**SPHERE's ELDoH and SHP webinar The STARS for Kids program-20250924\_033050UTC-Meeting Recording**

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 **Rebecca Bosward** 0:02
Welcome everyone. I might get everything started for today. Thank you so much for attending our seminar on Stars for kids programme and I look forward to hearing from all of you, hopefully during our Q&A session as well, just to start us off, I'd like to begin with an acknowledgement of country and that we acknowledge the traditional owners of the lands.

 **Sue Woolfenden** 0:10
Hmm.

 **Valsamma Eapen** 0:13
Yeah.

 **Rebecca Bosward** 0:21
In which Sydney University is located where I am today, which is the Gadigal people of the great euro nation, and we pay respect to the knowledge embedded forever within the Aboriginal custodianship of country and also to begin with, I would like to introduce our speakers for today, so please welcome valsa, which had Scientia, Professor and NH.
Which of our senior research leadership? Fellow at UNSW Sydney. She's also the chair of infant Child and Adolescent psychiatry and a clinical academic at Southwestern Sydney Local Health District and also the stream director for Elder. And I'd like to welcome sue Wolfenden, who is the director of Community Paediatrics at Sydney Local Health.

 **Feroza Khan** 0:50
OK.
Yeah.

 **Rebecca Bosward** 1:01
District and professor of Community paediatrics at the University of Sydney. She's also Co chair of the Sydney HealthPartners Child and Adolescent Clinical Academic Group and Co, chair of the Sydney Institute Women Sydney Institute for Women Children and their families at SLHD.

 **Feroza Khan** 1:02
Yeah.

 **Rebecca Bosward** 1:17
And lastly, I'd like to introduce Marty, who is a psychologist and research assistant at the University of Sydney. Marta Diaz has experience as both a clinical psychologist and researcher in Chile, where she worked on projects exploring interest in positive and adverse childhood experiences, parenting and the use of children's storybooks to support socio.

 **Feroza Khan** 1:17
Yeah.

 **Rebecca Bosward** 1:37
Like emotional development in early childhood, and I might hand over to you Matei, if that's all right to share the slides and just to let everyone know, we'll have 3 presentations and this will be followed by AQ and a of 15 to 20 minutes. So I look forward to hearing your hearing your questions and your feedback.
Thank you, Marty.

 **Valsamma Eapen** 2:02
Thank you everyone for joining this session. I would like to start by also acknowledging the traditional custodians of the land on which we are meeting today. The various places from which you are all joining and pay my respects to elders past and press and next slide. Please Marty.
Yeah.
Play song.
Next slide, yeah. So we will, we'll be going through a bit of background. Tell you what is stars for kids, stars, what does it stand for? We'll mainly cover 2 NHMRC projects, which one is medical research future fund programme, which I'll be, which I lead and we'll be covering a bit.
And also sue Wolfen then will be covering the ARC linkage programme, which she leads. Our manager will take us through the code design parts of the programme that we have already completed with some findings and we'll give you a sneak peek of how the trial recruitment is going. The early stages. Thank you.
So these are our wonderful partners and defenders.
Next one please. Yeah. So again, there is no surprises here on this slide. We all know every 9 minutes a child is born who is potentially going to be having a developmental challenge and Australian early development census suggests that one in five children are starting school without the developmental skills that they need to thrive.
But there's also significant inequity. You will get one in five in the general population, but we'll see one in three in Fairfield and Multicultural community and we will see one in two in some of the Aboriginal communities, significant inequity in terms of the.
Developmental issues that they are facing, but also access to care and that usually follows an inverse care law. Those the most disadvantaged background who have got the maximum risk of having the developmental issues for their children are the ones who are least likely to engage with our routine service.
Where there is the programmes that are available, but most of these families find it incredibly difficult to engage, access, engage and participate in those programmes, so we need to be kind of doing something different in order to reach the families who are currently.
Not engaging. That's kind of really the crux of what we are hoping to do through these programmes, because we believe early identification is the only lever for them to access, then the early intervention and then the supports that they dearly need. Next slide please.
Yeah.
So the Blue book is what we have in NSW and Sue and I when we started more than a decade ago, the rate we were we were meant to understand was that 30% of the NSW families are engaging with the Blue Book programme for development cheques at about 12 months. But I'll show you how things have gone backwards post code.
With, etcetera, particularly in some communities, in some districts it has been really, really difficult for families to engage and those access barriers are more for cultural industry, diverse people, those from low income families, those from regional rural suburbs. And for in this programme we have selectively.
Taken sides which represent these three communities.
And in addition to the communities that are struggling, there is also how we are serving the communities, right? So there is an inequity there as well. If you look at service issues, those who are well developed suburbs from well established suburbs have got much better.
Resources support because it's already existed, whereas the swaths of new suburbs that are coming up hardly anything there, so that services that we are delivering is also very inequitable and expect them to come to us and and and get the care. And it's very much developed for.
People who are well educated, good health literacy, middle class families, to, yeah, these programme sexes go help yourself, but that just doesn't happen for families, particularly when they are also struggling with mental health issues for parents and family, having significant social care needs as well. So we have got.
The three pillars, if you like, in our programme, one is, how's the child going in their development? Second is how are the parents going? Particularly parental mental health and what are the families situation, contextual needs, their social care needs. So those are the three things that we are focusing on this programme.
Next slide, please. And this is from the six months of 2024. Now between 3 to May 2024, I told you about 30% were engaging about a decade plus ago, but after 3000 children who are meant to be accessing the child development cheques in southern Sydney.
About 86% engaged at four weeks. You know, that's a very high uptake there, relatively speaking, but it comes down to 12% at 12 months, 3% at three years. Next slide, please. So that's really our families are not engaging. So in our first trend of watch me grow study.
We wanted to understand why is it the case? Why are they not engaging in order to reverse this inverse care law and some of the things that stood out for us in our Co design earlier on was that don't ask us to go make an appointment between 9:00 and 4:00 in a particular clinic that sits in the middle of nowhere. We ever have any transport.
And then that idea of using opportunistic contacts and one programme that absolutely is equitable, well taken up by families, is childhood immunisation. So one way of doing it would be leveraging the opportunistic contacts when they are coming to the GP clinics over there, coming to the child family health nurses or their.
Ending.
Early childhood sent us. It doesn't really matter. Leveraging those opportunistic contacts and going to where the children go became our motto. The second thing they said was that it's all very fragmented, it's, you know, go here. For one thing, go there for another thing, how can you make it a little bit joined up? And the third thing, they're absolutely struggling to navigate.
For the maze of our system. So how can we provide navigation support and then we made that kind of thing to to study, explore, examine, implement and evaluate. How can we leverage opportunity contacts, how can we provide a joint app service? How can we navigate them digitally and?
Also in.
In person, for those communities that needed very much so, and that includes the hubs, which is the one location, one stop shop where everything can be delivered. So different forms of navigation and support and then the blended tiered care because everybody doesn't need everything. So we need to kind of tier them into based on their needs.
And their preferences choices where they live, etcetera as to how we then match the services for them. I'll give you 2 examples from a very quickly from AGP setting and from a preschool setting to give you a flavour of background works. Next week's slide please.
So in this this is NHRC partnership grant, we've cluster randomised some GP clinics in Southwest Sydney and some GP clinics in Brisbane. And then we'll engage them in the waiting room of the practises and give them the watch me grow web link where they kind of do the developmental cheques and based on the results.

