether children who attend preschool within a Children's Centre have better development at school entry than children who attend a standard preschool? Descriptive information on the two groups is presented first (percentage of children vulnerable on each developmental domain and summary indicators), followed by logistic regression analyses to test whether these differences between groups were statistically significant. Overall, the findings, presented in Table 4.7-1 suggest that there were very few differences in the development of children who attended preschool in a Children's Centre compared to those who attend a standard preschool.

Table 4.7-1. 2015 AEDC results for children attending different types of preschools

	Standard Preschool (n = 3,510)		Children's Centre Preschool (n = 1,905)	
	N	%	N	%
Developmental domains				
Physical Health and Wellbeing	409	12.6%	226	12.7%
Social Competence	375	11.5%	225	12.7%
Emotional Maturity	344	10.6%	189	10.7%
Language and Cognitive Skills	269	8.3%	151	8.5%
Communication skills and General Knowledge	305	9.4%	158	8.9%
Summary Indicators				
Vulnerable on ≥ 1 domain	851	26.2%	462	26.1%
Vulnerable on ≥ 2 or more domains	442	13.6%	254	14.3%

Logistic regression analyses confirmed that there was no difference in the probability of being developmentally vulnerable on one or more AEDC domains between children who attended a Children's Centre preschool and those who attended a standard preschool. Once we adjusted for differences in gender, Aboriginality, language background, and socio-economic status, children who attended a Children's Centre preschool had slightly lower odds of being vulnerable (OR = 0.94, 95% CI 0.82-1.08) than children attending a standard preschool. However, this difference was not statistically significant and, as such, these analyses suggest there is no significant difference in the odds of being developmentally vulnerable at school entry between children attending different types of preschools. Table 4.7-2 presents these results.

Table 4.7-2. Logistic regression analyses – % of children vulnerable on 1 or more domains for children attending different types of preschools

		Unadjusted			Adjusted		
		N	OR (95% CI)	p	N	OR (95% CI)	p
Preschool type	Standard	3,244	ref	-	3,243	ref	-
	Children's Centre	1,767	0.99 (0.87,1.14)	.95	1,766	0.94 (0.82,1.08)	.36
Sex of child	Female				2,498	ref	-
	Male				2,511	2.40 (2.10,2.74)	<.001
Aboriginal status	No				4,674	ref	-
	Yes				355	2.13 (1.68,2.70)	<.001
Language Background other than English	English only				4,059	ref	-
	LBOTE				950	1.01 (0.86,1.19)	.90
Socio-economic status of the community where the child lives	Quintile 1 (most disadvantaged)				1,801	ref	-
	Quintile 2				1,432	0.78 (0.67,0.92)	<.01
	Quintile 3				936	0.65 (0.54,0.78)	<.001
	Quintile 4				602	0.37 (0.29,0.48)	<.001
	Quintile 5 (least disadvantaged				238	0.52 (0.37,0.74)	<.001

4.7.1. Were children who attended preschool in a Children's Centre less likely to be identified by their reception teacher as having additional/undiagnosed special needs?

Children's Centres bring together a range of different service providers to help support children and families. This integrated service model should support the early identification of children's needs before they commence school and support families with children who have special needs – speech, language, developmental, behavioural, emotional problems – to access relevant services and supports. Within the AEDC data collection, teachers are asked two questions; (1) whether children have any diagnosed special needs (*special needs*), and (2) whether children have additional needs that need further assessment (*additional need*s). Thus, as a result of the integrated service provision model, it is hypothesised that children who attend Children's Centres would be less likely to start school with undiagnosed special needs and that this would be reflected in teachers' responses to the question about children's additional needs that need further assessment.

To examine the extent to which this is the case, two comparisons were conducted. The first to examine whether there was a higher incidence of children with diagnosed additional needs and the second to examine whether there were differences in the proportion of children starting school who required further assessment. Table 4.7-3 shows the percentage of children in each of these groups based on their preschool experience. The percentage of children with special needs status was a little lower for children who attended a Children's Centre. There was, however, no evidence that children who attended a Children's Centre were less likely to have additional (undiagnosed) needs than children who attended a standard preschool.

Table 4.7-3. Special and additional needs for children attending different preschools (n = 5,415)

		Standard Preschool (n = 3,510)		Children's Centre Preschool (n = 1,905)	
		N	%	N	%
Special needs	Yes	252	7.2	127	6.7
	No	3,258	92.8	1,778	93.3
Additional needs	Yes	449	13.3	269	14.6
	No	2,928	86.7	1,570	85.7

5. Discussion

This evaluation report has presented findings as they relate to eight evaluation questions. Three sets of quantitative data were analysed, including: state-wide survey of staff, service providers and families; Early Years System (EYS) administrative data collected in Children's Centres about the range of services offered to children and their families and use of these services; and SA Government preschool data linked to 2015 AEDC data. Analyses of these data sets, sought to further develop understandings of the factors affecting integration in centres and the impacts that Centres have on children and their parents. These analyses built upon the themes reported in the Interim report; exploring quantitatively the extent to which the factors reported in focus groups and interviews were impacting integrated service delivery across the state.

5.1. Evaluation Questions

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

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

To better inform planning for the needs of children and families, an opportunity exists for Children's Centres to use population data for communities to identify and quantify level of need. This is particularly important for determining the required scale and intensity of any response. Issues identified using population data should then be combined with community and service provider consultation to understand: factors contributing to issues and assets available in the community that can be utilised to respond to the needs of children and families. That is ensuring these are:

- culturally appropriate
- cognisant of barriers to access
- acceptable to target group
- implementable with scale and intensity needed to shift issue
- amenable to change.

The Early Years System data examined for the evaluation demonstrated that a broad range of services were available across Centres, with some being far more prevalent than others. The evaluation was not able to determine whether this mix of services was appropriate to need. However, the evaluation did examine the extent to which staff, service providers, and directors reported understanding the needs of the community. Additionally, parents reported the extent to which services met the needs of families.

In planning services and supports, Centres reported having a better understanding of the needs of families using Centres than they did of families living in the local area. In focus groups and interviews, staff and directors reported that one way in which they came to know what supports families needed was by listening to families when they spoke about their challenges. In contrast, population data such as the AEDC and ABS data was spoken about as having limited utility for understanding community need. From the evaluation, it is unclear how extensively population data sources are used to support service planning. Considered alongside focus group and interview data, the survey findings illustrate that there is an opportunity to improve utilisation of population data for mapping community needs as well as resources available in communities.

While the majority of families reported that Centres understood their needs and provided services and supports that met their needs and the needs of their children, they did not feel like active partners in the design of services. Nevertheless, most families reported feeling supported by

Children's Centre staff. Moreover, families reported feeling comfortable seeking advice and support from staff when they were in need. Fewer parents felt that staff were committed to helping them or that they would find someone that could help them.

