Better Together: Strengthening the effectiveness of an Infant Mental Health Intervention in a System of Care in Western Australia

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Ypsilanti, MI
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Disclaimers

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The authors report no conflicts of interest.

Acknowledgement of Country

ECU is committed to reconciliation and recognises the traditional custodians of the land upon which its campuses stand and their connection to this land. We acknowledge and offer our respect to Aboriginal and Torres Strait Islander Elders and Aboriginal and Torres Strait Islander people.

Meet the Team: Edith Cowan University Faculty

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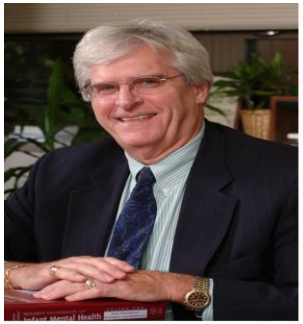

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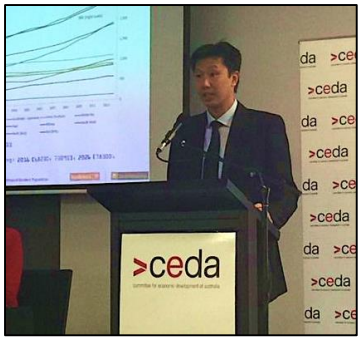

Dr Kenneth Leong

Better Together Transdisciplinary Team

Edith Cowan University	Primary Focus
Lynne Priddis, Clinical Psychology (Team Leader)	Mental Health & IMH*
Rochelle Matacz, Clinical Psychology	P2P Clinic & IMH*
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Julie Ann Pooly, Community Psychology	Consumer
Carolyn Barratt-Pugh, Education	Early Childhood Education

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Daniel Kiely, Economics	Systems Analysis, GIS
Alan Duncan, Economics	Systems Concepts
Kenneth Leong, Economics	Systems Mapping

Michigan State University	
Hiram E. Fitzgerald, Developmental Psychology	Systems Change, IMH*
Jessica Barnes-Najor, Developmental Psychology	Social Network Analysis

Reference Group Chair (Community)	
Fiona Reind	Participant Involvement (PAR)

*IMHE IV®

WA Primary Health Alliance (WAPHA)

WA Primary Health Alliance (WAPHA) is a planning and commissioning body which works in partnership with like-minded health organisations, clinicians and communities to build a robust and responsive patient centred primary health and social care system.

Ethics Committees: Approved by Western Australia Government Departments of Health and Communities; King Edward Memorial Hospital, Edith Cowan University, and Joondalup Health Campus

PIMH system in Western Australia

The PIMH systemic preventive-intervention framework:

- Is informed by the rapid advances in scientific understanding of experiential effects on gene expression (epigenetics).
- Provides a framework for prevention or intervention of adverse childhood experiences (ACES) and other indicators of risk.

The PIMH framework infused into Western Australia's System of Care, provides an avenue to promote or intervene in relationship issues within a system of social and health support.

Defining the PIMH Workforce in Western Australia

PIMH workforce characteristics:

- Diverse disciplines
- Fluid organisations
- Traditional siloed departments delivering specific mandated services
- Gaps exist in knowledge, skills and policy

No systems lens has been applied to understand the forces at play to bind the Western Australian PIMH system within the status quo.

Why a Systems Change Approach?

- PIMH is designed within the context of relational developmental systems (RDS)

- RDS change efforts, such as PIMH, strive to improve human service and community systems in order to create better and more equitable outcomes for consumers

- Changing a system has greater and more lasting impact than do efforts to “fix” one component of the system in isolation

ADVERSE CHILDHOOD EXPERIENCES

CONTINUUM OF ADVERSITY

ACES: Many biopsychosocial factors that additively predict poor developmental outcomes

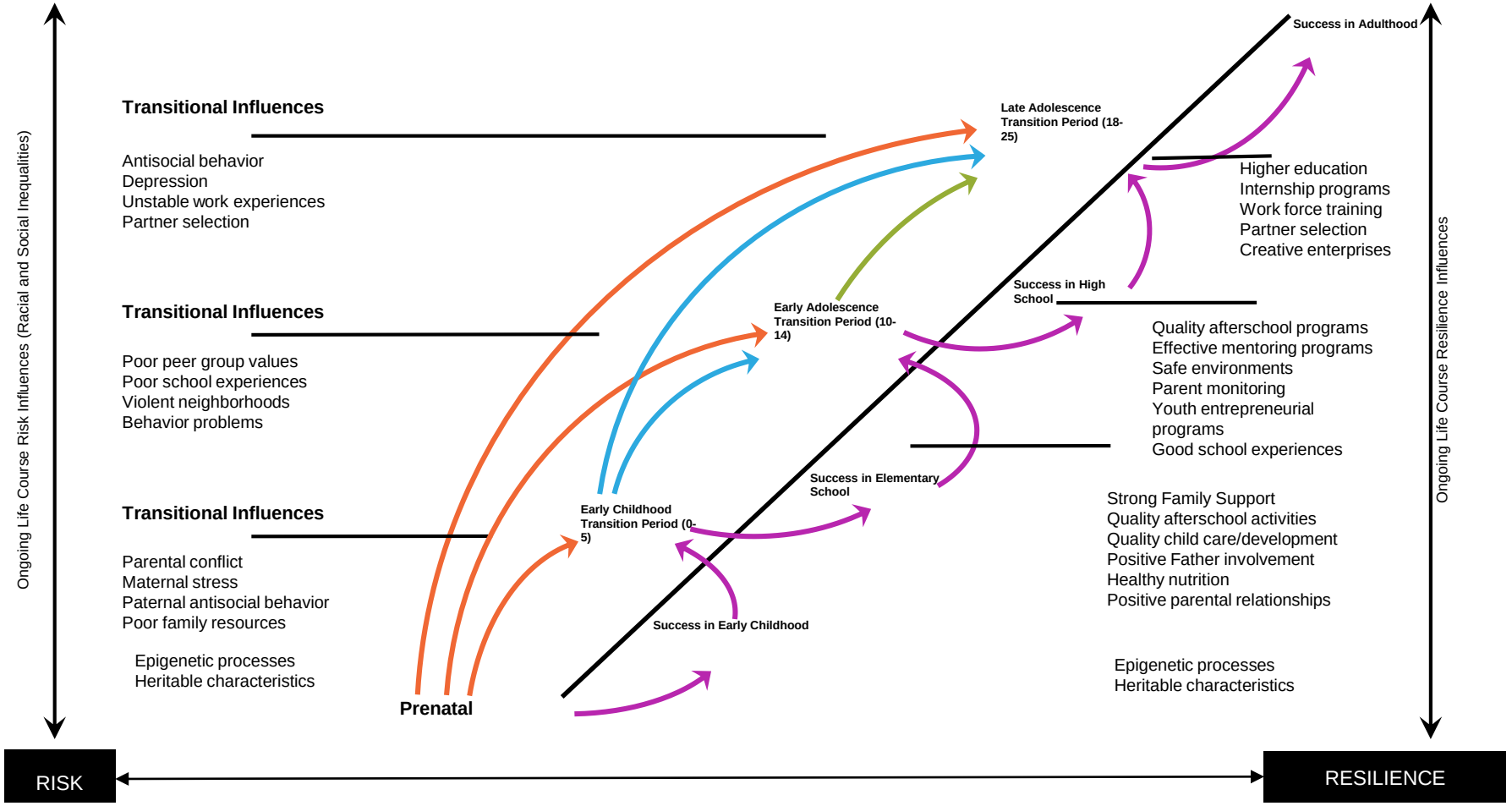
TRAUMA: Extreme frightening, harmful, or threatening event that has intense impact with long term effects.

TOXIC STRESS: Chronic exposure to ACES or Traumatic Events without supportive caregiving

Systemic Sources of Risk Development

- **Through Family Characteristics**
  - Children of alcoholics and other drug-using parents
  - Children of parents with antisocial personality disorder
  - Children of parents with clinical depression
  - Children of parents in conflict
  - Children of parents with low family resources
  - Children with poor prenatal & perinatal histories
- **Through Individual Characteristics**
  - Externalizing behavior, aggression, behavioral undercontrol, oppositional defiant disorder
  - Negative emotionality, depression
  - Attention problems, ADHD
  - Shyness, social withdrawal, social phobias
  - Biological diathesis (genetic, congenital, perinatal)
- **Through Social Environments**
  - High drug use environments
  - High stress environments (violence, poverty, unemployment)
  - Chronic exposure to toxic risk

Transitional Periods: Dynamic Factors Affecting Positioning on the Risk-Resilience Continuum from Conception to Adulthood.



