

Families First GP Collaboration Project 2004-2006 Final Evaluation

**For the South Eastern, Sutherland and St George Divisions
of General Practice**

Compiled by: Yvonne Rowling
(CEO Sutherland Division of General Practice)

Lesley Pullen (Families First Project Coordinator,
St George Division of General Practice)

Rosslyn Eames-Brown
(External evaluator)

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Executive Summary

This is a summary of the final evaluation report for the DoCS funded Families First GP Collaboration Project July 2004 – June 2006. The evaluation specifications for this project were agreed by an evaluation team which aimed to;

1. determine the operational effectiveness of the strategies,
2. identify areas for improvement, and
3. report the findings to the funding body.

The report describes the background to the evaluation, the methodological approach, and the evaluation results. It discusses the findings and identifies recommendations for future work with GPs.

The evaluation focused on the effectiveness of project resources and information dissemination strategies. Target groups evaluated the effectiveness of resources respective to their role in the Families First GP Strategy. For example, the “Level of Care for Families” guidelines (Appendix 1), the “Helping Families” GP Resource and referral form (Appendix 2) and Divisional Newsletter items (Appendix 3) were evaluated by GPs. The Memorandum of Understanding (MoU) between GPs and Area Health Services (Appendix 4) was evaluated by Child and Family Health Nurses, midwives and four GPs who participated in an in-depth interview. Personnel in family service organisations evaluated the “Communicating with GPs Resource kit” (Appendix 5) and new parents evaluated the Parenting Support Guide (Appendix 6).

The Families First Project (FFP) was coordinated by a project officer whose brief was to develop and implement strategies that would reach over 800 GPs in four Divisions of General Practice (St George, Sutherland, South Eastern Sydney and Eastern Sydney); and, with the help of the Families First Unit Coordinator (Northern & Central Networks), reach nurses, family service organisation personnel and patients, within a two year time frame.

One of the key elements of the project was a Central referral pathway. GPs however, did not appear to use the system and the GP Referral form as per the project design. This might have been due to lack of understanding about how the system was intended to work or a belief the referral could be executed more expeditiously if sent directly to the Child and Family Health Centre. Other forms developed to facilitate communication between GPs,

nurses and allied health personnel appear to have been under-utilised to various extents and for different reasons.

Most family service organisations indicated that they had no knowledge of the “Communicating with GPs Resource Kit”, although those who had found that the kit was useful, especially the examples of client focussed letters, which aimed to educate GPs about the services provided to their patients.

The Parenting Support Guide Z-cards were distributed to new parents via the “Blue Book” across the maternity units of seven hospitals in the South East Sydney area. These included Royal Hospital for Women, Prince of Wales Private, St George, St George Private, Calvary Hurstville Community Private, The Sutherland Hospital and Kareena Private Hospital. Key parenting messages were included along with website addresses and contact details of many family service organisations, to assist new parents in their roles. These cards were well received by new parents who found the information easy to find and understand. These Z-cards have been revised and reprinted to continue to spread key prevention and early intervention messages to parents.

The roll-out of Families First strategies, including the GP Collaboration project, commenced in South East Sydney in 2004. The earlier commencement of the GP Collaboration strategies precluded a more coordinated approach which could have embedded the GP strategies and resources in existing Families First activities. This may have resulted in better reach.

Recommendations as a result of the evaluation include:

1. Strengthen communication systems:
 - a. More widely investigate specific reasons for the low usage of the central referral pathway. Consider abandoning the approach if GPs prefer a local referral approach
 - b. Forge stronger local communication links between GPs, nurses and family service organisation personnel by building on existing relationships and traditional patterns of communication between all health personnel involved in the project.

- c. Appoint area specific liaison officers to facilitate communication between the GPs and other services. GPs wanting information could contact this liaison officer who would have a current knowledge of local support services.

2. Improve service promotion:
 - a. Continue distributing information (eg articles on early prevention and prevention strategies relevant to GPs; research about early life, information on activities relevant to the target group (supported playgroups, etc) to the target groups members through existing communication mediums eg. Division newsletters.
 - b. Develop web-based access to appropriate information (see above) in Divisions where this option is not already in place.
 - c. Continue to provide follow-up information and education sessions to **all** target groups. CPD and in-service education activities are possibly the most time effective methods.
 - d. Incorporate appropriate information (see above) into established Divisional programs such as Antenatal Shared Care, paediatric programs and neonatal programs and ensure it is attracts CPD points.
 - e. Request coverage of prevention and early intervention topics at paediatric conferences.

3. Abandon academic detailing as a means of follow-up education. Given the number of GPs in the area and duration of project, academic detailing was not a time efficient strategy.

4. Continue the distribution of Parenting Support Guide Cards or similar consumer-friendly resources.

Background

This is the final evaluation report for the DoCS funded Families First GP Collaboration Project July 2004 – June 2006. The report will cover the background, process and impact analysis of this project with discussion of outcomes and relevant recommendations.

South East Sydney was one of the final regions to implement Families First across NSW. Implementation for Families First began in the region in 2002/03 with the South East Sydney Strategic Directions being endorsed in May 2003 by the South East Sydney Families First Senior Officers Group.

In the South East Sydney Strategic Directions 2003-2006 a strategy was identified involving General Practitioners (GPs). This recommended a strategy to

'develop and pilot strategies in collaboration with the Divisions of General Practice, aimed at enabling GPs to have stronger linkages with the services network and enhancing awareness and practice of holistic assessment of families (psycho, social and emotional domains) Strategies may also link with the GP Antenatal Shared Care program'.

A number of consultations occurred to further develop planning for this initiative with the following groups being involved in the development of the project brief;

- The four Divisions of General Practice within South East Sydney, South Eastern Sydney, Eastern Sydney, St George and Sutherland Divisions of General Practice (Women's Health and Antenatal Shared Care representatives)
- Families First Project Management Group
- Families First Senior Officers Group
- Representatives from the South East Health (Now known as South Eastern Sydney Illawarra Area Health Service):
 - Families First Committee
 - Multicultural Health Unit

- o Women's Health Unit

Across the region the importance of General Practitioners was identified as a priority area, as GPs have an important role in the lives of families with babies and young children aged 0-8. At that time, the service network had an emphasis on families with physical and mental health issues. These families, who were not coping well or who had social or emotional issues that impact on their capacity to adequately parent and care for children, often find it difficult to access support. Although focus on those families is necessary, it is equally important to ensure that adequate service, including information and support, is given broadly to ensure that *all* families with young children receive support.