 **Ashok Abhyankar** 9:15
It.

 **Valsamma Eapen** 9:32
And the recommendations it goes to the family as soon as they submit as to what the results and recommendations are. It's also secure, delivered to the GPS medical record system. So by the time they go from the waiting room to the consulting room, both parties are quite, you know, well.
Intentionally able to engage in a conversation about the child stimulus. Sometimes it's just like what seems to be going well. Then we give them anticipatory guidance and a lot of resources from things like raising children's network. But if they are having like touch needs additional services, real targeted supports. If that's the need.
ETC. And what we found was that when we compared the intervention group that get got the watch me grow against the control sites where GP just clapped eyes and said, oh, is there anything the matter? We found that the sensitivity against gold standard assessments was 91% for the intervention group.
As opposed to the GP making a guess of what's going on 64%. So again we've shown that we can do it, we can engage with them opportunistically. We can deliver on their early identification accordingly. Next slide, please. Then what do you do? Become the next question. So this is some data from the preschool Ashcroft.
None.
Preschool Hub, Mirang and here we showed that once we identify them using the watch me grow and tear them based on their needs and the school the preschool hub provided them with supports, stimulation, nurturing care interventions in the form of learning support and also allied health support etcetera including.
Paediatric consultant that was needed. This is \*\*\*\*\*\*\*\* data from the education system saying that in 2024 the cohort of kids at Ashcroft Preschool had 31% reached the literacy phonetics required level and in a year's time following the following, the hub providing the intervention.
Close to half, 44% that is in education terms, according to the Director of Education. Big deal to get these children, you know, up for their phonetics and for literarism, which is going to have such an impact on their future life. Next slide please. So.
Here we are with this task for kids programme, so it stands for strengths based, tiered, accessible resources and supports. I told you a little bit about the the tiered care and the need for that and how do we make it accessible? How do we reach them et cetera is something that mita is going to talk about in the Co design work that we did to see.
How do you like it to be done? Et cetera. And then matching that support according to what the community says would best work for them. Next slide please.
And so we already covered that. I'm leading the MRF and the ARC, sorry, of the CRE Centre for Research Excellence, which are NHMRC funded and and Sue is leading the ARC linkage grant of evaluating the hub. We've got the best Australian site.
Professor Desiree Silva is the site lead and we've got an Aboriginal academic lead in anti Kerry Doyle. The three sites are a multicultural site in Fairfield, a regional rural but also good Aboriginal representation in Tari and a low socioeconomic site in Banneroo in WA.
And WA doesn't have a hub that Astari and Fairfield has got that hub physical hub, so that's not really is doing a completely online programme. Next slide, please. So again, these are the sites if you look at the ADC data again. So one in five we are talking about 28% in tarry and 33% in Karma almost.
1/3 of kids are not having the developmental skills necessary at the time of them starting school, and so we are hoping that at the end of this programme we might begin to see a shift for the families and the communities and the whole neighbourhood. Next slide please.
So in terms of the two trials that I talked about, the tiered care in the MRFF and the hub evaluation, which is the Integrated hub grant, so in the the tiered care, we've got three sites, the Fairfield, Tarry and Wanneroo in Western Australia, 140 kids each.
Six months to three years that we collect, so a total of 420, whereas Sue will take us through a little bit about the hub evaluation, which is 240 kids do sites that have got physical hubs, the Fairfield and the charity 120 each because that those are communities that we we we feel the community.

 **Ashok Abhyankar** 14:06
2nd.

 **Valsamma Eapen** 14:09
It needs a hub rather than only the digital ways of navigation. Even in person it's advanced stop shop that is going to be really needed for the community and also the community to feel that this is a trusted place. They that can they can come to a little bit that will come up again in the Co design. Next slide please.
I think I'm passing over to you, Sue at this stage.