Fitzgerald, H. E., & Puttler, L. I. (2018). *Alcohol Use Disorders: A Developmental Science Approach to Etiology*, New York: Oxford University Press..

Prevalence of Specific Reported Adverse Childhood Experiences (ACEs), Total and Age

Adverse Childhood Experiences	**National Percentage of Children**			
	All	0-5	6-11	12-17
Low Income	26	25	26	26
Separation/Divorce	20	10	22	28
Family Alcohol/Drug problems	11	6	12	15
Family Mental Illness	9	6	8	12
Witness Neighborhood Violence	9	3	8	14
Witness Domestic Violence	7	4	8	10
Parent Incarcerated Sometime	7	5	8	8
Parent who Died	3	1	3	5

Percent of children nationally with 0 (54%), 1-2 (35%) or 3+ (11%) adverse experiences (aged birth to 17).

74.2 Million children: .11 x 74.2 = **8,162,000 children with 3 or more ACES**

Adapted from Table 3: Sacks, Murphey, D., Moore, K. (2014). Adverse childhood experiences: National and state-level prevalence. Washington, DC: Child Trends. Childtrends.org

Australian Temperament Project:

recruited at 4-8 mo old; data from 27-28 yrs old

4 or more ACES

Emotional abuse
Physical abuse
Sexual abuse
Neglect
Parental separation
Domestic Violence
Household Mental Illness
Household Drug/Alcohol Abuse

Odds ratios increased risk at age 27-28:	OR
Formally charged by police	6.1
Non Driving offense	4.0
Driving offense	1.5
Baby before age 22	10.2
Chronic health problems	1.8
Physical health problems	2.9
Mental health problems	2.3
Drank alcohol 5+ times weekly	1.7
Binge drinking	0.8
Daily smoking	2.6
Marijuana use	1.9
ASB Score highest level	2.9
High school dropout	2.5
Main source of income: Gov.	2.8

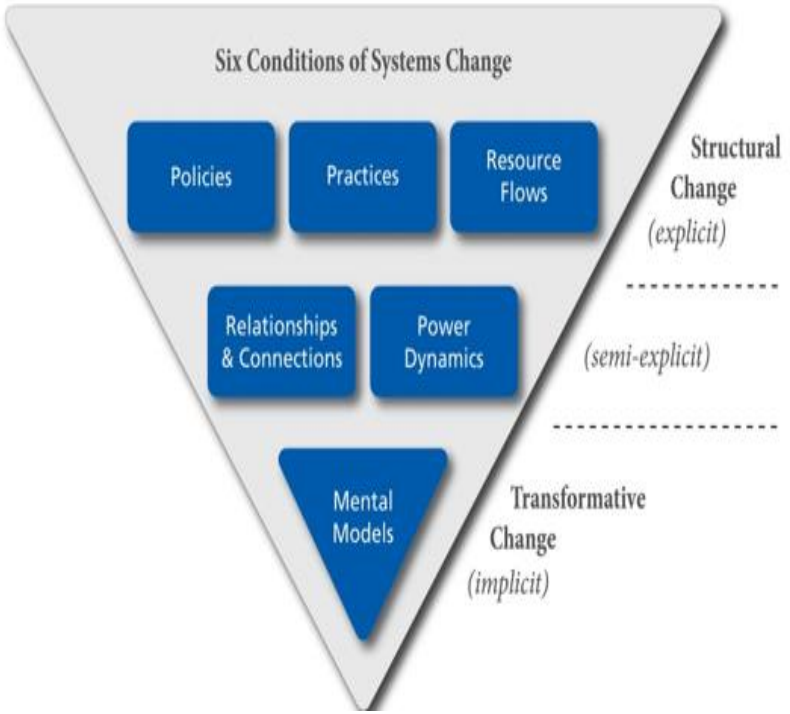
Doidge, J. C. (2016). The epidemiology of adverse childhood experiences in Australia. Doctoral dissertation, University of South Australia, Adelaide

Systemic Engagement

Principle	
Systems Thinking	Boundaries, Perspectives, Relationships
Collaborative Inquiry	Partnership Team/Multiple Knowledges
Support for On-Going Learning	Communities of Learning
Emergent Design	Co-Construction, CBPR, Developmental Evaluation
Multiple Strands of Inquiry and Action	Multi-Method, Multi-participant
Transdisciplinarity	Multiple Disciplines Multiple Stakeholders (Shareholders)

McNall, M. A., Barnes-Najor, J. V., Brown, R. E., Doberneck, D., & Fitzgerald, H. E. (in press). Systemic engagement: Universities as partners in systemic approaches to community change. *Journal of Higher Education Outreach and Engagement*.

Figure 1: Conditions of systems change (Kania et al., 2018)



System level policies and practices for mandated services and consumers

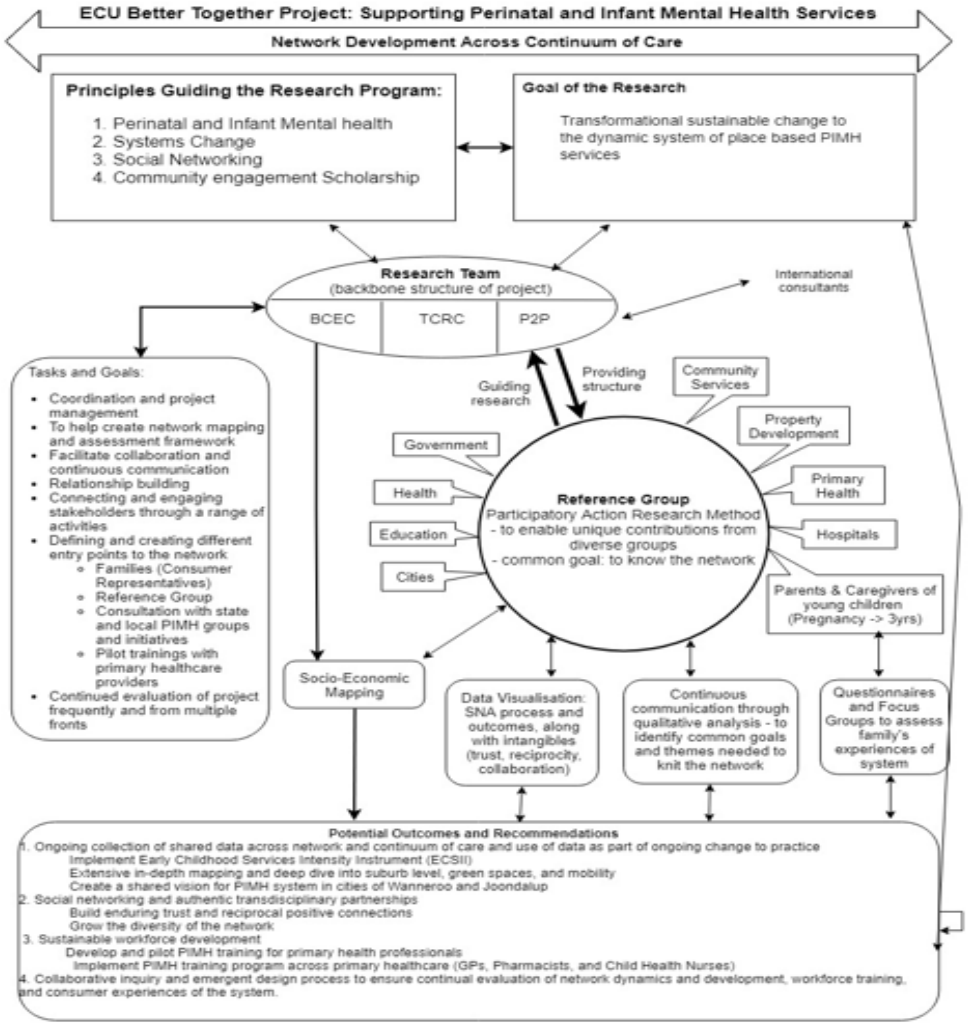
Organizational policies and practices and consumers

Individual practitioners and service delivery and consumers

PERINATAL INFANT MENTAL HEALTH SYSTEMS CHANGE MODEL

Priddis, L. (2018). Better Together Project, Annual Report. Edith Cowan University