Families First works on a universal population approach and aims to achieve outcomes that impact on a whole range of families in the community. It was anticipated that strategies developed within this project would have a universal approach and where a need was identified, some targeted strategies. Culturally and linguistically diverse communities (CALD) were also identified as needing additional information and support from health workers, particularly GPs.

In 2002 the Women's Health Unit, South East Health, undertook consultation with CALD women to identify their issues in regard to maternal and neo-natal health¹. The women involved in this consultation identified a range of information they would like from maternal and neonatal health services that they perceived were lacking (Table 1).

¹ Women's Health Unit South East Health. 2002. *Addressing health inequities in maternal and neonatal health services in culturally and linguistically diverse communities.*

Table 1: Maternal issues identified by the Women’s Health Unit

- | | | |
|---|---|---|
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Basic mother and baby health Information | <input type="checkbox"/> Parenting |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Women’s rights and policies in hospitals | <input type="checkbox"/> Post Natal Depression and other issues |
| <input type="checkbox"/> What to expect of the birthing process | <input type="checkbox"/> Information on pregnancy checks | <input type="checkbox"/> Feeding patterns |
| <input type="checkbox"/> What to expect of the hospital process | <input type="checkbox"/> Exercise for pregnancy | <input type="checkbox"/> Settling |
| <input type="checkbox"/> Information on free services | <input type="checkbox"/> Birth complication | <input type="checkbox"/> Sleeping patterns |
| <input type="checkbox"/> Importance of visiting a GP early in pregnancy | <input type="checkbox"/> Immunisation | <input type="checkbox"/> Identification of infant problems |

It was identified that GPs in south east Sydney are in an ideal position to disseminate much of this information to the community they work in, particularly the CALD community, as all the women involved in the consultation stated that they had visited their GP at least once during their pregnancies.

Initial feedback from GPs in the advisory group was that they were unaware of service providers who supported parents and therefore did not have contact information or referral criteria. Anecdotal evidence suggested that the GPs and the service network worked in isolation of each other and there was little communication between the two. GPs had been used to referring to the specialists’ network where they would receive a follow-up letter detailing the treatment given to their patient. The MoU with South East Health was developed to meet this need.

GPs believed that if they referred to the service network and community services, they would get no feedback as to the outcome of their patient’s care from these services and then would be unsure as to whether their patient had been followed up at all. GPs work in a time poor environment and find it difficult to follow up the outcome of every patient whom they have referred. It was therefore important when it came to the development the resources to incorporate feedback mechanisms to reassure the GPs that their patients were being followed up.

The primary focus for the GP Collaboration Project involved five strategies-

1. Provision of information to GPs about Families First in south east Sydney through;
 - Understanding what information GPs need about Families First
 - Identifying communication pathways for GPs that can be utilised to disseminate information.
2. Supporting learning and development through the Continuing Professional Development Programs conducted by the Divisions.
3. Supporting GPs to be able to link with the service network through:
 - Identifying entry points for GPs to refer to the service network those families who are expecting or caring for a new baby or young children (0-5 yrs) that need additional support or services.
 - Key contacts in the service network for referrals.
 - Identify systems and processes for linking GPs into the broader service network.
4. Provide GPs with resources to assist them to identify families needing additional support and provide timely information.
5. Assist GPs in being able to work collaboratively with the service network through linking and supporting current Divisional programs that complement the Families First objectives e.g. Child and Youth Health program, Antenatal Shared Care and Women's Health Programs.

Thus the objectives were determined to be:

1. To strengthen the communication mechanisms between GPs, South East Health and the broader service network supporting families who are expecting or caring for a new baby or young children (0-5 years).
2. To enhance the capacity of GPs to participate in care planning and joint delivery of support to families who are expecting or caring for a new baby or young children (0-5 years).
3. To enhance the capacity of GPs to link with the service network and provide resources for referral to support families who are expecting or caring for a new baby or young children (0-5 years).
4. To enhance the capacity of GPs to provide timely information to families who are expecting or caring for a new baby or young children (0-5 years).
5. To assist GPs in being able to provide a holistic approach to the health and wellbeing of families.

The project covered the 10 Local Government Area's (LGA's) of South East Sydney which include; Botany, Hurstville, Kogarah, Randwick, Rockdale, South Sydney, Sutherland, Sydney, Waverley and Woollahra. These LGA's are incorporated into the geographical coverage of the four Divisions of General Practice (DGP) in the south east Sydney region (South Eastern Sydney, Eastern Sydney, St George, and Sutherland DGPs) which includes over 1,100 GPs.

A project officer was employed and based at St George DGP and an advisory committee established to oversee the project. Membership included

- 4 GPs, 2 from the northern sector and 2 from the southern sector, who provided GP input.
- Chief Executive Officer, Sutherland DGP
- Women's Health Program Officer, St George DGP
- 2 Families First Project Officers (area based and division based)

- Input from Senior FFP managers, community services and DGPs as needed.

This committee oversaw the development and implementation of a strategic plan (Appendix 7) to address the project objectives, and evaluate their effectiveness.

The implementation of the strategic plan was undertaken by the project officer across the 4 DGPs. A multi-faceted approach was needed so as to:

- familiarise GPs with the service network
- facilitate and enhance relationships between GPs and Child and Family Health Nurses (CAFH) and the service network and
- enable women to have an understanding of the services available to support them during the postnatal period and into their life as parents.

The overriding approach of this project was capacity building, that is, one of developing ongoing sustainable relationships between GPs and other service providers as well as between GPs and their patients. In regard to this the following strategies were implemented:

1. A Memorandum of Understanding (MoU) between the Divisions of General Practice and the Area Health Service, South East Health was developed. The MoU outlined a universal entry referral pathways between GPs, maternity and child and family health nursing services, with referral and feedback fax forms aimed to address the barriers raised with regards to existing communication pathways. The MoU was used as a tool to clearly set out roles and responsibilities of both parties and it endorsed a documented process for the service network staff to follow. A central intake fax number was established with the health funded Families First Registration Officer, enabling GPs to fax their referral request and have it assessed and passed onto the appropriate service by the intake officer.

The form for the GPs to refer to the service network was made available as a Medical Director template so that GPs had easy access.

2. Articles about Families First and interest articles regarding support for families were disseminated in GP and some practice staff newsletters. This enabled key messages to be communicated to GPs involving:
 - Raising awareness of the GP being in the unique position to identify families that need support and how to provide that support
 - Evidenced based research that supports the Families First approach
 - Understanding of a partnership approach to patient care and the referrals and network pathways to resource GPs in that approach
 - Raising awareness of support services for referral so as to encourage the building of relationships.