On the whole, survey data illustrated the diversity in the ways in which Children's Centres operate across the state; some resembling service provision hubs that are acceptable to the community and others resembling community spaces that are owned by the community and run in partnership with the community. Although this diversity in engagement may be an appropriate reflection of the needs of the community, it may also reflect that an opportunity exists for some centres to improve their capacity to engage the community and work in true partnership with community. The evaluation has highlighted opportunities to develop and improve the way in which Children's Centres operate within the community and the extent to which they involve the community in the design and implementation of services and supports for families.

Recommendations:

1. Opportunities exist for Children's Centres to use population data at the community level to assess and monitor changes in child and family needs over time, and the extent to which current strategies are working to address needs.
2. Develop the vision of Children's Centres to include a clear model for how these work with or service communities. This must include: intended outcomes, means to achieve these outcomes, and supporting structures that enable implementation.

What are the referral pathways to additional support?

The Royal Commission into the Child Protection System noted a confusing early intervention support system for families in South Australia, with a dearth of information about the services and supports available to them. Families who took part in this evaluation similarly reported finding it difficult to find services before they found the Children's Centre.

In focus groups and interviews, staff, service providers, and directors spoke about Children's Centres as service provision hubs in their communities. Participants also noted that Children's Centres were connecting service providers to each other and to families. Discussions indicated that referral pathways were informal rather than formal, and relied upon relationships that were developed between individual staff within the Children's Centres and within service provider organisations.

Surveys further explored these themes and asked staff, service providers, and directors to rate referral processes and pathways across Children's Centres and the factors that facilitated these. Survey respondents tended to agree that Centres were supporting the building of local networks, and improving relationships between government and non-government agencies. Availability of additional staff (i.e. Community Development Coordinators and Family Service Coordinators) enabled Centres to attend local network meetings and connect with other service providers in the community. Staff, service provider and director survey responses about their knowledge of services in the community and the extent to which referral pathways to these services existed, highlighted an opportunity to continue to build connections to health and adult support services.

At the same time, most families reported accessing community based health services. The importance of connecting with health services to support families in children’s formative years was demonstrated by improved early uptake of services in Centres with antenatal and maternal child health services on site. Better connections with health services in the community should equally support the referral to Children’s Centres of families needing support.

An opportunity exists for Children’s Centres to become more visible as a place for families to seek support. The Community Development role in centres should routinely map all available supports and services in the community, noting restrictions on these (criteria for eligibility). At a local level this information should be routinely distributed to families through communication local services (e.g. maternal child health, general practitioners, Centrelink offices, child care centres, playgroups, and so forth).

Recommendations:

3. Promote Children’s Centres to families by strategically identifying and building referral pathways to and from agencies that are connected to families, from conception through to school age. Agencies may include: community health, hospital antenatal and paediatric services, housing services, child protection agencies, and social services.
4. At the executive level, continue to strengthen cross-agency partnerships and negotiate agreements that facilitate the strengthening or establishment of local partnerships. Cross-agency agreements should seek to address challenges to working in partnership; how information and data is shared to support the identification of the needs of families; formal referral processes; and reduction of duplication for families (e.g. reducing the need to fill in multiple enrolment forms to access a range of services at a single site).

What system level changes/supports/challenges are there to support Children’s Centres?

In focus groups and interviews, two key system level supports were reported to be enhancing the capacity of the leadership team within Children’s Centres to work in an integrated service setting. The first was the professional development program, which was said to be helping people develop an understanding of working in partnership to meet community needs. The second was the support provided by the Early Childhood Development Strategy Team, which was said to help staff from non-education backgrounds negotiate challenges they encountered in their work.

Two challenges were identified for the management of Children’s Centres. Primarily these were related to governance structures around line management and workload of directors. Surveys of staff, service providers and directors sought to quantify the extent to which these facilitators and challenges were impacting integrated service provision in Centres. Directors reported that the professional development program was a useful source of support—they both valued this and utilised what was offered. In contrast, although directors reported that the Early Childhood Development Strategy team had skills and knowledge to help them develop integrated services in their site, less than half reported that they utilised the team when they needed support in relation to establishing integrated services in their site.

An additional challenge to providing integrated services in Centres was said to be the physical structures themselves. The size and layout of buildings were spoken about frequently as either facilitating or hindering integrated service provision. This was not borne out as having an extensive negative impact; most survey respondents reported that the physical space in Children's Centres promoted the provision of integrated support to families.

Recommendations:

5. Continue to provide professional support and training opportunities aligned to the vision of Children's Centres.

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

In focus groups and interviews, parents reported that referral pathways were functioning better in Children's Centres than in standalone preschool or child care settings. However, not all parents identified improved access to services through referral pathways.

Staff, service providers, and directors noted that once families were using the Children's Centre, the capacity of staff and the quality of relationships between service providers and the Centre were important for improving referral pathways. Additionally, the increased capacity of staff to work with vulnerable children and their families, resulting from working in an integrated setting, was said to increase the rate of identification of families needing support.

Survey findings illustrated that although Children's Centres were improving referral pathways for families, there were still opportunities to make this consistent across the state. Centres were said to be supporting the early identification of children and families in need of additional supports, and the connection of families to the right service at the right time. Additionally, respondents agreed that Centres were helping to reduce duplication of services in the community, although this was not consistently reported. Three in four families reported they were able to access services and supports. Those families who reported not being able to access services they needed for themselves or for their children, tended to report difficulties in accessing both universal services and targeted supports. Barriers to accessing services tended to be cost, knowing about services, and long wait times. Families who faced additional challenges (parent or child having a disability or speaking English as a second language) reported more difficulty accessing services.

Recommendations:

6. Community Development Coordinators in Children's Centres should seek to identify gaps in services relative to population needs. These opportunities may involve addressing a lack of services or insufficient services to address the scale of the need. Mapping gaps in services must happen in all communities, irrespective of the level of disadvantage of an area.
7. At a whole of state planning level, an opportunity exists for the Department for Education and Child Development to refine the mix of universal services and targeted supports to ensure all communities have appropriate services available to them.

8. An opportunity exists to ensure that universal services to support parents are available in all communities and that these services have sufficient capacity to support the number of resident families. Further, there is an opportunity to ensure that targeted supports are matched to the scale of an issue, and resourcing reviewed with an emphasis on meeting existing need and bolstering early intervention resources that can help mitigate future need for high-cost intensive services.

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

Children's Centre's in South Australia are run on a model of distributed leadership. Whilst there have been extensive studies on the concepts and functioning of distributed leadership within schools Gronn and Hamilton (2004); Harris and Allen (2009); MacBeath (2005); Tian, Risku, and Collin (2016), there is far less work in early childhood with these studies having been carried out in an early years education environment. Distributed leadership requires that staff from diverse disciplines work together to create a holistic service with a joint vision.

In focus groups and interviews several factors related to the way in which staff work together were said to be facilitating or impeding integrated service provision. Where integration was said to be working well, staff were said to share professional knowledge; engage in shared curriculum planning; and work collaboratively to holistically support children and families. These qualities of integrated service provision were quantified in the survey of staff, service providers and directors.