 **Maite Diez** 14:34
I've moved because my computer's decided not to play, so hello, everyone. For those who don't know me, I'm sue Wolfenden. And it's a great pleasure to present. And I acknowledge the gadigal people of the Eora nation on who we're meeting and all the fantastic Aboriginal researchers, community members, families and children.

 **Valsamma Eapen** 14:37
Ha ha.

 **Maite Diez** 14:53
And colleagues that we have the pleasure of working with in this project up in Beirop island up in Taree. So Val just taking you through the tiered care approach. My specific area that I'm leading and is the actual does a hub make it have a role if you like is a proportionate universalist.
Approach in communities as opposed to usual care in increasing access to services within the hubs, and that includes increasing engagement with child and family health cheques, but also meeting parents needs because we know we have a very fragmented and siloed system that.
Contributes to the inverse care law, and also by doing that kind of reduces parental distress. So it you know, it's tricky assessing a hub versus usual care. The the current methodology that we've used a few times is to recruit kids and and I guess also an important thing is having people get LinkedIn.
In the hubs from the very beginning is to recruit Antenatally and post Natally, and if you live in the area of the hub you get the hub and if you don't live in the area of the hub we just follow up with usual care. So in this trial we're recruiting women 30 weeks gestation and more from either the Cara.
My area.
So that's Liverpool Fairfield and they can come into Caramel or Bankstown as our control for Southwest Sydney and then for Tari. It's anyone in Tari for the Tari hub called first steps count or they go. Those who live in Foster town. Curry will be in our usual care. Tari has a large aboriginal beer pie community who?
Working closely with us as well. Next slide please my take.
Oh, that's it. Do you want to do your tiered model of care, or do you want me to quickly? Do you want to speak to this mausa you do it so well?

 **Valsamma Eapen** 16:47
So here is the tiered care in terms of the universal services. Everybody should have access to early identification. So that's the universal part of it. And we do that through the watch me grow web link which has got the same land, the Science Act early which is recommended by the NSW Health and and if.
If everything is going well or not, they all get anticipatory guidance as a universal platform and we have used the raising children's network and also we have developed some specific resources with them for that universal. Everybody gets it. The second one is a light touch, you know a little bit of a difference that is emerging.
And.
In the area of speech etcetera and that's where we give a light touch intervention, it could be a parent group, it could be a group, that speech pathologist runs for parents and children who have got like speech and language issues, early communication issues or other development difficulties. So all of those kind of parent groups supports digital support.
That supports going to that additional. The next one is there. There is significant difficulty who needs targeted intervention and that again is tiered, some will have more than two domains involved in a significant way. They can then be supported to access the NDIS and those who need further assessment.
Yeah.
Through a multidisciplinary assessment and in within the state system, etcetera. So they get the targeted as needed based on their needs and then the service, navigation and support for those who have got significant psychosocial difficulties. So little Johnny's speech issue or the behavioural issue will not get any attention.

 **Ashok Abhyankar** 18:14
OK.

 **Valsamma Eapen** 18:27
And even if you give them referrals, unless you take care of that family's difficulties and their usual social care needs, which is the kind of the mask loss hierarchy you need to meet, that we need to do the wrap around social care in order for healthcare to be comprehensive.
Next slide.