3. A GP support resource, "*Levels of Care for Families*", showing 3 levels of care, prevention; prevention and early intervention; and early intervention and treatment; providing contact details for family service providers. This laminated resource enables the GP to have a succinct local resource to hand, which suggests services depending on the need of the family.

4. A GP support resource, "*Helping Families – GP resources*", designed to prompt GPs to ask psychosocial questions of parents when they bring in their child(ren) for immunisations. This was aimed at helping GPs identify families that may be in need of information and/or support. This resource was linked to the "*Levels of Care for Families*" resource and produced as one brochure.

5. A resource for the wider service network to promote and assist communication with GPs - *"Communicating with GPs Resource Kit"*. This kit had examples of client focussed feedback letters which would provide feedback to GPs about their patient as well as 'in-time' education for the GP about the service and what it can provide for families.

6. A *Parenting Support Guide Z-Card* was developed to support parents with information, and provide them with service providers contact details, websites and a communication tool to take to their GP for discussion. These were distributed to new parents via the "Blue Book" across the maternity units of seven hospitals in the south east Sydney area. These included Royal Hospital for Women, Prince of Wales Private, St George, St George Private, Calvary Hurstville Community, The Sutherland and Kareena Private Hospitals.

7. All the GP resources were promoted in GP newsletters, handed out at GP CPD activities and GPs were also visited in their own practices to have resources delivered and explained. Brief information announcements, explaining the rationale of Families First and the GP resources, were also included at CPD events.

A Families First specific CPD activity was trialled in St George DGP addressing *Early Child development; Families First and GPs: What's the connection?;* and *Psychosocial Issues and Service Collaboration*. Service providers were also invited to talk to the GPs about their service. It was decided not to expand this across to the other DGPs because of the poor attendance, 50 GPs had registered but only 25 attended on the night. Initial discussion regarding the establishment of a Families First specific website for GPs was abandoned as it was considered non-sustainable.

Evaluation methods

Introduction

The evaluation specifications for the Families First Project (FFP) were determined by an evaluation team comprising the chief executive officer of Sutherland Division of General Practice, the Families First Project coordinator for St George Division of General Practice and an external evaluator. This section of the report describes the evaluation aims and design, the target groups, development of data collection instruments, data analysis methods and the evaluation implementation procedures.

Evaluation aims

The FFP evaluation was carried out approximately two years after FFP strategies were introduced to the Eastern, South Eastern, Sutherland and St George Divisions of General Practice. The evaluation aimed to determine the operational effectiveness of the strategies, to identify areas for improvement and to report the findings to the funding body.

Evaluation framework

The project was examined from a process evaluation perspective. This approach provides information to program coordinators and administrators to guide decisions on program improvement while it is in formative stages (Owen 1993:25).

The evaluation focused on the effectiveness of six project resources. The resources were evaluated by the target groups which included GPs, midwives and child and family health (CAFH) nurses non-government health service providers and patients/clients (Table 2).

Table 2: Project resources for evaluation and target groups

Resource to be evaluated	Target group/s
Memorandum of Understanding (MoU) between GPs and Area Health Services with referral and feedback forms (Appendix 4)	GPs Child & Family Health nurses and midwives
"Level of Care for Families" practice guidelines (Appendix 1)	GPs
"Helping Families" GP Resource (including GP referral form) (Appendix 2)	GPs
Newsletter items in Divisional Newsletters (Appendix 3)	GPs
Continuing Professional Development (CPD) attendance	GPs
"Communicating with GPs Resource kit" (including proformas for client focussed letters) (Appendix 5)	Non-government organisation health service providers
"Parenting support guide" (Z card) (Appendix 6)	New parents

Methodological approach

Mixed Methods were used for data collection and analysis. This is a combined quantitative and qualitative approach that is commonly used in the health sciences (Dixon–Woods, Agarwal, Young, Jones & Sutton 2004; McLeod, Meagher, Steinert & Boudreau 2000; Anstine & Grinenko 2000; Guillemin, Challier, Urlacher, Vancon, Pourel 1999; Jordan, Price, King, Masyk & Bedell 1999). The approach acknowledges the benefit of using both qualitative and quantitative data collection and analysis methods to minimise the inherent limitations of both methodologies. Each addresses methodological issues including the establishment of research reliability, validity and credibility from different angles.

Reliability in qualitative research is addressed by providing lucid, complete and well checked set of data on the research topic (Grbich 1999 p.59). This was done in the FFP evaluation by checking the accuracy of interview transcriptions against the audio-tape. On several occasions this meant listening and re-listening to the tape to check a muffled word or phrase. Few corrections however were necessary to the text.

Once the accuracy of the transcriptions was verified the evaluator examined the interview data to categorise common themes. The categories were checked by the project coordinator and results from the analysis discussed by the evaluation team.

The reliability of the quantitative questions included in the interviews and surveys was addressed by ensuring questions were clearly written, not double-barrelled and were sufficient in number to address the key aspects of a topic and given an explanatory preface when required (Judd, Smith, Kidder pp.52, 234). These explanations sometimes included defining a construct or showing a document, such as the GP newsletter, to the GP being interviewed to exemplify the question in point. This approach aims to provide an accurate portrayal of the “social world” or phenomenon being studied (Grbich 1999 p. 59) and as such, it increases the validity of the research findings. Ensuring questions are posed to all participants in a similar manner is also important to reduce bias potential and to maximise the internal validity of inferences. To address this issue the interview approach was collaboratively determined by the project coordinator and external evaluator as they were to conduct the interviews.

Objectives for data collection

The objectives were to determine whether the target groups, comprising GPs, Child and Family Health (CAFH) nurses², personnel from non-government family service organisations and CAFH clients had:

- Received the resources developed for their use
- Read the resources
- Used the resources
- Perceived the resource as informative, useful, not useful etcetera
- Recommendations for the improvement of resources.

In addition, GPs, CAFH nurses and non-government family service organisations were asked whether the level of communication and collaboration between

² Formerly called Early Childhood Centres

themselves and other health professionals had changed as a result of FFP initiatives.

Development of data collection instruments

Seven instruments were developed for data collection, most of which collected both qualitative and quantitative data (Table 3: see Appendices 2-8). A decision was taken during the planning stages that long surveys would not be used as target group members would probably be time poor. It was speculated that the potential response rates would be higher if the survey focused on essential questions.