Importantly, site leadership was said to be critical to the functioning of integrated teams. Specifically, the way leaders facilitated staff to work together toward a common goal. The introduction of Children's Centres in South Australia has meant the creation of a new role, that of a Children's Centre Director.

Centre directors had all previously managed a team of educators. Expansion of the staff team at sites to include staff from diverse disciplines brought with it challenges for leadership, such as the extent to which leaders felt that they had adequate control over staffing issues, when these arose. Centre Directors are required to engage with a variety of stakeholder groups (families, governing bodies, service providers), whilst ensuring quality service delivery, managing staff and resources, and completing administration and reporting obligations.

The leadership role is complex, and has been recognised as such in the literature. Leaders of multidisciplinary teams in early years settings need to be "change managers, proactive and solution focused, […] with a high degree of emotional intelligence, able to form strong relationships and work in partnership to make a difference for children and families" (Sharp et al., 2012, p. 19). To explore the extent to which Children's Centre directors worked in this way staff and service providers were asked to rate their experience of Centre leadership. Also, directors were asked to rate the extent that they felt they had the authority and capacity to manage a diverse team. This included having authority to manage staff from diverse disciplines, ability to impact on staff behaviour, and adequate input in staffing decisions to enable them to develop a cohesive team. These questions were asked to explore themes related specifically to the model of Centre leadership in the South Australian context.

Overall, respondents tended to rate both integration and leadership as working well. To examine the extent to which this differed across Centres, individual responses were combined for each Centre. This generated a site-specific rating for how well integration and leadership was working. These Centre ratings were then explored to examine the degree to which leadership was impacting integrated service delivery at sites. Leadership was rated highly in around two thirds of sites. Where leadership was not rated highly, integrated service delivery was also rated as less functional. Staff and service provider experience of leadership was related to directors' ratings of their level of control in sites. That is, where staff and service providers rated leadership highly, directors also reported feeling that they had control over the way the staff team functioned at the site.

A growing body of research suggests that effective leaders in early childhood settings positively impact on both the developmental outcomes of children and the quality of the centre as a workplace (Bloom & Sheerer, 1992; Lower & Cassidy, 2007; Rodd, 2006; Sylva, Melhuish, Sammons, Siraj-Blatchford, & Taggart, 2004; Waniganayake, Cheeseman, Fenech, Hadley, & Shepherd, 2012). Nevertheless, it is common for leaders in early childhood to have come to the position by accident or default, and are subsequently under-prepared for the role (Ebbeck & Waniganayake, 2003; Sims, Forrest, Semann, & Slattery, 2015), with many viewing themselves as practitioners rather than leaders (Moyles, 2006). In this evaluation, leaders highlighted the enormity of the workload associated with running a high-quality education site whilst also managing a multidisciplinary staff team.

Although leadership issues identified in this evaluation are not unique to South Australian Children's Centres, it is imperative that the leadership structure is further developed with a view to identifying mechanisms that support or detract from the vision of Children's Centres being realised. Leadership roles and responsibilities, along with the associated skills required and performance indicators should be created to reflect the intentions of the role. Leadership positions should be primarily linked to the management of a multi-disciplinary team rather than the management of an education site. In addition, organisational accountability of the role should be reviewed and further developed to ensure this aligns with the aims of Centres.

In South Australia, Children's Centre leadership is line-managed through regional education management structures. That is, Education Directors are responsible for line management of preschool, primary school, and secondary school sites. It would be fair to say that most Education Directors, having themselves come from a school management role (e.g. school principal), may not have an in-depth understanding of the leadership required in Children's Centres to achieve South Australia's vision for integrated service provision in the early years. Indeed, in focus groups and interviews, staff and service providers noted that when the Children's Centre leadership was not functioning well systemic supports to hold them accountable were not in place. Specifically, management by education staff who may be unfamiliar with aims and vision of Children's Centres reduces the adherence to a model of integrated service provision to meet the needs of communities.

Leadership is integral to the way in which services and supports are planned and how the staff team works together. This has flow on effects for how the community is engaged with the Centre and the extent to which Centres meet the needs of families. Management of the education program should be one facet of the leadership team, as are family support, allied health and community development.

Recommendations:

9. Further develop the leadership model for Children's Centres and consider broadening the role to recruit staff from a range of disciplines.
10. Further develop the line management model of Children's Centre leadership.
11. For new sites, recruit leaders based on capacity to manage a multidisciplinary team rather than education management experience.
12. Role descriptions for all staff should be developed to reflect key outcomes of the roles specified along with the skills required to work effectively in the role.

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

The Interim report of the focus group and interview findings highlighted that there was an opportunity to improve the functioning of governance groups in centres as their value and the rate at which they were considered relevant to the functioning of the sites varied. The governance structure developed for centres specifies the role of three governance groups—parent engagement, partnership, and leadership. The parent engagement group is described as a formal mechanism that enables the community to have a say in the centre. The parent engagement group was envisaged as giving parents the opportunity to participate in setting the agenda of the centre, the services and supports that are offered, and the strategies used to work with the community. The partnership group is specified as the formal mechanism that brings together service providers in the community to share information and engage in shared planning at a community level. The leadership group, is intended to be made up of staff representing each of the disciplines in the Centre. It was intended that this group work together to set Centre priorities, manage operational concerns, establish a shared vision, and share information to support children and families.

Findings from both the qualitative and quantitative components of the evaluation highlighted an opportunity for this governance structure to be further developed. On the whole, parent engagement and partnership groups were reported either as not operational, or functioning at a below optimal level. The extent to which other mechanisms were used to engage families and service providers in the community was not able to be determined from this evaluation. Nevertheless, agreement with the intended functions of these groups tended to be low. The ability of Centres to work with the community to plan in partnership is hampered when structures to support this are not in place or not utilised as intended. In contrast, leadership groups tended to be reported as functioning well and their envisaged functions agreed upon. These findings highlight the opportunity to further develop parental engagement, and in doing so make further gains towards achieving their goal of working inclusively and in partnership with community.

Working in partnership with the community presents challenges for government services. There is a distinction between government organisations working with community in a model of community development and government agencies engaging communities. Community engagement operates from the premise that change initiatives will have the greatest impact in communities where citizens feel part of the process, are empowered to create change and have ownership over the process. There is no consensus on how community engagement should be conducted. An extensive review of community engagement for reducing health inequalities reported on a range of community engagement models. In these, the extent of engagement ranged from limited amounts such as providing information and consulting community to more intensive engagement involving shared development of and participation in initiatives and community empowerment (O'Mara-Eves et al., 2013). Table 5.1-1 outlines the potential variation in collaboration based on whether professionals act independently or with community members to deliver services (Bovaird, 2007).