Figure 3: Conceptual model



Source: Matacz, Priddis and Lauren, 2018

Economic and Social Context


INDIAN OCEAN
Kalumburu
Port Warrender
Wyndham
Bullo River
Kununurra
Gibb River
Rosewood
Lombadina
Beagle Bay
Derby
Bedford Downs
Lansdowne
Wilare Bridge Roadhouse
Fitzroy Crossing
Nicholson
Halls Creek
Broome
Thangoo
Cherrabun
Bohemia Downs
Sturt Creek
La Grange
Anna Plains
Nita Downs
Billiluna
Balgo
Wallal Downs
Sandfire Flat Roadhouse
Port Hedland
Goldsworthy
Yarrie
Karratha
Dampier
Whim Creek
Telfer
No.35 Well
Hillside
Mount Florance
Bonney Downs
Yarraloola
Onslow
Pannawonica
Roy Hill
No.24 Well
Exmouth
Tom Price
Paraburdoo
Newman
Ningaloo
Coral Bay
Lyndon
Docker River
Everard Junction
Cobra
Glenayle
Gnaraloo
Binthalya
Landor
Carnegie
Warburton
Carnarvon
Glenburgh
Moorarie
Windidda
Monkey Mia
Byro
Wiluna
Meekatharra
Wonganoo
Hamelin
Kalli
Darda
Bandya
Yamarna
Cue
Leinster
Neale Junction
Yallalong
Mount Magnet
Laverton
Kalbarri
Ajana
Yuin
Yalgoo
Leonora
Mount Ida
Blue Robin Hill
Pindar
Geraldton
Menzies
Menangina
Dongara
Morawa
Mouroubra
Yindi
Cundeelee
Loongana
Green Head
Watheroo
Beacon
Kalgoorlie
Boulder
Zanthus
Rawlinna
Cervantes
Koorda
Madura
Lancelin
Calingiri
Higginsville
Noondoonia
Cocklebiddy
Merredin
Norseman
Balladonia Motel
John Eyre Motel
Toodyay
Northam
PERTH
Fremantle
Mandurah
Lake King
Juranda
Israelite Bay
PERTH-ALBANY REGION
Esperance
Bunbury
Kojonup
Dunsborough
Bremer Bay
Karridale
0 200 400 km
0 100 200 miles
STN


CANADA
WASHINGTON
Seattle
Tacoma
OLYMPIA
Spokane
Great Falls
Missoula
HELENA
MONTANA
Portland
Vancouver
Gresham
SALEM
Billings
Eugene
OREGON
IDAHO
SOUTH DAKOTA
Meridian
BOISE
Gillette
Idaho Falls
Pocatello
WYOMING
Casper
Ogden
Laramie
CHEYENNE
Reno
SALT LAKE CITY
West Valley City
Provo
Fort Collins
CARSON CITY
NEVADA
UTAH
DENVER
SACRAMENTO
San Francisco
Oakland
COLORADO
Colorado Springs
Pueblo
San Jose
PACIFIC
Fresno
CALIFORNIA
Las Vegas
Henderson
SANTA FE
Rio Rancho
Flagstaff
Albuquerque
OCEAN
Los Angeles
Channel
ARIZONA
NEW MEXICO
Glendale
PHOENIX
Mesa
San Diego
Yuma
Tucson
Las Cruces

Western Australia:

976,790 square miles, population 2,589,000 (Perth, 2,022,044)

Western United States (Excluding Alaska and Hawaii)

1,279,301 square miles, Pppulation 66,680,927

Joondalup

population, 154,727, and declining
land mass of 38 sq miles
socially and economically advantaged in many SA2 regions

Wanneroo

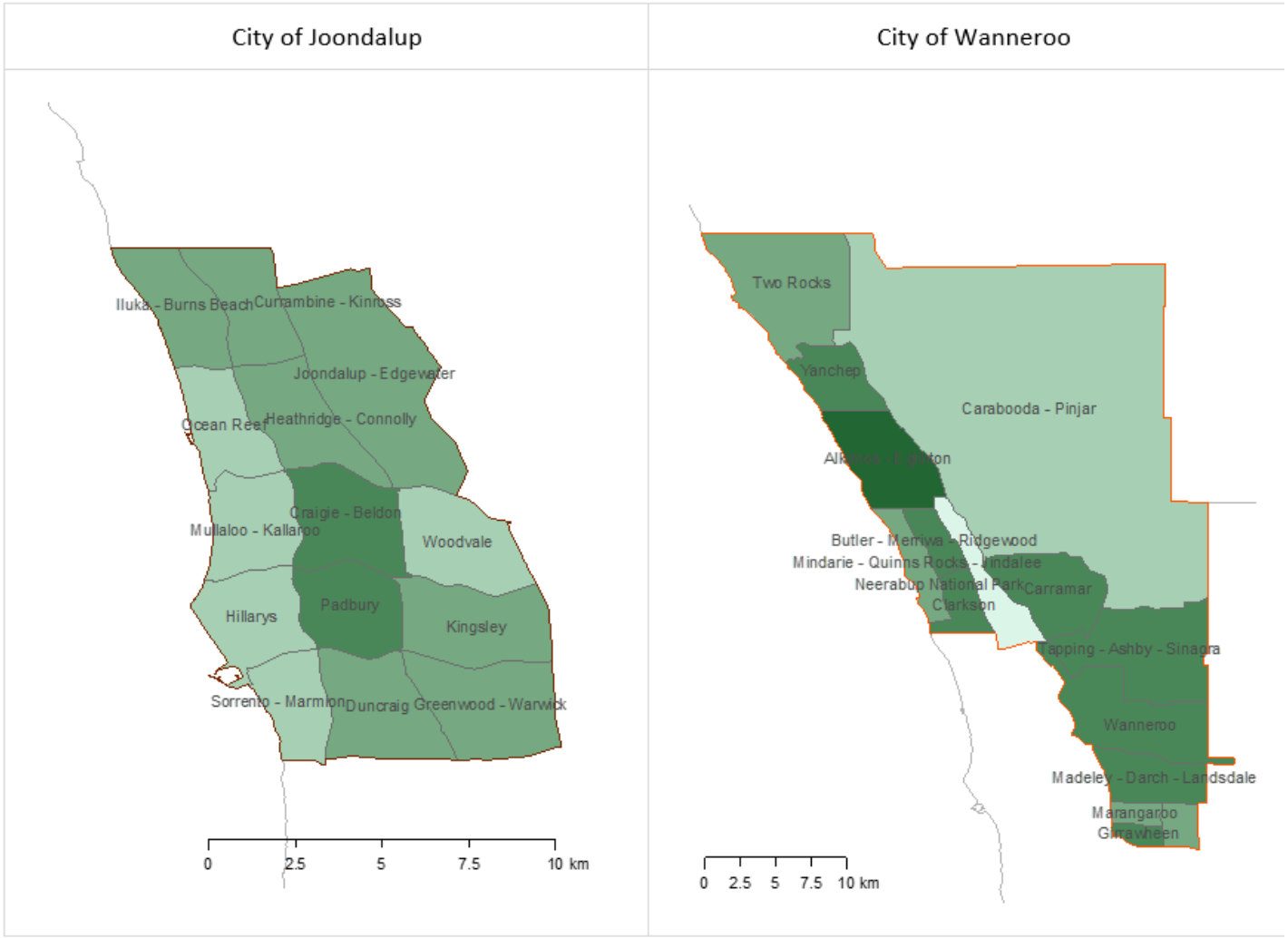
population, 187,957, rapidly growing
land mass 264 sq miles
high levels of disadvantage in many SA2 regions

Each of these cities includes 14 SA2 regions (smaller cities, towns) within their borders.

Population Statistics

	Joondalup		Wanneroo	
Population	154,727		187,957	
Ages 0 – 4	8,904	5.7%	14,970	8.0%
Births 2016	1,798		3,212	
Fertility Rate	1.78		1.94	
15-39 age females	23,384		35,166	
Immigrants				
total	58,478	37.8%	76,885	40.9%
European		66.1%		54.4%
Asian		13.4%		24.3%
Americas		3.1%		2.3%
African		17.4%		17.4%
Single Parents				
Female	924	4.0%	2,340	6.7%
Male	125	0.5%	221	0.7%
Total	1,049	2.2%	2,571	3.7%

Figure 4: Population aged 0-4 as a percentage of total population, 2016



BANKWEST CURTIN ECONOMICS CENTRE | Authors' calculations from Census of Population 2016 and 2011. Data extracted using TableBuilder.

Priddis, L. et al. (Feb 2019). Better Together Project, Annual Report. Edith Cowan University, Department of Psychology: Joondalup, Western Australia.