Table 3: Data collection instruments and type of data collected

Data collection instruments	Type of data collected	Sampling method
1. GP Interview questions	Qualitative and quantitative	Key informants
2. GP survey questions	Qualitative and quantitative	All GPs in Divisions invited
3. Parenting support guide card survey	Qualitative and quantitative	Convenience
4. Child and family health nurses (CAFH) survey)	Qualitative and quantitative	Purposeful (a range of centres targeted in each area)
5. CAFH Nursing Unit Managers survey	Qualitative and quantitative	All informants invited
6. Non-government Family Service Organisations survey	Qualitative and quantitative	All organisations invited
7. Non-government Family Service Organisations	Quantitative	All organisations invited

GP questions- for the interview and survey

Interview questions were drafted by the external evaluator, discussed with the other two team members and revised accordingly. The interview schedule comprised a total of 12 questions of both open and closed types, some had sub components. Questions were piloted with four practicing GPs. No changes were required to the interview questions (Appendix 8).

The purpose of the GP interviews was twofold. To:

1. Pilot questions to guide the development of quantitative questions for distribution to the GP populations of Eastern, South Eastern, St George and Sutherland Divisions of General Practice.
2. Obtain a detailed understanding of the operational effectiveness of the program that could not be quantitatively attained.

The evaluation team developed three questions, one with several components, for the Annual GP survey (Appendix 9) by the evaluation team. Questions were based on several interview questions. Questions were reviewed by the evaluation team and aimed to quantify GPs' perspectives regarding crucial aspects of the program, specifically, whether they had received the GP resources, read them and used them.

Questions for Child & Family Health Managers and Nurses

The development process for the CAFH nurses survey (Appendix 10) and the CAFH Nursing Unit Managers survey (Appendix 11) was similar to the development of GP questions. The evaluator drafted questions based on the data collection objectives. Questions were discussed by the evaluation team and refined. Questions were then reviewed by the three CAFH Nursing Unit Managers. The survey comprised a total of 15 questions of both open and closed types, some had sub components. Questions primarily aimed to determine whether the resources had assisted the nurses in supporting parents with young families.

Questions for the non-government family service organisations- the postal survey and the fax-back survey

The Non-government Organisations (NGO) survey (Appendix 12) reflected the C&FHC nurses survey as both groups received the same resources. Service providers in non-government family service organisations were asked 12 open and closed questions. The survey sought to determine whether the resources had assisted them in supporting parents with young families.

This survey yielded a low response rate with most respondents stating they had not received the resources. A three question fax-back survey (Appendix 13) was subsequently produced in a bid to determine the number of organisations that had heard of the FFP initiatives, whether they had received the resources and if not, whether they would like the resources.

Questions for the Parenting Support Guide card survey

The Parenting support guide card survey (Appendix 14) was drafted by the external evaluator, discussed with the other two team members and revised accordingly. The parent of an infant accessed through a personal contact piloted the questions. He found them easy to understand and answer. Parents were asked seven questions, most of which were closed. The purpose of the Parenting Support Guide Card survey was to determine whether the information it provided met a parental need.

Data collection process

GPs provided interview data and survey data. CAFH nurses, service providers from non-government family services organisations and the parents of infants supplied survey data. Each target group had a separate survey form although the questions on some were similar in many aspects.

The GP interviews

The first stage of the data collection process to be undertaken involved interviewing GPs. Four FFP advisory committee members were identified as key informants and invited to participate in an interview. Interviews were conducted in late May and early June, 2006, either in the GP's surgery or home. GPs' were reimbursed for their time at the hourly rate paid for attending committee meetings. GPs' gave permission for audio-taping and interview data was de-identified. Prior to the interview they were given a copy of the interview questions but they were also encouraged to raise relevant issues not addressed by the set questions. Interview length was approximately one hour in each case. Interviews were professionally transcribed.

Parent surveys

The second stage of the data collection process was the Parenting Support Guide card survey. It took place between September and November 2006. The CAFH Nursing Unit Managers are responsible for the day to day administration of CAFH Centres and they, or delegate organised the distribution of surveys to staff.

Nursing Unit Managers or delegates were asked, where possible, to distribute surveys forms to nurses from a range of demographically diverse centres to increase the scope for obtaining a cross-section of parental views. This helped to obtain a maximum variation sample. The reason for the evaluation, the mechanics of the process and the nurses' role in facilitating data collection was explained to staff.

The nurses were asked to invite parents of newborns attending the centre to complete an anonymous survey and to return it to a Reply box or Reply envelope in the Centre. Surveys were in English, most questions had tick box responses and parental participation was voluntary.

FFP questions in Divisions' Annual GP survey

The third stage in the data collection process involved canvassing the views of a larger GP sample. This was achieved by asking four divisions participating in the evaluation to include three FFP questions in their Annual GP Survey. Three divisions did this between July and September 2006. The fourth division did not do it for reasons they not disclosed.

The non-government family services survey

In the fourth stage of the data collection process 33 non-government family service organisations listed on the Levels of Care guidelines were posted surveys. This was followed up six weeks later with a fax survey for non-responders.

Surveys for the Child and Family Health Managers and Nurses

The views of CAFH Managers and Nurses were polled in the fifth stage of data collection. Potential modes of survey distribution were discussed with the Nursing Unit Managers from each of the three area health service CAFH teams (Note: this project was initiated before the amalgamation of South Eastern Sydney and Illawarra Area Health Services, therefore when referring to 'area health service' the intention is to capture south east Sydney). Nursing Unit Managers from two teams

distributed survey forms to CAFH nurses at a staff meeting between December and January.

Surveys were posted to individual centres in the team. Reply paid envelopes for completed survey forms were included for each area health service. Nursing Unit Managers from each area were also asked to complete the Nursing Unit Manager survey form.

Data analysis

Each data collection instrument used in the evaluation supplied quantitative and qualitative data. Quantitative data was coded and statistically analysed with the assistance of the Excel quantitative software. The small amount of qualitative data supplied on the surveys was manually analysed for common categories.

Nvivo 2 a computer qualitative software package supported data coding and identification of similar and divergent themes from the interview transcripts as a greater quantity of data was involved. Nvivo 2, however, does not perform the analysis.

A three stage analysis process was used for the interview data;

- 1). Data was coded, themes were identified and propositions developed
- 2.) Themes and propositions were refined
- 3) Findings were documented

This process relies on simultaneously coding the data, reflecting on it and analysing it (Taylor & Bogdan (1984) in Minichiello, Aroni, Timewell & Alexander 1997:247). The analysis process continues while the findings are being documented and ceases when themes and propositions are verified by the data (Eckett (1988) in Minichiello, Aroni, Timewell & Alexander 1997:250; Minichiello, Aroni, Timewell & Alexander 1997:273).