Table 5.1-1 Range of Professional-Community member relationships (Adapted from Bovaird, 2007)

		Planning involvement		
		Professionals as sole service planners	Community members as co-planners	No professional input into service planning
Service delivery involvement	Professionals as sole service deliverer	Traditional professional service provision	Traditional professional service provision with community members involved in planning and design	N/A
	Professionals and community members as co-deliverers	Community members' co-delivery of professionally designed services	Community member/professional coproduction	Community member co-delivery of services with professionals, with little formal planning or design
	Community members as sole deliverers	Community members' delivery of professionally planned services	Community member delivery of co-planned or co-designed services	Traditional self-organised community provision

The National Institute for Health and Care Excellence in the UK published NICE guidelines for community engagement in March 2016. The guidelines present the most recent review of community engagement and outline best practice principles to reduce health inequalities and ensure that health and wellbeing initiatives are effective. The guidelines were specifically developed for public health practitioners in local authorities, and translate well to the settings of Children's Centres in South Australia. Key recommendations of the guidelines include:

1. Ensure local communities, community and voluntary sector organisations and statutory services work together to plan, design, develop, deliver and evaluate health and wellbeing initiatives, by:
    - using evidence-based approaches to community engagement
    - being clear about which decisions people in local communities can influence and how this will happen
    - recognising, valuing and sharing the knowledge, skills and experiences of all partners, particularly those from the local community
    - making each partner's goals for community engagement clear
    - respecting the rights of local communities to get involved as much or as little as they are able or wish to
    - establishing and promoting social networks and the exchange of information and ideas (on issues such as different cultural priorities and values)
2. Recognise that building relationships, trust, commitment, leadership and capacity across local communities and statutory organisations needs time and:
    - plan to provide sufficient resources (see identifying the resources needed)
    - start community engagement early enough to shape the proposed initiative
    - establish clear ways of working for all those involved
    - start evaluating community engagement activities early enough to capture all relevant outcomes
3. Support and promote sustainable community engagement by encouraging local communities to get involved in all stages of a health and wellbeing initiative. Do this by:
    - identifying and working with community networks and organisations, particularly those reaching vulnerable groups or recently established communities
    - involving communities in setting priorities
4. Ensure decision-making groups include members of the local community who reflect the diversity of that community. Encourage individual members to share the views of their wider networks and others in the community.
5. Feed the results of engagement back to the local communities concerned, as well as other partners. This could be communicated in a range of ways, for example, via the local newspaper or community website, via community groups or via public events in community venues or other widely accessible places.

Recommendations:

13. Further develop the governance structure of Children's Centres and align this to the vision for Centres' work with communities.

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

The Children's Centre Outcomes Framework provides a guide to Centres to help them align their work to the overall aims of Children's Centres. Specifically, Children's Centres are tasked to provide universal services with targeted support in order to effect population outcomes in four areas:

1. Children have optimal health, development and learning

2. Parents provide strong foundations for their children's healthy development and wellbeing

3. Communities are child and family friendly

4. Aboriginal children are safe, healthy, culturally strong and confident (Department for Education and Child Development, 2011)

As a result of the Children's Centres mandate to be responsive to community need, it is expected to find variation in the range of services and supports available to families. For example, in communities where there is dearth of high quality child care available, Centres may run long day care services on site. In regional communities facing service shortages Centres may seek to address gaps in service provision. In communities that accommodate large numbers of newly arrived refugee families, Centres may establish support groups and services to meet the needs of these families. In this way, service provision across Centres will vary dependent on community context. However, it is also expected that there will be overlap in service provision, and this will be especially prominent for the types of services all families can benefit from. For instance, playgroup, parenting supports, and allied health services should be available in all Centres. This is because these types of services are general supports that are valuable to all families, no matter their context.

To examine the extent to which services across Centres varied in South Australia, administrative data from the Early Years System detailing available programs was interrogated. The data demonstrated that some Centres provided a large range of program types while others provided fewer program types. Correspondingly, some Centres ran 30 or more programs each term while others ran 10 or fewer programs. As discussed earlier in this report, the types of programs offered varied in the extent to which they were offered across sites. Parenting support services, family support, and supported playgroups were most frequently offered across Centres, followed by community groups and health services. Given that these types of programs are relevant to most communities, it is encouraging that this is reflected in the data. However, the evaluation is not able to determine with any certainty whether variation in Centres is due to community level variation or some other driver related to the capacity of Centres to deliver services.

The evaluation did not quantitatively measure the extent to which the Outcomes Framework was being utilised in Centres. In focus groups and interviews, the Outcomes Framework was discussed, with participants mentioning their uncertainty of how it should be used. Anecdotally, there have also been changes in the way this is communicated to Centres. Analyses presented earlier in this report related to families' access to services, suggests that there is an opportunity for improvement to ensure that services are appropriate to need and that all families have access to services and supports in the community. The way in which Centres work toward this should be documented and monitored at the local level and form part of any performance indicators for Centres. Specifically, to ensure that the needs of communities are met and that service provision is context dependent, Centres should document the planning process, including: identified needs, available resources, planned response, intended reach (who is the support aiming to reach), and envisioned outcomes. This will better enable Centres to monitor the extent to which services and supports meet the needs of communities.

There is potential for the Outcomes Framework to provide a template for planning and monitoring if Centres value the Outcomes Framework. It is important that Department also consider the Children's Centre Outcomes Framework within the broader array of frameworks for children. That is, any further development of the Children's Centre Outcomes Framework should be conducted alongside existing frameworks. There are a number of national frameworks for supporting children's development. Two prominent frameworks used in the early years include ARACY's Nest (Australian Research Alliance for Children and Youth, 2014) and the Early Years Learning Framework (EYLF, Australian Government, 2009). Although these documents differ in their intents and audience, both outline areas in which children's development is to be supported. A recent addition to this space is the National Interdisciplinary Education Framework for Professionals working in the Early Years (Grant, Parry, & Gregoric, 2016). This framework sets out a shared approach to supporting children and families from birth to five years. The framework also includes a statement of outcomes across five domains. Outcome areas across all frameworks align, to some extent, with outcome areas in the Children's Centre Outcomes Framework. Moreover, early years education and care programs in Children's Centres already work within Early Years Learning Framework (EYLF). Drawing this information together in a coherent way can provide Centres with a consistent approach and set of expectations to support their planning for children and families.

Recommendations:

14. An opportunity exists to develop a reporting plan and reporting framework for Children's Centres. In doing this, consider the Children's Centres Outcome Framework and how this is currently being used.

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

Data available for the evaluation was not sufficient to determine reach or dose for children and families. Determining reach and dose of Centres is critical and should be prioritised. At the outset of the evaluation, a data gap analysis was conducted to determine what data was being collected in Children's Centres. The data gap analysis also sought to inform what data should be collected administratively to report on the ongoing value of Children's Centres in the South Australian service mix. This data gap analysis identified that only Preschool, Occasional Care, and Long Day Care enrolment information was being routinely collected in Children's Centres. Enrolment and attendance data for the additional services and supports that were part of the Children's Centre mandate (e.g. community and target playgroups, parenting programs and individual parenting support), was not being collected routinely and what was being collected was stored in a range of ways at sites with no central database. The exception being the Family Service Providers, who were regularly reporting data on their activities in a spreadsheet to line management in the (then) Office for Children and Young People.