Service Mapping

Figure 11: Government Health and Mental Health Services, 2018

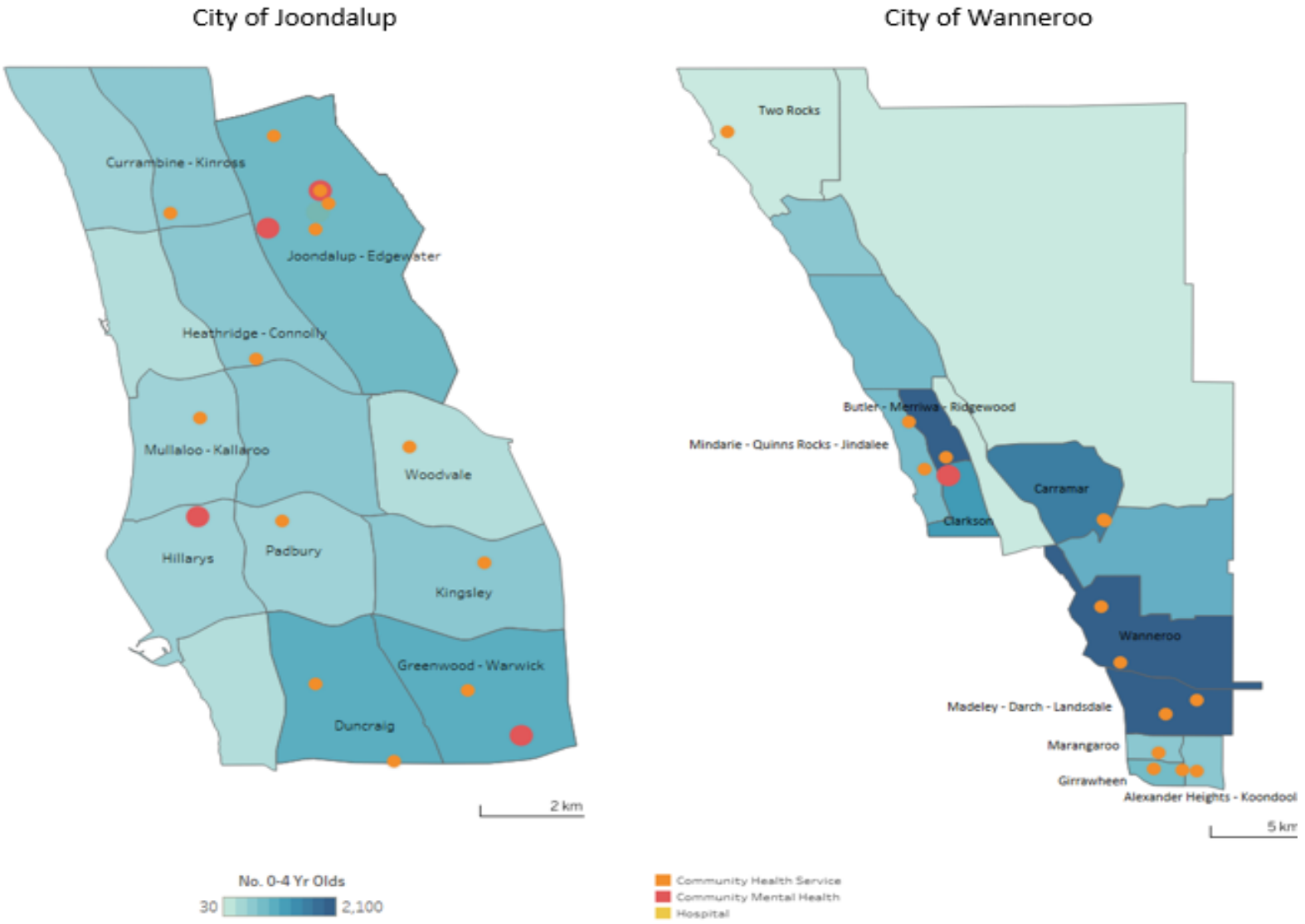


Figure 12: Early Childhood Education and Care, Community Services and Libraries, 2018