Ethical issues

Obtaining consent to access target groups for evaluation purposes is a major ethical issue. Four separate target groups featured in these evaluations- GPs, parents of young children, CAFH nurses and health service providers in non-government family services organisations.

Official consent to survey GPs was not required because CEO's of the Eastern, South Eastern, Sutherland and St George Divisions of General Practice were aware that an evaluation was a reporting requirement of the FFP funding body. The evaluation team however, did liaise with the Divisions in this regard to facilitating the evaluation.

Permission was however necessary to access the parents of newborns and infants attending Community & CAFH Centres. Approval to invite parents attending these Centres to participate in the evaluation was obtained from the Departmental heads of Maternity and CAFH services of the Area Health Service affiliated with each team. Permission was also required to survey CAFH nurses. This was obtained from the Nursing Unit Managers of each CAFH team. It was not possible to seek permission to survey non-government family service organisations as there was no specific authority to contact. Therefore, surveys were sent to all organisations listed on the FFP non-government family service organisations data base.

A second major issue is the maintenance of data confidentiality and participant anonymity. Data was de-identified, pooled and anonymous. Audio-tapes were stored in a locked cupboard at the St George Division of General practice.

Results

Evaluation data for the Families First Project was obtained from personal communiqués, interviews and surveys. This section reports results pertaining to the:

1. Dissemination of information to GPs' about the Families First GP initiative strategy
2. Utilisation rate of the Central pathway for patient/client referrals
3. GP interviews
4. Annual GP Survey for Divisions
5. CAFH Nurses and Nursing Unit Managers surveys
6. Family services organisations surveys
7. Parenting Support Guide survey.

A brief summary of the results concludes this section of the report.

1. Dissemination of information to GPs'

Information about the Families First strategies was distributed to GPs through CPD³ meetings, academic detailing at practice visits, mail-outs to surgeries and in Divisional newsletter articles.

CPD sessions

Families First information was provided at 10 educational activities (Table 4). This included a short presentation by the project officer explaining the purpose and mechanics of the project and a presentation of the resources for supporting the various target groups.

³ CPD- acronym for Continuing Professional Development

Table 4: Number of GPs' attending CPD sessions that incorporated Families First information

CPD session focus	DGPs	No. CPD sessions	No. GP attendees	No. nurse attendees
Women's Health	South Eastern and Eastern Sydney (joint activity)	2	275	-
ANSC	Sutherland	1	38	-
Paediatric update	Sutherland	1	46	-
ANSC	St George	3	184	4
Small Group Learning sessions	St George	6	60	-

Academic detailing

The Families First Project Officer provided individual academic detailing of the project initiatives to 43 GPs across the four Divisional areas (Table 5). This approach is, as one GP interviewed for the evaluation said:

GP1: "... a good way of doing it (but it is) very time intensive ..."

Table 5: Number of GPs in Divisions who received academic detailing of the Families First GP strategies

Division	No. GPs
Sutherland	15
Eastern Sydney	12
St George	10
South Eastern Sydney	6

Newsletter articles

Twenty three Families First items were published in the newsletters of each of the participating Divisions between August 2004 (project inception) until September 2006. Topics included prevention and early intervention strategies, services for families with acute, chronic or complex care needs, postnatal depression groups, peri-natal mental health services, child protection and child and family health services specific to divisional areas (Appendix).

2. Utilisation rate of the Central pathway for patient/client referrals

A core element of the Families First initiatives was the development of a central system or pathway for patient/client referrals to key South East Health services. The purpose of the central referral pathway and the GP referral form was to facilitate the referral of patients to Maternity or CAFH Services. For this pathway, GPs would complete the form for patients; fax it to a Families First Registration Officer who would forward it to the appropriate CAFH centre proximal to the patient; Staff at the centre in turn would follow-up the patient.

Data regarding the extent of utilisation of the Central Referral pathway was obtained from the South East Health Families First Registration Officer. Few GPs used the system as shown in the Table 6.

Table 6: Number of GPs who used the Central Referral pathway between August 2004 to December 2006

DGP	August 2004-October 2005	November 2005-December 2006
St George	0	7
Sutherland	2	4
South Eastern	1	3
Eastern	1	2 referrals made from GPs at Broadway and Redfern. Patients were out of area

(Source: Wessels, personal communication 23 January 2007)

3. The GP interviews

The four GPs who steered the development of the Families First GP strategies were considered key informants and subsequently interviewed. They answered 12 questions about the effectiveness of the Families First GP initiatives. Questions 1-2 investigate the Families First communication mechanisms, primarily the Central Referral pathway. Questions 3-5 examine the effectiveness of the GP resources⁴. Questions 6-11 examine program sustainability and question 12 seeks

⁴ GP resources comprise the GP referral; the Helping GP Resources booklet and the Levels of Care for Families guidelines

recommendations for the project's development and additional comments.
Responses to the questions follow.

Communication mechanisms

Question 1. Have you used the Central Referral System?

Two GPs had used the central referral pathway and two had not.

The pathway when used worked satisfactorily -

GP1: "The result was great ... it turned out that my patient was just out of area however she got linked up with her local early Childhood Health Centre and there was a really good outcome. The hiccup was in the starting bit... it took a few days to get a response and I had to send a couple of faxes and wasn't really sure what was happening, so the communication didn't work beautifully..."

GP3: "Yes, I did use it...I was quite happy with the outcome..."

Neither GP received follow-up information from the family service organisation to which the patient had been referred. They followed- up the situation independently.

The other two GPs had not used the Central Referral System because:

GP 4: "... the resources ...got lost in some sort of mountain of paper work and I just haven't had the chance to just sit down and work out how it works and how much it is going to benefit me".

GP2: "...I'm in a child and family health focused practice, so we already do what this is intended to do..."

Question 2. In general, have you noticed a change or an improvement in the communication from Child and Family Services?

No improvements in communication had been detected. GPs1 and 2 commented they already had strong, long standing professional relationships with their local Child & Family Health Centre that resulted in an effective communication network.

For example:

GP1 "... We have a good relationship with our local early childhood health centre, always have had ... it hasn't been affected by the project at all ... the sister works very

well through the patient, so the patient will come in and say 'bla bla', told me to come in and see you about this' and the communication works really quite well via the Blue Book".