 **Maite Diez** 18:47
Thanks. Pasa. So I'll talk about the Hib, the hubs research. So just to sort of finish off so people understand, because it can get quite messy how the MRFF and the ARC work the MRFF is recruiting children from anywhere in the community who are aged, make sure I've got this right six months to three years.
And they, depending on their needs, will go through the tiered hub, the integrated Kids Hub evaluation is doing. Anyone recruiting antenatally after 30 weeks gestation up to three months. Thanks mighty. I think we've already gone over this about the fact that we're not getting any better in terms of development.
Mental vulnerability. As a country, it hasn't really got any better over a large number of years. We need to start doing things differently. Our current child and family health system is not meeting the needs of children, so we have to think differently. There are lots of reasons why those children are developmental vulnerable.
And are developmentally vulnerable, but we have a very different system and need now a very different kind of societal system and need now compared to when services were first set up. And so we know and lots of clinicians know this, if they talk to any of their schools in high needs areas, they don't.
Often only 1/3 of children will actually have their need. Their developmental needs met before they arrive. You know they've only had these cheques and a lot of schools tell us that they often have about one in three children actually have additional needs when they turn up, and they've had no support.
And we know the priority populations experience lots of additional service access barriers. Some of those are financial, some of those are logistic. We've got a lot of two parents working. We've got grandparents looking after children. Some of people come from countries where our standard child and family health nursing system, for example, didn't exist there. It's all done through primary healthcare.
Some.
It's a language barrier. Some kids don't have a blue book. They've come to the country afterwards for some Aboriginal communities, it can be a whole issue around trust and the whole issue of colonisation and historic racism as well history and racism. So we really do need to find solutions that will really do two things, improve engagement with our child and family health service.
For parents, but also the other thing we see is kids falling off the Cliff where they've had quite a lot of families having quite a lot of support in the before the baby is born, and then when the baby is born, we kind of lose the families again. And so we really need to be thinking about continuity of care as well.
Nick.
Next slide, please, Marte. So hubs are one of the many potential solutions. I'm not saying that every community needs a hub. I think well resourced communities which engage find our universal platform, reasonably simple to engage with the system works. We don't actually need to change that, but there are many.
Many communities that are organically building hubs because the community members are actually struggling to engage with our usual systems. So a hub is different to just colocation. So having four services altogether.
Not talking to each other or saying hello, but not really integrating their systems. That's not a hub, that's colocation. A hub isn't a single service either. It's not just everyone in health being in one spot. A hub is a deliberate thinking about let's combine health.
With often a non government organisation, possibly education, will play in that role, possibly other welfare services will play in that role. It really kind of depends on what the community needs, but also what the various partner you've got, a group of partners who want to play together as well.
Some of the hubs we'll show you are fantastic. Have millions of dollars in their building and they are beautiful and welcoming. You don't need to wait for millions of dollars to build a hub. Many of our hubs have just started out of out of a sheer need to engage, often with a hub. You you will have a navigator who supports families in terms.
Reaching additional needs, those navigators can be funded by health, non government organisations, but critical to the hub is you must have a hub coordinator. You need someone who does that really hard work of making sure people integrate without a hub coordinator it's very hard to be anything more than colocation. The Hub coordinator takes an active role.
And engagement and referral of families with health and social service partners. Thank you. This is just some this is now published in paediatrics. Katarina Osagic and Nan, who were the lead authors on this. And essentially it's from a translational research grant where we.
Evaluated the effectiveness of hubs in engaging children and their families in the first 12 months afterlife in the Rockdale area and in the Miller area, and we essentially used this same technique of recruiting migrant and refugee women, people who've been in the country for less than 10 years.
Antenatally and post Natally and then we LinkedIn those who lived in the hub area got LinkedIn with the hub coordinator and navigator and those who did not. We just followed them up through their routine EMR and what we clearly see is that hubs are superior in terms of keeping.
Families engage with their child and family health, nursing services and accessing those services four times as much as usual care and that point balsa made about only 10% of children are engaging at 12 months. That that's pretty consistent in a lot of data that's out there in terms of usual services.
The usual services do a great job, it's just the whole issue I think partly of promotion of where those are and people feeling that they can engage in those next slide please. We also know that for our migrant refugee women that they really like the hubs that they, they really like the fact that there was a continuity.
Where the midwives, who they'd already developed a strong relationship with, told them about the hubs and they got engaged. They love the convenience of the hub and that it's really close to home. So many of these women don't have a car. They're really relying on public transport or walking.
They really love the relationship that is that they had with the child and family health nurse. So I think that's one of the points where the hub, it's often the same child and family health nurse seeing you all the way through, there's a little bit more flexibility and time in terms of working, in terms of being able to text families.
Do reminders, change appointments. Mum's really enjoyed the easy schedule to reschedule appointments. There was the point quite clearly that many of these ladies still need to go to their GP for their vaccinations and you know, if I'm going to my GP for a vaccination or I'm going to my same language.
GP I don't necessarily see the point in child and family health nursing services. I think families don't really understand that difference in the Blue Book and as far as they're concerned, they've had their blue book check. But overall, we found that hubs were very feasible, acceptable, quite a modest.
Investment to actually it's really a hub coordinator and some of the additional needs around that, which is an HSM, three about .6. So it's quite a modest investment with quite clear criteria around how we get one up.
And then really, very effective in engaging women and keeping them in the child and family health nursing system, at least in that first 12 months. And what our next bit of work, which we'll talk about is going to do is going to watch women for longer. Next slide please.
So our two sites for this piece of research, so that was our preliminary research research we're now doing is going longer. We're doing the same thing, but we're now recruiting for a wider group of people for up to two years to see if we keep those that kind of level of engagement or we have kids sort of fall into that silent zone.
And umm.
That we all worry about where we sort of lose them and that's where developmental issues start to come and no one's got eyes on the child. The two sites of the Fairfield Integrated Child and Family Hub led by Karatani and Karima. That's gonna be looking. It's just about to go into its build. It's gonna look fantastic and the next site is first steps count I strongly.
I recommend anyone who's up in mid North Coast who wants to see amazing state-of-the-art hub embedded in an aboriginal community for all members of the community in Taree that is welcoming that has children giving their feedback on what they like in the hub. That is sort of nature based and sustainable pop.
First steps count. It's fantastic. Next slide, please. So I think you know our primary objective of this research is really as we've said before, is to see do hubs add to in terms of access increase engagement with child and family health, nursing services, increase identification.
Of any developmental needs and intervention and over the first three years of a child's life, it'll probably be two years due to our funding and then looking at our psychosocial needs and our Community connectedness and looking at some social return on investment.
That was the idea. I think we might actually go into the Co design now. I think we can talk about this in any of the meetings afterwards because that was the idea and this was sort of our plan of how we bring women in. But we've actually done quite a bit of a period of Co design to then adapt our trials following that.
So I'm gonna hand over to mighty. Hi everyone. My name's mighty. I'm a research assistant at use it and I've been working in the codesign phase of the stars for kids. So prior to Codesign, we did some service mapping to see what child development, parental mental health and community resources and.
Services were out there. We engaged with those services with local community, with we went to events with libraries, child and parents centres to sort of get to know what they're doing, what services they're offering and then for them to know us as well.
And we.
Created advisory groups, knowledge translation groups and steering committee, so they include parents, service providers and community reps that are guiding us through conducting the research and on how to engage best, engage with our community and the Taree side also developed the first step Scout narrow.
Called the Aboriginal Community Consultation Group, which is guiding the research in Tari.
So the idea with the coda sign is to speak to parents and caregivers of children under five years and to healthcare professionals and community organisations who support families to try to understand their experiences, challenges and priorities when seeking information that is relevant for their well-being.
When seeking support and services for themselves and their children, and to get their feedback and input on the stars for kids model as well.
So we've done interviews and focus groups with families and service providers in this first initial stage of codesign, so codesign will be iterative throughout all the project. But we did like an initial phase of Codesign that informed the way we are doing.