Following this data gap analysis, a proposal to extend data collection in Children's Centres to capture Family and Community Programs (FCP) use was developed in conjunction with the Office for Education and Early Childhood (then the Office for Children and Young People). The proposal was progressed and the Early Years System (capturing preschool and occasional care information for SA government preschools) was expanded to enable the capture of FCP utilisation data. In 2014, quantitative evaluation works were put on hold to enable the evaluation to utilise EYS data once this was collected. At this time, it became clear that initial ideas about how the evaluation might measure impact of Children's Centres (presented in the Three Year Evaluation Plan – see, Brinkman & Harman-Smith (2013) were not feasible within the timeframe of the data collection enhancements. An alternative set of analyses to report on the range of services available in centres and who was accessing these services, and the impact of attending preschool in a Children's Centre site was developed.

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

Where data was entered, it was evident that the vast majority of children were enrolled for a single service during a term in a Children's Centre, with few children making use of multiple services. Although reach and dose could not be determined, the limited service provision data that was reported was analysed to examine whether particular population groups had better access to services in Children's Centres than did others. Demographic distributions for children using Centres were compared to the South Australian demographic distributions to examine the extent to which children attending Centres are representative of all children in SA. These findings should be considered preliminary until more comprehensive data is available.

Compared to SA population distributions, children attending Centres tended to live in more disadvantaged areas, come from an Aboriginal background, and live in remote areas of the state. Children from CALD backgrounds appeared to be under-represented in the group of children attending a Children's Centre. There were also demographic differences in the extent to which families used universal and targeted services. Children with an Aboriginal background had higher rates of preschool and health service usage when compared to the composition of the population. Families living in areas with high socio-demographic disadvantage were more highly represented in universal service usage data for all program types except for playgroup. In contrast, targeted supports tended to be more heavily utilised by families living in more socio-economically advantaged suburbs, and families who are from English speaking backgrounds. There was mixed representation in service usage data for families living in regional and remote regions, with some services more heavily utilised and others underutilised. No population comparisons could be drawn for children under the Guardianship of the Minister (GOM). However, overall these children tended to have low reported universal service use—with most children enrolled only in preschool and several of these receiving preschool supports.

These preliminary findings indicate that although Children's Centres are located in areas of higher need, and thus attract families from suburbs with greater socio-economic disadvantage, additional supports in Children's Centres tended to be utilised more heavily by families from less disadvantaged communities. In the first national evaluation of Sure Start, adverse effects of the program were reported for the three of the 14 outcome variables for the most vulnerable populations when compared with those families in communities with no Sure Start centre (Belsky et al., 2006). It was postulated that this finding may have resulted from a paucity of service use in Sure Start Centres by families in the community facing the greatest barriers to service access—with services being primarily utilised by families facing fewer barriers.

Although a paucity of service use data limits the ability of the evaluation to definitively determine reach of services, the evaluation highlights the importance of administrative data collected in centres being used to monitor the effectiveness of any targeting strategies. That is, examining whether the program or service is reaching the people who need support. It must be noted that it is not sufficient to target programs based solely on demographic characteristics of families. Instead, Children's Centres should continue the work they already do to build trusting professional relationships with families that enable them to feel comfortable to share information about challenges they are facing. Referral pathways into the targeted services provided through Children's Centres should be investigated to understand why higher need families are not accessing the services. To enable those families who may not feel as comfortable talking to staff about their challenges, Centres should consider using intake forms and routine assessments of support needs. Intake procedures for targeted programs should assess child and family challenges so that these can be best fitted to available programs or supports.

Recommendation:

15. Investigate barriers impacting on the collection and entering of enrolment and attendance information for Family and Community Programs.
16. An opportunity exists to respond to identified challenges and enablers by consulting with Children's Centre staff to design and implement a strategy to improve the capacity of sites to collect and enter data.
17. Mandate administrative data collection in the same way it is mandated for other government provided services.

18. Consider implications of mandating data collection for service provision partners and what data sharing agreements will need to be negotiated at an agency level to best support planning and program monitoring.
19. Refine assessment and intake criteria and associated processes for the additional targeted support services.
20. An opportunity exists to design intake assessments in such a way that specific needs of families are matched to available services and that these are delivered as locally as possible.
21. Continue to engage all families in the community in universal services. Where universal services in Children's Centres are at capacity, connect families to similar services in the community.
22. Geographical boundaries for services should only exist for services that are available in each community to ensure that the capacity of each service point is utilised.
23. Opportunities exist for Children's Centres to create strong links between all Early Childhood Education and Care services (government and private long day care and preschool providers) and community health across suburbs to ensure all families have access to additional services and supports that have been located in Children's Centres for the benefit of the whole community (rather than solely the children attending ECEC services in a Children's Centre).

An additional recommendation is made in light of the findings of the Child Protection Systems Royal Commission Report. This recommendation is made along with three points for consideration.

24. Consider the role Children's Centres might play in the prevention/early intervention arm of a reformed child protection system in SA.

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

In focus groups, Children's Centres were spoken about as positively impacting on parents' wellbeing, parenting capacity and parenting practices. Support for parents and parenting happened through the provision of programs, but also through interaction with the Children's Centre staff, who were said to be supportive, understanding, and to have a greater capacity to promote positive parenting practices. Parents said that they were able to talk to staff about any parenting challenges because they knew staff were on the same page as them and could offer helpful ideas about things to try. Parents felt supported in their role through interactions with staff.

Additionally, parenting programs were spoken about as improving the way parents interacted with their children and with their partners. Parents also reported that attending Centres connected them to other parents in the community and in this way built peer-support networks. To explore quantitatively the impact of attending a Children's Centre on parental wellbeing, parenting practices and social connectedness, the parent survey included a number of validated parenting and wellbeing scales.

Parents using services in Children's Centres reported good overall wellbeing and rated themselves positively as parents. Parents also reported engaging in parenting practices that reflected high parental warmth and low levels of hostile parenting. Parents reported that they frequently spoke to their children about their behaviour, the consequences of behaviours, how behaviours impact on others, and the need for rules. In comparison to the favourable responses for other scales, parents reported less consistency in their parenting behaviours. Parents also reported having high levels of social support. Additional analyses were conducted to examine the extent to which this varied across demographic groups, with differences noted for a number of groups of parents. Specifically, parents with a health condition or disability, parents of children with a health condition or disability, parents with more children, parents in their early 20s, and single parents reporting less favourable outcomes. Parenting, wellbeing and social connectedness did not differ uniformly across these groups of parents. Instead, these appeared to be related to the unique challenges faced by each group. For example, single parents reported less social support and parents with five or more children reported feeling greater time pressures.