GP resources

*Question 3. Have you used the resource Levels of Care?*⁵

None of the interviewed GPs had used the Levels of Care guidelines, mainly because the guidelines did not provide them with new information. GP 3 pointed out that various aspects of the guidelines overlapped with antenatal care guidelines and the Divisional local health services directory while GP 2 said she already networked with intervention services and referred patients to the Department of Community Services on a frequent basis. GP 4 however did not realise she had the guidelines, did not know how to use them and lacked the time to work through the process.

Two GPs complimented the quality of the guidelines saying:

GP3: "...it is well put down... it is one page verses a book- so it is good reference".

GP1: "... I have talked to colleagues about it...and I have said, go and have a look at that and it's been useful for them too, so I...think that's a terrific thing to come out of the project. I guess it depends on what kind of relationship you have with your local services anyway, but I think that would be extremely useful".

*Question 4. Have you used the "Helping Families" resource?*⁶

None of the GPs had a copy of this resource. Two of them received a hard copy however, one was lost during the re-location of a practice (GP 3) and the other was misplaced (GP 4). The other two GPs did not receive a hard copy. GP 1 had seen a copy on the Division's website and GP 2 had been consulted about content when the guidelines were being developed.

⁵ A laminated chart that identifies referral alternatives for GPs and means of connecting psychosocially vulnerable families with support services.

⁶ This resource comprises the current immunization schedule, prompt questions for GPs to ask at immunisation visits to assess a family's psychosocial vulnerability, tools for rating risks and the contact details for support services.

Question 5. In general, have these resources increased your awareness of where to access information and/or to refer mothers and children for services?

The resources produced for the Families First project include the Levels of care Guidelines, the Helping Families GP Resources, the GP Referral form and GP newsletter items. Two of the four GPs found the above resources useful. GP1 said they were helpful except for the referral pathway. GP 3 found the resources useful not only for early intervention with vulnerable families but for implementation of aspects of antenatal shared care.

The resources had not increased GP 2's awareness of where to access information and/or to refer mothers and children for services but as she said:

GP 2: "...I think...you're asking the wrong person. We've got a high level of usage and referral anyway".

GP 4 who had misplaced some of the resources, indicated that her awareness where to access information and/or to refer mothers and children for services had not increased. She said however that "... I really want help with that area".

Program sustainability

Question 6. In your view, how much genuine GP support is there for this type of intervention role?

All four GPs said early intervention strategies were necessary and that most other GPs would agree with this position, even if just theoretically. Interviewees suggested the intervention role is:

GP1... "an absolutely vital role, so I think there would be a lot of support to do this kind of intervention".

Because:

GP 4: "...you want to help people as much as you can, but it's just impossible to know everything's available."

However,

GP 2: "... in theory there's good support ... when it comes to accessing and detecting families in trouble, I actually don't know that we're that good at it".

Question 7. What are the barriers to increasing that role?

Interviewees identified six barriers that could limit GPs' capacity to execute their early intervention role.

- Insufficient time (n=3).

GP1: "Time is always the barrier. I think this is probably reducing barriers in terms of having the information so clearly set out. You spend less time looking for the resources..."

- Lack of confidence in handling psycho-social and family related issues (n=1)

GP 2: "... sometimes we don't want to ask certain questions because you kind of know what the answer might be. I've had GPs' who've told me they... don't want someone to ...disclose how terrible they're feeling because then...they have to do something about it and often they don't feel confident".

- Concerns about the adequacy of some services (n=1)

GP2: [GPs] "are miffed about some of the services...there's lots of true and scary truths..."

- Inability to get patients into support services (n=1)

GP 2: "...some of the best services you can't get into, so it's all very well talking about helping GPs' interface with the early intervention services and support services but if you can't get into Tresillian or Karitane or the early intervention service, what do you do then?...I think that's a real issue towards improving GP uptake of services because they ...are under funded and under resourced".

- Lack of incentive to be involved in this type of initiative (n=1)

GP 3: "In GP practice we've got a lot of government sponsored initiatives to do diabetes prevention, weight loss prevention...but we don't have ... anything to support a referral sent in to the prevention services... there is no incentive for us to go this way..."

- Lack of an opportune time (n=1)

Finding an opportunity to discuss parents' psycho-social needs may be difficult when mothers and children are tired, agitated or have been waiting a long time in the surgery (GP 2).

Question 8. What will assist GPs to become more involved?

To increase GPs' involvement in the program interviewees suggested that:

- The barriers listed above are redressed (GP 2)
- Strategies be implemented to engage GPs' more deeply with the project aims and processes (GP 2)
- The program's profile should continue being promoted, for example, through lectures, wider distribution of resources and newsletter articles (GP 1)
- Divisional websites be developed, where they are not currently in place, to facilitate distribution of Families First GP support resources
- GPs be given the name of a contact person for the various services to facilitate the initiation of communication with family service support organisations (GP 2)
- GPs be informed when services are terminated or amalgamated. At present, "...some services disappear without us knowing about it" (GP 3)
- Families First GP initiatives be integrated into a broader scheme such as the Practice Incentives Programs and be remunerated accordingly (GPs 1, 3).

However, as GP 3 noted, it is unrealistic to expect the project to resonate with all GPs because:

GP 3: "There are GPs' who obviously work with the elderly patients...this program is... applicable to practices where there are more younger children, so medical centres, big medical centres where a lot of immunisation is done, smaller practices ... where there is a special interest for prevention".

And there are others, particularly older GPs who see the program as relevant to

GP 2: "...families having real difficulties and problems... [and]my patients aren't like that..."

Question 9. Are GPs the most appropriate health professional to provide this service?

All GPs agreed the early intervention assessment service should be provided by GPs, although other service providers might also be appropriate. For example:

GP 1: "... some women will see their GP as their primary support in that time ... others ...see early childhood centres, so there needs to be both in parallel, not just the GP's, not just the early childhood...as... different people access different ones'.

GPs were seen as the appropriate professional to conduct early intervention assessments because they were the point of first contact for many patients (GP 4) and they often had pre-existing relationships with these patients, especially if they have provided antenatal shared care (GP 1 , GP 3). In addition, GPs are able to assess the family in terms of broader health and welfare issues (GP 1) and GPs have a "captive audience... for the first immunization" (GP 2) which is a good opportunity to conduct an initial assessment.

Health professionals in other organisations such as CAFH could also be appropriate in some cases as:

GP2: " ...a lot of mothers relate better to the staff in the early childhood centres...they're often ideally placed to deal with things, but I think they're hamstrung if they don't have a good relationship with the GP's".

GP 4: "...we are first line...we need some way of referring them to services because we need to know what's available to tell people their options...The problem is...we can't keep up to date with it...(for) this sort of service I think a Social Worker is probably more appropriate".