The trial at the moment, so the first stage was trying to understand what families, thoughts, feelings and experiences are when attending child services, what their priorities are, what challenges have they faced on that journey and what strengths they see.
In the system as well. With that data, we then got together again with families and service providers to define what are the most important strengths, problems, features that they see on those systems and what solutions can the stars for kids model.
Bring into the system, then we brainstormed around those findings and generated ideas on how to solve those problems and also incorporate strengths. We then built a prototype that we examined with families and service providers. We did many faces.
Of that prototype. Then we tested it with a small group of parents and community reps, and then finally we are in the stage of implementing it throughout the trial.
So we did one-on-one interviews and focus groups to explore how families want to find information, how they would like to get support, what their experiences have been, how can service providers support families, what they're doing right, what challenges they're experiencing and that.
Perspective from the side of service providers and families and we also talked about barriers errand and enables enablers to provide support. We then transcribed all of that information and analysed it using nvivo. And so we got codes and themes.
From that information.
These are the numbers of interviews that we did. So for our initial in depth one-on-one interviews WA did 10 parents and 10 service providers. SW Sydney did similar numbers and Taree is in the process of doing that initial interview phase.
And then with Southwest Sydney and WA, we did Co design workshops of around five families in WA and 13 families and seven service providers in Southwest Sydney.
OK.
So I just wanted to show you some of the things that came up during that initial phase of understanding what families priorities are. So these are some examples of interviews we had with parents. So the first one talks about the need of having a whole family approach. So this participant talks about.
How it's really important to support a child that is having certain needs in the family, but also the whole family. So they're talking about how it will be good to have emotional support for children, especially when you have a family with children, with a disability but supporting the.
Children in the family that don't have the illness, so supporting the whole family. We also talked about parents needs of having different opening hours so that children don't have to miss school to go to appointments and a big one was also having more information around the services that are available.
So families were finding it difficult to know what services were out there. They could see that there were many services, but they were not getting the information.
This are some quotes from the work in Taree, so interviews with service providers in Taree. There was a lot of talk. There is being a lot of talk around trauma, intergenerational trauma and poverty as well. So the first one is support around that need of.
Ensuring that basic needs are covered and how trauma is also affecting the the Community and the need for services around trauma. And then the second one is around how first steps count has been of support and of.
Like a welcoming space for families.
And So what things have we talked about in Co design? We covered many things. First, we talked about the resources that starts for kids can provide families. So we designed the infographics with families and the service providers. We talked about the design, the colours.
What data needed to be included in that infographic? We talked about what local and universal resources needed to be included and how we can adapt it to make it multicultural and the language around that, how we can include, for example, translation and interpreter services. Details on.
Infographic as well, and which languages should we have those infographics in?
We also talked about the general language in questionnaires in the stars for kids website and so families preferred the need to have non judgmental, strength based family child focus language that is less clinical and it's easier to understand.
That it's short, simplified, and easy to read with visuals that make it more friendly for families. We talked about the actual questionnaires of both the MRFF and the ARC projects, family said it was really important to have a confidentiality statement at the beginning of the.
Survey. So we had it sort of like at the end and in an e-mail, but they wanted that highlighted because it felt really important to know that their information was going to keep be kept private. We code assigned the questionnaire blurbs, which are sort of an explanation that we include in some questions.
So families wanted to know why we're asking questions, that it's not just for the sake of asking, but why that information is going to be helpful for us to understand their needs better and to support them in a better way. And we also talked about the words we use in the hub. So calling the Hub a hub, for example, was something that they like.
It it seemed like a welcoming place and they they agreed with calling it a hub. But then we were calling the service navigator and they said that sounded like a bot like an not an actual person that was gonna support them. And it didn't feel like a friendly person.
So we changed the name to family supporter. We talked about the resources that we're gonna be giving through the stars for kids project and they said that they would rather have not a lot of resources. So it's not overwhelming but.
Variant. Various types of resources, so videos, podcasts, short videos that they can see at any point, and one big issue there was they highlighted that there's a lot of information around, so they usually see things on TikTok on Instagram.
On websites and they're overwhelmed by the amount of information, but they don't know what information to the trust we talked about the process of the of both trials. So we did service mapping. We talked about how they would like their data to be managed and then what would make them feel secure as well.
So things like they usually don't answer unknown phone numbers and they were worried about being able to contact the navigator and so a potential solution was the navigator sending a text message before calling, introducing themselves and giving a time where they.
Going to be called so that they know it's them. We talked about soft entry and recruitment as well. They would prefer antenatal recruitment. So to have that support before a baby is born, but also to do post Natal recruitment as well so that we don't miss any mothers.
And finally, we talked about the hub design itself. So as Sue said earlier, the Karitani Karamar hub is having a build at the moment. So we were very lucky to be a part of their codesign workshops that they did with families and the architects and.
Designers that are working on that build, and so we talked about things like colours, playgrounds. We included parents and children as well. So they had different images of playgrounds, colours, textures and the kids were giving stickers and they could place the sticker on the things that they prefer.
So that was a beautiful workshop. We talked about what things needed to be included in the hub so that it felt like a secure place, a safe place and welcoming for everyone, and also how how they like to be approached in the hub.
And a big thing that appeared in Southwest Sydney was the need to have classes and activities for families so that they could meet other families and engage and have that social connection.
This is an example of a synthesis that we did so we would do this after every session of Co design. So we've spoken about almost all of this, but I think another important one was the waiting period. So families recognise that there's a long waiting list for services.
Usually, and that they would like online resources that we can send while they're waiting, have also regular check insurance with them so that they don't feel that we've forgotten about them being on the wait list. So we talked about different things that can be done to make them feel more secure and welcome.
This is an example of a code assigned resources. This is the infographic that we have for immediate support. The left we have our initial version and on the right the one that we landed. So that's version five. We changed colours, we changed. We included opening hours and we changed some services as well.
Based on the families and service providers feedback.
This is another resources. This is the recruitment flyer. We simplified the language, we made it easier to for families to read. We also Co designed the stars for kids website. So what was important to include there.
What resources do parents want to see?
And this is the child development infographic. So this resource was developed with raising children's network. So we partnered with them to have all that information in in the child development.
Infographic.
And to wrap up, that code assigned stage, I just wanted to show you some quotes that we get from we got from the Community representatives and their experience in this code assigned process. So one of them said it's really important to make sure that the study is aimed at the community needs are not simply based on the knowledge.
Knowledge of the panel as this sometime misses the needs in the community. Someone else said, allowing for community representatives to take some questions and informations into the community and having focused meetings in order to bring a larger base of knowledge and input from the greater community.
And last one said, I have learned that we do have a voice and that it is valued that having a community representative a bit part of the process allows for layman's opinion and for needs to be met outside of the scholarly discourse.
Also, do you want to give some updates on the trial for the MRFF? Or you can go ahead I think.
I can go ahead if. Yeah. So these are just some updates on on the trial. So for the tiered model of care in the Southwestern Sydney side, we have 76 baseline service completed, 39 from the intervention Group, 37 from the control group. We have been recruiting at playgroups libraries community.
Events and we will keep recruiting for the WA site as well, so that's in process.
And for the integrated kits hub in Southwest Sydney, we have 74 participants that have completed the survey, 52 from the intervention and 22 from the control group. Most of them live in Liverpool. So we have 42 participants living in Liverpool, 10 in Fairfield and 22 in Bankstown.
And in the graph you can see their cultural or ethnic background.
Ed as who was highlighting before, we will do this follow up questionnaires when the child is 8 months, 14 months, 20 and 26 months old. So it's a bit after the due date of the Blue Book just to give them some time to complete.
That, that Blue Book check, and then we'll check how that's going.
Thank you. Thanks. Mike might stop sharing. So we'll get to see everyone.

