Deconstructing the barriers to engage families with complex needs in early intervention services

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The challenges for early intervention (EI) service providers are many and varied. This paper explores the efforts of the Healthy Families Team and Clare Medical Centre (CMC) in Clare, South Australia to engage families with complex needs in a meaningful and sustained way with EI service. Play2Grow is a supported playgroup, run in partnership with the CMC and facilitated by allied health clinicians from the Healthy Families Team and a mental health nurse from CMC. Play2Grow has evolved over the past two years to offer three separate sessions of playgroup in Clare and Balaklava. A total of 25 families, including 32 adults and 43 children, have been invited to Play2Grow this term. Play2Grow is accepted as core business for the Clare Healthy Families Team. It is intended that the Play2Grow model will be implemented by the equivalent Early Intervention team from the Yorke Peninsula when staffing permits.

Play2Grow considers the socioecological approach to health, seeking to address the broader determinants of health as well as risk factors for disease in the context of deconstructing barriers to engage with health services.1, 2 Play2Grow provides a space and structure and acts as the conduit for other government and non-government organisations to access and support families.

Healthy relational interactions with safe and familiar individuals provide a social connectedness and serve as a protective factor against life stressors.3 Families with complex needs including parent mental health issues, social isolation, history of trauma, unemployment, housing and financial stress are over-represented in our client population and have often been difficult to engage with EI services.

Play2Grow provides the opportunity for early intervention workers to build relationships with these families in a positive, safe and supportive environment on a regular basis. By offering continuity of access to early intervention clinicians as well as a secure base for exploration of parental fears and challenges, Play2Grow has a strong foundation. The playgroup provides a safe haven for reflection and modelling of change that somewhat emulates the Circle of Repair in that the families trust that the relationships built with facilitators “will (almost) always set things right”.4 By creating this safe environment for families, facilitators develop the opportunity for therapeutic interventions that promote changing behaviours that in a traditional early intervention ‘package’ would potentially be interpreted as firm and uncompromising. The facilitators’ ability to ‘hold’ the group whilst modelling and encouraging behaviour change is key to the playgroups’ success. All facilitators of Play2Grow engage in their own reflective practice and have a deep understanding of the benefit of responding to the evolving needs of the playgroup.

The Play2Grow playgroup utilises a trans-disciplinary model of care where the boundaries between disciplines are deliberately blurred to enable a flexibility that promotes broad positive outcomes.5 Trans-disciplinary practice is especially relevant in the rural context where staffing issues necessitate a sharing of responsibilities and skill base for the fluid provision of client services. This model of practice supports the opportunity for clinicians to cultivate consistent relationships with families and also allows access to knowledge from a wide array of health disciplines. If necessary, more formalised referrals to relevant professionals and community organisations can be discussed and actioned.

Each playgroup is semi-structured starting with a ‘hello song’, after which activities for the session are introduced. A gross motor activity, pretend play and fine motor activity are provided, as is access to play resources and equipment to encourage child-led free play. A sit down fruit time is provided mid way through the session to promote and teach pro-social behaviours. A ‘goodbye song’ ends playtime and introduces parent and facilitator reflection time. Facilitators harness the key elements of mindfulness practice when leading reflection: interest, curiosity and reflection without judgement.7
The two hour Play2Grow sessions allow for real-time practise of therapeutic strategies and for parents to receive feedback. Facilitators purposefully delight and reflect alongside families during playgroup sessions recognising and commenting on efforts made and positive child-parent interactions. Gentle modelling and coaching is provided when appropriate and this is carefully monitored by facilitators so as to be fluid and opportunistic whilst considering each family’s capacity in that moment.

As we begin our third year of facilitating Play2Grow, we are able to evaluate outcomes for families at different levels. This initial evaluation is informed by standardised developmental testing, reflection, interviewing partner organisations and observations of changing family functioning, behaviours and involvement in community. The following three case studies illustrate this evaluation process.