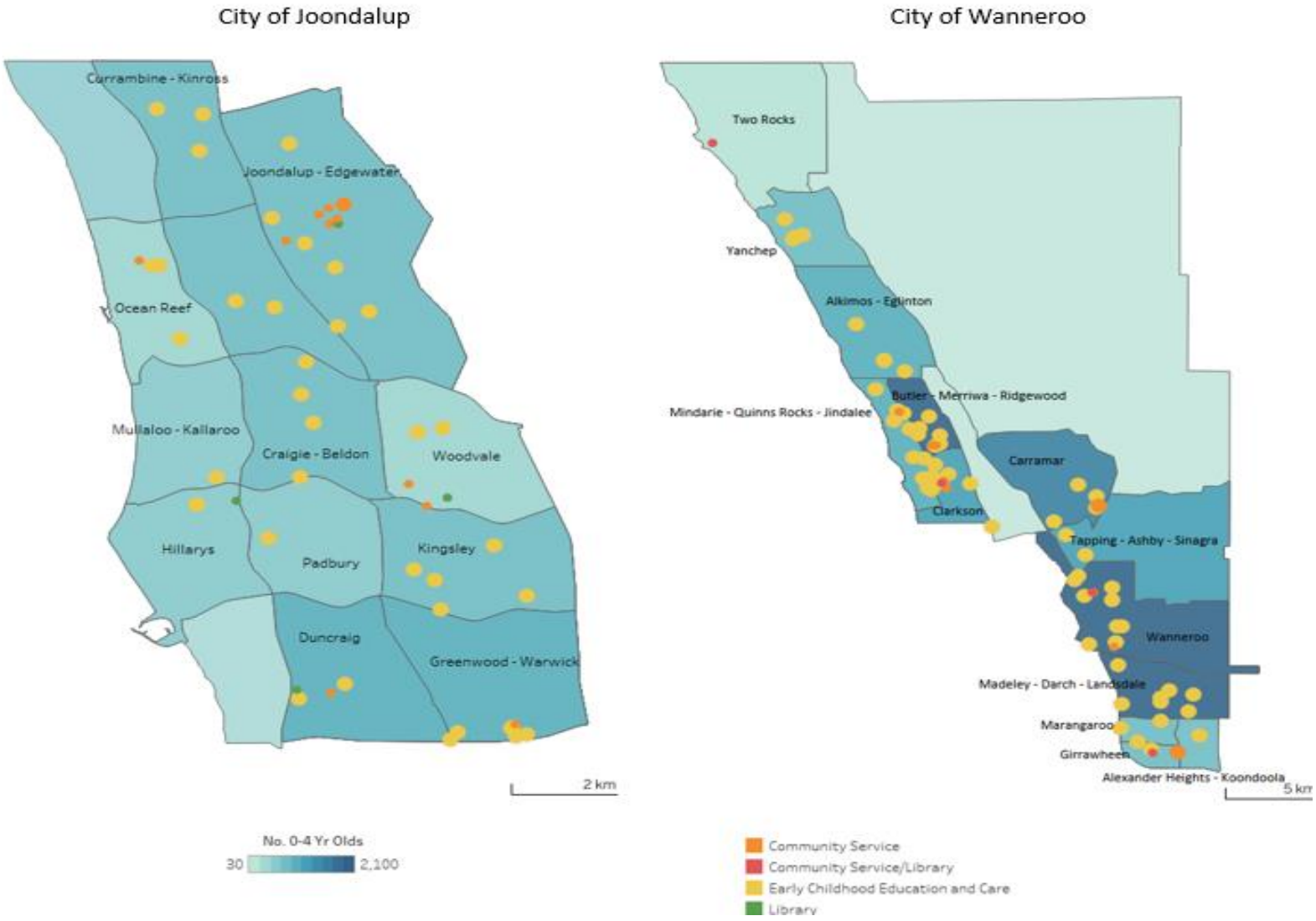


Figure 13: Universal Services, 2018

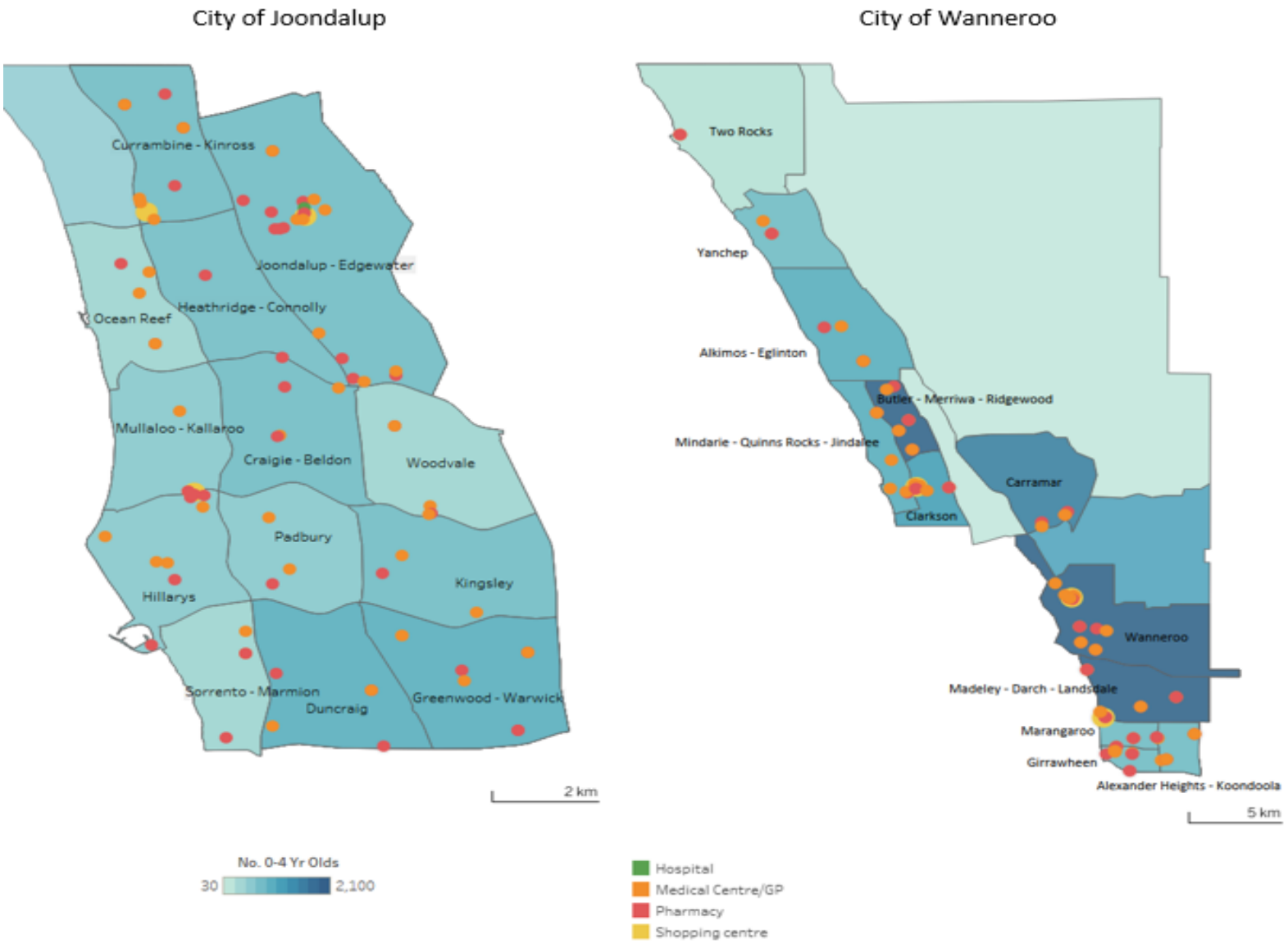
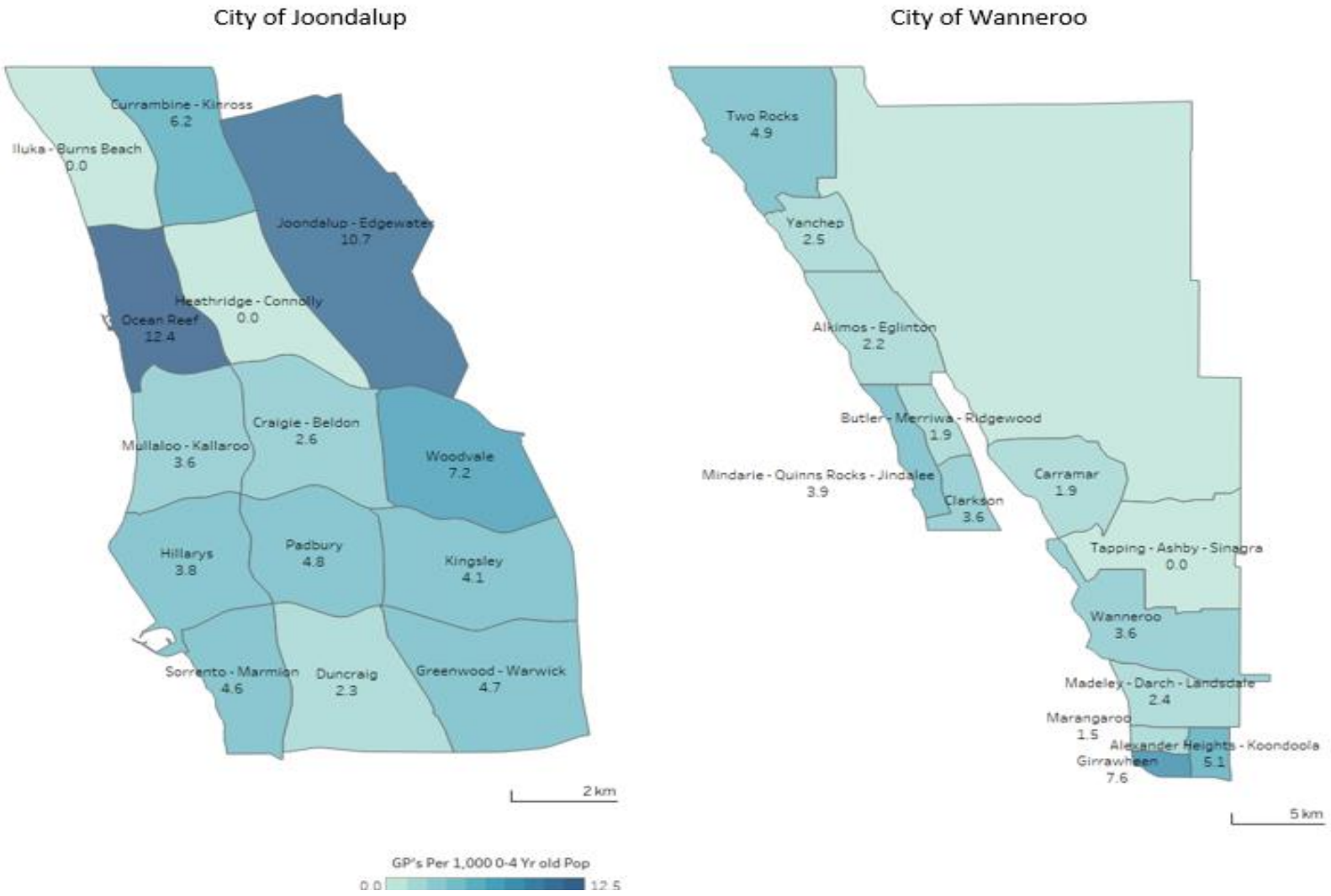


Figure 14: General Practitioner Services per 1,000 of the Population of 0-4 Year olds, City of Joondalup and City of Wanneroo



Provider Survey Results

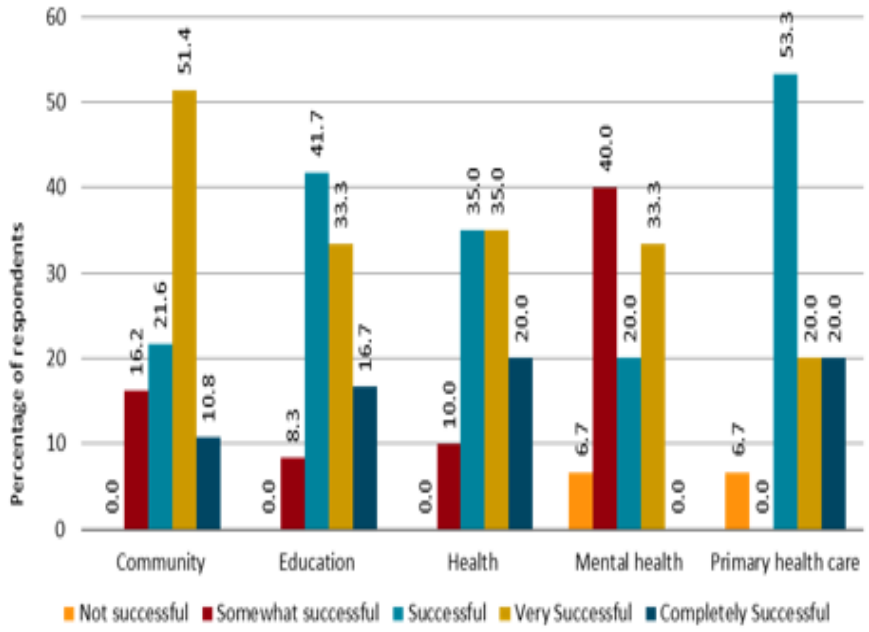
Length of Time Working in Category

Years	Percent
0 – 4	22.3
5- 10	26.3
11-20	28.3
21 -	23.2

Proportion of Respondents by Service Category

Category	Percent
Community	40.5
Health	20.7
Mental Health	13.5
Primary Health Care	13.5
Education	11.7

Figure 19: Self-reported Agency/organisation Success in supporting the needs of children aged 0-3 and their families, by Service Category



Notes: N = 99. Community (37); Education (12); Health (20); Mental Health (15); Primary health care (15)
Source: Authors' calculations from ECU Better Together Workforce Survey data.