 **Rebecca Bosward** 44:03
Thank you very much. Also, Marte and Sue, that was a really wonderful presentation. I would like to open up to everyone here in the webinar now for Q&A. If you have any questions, I will be keeping an eye on the chat function. Other than that, you can please raise your hand as well, but I would love to open it up for any feedback comments.
Thoughts. Questions. You're very welcome.

 **Maite Diez** 44:36
Can I make a comment? Is that all right? I think Co design is hard and it's taken us. Oh, I think we've been doing this for about two years. Probably all up, but it's really.

 **Rebecca Bosward** 44:39
Please.

 **Maite Diez** 44:51
If you're doing a commute, I would say and I'd love vouchers. View on this. I think if you're doing a community based intervention, which is all about engagement and access, it is fundamental to making sure you're on the right page.
Particularly with priority populations, who usually do not get get a voice in Co design and consumers, and it's also really reassuring, it's also very helpful from the research point of view when you're putting in your ethics and you're able to talk to research committees and say, you know, they often come with.
It's really reasonable suggestions to say, yeah, we've actually had that conversation already with our consumers and this is what they would prefer. I also think what's reassuring for us is while we have the trial and it's well done to my advertiser in the recruitment that they've been doing with the trial, it's been fantastic.
This bit with the Co design and the ongoing iterative implementation Co design going through is just as important and really important in terms of making sure that the hubs are changing with the needs as people start to engage. So I'm just going to do a plug for Co design. It's hard, it takes a while, there's a lot of thinking involved.
But it is really makes makes this project.
I don't know. I can see dalal's there online and I'm picking on Dalal because she's a consumer for Sydney HealthPartners. But we can do high lock as well first.

 **Hei-Lok Cheng** 46:26
Hi I couldn't have a question in there. I I think my missus earlier was anything about health economics evaluation of the staff.

 **Dalal Baumgartner** 46:26
Yeah.

 **Maite Diez** 46:35
Yeah, valsa. I can do it for the hub. We're doing a social return on investment with Lynn Kemp's team that will feed in. And valsa do you want to speak for the MRFF and stars for kids more broadly?

 **Dalal Baumgartner** 46:47
Hi.

 **Valsamma Eapen** 46:48
You want to do first or I can do so. Yeah. OK, so we didn't have the time to go through the aims and objectives and in terms of what the hypothesis and outputs are for the both the trials in detail, but it has got three parts, if you like. One is, what's the impact, whether it is the tiered care or whether it's.

 **Maite Diez** 46:50
No, no. So I've done social tenant environment you, yeah.

 **Valsamma Eapen** 47:08
Hub second is what? How? How is the implementation process happening? So is it acceptable, feasible, sustainable in all of those implementation aspects? And then there is the economic evaluation is the kind of value for money, right? So there is the straightforward value for money prepositions in terms of.
And the cost benefit etcetera, but for the hub, we'll also be looking at not just the cost in terms of real dollar, but also what does it mean for the wider society in terms of social return. So parents being able to kind of participate better being to be back in employment.
As I said, we are not only looking at the child development but also payment, health and the family cycle still needs. So if we can make a shift there, what would that mean for them in the general societal level as well? And we are also with the centre of Research excellence, additional funding that we've got.
We're going to also do dynamic simulation modelling, so it's it's if we can take the current outputs and the data from the trials and find the cost benefit, but we want to know if we made a change as I was saying earlier in the preschools, if it helped with the.
Literacy of a child by the time they you know in the front from that preschool attendance through the hub and the intervention, they got to the time they started school, what would that really mean? What's the modelling telling us in terms of the longer term impact in terms of trajectory outcome, finishing school?
We meant being away from, you know, all of those substance use or criminality except so it that that is the kind of long term impact that we are also hoping to do. So it's not really the cost benefit, not only the social return in terms of wider impact on the parents, the society, the community.
But also, what's the long term modelling telling us that what builders do for the participants and for the communities? So yes, definitely it's in.