In addition, it was suggested that the development of this role for general practitioners was a natural professional evolution that would appeal to some practitioners more than others-

GP 3: "... GP work is forever evolving...everybody finds there own style and where they would like to fit in...for myself... to work with families there is nothing more rewarding

and to do prevention to support the families in terms of ongoing education and health advice there is nothing better for me”.

Question 10. How would you see these resources and information being distributed to GPs in the future?

Interviewees suggested a range of distribution methods were required to accommodate the diverse preferences of the GP population. These could include:

- periodical or saturation ongoing mail-outs (GP 1)
- Web access to resources (GP 1, GP 2, GP 4)
- academic detailing -a good but time intensive approach (GP 1)
- distributing resources at CPD meetings (GP 1)
- incorporating resources into, for example, ante-natal share care, neo-natal and paediatric CPD presentations⁷ (GP 1, GP 2, GP 3)
- newsletters (GP 1, GP 3)

Question 11. Do you recall seeing the family first articles in the newsletters?

This question ascertained GPs perceptions about the effectiveness of the Newsletter as a means of information distribution and communication. It was considered effective by all interviewees. All four GPs recalled seeing Families First items in the GP Newsletter. Newsletter items were valued for different reasons. For instance- They have local relevance.

GP1: “...I might pile up the Aus Docs and Medical Observers and get round to them eventually. I read the local stuff because that’s much more relevant and more focused...”

They promote the program to GPs:

GP3: “...I thought it was great to promote it... I thought it was great to know that there is a program that supports my work on a day to day basis, and if I need assistance I can ring and refer ...”

⁷ Promoting Families First project resources at educational meetings provides an opportunity to explain the mechanics of the program, the content of the resource and to address GPs questions or concerns.

GP2: "...even if it's not immediately helpful to people, it does put child and family health on the agenda ... I'm not sure you'd have to have twelve articles over a year ... but then again maybe everyone's not reading it all the time..."

GP 4 however said:

GP4: '... my impression was that it's just another bit of information...The problem is that we've had so much information in the last few years about everything, item numbers SIPS⁸, PIPS⁹... I think a lot of us are really overloaded... we need it desperately but we just can't take it in...unless...someone ...spoon feeds you, and takes you through how to do it...the government's putting regulations and guidelines out for everything... we have to jump through all these special hoops to be able to be paid for seeing somebody... it's overload. I think newsletters are really good places to distribute it because we all read the newsletter, but at the moment I think a lot of people are really overloaded and just can't take any more in".

Question. 12. Are there any additional comments or recommendations that you'd like to make? Is there anything else that you think we'd need to know?

Interviewees offered the following comments:

- GPs might benefit from up-dating their theoretical understanding of the management of psycho-socially vulnerable families.
- GPs might also be interested in learning about the empirical evidence justifying the early intervention role.
- CPD or other educational modes could be considered for this task (GP 1). This suggests CPD content could address theories relevant to family and child care assessment and management.

GP 2 said:

G2. "I think there's too much written material and not enough linkages with the coal face and with the GP's themselves. I think we accept there wasn't the money to do this and not all the Divisions actually had paediatric programs... so there wasn't something

⁸ SIPS - acronym for Service Incentive Payment

⁹ PIPs – acronym for Practice Incentives Program

to link into apart from ante-natal share care”.

This suggests GPs need further clarification about how to best use the written resources.

This GP also points out that a time effective method for information delivery, perhaps an electronic method is required due to the difficulties of:

G2. “... just physically getting to all these things that we're supposed to get to. I guess that on-line resource, this is the way because it's cheap to develop, I mean you've got all the stuff here, you know answers and questions before... you study this material, answer some questions...tie it in with points...”

GP 4 said:

“...the project was a great idea but extremely under funded... it didn't give us the chance to do what we really wanted to ... we wanted someone at the end of the phone who we could ring and refer on the phone line...they couldn't actually employ anyone ... because ... we're (the project) across a couple of areas...to have someone for our just our area, who knows all the resources and what's available for people in our area, but the area was too big and they didn't have the funding...”

This GP suggested the distribution of information via a Divisional website would greatly assist GPs, as would being able to phone a person for the information.

GP 4: “A lot of GPs' use the Division all the time. Like we ring our immunisation girl...and say... what do I do about this? And she either tells you or finds out for you...maybe we need to have...like with mental health we employ a psychologist. Maybe we need to employ a social worker who people can go and see and be sorted out”.

GP3 suggested family support services should be available free of charge to the needy where this does not already occur.

Additional recommendations were drawn from the interview dialogue as part of other questions. GP 2 for example suggested psycho-social assessment needs greater coverage in undergraduate medicine because:

GP 2: "I did training in ethical, tricky problems in general practice at college and I can tell you that the vast majority of medical students and GP trainees were not able to tell you what to do with a six week old baby with cigarette burns on its body..."

GP 1 and GP 2 both suggested ties between GPs and local family service organisations be strengthened. In the view of GP 2, the Central Referral Pathway was a weakness in the Families First approach, claiming it:

GP 2: "...was probably too centralised and maybe most GPs need to forge local relationships, rather than central ones".

She explained how ties were strengthened in her Division

GP 2: "...our Division ran a series of workshops and we got Betty (pseudonym for a particular Childhood and Family Service nurse) to come to them... it was just really good for everybody to put a face to the service...she's built up a tremendous amount of good will".

Patient care plans might be developed for vulnerable women as per patients with chronic disease so the service is appropriately remunerated (GP 1).

4. The GP Survey

GPs in the St George Division, South Eastern Division and Sutherland Division were asked about the Families First initiatives via their Annual Divisional GP Survey. Eastern Sydney Division declined to participate. Three hundred and forty five GPs from across three Divisions participated in the survey. One hundred and fifty eight GPs responded from St George Division, 107 from South Eastern Division and 80 from Sutherland Division. They were asked three questions.

Question 1: Have you heard of the Families First initiative?

Ninety five GPs (59%) from the St George Division had heard of the Families First initiatives, 45 GPs (56 %) from Sutherland Division had heard of it and 36 GPs (34%) from the South Eastern Division had heard of the initiatives.

Question 2: Do you recall seeing Families First articles in the GP Newsletter?

A total of 149 GPs recalled seeing Families First articles in the GP Newsletter. Eighty three (52%) St George GPs recalled them; 34 (42.5%) Sutherland GPs recalled them and 32 (30%) South Eastern GPs recalled them.

Question 2a: If Yes, were the articles informative/useful/ no use/other?