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**Case Study 1**

Cliff, Clair, Sondra, Denise, Theo, Vanessa & Ruby Cosby

The Cosby family live in one of the lower socioeconomic small outlying towns within the Lower North region. The blended family consist of two older children of Clair and three younger children of both Cliff and Clair. The Healthy Families Team was introduced to the Cosby family via referral of Theo, the eldest child of both parents. Theo was referred in 2009 at 2 years and 3 months of age with concerns primarily around his speech development. A developmental check was conducted which indicated global developmental delay. The family agreed to therapy sessions within their home town; these were poorly attended and therapists were even refused entry on arrival to home visits despite prior confirmation of appointment on the day. Frequent aborted visits over a 12 month period and escalating concerns regarding the home environment and limited opportunities for the children’s social and skill development led to Families SA involvement in 2010. The team recognised the family’s primary needs at this time involved support for housing, basic parenting skills, clothing, food, budgeting and that our team’s involvement was secondary to this. Families SA provided intensive support for the family through the Uniting Care Wesley “Targeted Early Intervention Program”.

Engagement in a one-to-one therapy situation continued to be a challenge and attendance was once again sporadic and therapeutic outcomes were not met. In late 2011, The Healthy Families Team conducted a ‘Busy Bee Developmental Screening Day’ at the local kindy and the Cosby Family were strongly encouraged to attend by the kindy director. It was at this screening that all 3 children of Clair and Cliff were identified as having developmental delay in several areas. At this time, the family was offered a place in the Play2Grow supported playgroup. Uniting Care Wesley (UCW) and Families SA encouraged the family to attend and UCW assisted by providing petrol vouchers for the 100km round trip. In early 2012 the three children were assessed using the schedule of growing skills and delays of between 6 and 18 months were seen in all areas of their development. As the therapeutic rapport with the Play2Grow facilitators developed, Clair and Cliff discussed their feeling of isolation within their home town. The family reported being primarily house bound and fearful of judgement by others in the town. The children were never taken to the park, did not attend the local playgroup and Clair avoided kindy drop off altogether. At Play2Grow Clair and Cliff were initially reserved and avoided eye contact with other participants. Vanessa did not speak and hid behind Clair or under a chair and looked down if she was spoken to. Ruby was aggressive and would shout “no no no”, cover her ears and threaten to throw instruments at therapists during song time. Any interaction with Ruby would be responded to with growling and tiger clawing gestures.
As 2012 progressed the children became less afraid and less reactive to social interactions. They arrived early to playgroup and would bang on the sliding door asking to be let in. Supported by a consistent warm, positive and inclusive regard the whole family gradually became solid, regular and positive members of the playgroup. At the same time as the family were reengaging with the EI team Clair was making extraordinary efforts to lose weight. She attended another health service initiative 'community foodies' and used her new found knowledge to support her children’s kindy and school as a volunteer establishing a vegetable garden and cooking with the community’s preschool children. Exploration with the CMC mental health nurse facilitator around parental anxiety was discussed and strategies were provided to Clair in particular. These strategies were practised in the context of a group and were supported by all facilitators. The children’s growing confidence was acknowledged and celebrated continually through reflection. Vanessa seeks out interactions with therapists and is becoming comfortable playing with other children. She is now being challenged by the growing size of the morning playgroup and is learning how to manage her anxiety with support from facilitators and guided parental support. Ruby enjoys the informal structure of playgroup, is always ready for song time and participates with joy and confidence. She also packs up all our musical instruments at the end. She has learnt to share and is always polite and inclusive of others in the group. Theo also made great gains in confidence and skill which prepared him well for starting school in mid 2012. At the beginning of 2013, a year after engaging with early intervention services through Play2Grow a ‘Schedule of Growing Skills’ was again conducted to review Vanessa and Ruby’s development. At this time both girls sit within developmental norms for their ages in all respective areas of development. This is consistent with therapists’ observations.

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Case Study 2
Homer, Marge, Lisa, Bart & Maggie Simpson

The Simpson family live in a very small, isolated rural town in the Lower North region. Marge is a stay at home mum of three children, Bart (6), Lisa (4) and Maggie (2). Homer works 5 days a week. The Healthy Families Team were first introduced to the Simpson family when Bart was referred by his kindy for assessment of gross and fine motor skill delays. During the course of a home assessment, it was identified that Marge had significant anxiety and depressive symptoms following the birth of Maggie who was approximately 4 months old at the time. Assessment revealed that Bart was extremely fearful of any movement experience, in particular those where his feet were not firmly connected to the ground. Bart communicated well with adults but found peer interactions challenging. Given the Simpson family’s circumstances Play2Grow was offered as a whole family intervention. Marge, Bart, Lisa and Maggie started attending Play2Grow at the beginning of 2011.