Although the evaluation sought to compare the parenting outcomes of families using Children's Centres to those not utilising Centres, insufficient survey responses were received from families not using Centres. A similar survey of families using an integrated service or those not using such services was conducted as part of the evaluation of Tasmanian Child and Family Centres (Taylor et al., 2015). The Tasmanian evaluation reported similar levels of parenting self-efficacy ratings and social supports as reported here irrespective for both service users and those families not using services.

Self-report parenting measures provide some insight into the mechanisms that may be supporting children's development. Instead of providing a decisive conclusion about the impact of Centres, these measures are better used to differentially identify needs of families and whether these are being met for all families using Centres. Moreover, findings derived from self-report measures should not be considered definitive, but rather should be viewed alongside other outcomes data. In this way, a more complete story can be told about the ways in which Children's Centres enhance the outcomes of children.

The evaluation did not seek to measure the specific impact of the various range of parenting supports and programs available in Centres. Instead, this type of evaluation should be routinely conducted at the Centre or program (where it is being delivered across a number of sites) level. Collecting information about the impact of specific parenting supports on parents can also help to evaluate the appropriateness of these programs for addressing identified needs. Although Centres usually select evidence-based programs when seeking to implement supports for parents, there is little information about the extent to which these are implemented with fidelity and whether desired impacts are achieved. For such evaluation at the local level, it is important that measures are selected that are aligned with the desired outcomes. For instance, a parenting program that seeks to improve parent-child attachment should seek to collect information about parent-child attachment pre and post program. Measures should be selected that have been validated and found reliable and sensitive to change.

Recommendations:

25. Opportunities exist to measure and evaluate the impact of targeted supports, such as parenting programs or supported playgroups, to ensure these are having the desired effect for the target issue they seek to improve.

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

Earlier identification of children's needs

The model of integrated care in a preschool setting is intended to support families to connect to services and supports early. Children's Centres bring together a range of education, health and family support staff. These staff offer a range of 'soft touch' supports (such as playgroups, community groups, and information provision) alongside targeted supports for children and families with complex needs. Bringing together diverse staff and services is intended to improve service coordination and referral process as well as enhance the capacity of staff to identify the needs of children and families. In focus groups and interviews, staff, service providers, Centre Directors, and families identified this as a key benefit of Children's Centres. Although this was reported anecdotally, this was not reflected in the linked AEDC and preschool data. While it is possible that Children's Centres are not systematically supporting early identification of children's additional needs, there are a number of possible explanations for this finding. The data included in the analyses utilised preschool enrolment data which is unlikely to accurately reflect the earlier use of Children's Centres. That is, not all of the children who attended preschool in a Children's Centre will have used additional services within the Centre. In the data presently available, there is no way to identify who has used services before preschool and who has only attended preschool. It is also not possible to identify children who may have utilised services in a Children's Centre but attended a standalone preschool. Another explanation is that a single year of preschool does not provide enough contact with non-education staff who work in Children's Centres that this is sufficient in and of itself to enable earlier identification of additional needs. At this stage, available data does not permit direct analysis of the benefits of integrated services before preschool. Enrolment and attendance data for all services offered in Children's Centres is required to comment on the extent to which these services are enabling early identification of children's needs.

Improved child development outcomes

Through early identification of children's needs and timely referrals to appropriate services and supports Children's Centres are thought to have the potential to improve the developmental outcomes of children. In addition to the benefits of early intervention, the parenting support provided within Children's Centres has the potential to improve the children's early experiences in the home environment, thus lead to improved developmental outcomes for children. Anecdotally, focus group and interview participants highlighted this as a key benefit of Children's Centres. In the present study, analyses of the linked AEDC and preschool administrative data were conducted to explore the developmental outcomes of children who attended either a standard or Children's Centre preschool. The AEDC provides a holistic snapshot of children's development across five domains (physical health and wellbeing, social competence, emotional maturity, communication skills and general knowledge, and language and cognitive skills). No differences between children who attended a standard or Children’s Centre preschool were found on any of these AEDC domains. Again, limitations in presently available data about the services children accessed in Children’s Centres before school, may make it difficult to detect any impacts Children’s Centres are having. What is clear is that attending preschool in either a standard or Children’s Centre preschool is likely to be equally beneficial. Who is accessing earlier services, what services they are accessing, and how this supports children’s development will be able to be explored as data collections in Children’s Centres improve.

Recommendations:

No additional recommendations are made. Recommendations 17 and 25 are further supported by the findings of these analyses.

6. Conclusion

It is important to note that the initial aims and scope of the evaluation were developed in 2012. Since that time there have been a number of changes in the South Australian service provision landscape for children and their families, hence, it is important to consider the findings of this evaluation in light of these changes. Here we consider the service system in South Australia, recent changes, and the potential role for Children's Centres in the changing service provision landscape.

At the commencement of this evaluation in 2012, Children's Centres were considered a pilot project. The first two centres in South Australia were established in 2005. By 2009 an initial nine centres were operational. In 2010 a report published about the characteristics of families attending the first seven Children's Centres (Luddy, Lynch, & Sawyer, 2010) noted that limited data was available to assess what services and supports were available in sites and who was accessing the available services. A further 18 centres were progressively opened during 2010–2012, and a further 15 centres have been opened since the commencement of this evaluation in mid-2012.

In addition to the growth of the Children's Centre program, there have also been some changes to the range of services offered in Children's Centres—specifically the addition of the provision of community based antenatal services in five sites. This has provided families with connections to support in their community within a routine care environment, which can help support them beyond the birth of their child. Arguably this has been an important addition in improving the potential to provide early intervention and supports at a time that is critical for children's development. Indeed, there is a dramatically increasing body of evidence showing that the pathways to some adult diseases start in utero and early childhood. Whilst there may still be some residual tension with the 'traditional' public health groups who believe that the most important pathways involve adult lifestyle exposures (i.e. lifestyle health choices that are made by adults that can be impacted through public health campaigns and so forth) there is increasing realisation that the opportunities for prevention and public health interventions may be expanded by better understanding how the early pathways to disease start (Lynch & Davey-Smith, 2005). There is now clear evidence that a combination of exposures and social circumstances during childhood crucially influences health inequalities across the whole life course (Marmot, 2010).

Globally, an increasing investment in early years services have stemmed from a growth in the understanding of the importance of these early years, not only for later health outcomes but also as a critically important time in brain development (Gable & Hunting, 2000). Early childhood experiences have a decisive impact on the architecture of the brain, and on the nature and extent of adult capacities (Shore, 1997). The environment that shapes child development includes family and the immediate neighbourhood as well as the socio-economic, political, and cultural context. Children who have endured negative early life experiences are more likely to suffer mental and physical health problems, participate in delinquent activities, drop out of school and face prolonged unemployment (Hertzman & Wiens, 1996; Kuh & Ben-Shlomo, 1997; Robins & Rutter, 1990; Willms, 2002; Zubrick, Williams, Silburn, & Vimpani, 2000). For service systems aimed at supporting families, it is therefore critical that we examine the extent to which we reach families during this critical time.