Barriers to Network Success

Barriers	Percent
Staff turnover	52.8
Lack of resources	16.7
Political landscape	13.9
Geographical location	8.3
Lack of time	5.6
Competing priorities	2.8

Expected Benefits of Greater Cohesion of Services

Benefits	Percent Respondents
Improved health outcomes	26.2
Improved understanding of IMH issues	26.2
Improved interagency connections	14.0
Improved engagement with consumers	7.5
Improved referral pathways	7.5
Improved partnership with consumers	3.7
Improved educational outcomes	1.9
Increased knowledge sharing by services	0.9
Improved access and uptake of services	0.9

Availability of Training in IMH and PIMH for Agency/Organisation Staff

	Infant Mental Health	Perinatal Infant Mental Health
	Percent	Percent
Yes: Within agency	50.0	37.6
Yes: External	35.0	42.6
No/Unaware	15.0	19.8

INTERVENTION

Training programs based on the Michigan Association for Infant Mental Health competencies were conducted with agency personnel.

Defining Infant Mental Health

- Infant mental health (IMH) is an interdisciplinary field that has steadily grown internationally over the past 35 years.
- One definition commonly accepted is ‘the healthy social and emotional development of a child from birth to 3 years; and a growing field of research and practice devoted to the:
  - promotion of healthy social and emotional development;
  - prevention of mental health problems;
  - treatment of the mental health problems of very young children in the context of their families. (Zero To Three, 2012)

Case: Amy & Abby, 8 weeks

Defining Perinatal Mental Health

- The emotional and psychological wellbeing of women, encompassing the influence on infant, partner and family, and commencing from preconception through pregnancy and up to 36 months postpartum.
- The term perinatal mental illness covers a variety of mood and behavioural disturbances that a women maybe experiencing during pregnancy and the postpartum period (Mares, Newman & Warren, 2011).

Case Study: Amy & Abby, 5 months

Why do we need a system to support perinatal and infant mental health?

- No one organisation or service can provide the breath of interventions and supports needed to ensure all infants and young children reach their full potential and thrive in life.

- Building on existing networks is an opportunity to create a more coherent and coordinated system of care for families living in Wanneroo and Joondalup.

- Often the first point of contact for a family experiencing troubles in Perinatal and Infant Mental Health are primary health care professionals and universal community services.

    - General Practitioners
    - Child Heath Nurses
    - Community support groups

Better Together: Supporting Perinatal and Infant Mental Health Services

The project maps how services in the cities of Wanneroo/Joondalup interact to enhance the quality of perinatal and infant mental health services for the community.

Service providers have been invited to work with the research team to design, implement and evaluate the network of services that families with infants and young children access.

Action research methods are used to analyse the system as well as the client experiences.

Together with the community, the project is working to improve the system responsiveness to the social wellbeing and mental health needs of families with infants and young children, from both prevention and intervention perspectives.

Detecting infant - parent relationship difficulties

- **Shifts in social relationships in babies during first two years:**

- Newborn/first month: Attraction to people
- 2 months: Core relatedness
- 4-5 months: Topic based relatedness
- 9-10 months: Connected up relatedness
- 18 months: Cooperative relatedness

Touchpoints

- Pregnancy*
- Newborn *
- 2-3 weeks
- 6-8 weeks
- 4 months*
- 6-7 months
- 9 months
- 12 months
- 15 months*
- 18 months*
- 2 years
- 3 years *

Developmental Domains

- Social development
- Attachment relationships
- Self regulation
- Cognitive development
- Neurobiological Organization

Observation in the consultation room

- Back to our case – **what did you notice about AMY's conversation with her baby ?**

- **Other things pregnant mothers have said**
- *This is someone I know*
- *I feel really good about um, my baby being, she's kicking me right now. I feel really good about my child, um, being inside me and, and I feel like we're really connecting more and more each day.*
- *He kicks me a lot – he's just like his father vicious and angry*

- **A mother about her 2 day old baby** *She is pretty, but she is very greedy.*
- *I have no idea why the baby cried all night, he was warm, fed and had no reason to cry*

1. Facial expressions in the relationship

Tuned In: Parent looks at child warmly and is alert and responsive to the child's demeanour. Child openly references the parent.	1 2 **Rarely Tuned In**	3 **Sometimes Tuned In**	4 5 **Mostly Tuned In**
<u>Tuned In:</u> The dyad will reference each other for mutuality. They will look at each other with appropriate expressions when excited, interested, or achieving something as well as when worried, frightened, or surprised. As an observer, you will have a sense that this dyad are good companions, have a close and trusting relationship, delight in each other and share experiences.	<u>Not Tuned In:</u> The dyad focuses exclusively on toys, objects, or the camera. When closely observed, one can see that they mostly miss each other. Facial expressions may be blank or withdrawn. Facial expressions may be incongruous with each other or with what is happening. As an observer, you sense that closeness and intimacy are lacking.		

2. Use of voice in the relationship

Tuned In: Voices are warm and pleasant. Talking is reciprocal and there is a balance between silence and speech.	1 2 **Rarely Tuned In**	3 **Sometimes Tuned In**	4 5 **Mostly Tuned In**

<u>Tuned In:</u>

The parent appropriately modulates his/her voice to regulate the child's affect, beginning at the child's level.

The parent appropriately permits quietness and silence to exist between them.

The parent allows the child to warm up to the room and the toys at his/her own pace.

The parent talks with the child about what is happening in the room and between them.

The parent mirrors the quality of the child's vocalisations so that he/she is encouraging if the child is uncertain, excited if the child is excited, etc.

<u>Not Tuned In:</u>

The parent tone of voice may be incongruous with what is happening. For example:

Overbright or false bright with high pitch

Forced

Flat and minimal

Demanding of attention

Pleading

Nervous or anxious

Annoyed.

Bizarre

The child may be particularly silent.

3. Body positioning in the relationship

Tuned In: The pair positions themselves in a relaxed fashion, where they can see each other's faces and touch each other if they wish.	1 2 **Rarely Tuned In**	3 **Sometimes Tuned In**	4 5 **Mostly Tuned In**

Tuned In:	Not Tuned In:
The dyad move in relation to each other in a warmly connected manner.	The dyad does not move in synchrony; they miss each other's cues.
When carrying the child, the parent does so warmly and settles the child reassuringly.	The dyad appear uncomfortable and awkward with each other.
There is synchrony in their movements as they move in the service of mutual interactions with toys.	They may be too close, or too distant with each other, or suddenly loom into each other's space.
They settle into positions that are a comfortable distance for each other so that they are close enough to jointly share an object, touch each other, and be physically available for mutual play.	Some parents may initiate rough play that the child does not appear to enjoy.
The parent is close enough to provide support to the child if it is needed.	Some parents may ignore or respond mechanically to their child's approach.
Both the parent's and child's movements and posture are free flowing.	Sometimes, one part of the body of either the child or parent is held rigidly so that the impression is one of tension.

4. Following the child's lead			
Tuned In: Parent allows the child to lead and joins in when invited. Parent responds to child's invitation and waits for child's turn.	1 2 **Rarely Tuned In**	3 **Sometimes Tuned In**	5 **Mostly Tuned In**
Tuned In: The parent waits for his/her child to warm up to the room and to the toys. If the child appears uncertain, the parent will comment from the perspective of the child and will leave space for the child to respond. If invited by the child, the parent will explore with the child, allowing the child the lead wherever possible. The observer will have a sense of two people warmly collaborating with each other to enjoy the equipment provided.	Not Tuned In: The parent does not provide space for the child to become familiar with their environment. The parent may appear to "take over" the equipment in the room. The parent may use a teaching style to instruct and direct the child's play. The parent may change pace regardless of where the child is at. Some parents appear to have few resources for play. Some parents appear to have a preference for parallel play which is separate from their child. As an observer, it is painful to watch eg parent teases child with a toy.		