At Play2Grow it was noticed that the youngest child, Maggie, spent the majority of the 2 hour playgroup watching from the safety of her stroller. Any attempt by playgroup members to interact with Maggie caused her significant distress. She became inconsolable and her distress was enduring. It was observed that Maggie’s distress increased Marge’s level of anxiety. The team supported Marge to sit with her anxiety as Maggie was encouraged to be included in age appropriate social and play interactions. Delays in all areas of Maggie’s development were noted by clinicians. Like Bart, Maggie was also hypersensitive to movement experiences and any proprioceptive stimulation through her joints. Consequently, Maggie was delayed in her gross motor milestones. A 12 month Ages and Stages Questionnaire (ASQ) supported our developmental concerns. The 12 month ASQ generated a formal referral to the Healthy Families team and a Paediatrician, and Maggie continued to attend Play2Grow.

It was decided that in context, providing Marge with a safe environment, secure relationships and unconditional positive regard would give her the best chance to develop the confidence to tolerate Maggie’s distress. Clinicians would engage with Maggie in very short bursts of gross motor activity, such as facilitated supported stand, to induce Maggie’s distress and teach both Marge and Maggie that they could tolerate ‘big feelings’ and uncomfortable physical sensations and that everything would be ok. This was practised over and over. Time spent engaged in gross motor practise was increased slowly and the level of skill difficulty also gradually increased. Marge learnt to sit with Maggie’s distress for short intervals and Maggie’s anxiety about practising new skills lessened. All gains were recognised and celebrated. A shift in Maggie’s sense of self confidence was noted by facilitators when her language changed from “I can’t” to “I can” statements.
A Play2Grow session run at a local park adjoining the community gym provided an opportunity for a playgroup facilitator to support Marge’s enquiry about attending the gym through the subsidised ‘Wellbeing Program’ offered through the Clare Medical Centre. This introduction to exercise has given Marge the confidence to seek out a local kindy mum as a walking partner. Marge’s previous social connections had been limited to Facebook groups. In a recent reflection by Marge at Play2Grow, she described her new found confidence to arrange a play date for Maggie, attend and enjoy the social contact with a friend. She commented that this was a new experience that she would have avoided in the past. Play2Grow provides the opportunity for and encourages continuous reflection in all areas of child and parent growth. In parallel, Marge and Maggie’s confidence has increased and anxiety has decreased.

A recent 33 month ASQ assessment has supported facilitators’ observations that Maggie is now meeting age appropriate developmental norms, she is no longer under the care of a Paediatrician. Maggie has become a socially confident child who can initiate play interactions with peers and adults, join in positively with group song time and enjoys the company of other playgroup members.

Case Study 3
Darren, Samantha, Tabitha Stevens

The Stevens family live in a large rural centre in the Lower North Region with access to multiple local services. They were introduced to the Play2Grow playgroup by the Mental Health Nurse from the Clare Medical Centre as both parents (Darren and Samantha) had a diagnosis of schizophrenia. Tabitha was approximately 22 months old when Samantha started bringing her to Play2Grow with a Centacare support worker. Prior to this, Tabitha and her parents had limited experiences of socialisation outside the home. Engagement with service was the primary goal for the Stevens family. Initially, intervention was centred on making the family feel welcome and they soon became regular playgroup attendees.

It was noticed during the first term of attendance at Play2Grow that Tabitha had an ataxic gait and a tendency to fall frequently. Samantha explained that Tabitha had only recently started walking and after falling over and hurting herself, had become scared of walking. Therapists did not observe this fear and became concerned that Tabitha’s walking and balance was not improving over time. The Healthy Families team physiotherapist was asked to visit the Play2Grow session to informally assess Tabitha’s gait. Subjective examination led to disclosure from Samantha that Tabitha spent 16 hours in her cot each day and 5-6 hours sitting in her highchair. Further exploration around the reasons for containing Tabitha identified a lack of understanding about normal child development and play. A significant amount of time was spent with Samantha problem solving the reasons she was not able to let Tabitha explore her home environment. Solutions were not forthcoming from Samantha and suggestions by the physiotherapist were dismissed. A notification to the Child Abuse Report Line (CARL) was deemed necessary, however as Samantha and Tabitha were actively engaged with service, a notification without intervention was requested. Discussions with other agencies involved in the family’s care resulted in a formal referral to the Healthy Families Team for an in home physiotherapy assessment. Samantha would not agree to a home assessment, but did consent to a centre-based physiotherapy assessment which her Centacare worker attended to support Samantha. Efforts were made by the team to maintain the therapeutic relationship and within its strength make clear the importance of considering the team’s recommendations.