Amid this expansion of the Children's Centres program, there have also been a number of important investigations of the functioning of the South Australian Child Protection System (Child Protection Systems Royal Commission, 2016; State Coroner, 2015) and subsequent revisions to thinking about how vulnerable children and families are supported in South Australia. The Child Protection Systems Royal Commission Report made a case for the importance of intervening early by presenting three arguments for the evidence for early intervention:

1. Early intervention offers an opportunity to interrupt painful, adverse experiences for children that can damage their later development and opportunities.
2. Damage caused by abuse and neglect is difficult to reverse.
3. It is costly to try to solve these problems in adulthood and early interventions are often a more cost-effective use of public resources.

Early intervention (in the primary and secondary services space) must consider the role of both universal services and targeted supports. A contraction of the universal service base in the interests of providing greater targeted supports is likely to have adverse impacts for large numbers of children. This is because, in the absence of a strong universal service base that is available to provide light touch supports to all families, children and families' needs will go unidentified until these become critical.

Light touch supports during children's formative years, when all families face some challenges, can help keep children and families on track and prevent them from needing more intensive supports. Indeed, the National Framework for Protecting Australia's Children (2009–2020) (Council of Australian Governments, 2009) called for the provision of both universal and targeted supports to families early to reduce the risk of children and families entering the statutory child protection system. Among a range of services for vulnerable families in South Australia, Children's Centres were noted in the mix of services as a place where families could access universal supports in a non-stigmatising space and be supported to access targeted supports where additional needs become evident.

Certainly, in its assessment of the functioning of the child protection system in South Australia, the Royal Commission Report (Child Protection Systems Royal Commission, 2016) stated the importance of universal and targeted support mapping at a community level. The Royal Commission's review of the early intervention service system in South Australia found a difficult to navigate mix of services with unclear referral pathways and stated that:

"Effective prevention and early intervention require an integrated system of primary, secondary and tertiary interventions (whether delivered by government, not-for-profit or community organisations) to identify and respond to the needs of vulnerable and at-risk families and their children. A public health approach, as advocated in the National Framework, involves more than providing generic services that fit the intensity level of universal, secondary and tertiary responses. It requires identifying and addressing the risk factors that compromise the safety of children in families, and delivering services that respond to those needs." (Child Protection Systems Royal Commission, 2016)

The extent to which Children's Centres have a role in or the capacity to undertake such community mapping of need should be further explored. A recent review of the role of Community Development Coordinators in Children's Centres (Harman-Smith & Brinkman, 2016) highlighted the opportunity to utilise this resource more effectively to support a greater number of children and families across the State. In Justice Nyland's call for reform of early intervention and service coordination, she stated that effective prevention and early intervention relies on:

- selecting and funding appropriate, evidence-based service models;
- robustly identifying vulnerable families, assessing their needs and referring them to evidence-based services; and
- coordinating support services with coherent referral pathways, and committing to share information and promote collaborative practice.

Given the range of services and supports available in Children's Centres, their capacity to support families holistically, and their child development expertise, the Department must consider the role Centres play within an effective early intervention and service coordination system. Children's Centres represent a large investment, but more importantly they are uniquely places that are for children and their families. Therefore, it is vital that Centres operate on a premise of using the best available data to understand the needs of the whole community; develop processes for effectively and efficiently identifying families who may need additional supports; and providing timely referrals to evidence based programs that address identified needs.

Children's Centres must do more than provide evidenced-based programs alone and to fill these with families who may be attending centres. Key to providing an equitable service system is identifying who may be missing out on services, what barriers are preventing those families from accessing appropriate and timely supports, and what needs to change to support the families who are falling through the gaps. This is a task that Children's Centres cannot undertake on their own. Fraser Mustard (Mustard, 2008) identified this need for joined up services in 2008 and there is still a way to go to realise this vision for all families.

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8. Appendices

Appendix A—Invitation letters

Appendix B—Consent text

Appendix A—Invitation letters

- Director Invitation Letter
- Parent Invitation Letter (parents who had used services in a Children’s Centre)
- Parent Invitation Letter
- School Principal Invitation Letter
- Staff and Service Provider Information Letter

Information letter – Director and Heads of School Early Years

Children's Centre - Survey

Children's Centres bring together a range of services for children, families and communities in South Australia. We are investigating how these services work together and what benefits there might be for children, families and communities. As a Director or Head of School Early Years of a Children's Centre, we invite you to complete a questionnaire that asks you about your experiences of Children's Centres.

Participation
Participation will involve completing an online questionnaire that will take about 20 minutes. We will ask you questions about your experience of managing integrated service provision in a Children's Centres and impacts of this model of service that you see for children, families and communities.

Risks
There are no known or anticipated risks to you from participation in this research.

Confidentiality
All information you provide will be kept confidential and grouped with responses from other participants. The information you provide will be treated with strict confidence and kept secure. Although there is no intent to identify individuals, from the information you provide, it may be possible for the researchers to identify you. We need to collect this information to be able to match the perceptions of staff as to how the Children's Centres are working, to the perception of families attending the same service, however, all information collected will be stored securely and access to this information will be limited to members of the research team only and no names of participants or organisations will appear in any reports.
The information collected will be kept in a physically and digitally secure environment for a period of seven years at the Telethon Institute for Child Health Research.

Right to withdraw
You can choose to withdraw from this research at any time. However, once you have completed and submitted the questionnaire we won't be able to withdraw your responses, because all responses become anonymous once they are submitted.

If you have any questions about participation in this research, please feel free to contact Dr Yasmin Harman-Smith on 0438 112 418.

If you are interested in receiving a copy of the report of these research findings, please contact Dr Yasmin Harman-Smith at yasminh@ichr.uwa.edu.au.

Ethics approval for this study has been granted by SA Health Human Research Ethics Committee.

Should you have comments or concerns resulting from your participation in this study, please contact Dr David Filby (8226 6367, SA Health Human Research Ethics).

Information letter - Parent

Children's Centre - Survey

Children's Centres bring together a range of services for children, families and communities in South Australia. We are investigating how these services work together and what benefits there might be for children, families and communities.

As a parent who has used a service in a Children's Centre, we invite you to complete a questionnaire that asks you about your experiences of Children's Centres. The questionnaire also asks you about your experience of being a parent.

Participation

Participation will involve completing a questionnaire that will take about 20 minutes. We will ask you questions about your experience with Children's Centres, parenting and your wellbeing. You can complete the questionnaire online or in paper copy. Paper copies are available in the Children's Centre and can be returned to a sealed box in the Children's Centre.

Risks

There are no known or anticipated risks to you from participation in this research.

Confidentiality

All information you provide will be kept confidential and grouped with responses from other participants. The information collected will be kept in a physically and digitally secure environment for a period of seven years at the Telethon Kids Institute.

Right to withdraw

You can choose to withdraw from this research at any time. However, if you complete the questionnaire online we won't be able to withdraw your responses once you have completed and submitted the questionnaire, because all responses become anonymous once they are submitted.

If you have any questions about participation in this research, please feel free to contact Dr Yasmin Harman-Smith on 0438 112 418.