5. Support for exploration and organisation of feelings			
Tuned In: Parent is available to support the child's exploration and needs for reassurance or comfort.	1 2 **Rarely Tuned In**	3 **Sometimes Tuned In**	4 5 **Mostly Tuned In**
<u>Tuned In:</u> The parent accepts and names the child's anxieties. In doing so, the child calms and one observes increased confidence and pleasure in the child's exploration. The child is supported and encouraged to explore the room and equipment. The parent allows the child to express negative affect and appropriately comforts the child when required. Appropriate boundaries are set (for example, in situations of unsafe behaviour). The dyad is also comfortable with inactivity.	<u>Not Tuned In:</u> The parent appears unaware of the child's needs or desires. The parent offers comfort when not required. The parent inhibits the child's exploration. The parent offers distraction or criticism when the child is in need. The parent sets inappropriate or unnecessary boundaries. The child does not openly cue the parent for comfort. The child becomes distressed or clings to the parent.		

Summary of Ratings	Rating	Comment
Facial expressions		
Use of voice in the relationship		
Body positioning		
Following child and turn-taking		
Support		
Overall TUNED IN Rating		

Consumer Survey Results

Reported First Point of Contact

General Practitioners	67.9%
Family Services	13.2%
Child Health Nurse	7.5%
Obstetrician	3.8%
Paediatrician	1.9%
Pharmacists	0.0%

Source of Difficulty in Accessing Services, 2018

	None	low	Medium	High	Extreme
Distance/Transport	30.4	37.0	21.7	6.5	4.1
Private Health Insurance	43.6	25.6	12.8	5.1	12.8
Financial Constraints	20.8	37.5	27.1	8.3	6.3
Language/Culture	75.7	16.2	5.1	0.0	1.0
Waitlists	20.0	25.0	30.0	15.0	10.0
Flexibility of Service	16.7	31.0	47.9	7.1	1.0
Insufficient Service	16.3	34.9	37.2	11.6	0.0
Inappropriate Quality of Service	22.0	46.3	22.6	7.3	1.0
No response from Agency	38.1	42.9	14.8	1.0	1.0
Agency/Organization Closed	44.7	30.8	12.6	5.1	1.0

Reported Sources of Information

	Parental Well-Being	Infant Social-Emotional/Behavior Development
Agency Connected to	73.1%	76.5%
Family & Friends	63.5%	58.8%
Internet/Social media	53.8%`	39.2%
Other Agency	9.6%	17.6%
Do not know	5.8%	13.7%
Other	3.8%	

Consumer Reports

Degree of Interagency Communication

None	20.8%
Small amount	29.2%
Fair amount	41.7%
Great deal	8.3%

Desire for additional information

Knowledge of agency services provided	58.5%
Concerns for 0-3 year olds	56.6%
Concerns during pregnancy	34.0%
None	24.5%
Other	5.7%

Participatory Action Research Findings

Table 12: Summary of Better Together Reference Group Meetings

	Attendees	Meeting activities	Meeting outcomes
Meeting 1	23 attendees	Introductions Defining PIMH and this project Reference Group TOR Discussion questions	Consumers and service providers Identified: Important components of the PIMH system Sources of support Challenges for young families Service accessibility Leverage as change agents
Meeting 2	32 attendees	Feedback of activities Case study Create current network Using a provided case study - how the system might presently meet this consumer's needs Create ideal network Using the same case study, map out how needs might be best met by the system SNA overview	Activity board construction of system: As it currently is As might be in ideal world Gaps in services
Meeting 3	35 attendees	SNA survey questions and update Demographic data update Small and large group discussions	Discussion on: Priorities for the PIMH system Action to be taken to achieve Results of inaction Agency/organisation priorities Hopes for current project outcomes
Meeting 4	12 attendees	SNA results How these matched reference group experiences? Snapshot of report in PowerPoint	Discussion on : SNA results with input and commentary from Distinguished Professor Hiram Fitzgerald Consensus SNA was representative.

Social Network Analysis

We used SNA to assess

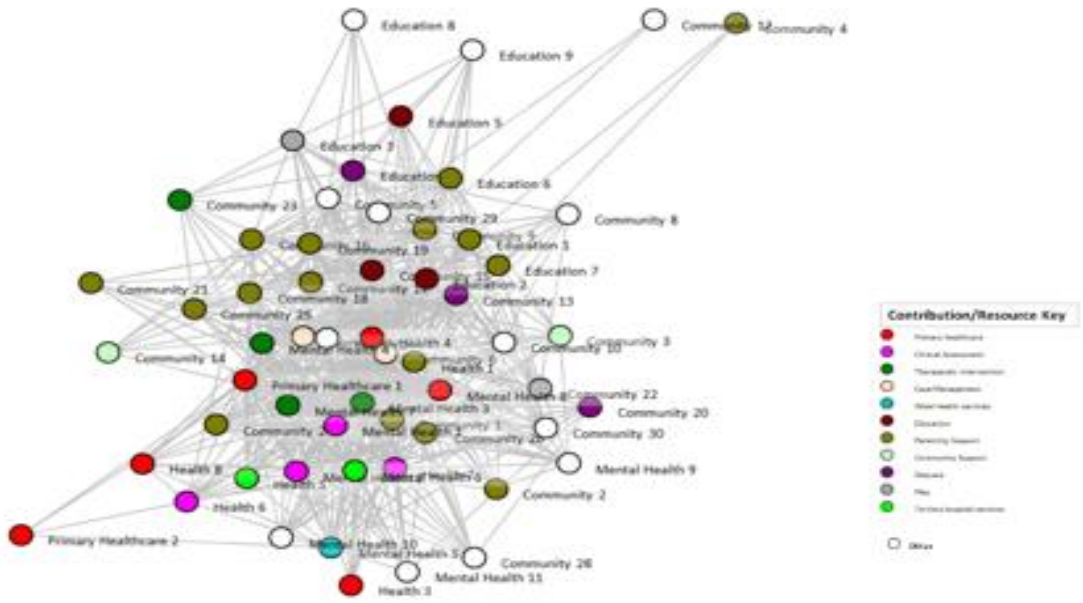
-infant mental health services provided,
-barriers to network success,
-expected benefits of an integrated service,
-proportion of agency funds focused on families (prenatal to age 4),
-the interconnections of agencies,
-their degree of trust and value of one another,
-and a wide variety of functions provided by the agencies.

Personnel training and experience in relation to inter-agency connectivity was also assessed

Participating Agencies

Community:	40.0%
Consumer:	19.0%
Education:	12.0%
Health:	10.0%
Mental Health	15.0%
Primary Health care	4.0%`

Figure 41: Agencies/organisations Most Important Contribution to the Network



Source: ECU Better Together PARTNER Report September 2018

Codes:

Primary Health Care
Clinical Assessment
Therapeutic Intervention
Case Management
Allied Health Services
Education
Parent Support
Community Support
Day Care
Play
Tertiary hospital services
Other

Partnerships identified: 1684
Service Referrals: 45%
Factors influencing inter-agency relationships:
training needs (23%),
educational programming (38%),
developing new initiatives (25%),
service delivery (20%),
referral pathways (44%).

Factors contributing to relationship development included,
developing relationships with specific individuals (36%),
practice efforts leading to connections with other individuals (31%),
and participation in service related committee (48%).

Little attention was given to
data collection (1%)
research/evaluation (.2%)
or policy change (5%).

What aspects of collaboration contribute to agency success? Number of Respondents.