 **Maite Diez** 49:17
Yeah, and and just a comment, there has been some social return on investment work and I think the dynamic simulation modelling is particularly interesting for our partners as well. Sri work in both schools and in hubs in Victoria and it's a one in three return we think. So we're really interesting to see what we have.

 **Valsamma Eapen** 49:34
Yeah.

 **Maite Diez** 49:34
Becca, I can see you. Cuba's gone 1st and then Carolyn.

 **Rebecca Bosward** 49:35
Yep. Caroline, would you like to?

 **Valsamma Eapen** 49:36
Yeah. And recently for the Karatani service navigation, it was found $7.00 to a dollar investment.

 **Maite Diez** 49:42
Hello.
Yeah.

 **Valsamma Eapen** 49:45
Yeah.

 **Caroline Mills** 49:46
Hello. Thank you. That was really interesting. I'm really pleased to hear about that. I'm in allied health and I just wonder if there was any scope for exploring the early place of Allied health with this and where that sits. And I think we know there's possibly a return on investment for.

 **Maite Diez** 50:02
That.

 **Caroline Mills** 50:05
Early intervention for allied health, so I wonder if there was any scope for that.

 **Maite Diez** 50:06
Yeah.
Yeah, but can I do hubs first and then you do MRF. So yeah, I think what's really interesting. So from our work in Rockdale, we know that, yes, hubs increase identification and needs. But what it's identified most is language, language, language, language followed by behaviour, behaviour. The kids who had.

 **Valsamma Eapen** 50:13
Yeah.

 **Maite Diez** 50:27
Clear developmental issues. Yes, it's a bit easier and our current allied health models well, some allied health models have a one-on-one clinician, they're not appropriate. It's more of a public health or or a playgroup thing. And certainly we have a very clever speech. Well, we have clever speech pathologists in our team, but we also have a clever.

 **Caroline Mills** 50:38
Yeah.

 **Maite Diez** 50:47
Speech pathologist who's looking at different models, certainly at both hubs at karatani. First sets count allied health are quite intrinsic to that, but it does need a when you're going to start doing these sort of developmental surveillance in a different way. And this is something to do with thriving kids, you do need different models to respond. So or else you're going to overwhelm your allied health.

 **Caroline Mills** 50:55
Yeah.
Yeah.

 **Maite Diez** 51:07
Waiting lease, which are already pretty slammed already valsa did you want to comment?

51:11
Yeah.

 **Valsamma Eapen** 51:12
Yeah. We would just say that I still was saying that we need to have a different model to be able to kind of really do that at this level. Again, if it's not the clinical cases that come on a one-on-one. So Kate Short, who is a speech pathologist in Southwest, has got the Deki model and and that's about providing that groups for parents of children.
Having this speech and language delay, isn't it? So you're kind of borrowing a one hour of a speech for dollars and one hour of OT from your state service and servicing this community. You know, in terms of the parents who in that initial phases, they can do a kind of really clear assessment as well as how do you do the nature.

 **Caroline Mills** 51:32
Hmm.

 **Valsamma Eapen** 51:51
Bring care and the stimulation and this, you know, all of that, Lovejoy. Play, sing type of thing in real life. Do it with other parents and learn from each other. And you know, often we say about, you know, Allied health has to be one-on-one. But that is said that at a different level when you've identified.

 **Caroline Mills** 52:01
Hmm.
Doesn't.
Hmm.

 **Valsamma Eapen** 52:11
Charger.
Support, but here we are talking about that in that additional services space then there is slight differences. There's a lot that can be done with very limited resources like as I was saying here and and Kate always says that if for those kids who are below 3 years of age, in particular, if you pay $2000 and.

 **Caroline Mills** 52:22
Hmm.

 **Valsamma Eapen** 52:32
This is a big assessment in three months time or six months time. That's not the child's profile at all. You're wasting your time and money. Whereas this he gives you an opportunity to see them in action. It's not really that you're doing on the spot. Assessment of the child, but also the parent child interaction.

 **Caroline Mills** 52:37
Mm-hmm.

 **Valsamma Eapen** 52:48
And then they can say you, you and you, we're going to send you to support you to NDIS, you, you and you come along, we'll give you more multi disciplinary assessment to see what's going on here. You, you I know wonderfully. You know you're doing go forth and do the same thing. We'll keep an eye then and watch me grow. Once you engage them based on the date of birth of the child we'll send.

 **Caroline Mills** 52:54
Hmm.

 **Valsamma Eapen** 53:08
Reminder emails. So if I captured them at 12 months from AGP wait list or from a preschool or from the community, we can send the reminder at 24 months, 36 months, 48 months, etcetera. So it's an ongoing monitoring. So they go forth and do what we have kind of said that should do for now, but in case things change again.

 **Caroline Mills** 53:10
Hmm.
Hmm.
Hmm.

 **Valsamma Eapen** 53:28
Yeah. There. So it's kind of much more fluid and dynamic and responsive than the kind of the standard allied health inventions, yeah.

 **Caroline Mills** 53:33
Yeah, yeah, there's certainly scope for a tiered model with some people don't need it. Some people need a bit. Some people need more. Yeah.