If you are interested in receiving a copy of the report of these research findings, please contact Dr Yasmin Harman-Smith at yasmin.harman-smith@telethonkids.org.au.

Ethics approval for this study has been granted by SA Health Human Research Ethics Committee.

Should you have comments or concerns resulting from your participation in this study, please contact Andrew Alston (8226 6367, SA Health Human Research Ethics).

Information letter - Parent

Children's Centre - Survey

Children's Centres bring together a range of services for children, families and communities in South Australia. We are investigating how these services work together and what benefits there might be for children, families and communities.

As a parent of a child who has recently started school, we invite you to complete a questionnaire that asks you about your experiences of accessing services before your child started school. The questionnaire also asks you about your experience of being a parent.

Participation

Participation will involve completing a questionnaire that will take about 20 minutes. We will ask you questions about your experience of accessing services, parenting and your wellbeing. You can complete the questionnaire online or in paper copy. Paper copies are available in your school and can be returned to a collection envelop at the school.

Risks

There are no known or anticipated risks to you from participation in this research.

Confidentiality

All information you provide will be kept confidential and grouped with responses from other participants. The information collected will be kept in a physically and digitally secure environment for a period of seven years at the Telethon Kids Institute.

Right to withdraw

You can choose to withdraw from this research at any time. However, if you complete the questionnaire online we won't be able to withdraw your responses once you have completed and submitted the questionnaire, because all responses become anonymous once they are submitted.

If you have any questions about participation in this research, please feel free to contact Dr Yasmin Harman-Smith on 0438 112 418.

If you are interested in receiving a copy of the report of these research findings, please contact Dr Yasmin Harman-Smith at yasmin.harman-smith@telethonkids.org.au.

Ethics approval for this study has been granted by SA Health Human Research Ethics Committee.

Should you have comments or concerns resulting from your participation in this study, please contact Andrew Alston (8226 6367, SA Health Human Research Ethics).

Information letter – School Principals

Children's Centre - Survey

Children's Centres bring together a range of services for children, families and communities in South Australia. We are investigating how these services work together and what benefits there might be for children, families and communities. As a School Principal in a region that has a Children's Centre, we ask for your support to recruit the parents of children who have commenced in reception in your school this year.

Parents who volunteer to take part will be asked to complete a brief survey, either online or in hard copy, that asks about their experiences of accessing services and supports for their child in the year before commencing school. The survey also asks some questions about people's experience of being a parent.

Risks

There are no known or anticipated risks to parents from participation in this research.

Confidentiality

All information parents provide will be kept confidential and grouped with responses from other participants. The information collected will be kept in a physically and digitally secure environment for a period of seven years at the Telethon Institute for Child Health Research.

Right to withdraw

Parents can choose to withdraw from this research at any time. However, once they have completed and submitted the online questionnaire we won't be able to withdraw their responses, because all responses become anonymous once they are submitted.

A researcher from the Fraser Mustard Centre, Telethon Kids Institute will contact you in the coming weeks to discuss recruitment of families through your school. If you would prefer not to be contacted, please email yasmin.harman-smith@telethonkids.org.au.

In the meantime, if you have any questions about this research, please feel free to contact Dr Yasmin Harman-Smith on 0438 112 418.

If you are interested in receiving a copy of the report of these research findings, please contact Dr Yasmin Harman-Smith at yasmin.harman-smith@telethonkids.org.au.

Ethics approval for this study has been granted by SA Health Human Research Ethics Committee and approval to recruit parents through DECD school sites has been granted by DECD.

Should you have comments or concerns about this study, please contact Dr David Filby (8226 6367, SA Health Human Research Ethics).

Information letter – Staff and Service Providers

Children's Centre - Survey

Children's Centres bring together a range of services for children, families and communities in South Australia. We are investigating how these services work together and what benefits there might be for children, families and communities.

As a person working in or working with a Children's Centre, we invite you to complete a questionnaire that asks you about your experiences of Children's Centres.

Participation

Participation will involve completing an online questionnaire that will take about 20 minutes. We will ask you questions about your experience of working in or with Children's Centres and impacts that you see for children, families and communities.

Risks

There are no known or anticipated risks to you from participation in this research.

Confidentiality

All information you provide will be kept confidential and grouped with responses from other participants. The information collected will be kept in a physically and digitally secure environment for a period of seven years at the Telethon Institute for Child Health Research.

Right to withdraw

You can choose to withdraw from this research at any time. However, once you have completed and submitted the questionnaire we won't be able to withdraw your responses, because all responses become anonymous once they are submitted.

If you have any questions about participation in this research, please feel free to contact Dr Yasmin Harman-Smith on 0438 112 418.

If you are interested in receiving a copy of the report of these research findings, please contact Dr Yasmin Harman-Smith at yasmin.harman-smith@telethonkids.org.au.

Ethics approval for this study has been granted by SA Health Human Research Ethics Committee.

Should you have comments or concerns resulting from your participation in this study, please contact Andrew Alston (8226 6367, SA Health Human Research Ethics).

Appendix B—Consent text

Consent to take part in online Questionnaire

All participant groups

Thank you for taking part in this study being undertaken by the Fraser Mustard Centre, the Telethon Institute for Child Health Research.

The information you provide will help build a better understanding of the facilitators and barriers for providing integrated services for children and families in Children's Centres, and the impact of Children's Centres on children, families and communities.

The anonymous questionnaire takes about 20 minutes to complete. By completing it, you will be indicating your consent to participate. It will not be possible to withdraw your consent after finishing and submitting your answers, because individual responses won't be identifiable. However, if you do decide to participate but then change your mind before finishing the questionnaire, simply close your web browser.

The information you provide will be treated with strict confidence and kept secure. Access to study information will be limited to members of the research team and no names of participants or organisations will appear in any reports.

The research has been approved by the SA Health Human Research Ethics Committee. If you have any questions about the study, feel free to contact Yasmin Harman-Smith by phoning 8207 2089 or emailing Yasmin.harman-smith@telethonkids.org.au

ABOUT THE FRASER MUSTARD CENTRE

Working together to improve the development, education, health and wellbeing of young Australians, the Telethon Institute for Child Health Research and the South Australian Department for Education and Child Development have joined forces in a unique approach to research translation. The Fraser Mustard Centre collaboration aims to:

- Improve and promote the health and wellbeing of all children and young people in South Australia through the unique application of multidisciplinary research
- Help shift focus from the historical delineation between health and education services to an integrated approach with a focus on child development
- Build capacity amongst public sector staff and academic researchers to design, undertake and use research to improve the environments in which children live and the service systems which support families
- Attract funding for shared priorities for research that leads to improved developmental, education, health and wellbeing outcomes for children.

The Fraser Mustard Centre brings forward-thinking policy makers and world class child health researchers. It reflects a shared view of policies and outcomes for children and young people. The Centre is a unique collaboration between two organisations passionate about making a difference.

A COLLABORATION BETWEEN

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