Exchanging information/knowledge	23
Information relationships created	20
Meeting regularly	20
Bringing together diverse stakeholders	16
Sharing resources	15
Having a shared mission/or goals	14
Advocacy	13
Collective decisions making	10

Perceived Barriers to Success of PIMH's System of Care: Number of Respondents

Lack of time	17
Staff turnover	17
Competing priorities	15
Lack of resources	13
Geographical distance/location	13
Funding stream/funding structure	11
Political landscape	8
Lack of knowledge/training/understanding	8
Level of autonomy	6
Lack of trust	5

Table 13: Network Scores: Density, Centrality and Dimensions of Trust

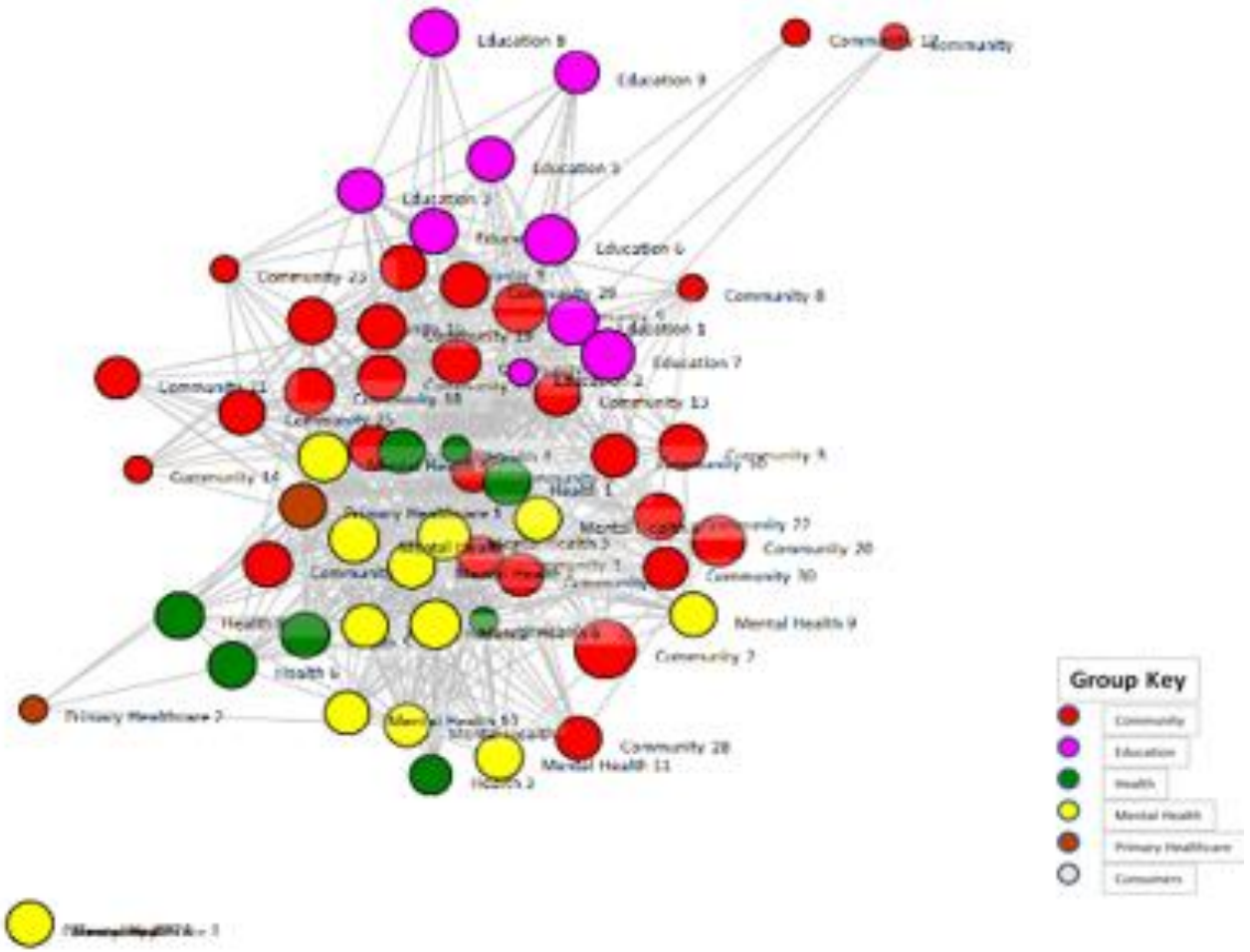
Network Measure	Network Score	Definition of Network Measure
Density	20%	Density: Percentage of ties present in the network in relation to the total number of possible ties in the entire network.
Degree Centralization	43%	Degree Centralization: The lower the centralization score, the more similar the members are in terms of their number of connections to others (e.g. more decentralized).
Dimensions of Trust	Moderate	Trust: The higher the trust score, the more that component parts of the system believe that system collaborations are trustworthy, reliable, and that communication is open.

Trust: level of trust between agencies was low

Value: degree of valuing other agencies was low

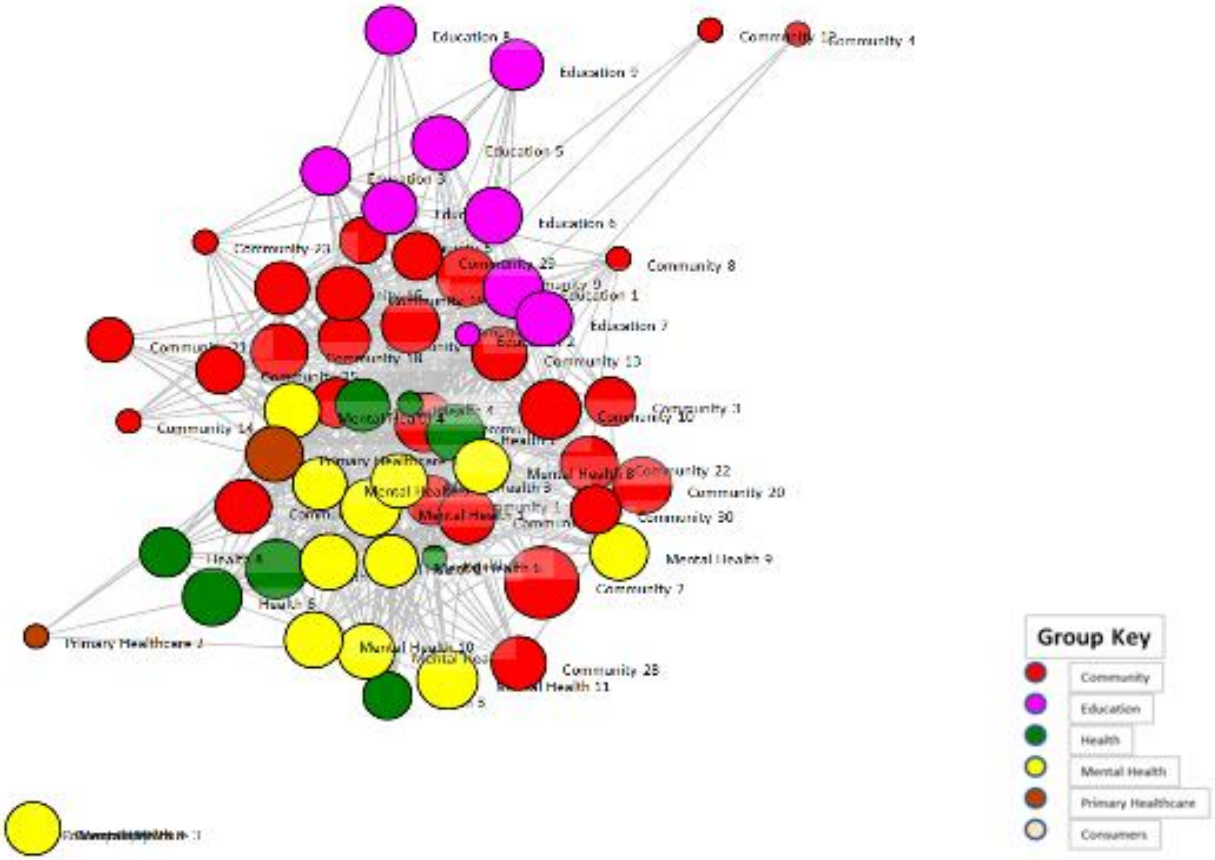
System Interconnectivity: modest

Figure 43: The Relative Trust of Organisations



Source: ECU Better Together PARTNER Report September 2018

Figure 42: The Relative Value of Organisations



Source: ECU Better Together PARTNER Report September 2018

Partnership Dynamics: 1877 Agencies in Network

Dynamics	%	N
None/Awareness	58.0	1,081
Cooperative Only	23.0	436
Coordinated Only	12.0	226
Integrated Only	7.0	134

System components:

Organizations have low levels of trust and value.

Partnerships are minimally coordinated and integrated.

Greater need to build intangible factors that affect relationships.

Need to use formal tools (e.g., Early Childhood Service. Intensity Instrument) to promote capacity building, trust, communication, and collaboration to enhance system effectiveness.

Need to continue PAR elements throughout systems change.

Better Together Recommendations

- Investigate ways to enhancing cohesion and integration in the System of Care using technology.
  - PCN App
- Align SNA and service mapping data to determine the extent to which geographical location accounts of the degree of connectedness to other agencies/organisations
- Building innovative ways of increasing the connectivity between agencies/organisations and between families and organisations across the PIMH System of Care in the Cities of Wanneroo and Joondalup.
  - ECSII
  - Innovative workshops that broaden and mobilise agencies/organisations within the PIMH System of Care
- Deliver the PIMH Primary Health Care training package to a wider set of service providers.
- Consider ways of creating a more diverse workforce to meet the need of CALD families.

QUESTIONS?

COMMENTS?

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