 **Maite Diez** 53:34
Yes.

 **Valsamma Eapen** 53:37
Yeah. Yeah, yeah. Yeah, yeah. Yeah, yeah, yeah, yeah.

 **Maite Diez** 53:37
Yeah.
Yeah, yeah. And and just from that lovely comment about OT. Yeah. So one of the responses in our earlier iterations of Rockdale was the spot playgroup. So we had this species and the O TS developing more that public health. You're right, because the language stuff often goes with sort of everyone sees the language stuff, and we miss the fine motor issues, and we all.

 **Caroline Mills** 53:59
Mm-hmm.

 **Maite Diez** 53:59
Why they end up being the learning difficulties that hit mainstream schools. So yeah, so the spot plan. Yeah. So what, what they did?

 **Caroline Mills** 54:03
Yeah, they turn up at 5:00 and they can't write. Yeah.

 **Maite Diez** 54:09
That's fantastic, because then it took the kids who were coming up through the hub it it did not it it kind of gave them more what they actually needed. Maybe these kids did not need a one-on-one. They needed a push up and stimulation. And then those kids who really needed the one-on-one, then they could be filtered appropriately to the right triage. I mean it's very similar with a paediatrician. It's not.
Every child needs a multi dis assessment for an autism assessment either. So I think it's a really nice trauma informed model for parents as well because they don't differentiate all the people who work in a hub, you know, they just they just don't. You can be and I just see the last comment you can be working as a family support worker. You could be a play group, A supported play.

 **Caroline Mills** 54:29
Hmm.
Hmm.

 **Maite Diez** 54:47
Group worker. You can be early childhood education. Whatever. You're just the people who work at the hub.

 **Valsamma Eapen** 54:53
Yeah.

 **Rebecca Bosward** 54:53
So just to get in there before any more questions pop up, I do have one in the Q&A. So great presentation and work two-part question. First trials are a useful way of examining what worked. Any thoughts about how community inputs informed or might have been formed, the analysis plan?

 **Maite Diez** 54:54
Sorry.

 **Caroline Mills** 54:54
Thank you.

 **Maite Diez** 55:06
Yeah.
Good question yakuba. I can say that for the the hub, my initial rather stupid idea when I wrote the grant was that we would screen. I don't know why I thought this Annie Natal and Post Natal women and those who are high risk they, you know, had a higher social and and they were going to be the people who got the hub and.
I started doing the Co design. We're the community that went. That's just you're not. Nah, we're not doing that. And I went. Yeah, you're actually right. That's just a ridiculous comment. So I think it's made us much safer, culturally safer. And I'm going to hand some stuff over to Martha about this. I think it's also certainly working with the Aboriginal community. It needs to be acknowledged.
Models of care have been with Aboriginal communities for 60,000 years. At shows are the original and fantastic hubs, as is social prescribing, so really taking the strengths based learnings with them, not from them. I think data sovereignty's a big issue for us up in Taree who owns those stories.
And I certainly for our analysis plan, we're going to be using strengths based analysis approaches because I, I, I don't want to admire the problem and be going on about deficit isn't going to be particularly useful and you miss the flavour. Marty, have you got any comments? Yeah. Val, Sir. Have you got any comments about community inputs and the analysis?
Yeah.

 **Valsamma Eapen** 56:27
No. We've kind of changed it because so this is another thing that I want to highlight. It's not a Co design in the beginning and then we are off, it's an ongoing process, so can no Co design runs all through. So it's a kind of as we get more information as we do more things, we kind of get the feedback more and then we are so it's it's a trial but it's done in a.

 **Maite Diez** 56:31
Again.
Yeah.
Yeah.

 **Valsamma Eapen** 56:47
In a way that allows us to kind of refine and and make the changes as we go along. So because it's we are figuring out, we've got a structure of a tiered care, but you know every element we can kind of refine as we go along as much as we might stick to some very basic, you know things that have to stay the same for the trial purposes. But there is a lot of opportunity.

 **Maite Diez** 56:50
Understood.
Yeah.
Yeah.

 **Valsamma Eapen** 57:07
And it's ongoing. The Co design runs all through.

 **Maite Diez** 57:11
Yeah. And the point about future sustainability plans, yeah, we are very engaged with. I think that's the beauty of partners working with our partners. They we are serving them in, in terms of the hub work, they need to know if their hub's affected or not. Certainly we've got online, we've got rapid translation of.
Co design findings already into hub design we have knowledge translation committees and I think valsa's CRE has really allowed us to really think about how this sustainability informs not only NSW Health, but Australian wide and also a partnership with the National Child and Family Hubs Network VALSA. Do you want to say anything more about that?

 **Valsamma Eapen** 57:48
No. Yeah, that's good.

 **Rebecca Bosward** 57:53
Yeah, I think that's about answered all the questions I've seen in the. Yeah, I think we've wrapped that up really well.

 **Valsamma Eapen** 57:55
I'm looking at the time and hence I'm.

 **Maite Diez** 57:56
Yeah, I think I think we're please feel free to e-mail us any of us for a chat.

 **Rebecca Bosward** 58:01
Yes.

 **Valsamma Eapen** 58:01
Yeah, yeah.

 **Rebecca Bosward** 58:04
Yeah. I think the last questions were just about assurances for ongoing funding and sustainability, but those have been addressed by our wonderful speakers. I might wrap this up, then we've hit 130 on the mark and that's been perfect timing. Thank you so much everyone for attending today. It was a very interesting and engaging webinar as as again if you have any follow up.
Questions or comments, please feel free to e-mail me or e-mail our speakers as well and thank you for your time and I hope you have a lovely rest of the day.

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