The Healthy Families team and Centacare purchased a child safe gate for the home and modified it to allow for the family’s cats to access their food and water. A written, structured daily program for Tabitha was provided for the family. It clearly directed time to be spent playing on the floor, and limited time spent in the highchair and cot. Tabitha’s progress was consistently monitored through the Play2Grow playgroup and after only two weeks, Tabitha’s walking had improved. It was acknowledged that the changes had been challenging for the Steven’s family and positive feedback was given to Samantha each week as improvements were noted in Tabitha’s skills across many developmental areas.
The approach with the Stevens family was structured, directive and not negotiable so far as a follow up notification would escalate Families SA intervention priority. The strength of the relationship developed with the team in Play2Grow allowed for this intervention and for the family to continue their engagement with services. The Play2Grow structure has allowed for closely monitored follow up

Samantha’s own confidence has grown over this time. She attends Play2Grow independently each week and is now involved in further study.

The Play2Grow model of intervention supports SA Health’s Primary Prevention Plan 2011-2016 which states that “To have an impact on health inequalities we need to address the social gradient in children’s access to positive early experience”.8 “Marmot’s recent research has clearly identified that sustained investment in effective early childhood interventions proportionately targeted to those in need will contribute to long term savings in health care as well as returns to education, employment and social cohesion”8. It goes on to say “The challenge is to ensure greater reach of programs that successfully provide access and services tailored to the needs of higher need families. Parents with children need ease of access to treatment services, and a whole-family approach is required when parents are being treated, for example for a mental illness. Services for more vulnerable families need to be strengths-based, developmental and long term. They should build life skills, confidence, capacities and supportive relationships with others in the local community”.8

A cost-benefit analysis has been undertaken comparing the Play2Grow model with traditional multi-disciplinary service delivery. This analysis clearly supports Play2Grow as the service delivery model with the most efficient price and far reaching outcomes. In the example of case study 1, Play2Grow as an intervention over a one year period cost approximately $1,400 compared with a multi-disciplinary service approach costing approximately $6,615. However, this considers only the Healthy Families Team and CMC intervention. It does not consider the significant cost savings to other organisations as they are no longer required. The Play2Grow model of intervention provides a nurturing, inclusive and supportive learning environment. This has huge implications for the effectiveness of this type of intervention in reducing health inequality throughout the lifespan and subsequent generations. The well known ‘Head Start’ preschool program developed in the USA in the 1960’s sought to offset economic disadvantage by providing locally based nurturing learning environments has provided evidence that social and economic benefits gained by participating in this program persisted into adulthood.9 The efficient price of Play2Grow could also include the benefits of increased capacity and empowerment of the parents as in the example of case study 1 where a parent sought voluntary work in their local community.

The three case studies presented demonstrate just some of the outcomes we have seen for families that regularly attend Play2Grow. As early intervention practitioners, we continue to be amazed and humbled by the capacity of families with complex histories and difficult life circumstances to embrace Play2Grow. We share in the joy of genuine reciprocal relationships with participants and are reminded that although early intervention is key to reduced pressure on health spending in the long term, with opportunity human development continues until we die.9 If parents and carers of children are supported by safe secure relationships they also have the opportunity to develop and learn skills that better equip them to contribute to positive health outcomes for their children. To date the outcomes of Play2Grow have been multifaceted and exciting and as a team of EI clinicians we look forward to continuing to celebrate with families as they Play2Grow.

Recommendations for the National Rural Health Conference

- To consider the efficient price of the Play2Grow model compared with traditional early intervention services.
- To consider the health outcomes of a whole family intervention that is supported by evidenced based research, beyond that, which can be measured in a funding cycle.
References