The 149 GPs who recalled the newsletter items were asked whether they were informative or useful. Fifty nine GPs (40%) said they were informative and 79 said they were useful. Of this group of 149 GPs, 40% percent agreed the items were informative, 53% said they were useful and 7% did not find them useful (Table 7).

Table 7: GPs perceptions of the usefulness of FFP newsletter items

DGP	Informative	Useful	No use	Other	No response
St George (n=158)	37 (23%)	45 (28%)	4 (2.5%)	2 (1%)	70 (44%)
Sutherland (n=80)	17 (21%)	13 (16%)	3 (4%)	0	47 (59%)
South Eastern (n= (107)	5 (5%)	21 (20%)	4 (4%)	0	77 (72%)
Total	59	79	11	2	194

3. How useful were the Families First resources in assisting you with patient assessment and initiation of an early intervention?

The third question asked of GPs in the Annual GP Survey related to the perceived usefulness of the GP Referral; the Levels of Care for Families –GP Referral options and the Helping Families GP Resources (booklet). GPs were asked to indicate whether each resource had been highly useful, moderately useful, slightly useful or not useful. Alternatively, they could indicate if they had not used the resources or did not have them. Comments were optional.

GP Referral

One hundred and seventy six GPs responded to the question on the GP Referral form for Maternity and Child and Family Health services (Appendix). One hundred and thirteen GPs (64%) had the resource and 63 GPs (36%) did not (Table 8).

Table 8: Number of GPs in each Division who had the central GP referral form

DGP	No. respondents	No. GPs who had resource	No. GPs with no resource
St George	80	66	14
Sutherland	48	25	23
South Eastern	48	22	26
Total	176	113	63

Forty six GPs who had the resource however had not referred to it. This left a total of 67 GPs who were in a position to evaluate the utility of the GP referral. Sixty five GPs from the 67 who evaluated the referral form (97%) said it was useful. Ratings ranged from highly to slightly useful with approximately half the total number of respondents giving it a moderate rating (Table 9).

Table 9 Utility rating of GP referral (n= 67)

DGP	High	Mod	Slight	Not Useful
St George	13	18	14	2
Sutherland	2	9	1	0
South Eastern	0	5	3	0
Total	15	32	18	2

Levels of Care for Families –GP Referral options

One hundred and sixty three GPs responded to the question about the Levels of Care resource. One hundred and sixteen GPs had the resource and 47 GPs did not have it or could not recall it. However, 36 GPs who had the resource had not used it. This left a total of 80 GPs who were in a position to evaluate the Levels of Care for Families –GP Referral options resource (Table 10).

Table 10: GPs' perceptions of the usefulness of Levels of Care -GP Referral options (n=80)

DGP	High	Mod	Slight	Not Useful
St George	12	24	16	1
Sutherland	3	4	5	2

South Eastern	1	8	3	1
Total	16	36	24	4

Seventy six out of 80 GPs reported that the resource was useful. Ratings ranged from highly to slightly useful with almost half the GPs giving it a moderate rating.

Helping Families GP Resources

One hundred and seventy five GPs responded to the question about the Helping Families GP Resource booklet. One hundred and three GPs (59%) had the resource; however, 31 of them had not used it. This left a total of 72 GPs who could evaluate the Helping Families GP Resource booklet (Table 11).

Table 11: Helping Families GP Resources (booklet) (n= 72)

DGP	High	Mod	Slight	Not useful
St George	12	22	14	1
Sutherland	2	8	2	2
South Eastern	1	6	1	1
Total	15	36	17	4

Seventy two GPs rated the usefulness of the resource. Sixty eight GPs out of 72 described the resource as useful to varying extents. Most said it was moderately useful. Four GPs did not find the resource useful.

There were seven brief comments on the initiatives -

“Hard to apply, no time”

“Unsure” (the subject of the uncertainty was not stated)

“Not followed up”

“Available resource when need arises but not used”

“I have filed the contact details. Sorry I haven’t specifically used the service”

“I have not used the Families First program at all”

“I haven’t had many cases (where) it could be useful”

5. Child and Family Health (Early Childhood) Nurses survey

This survey aimed to determine the effectiveness of the Families First communication strategies from the perspective of CAFH nurses. A Memorandum of

Understanding (MoU) was produced to clarify the communication process to be used by midwives and CAFH nurses when referring clients to GPs or family service organisations. It included a *Consultation Request to GP* proforma. The form also had a faxback section that the GP could use for informing the midwife or CAFH nurse of the actions taken and outcomes of the referral (Appendix).

The survey comprised 15 questions. In questions 1-3 demographics information was obtained to ascertain respondents' professional status, employment pattern and locality of practice. There are 10 CAFH centres in the Sutherland area, 11 in the St George area and eight in the South Eastern area.

(www.sesahs.nsw.gov.au/aboutus.asp) (21.3.07). Questions 4-13 addressed the communication process with GPs and questions 14-15 pertained to the Parenting Support Guide (Z card).

Questions 1-3- Demographics

Twenty four registered nurses from CAFH centres and one midwife from a maternity service participated in the survey. They practice in suburbs from the catchment areas of St George, Sutherland and South Eastern Divisions. Eight were employed full time in CAFH and 17 were part time, working between 2-4 days a week.

Questions 4-13- The communication process

Nurses were asked if they had read the MoU to determine their awareness of the agreed process for nurse-GP and nurse- family service organisation communication. Fifteen out of 25 nurses had read the MoU, eight had not and two nurses did not answer the question.

To determine the level of GP initiated communication with nurses, respondents were asked:

Question 5. Have GPs referred clients to your service with the GP referral?

Three respondents, one from each division, indicated they had received a referral. For one respondent this happened once and another, twice in the past year. The

third did not indicate the frequency. The other 22 respondents indicated they had not received a referral.

Question 6. Has your service referred clients to GPs with the Consultation Request form?

Thirteen nurses from two divisions said their service had referred clients to GPs using the Consultation Request form. The minimum number of times this occurred was once and the maximum was 10. Twelve nurses said it had not happened.

Question 7. How do you usually communicate with GPs about clients?

Nurses sometimes used more than one method for GP communication. Nineteen nurses communicated by phone, eight by letter, three by the Feedback to GP Form, one by the GP Consultation request form. These forms or letters were variously faxed or posted to the GP or given to the patient to give to their GP. Two nurses communicated with the GP via the client but did not describe the approach. Presumably the nurse gave the client verbal or written information for their GP.

Question 8. How often do you usually communicate with GPs

Fourteen out of 25 nurses reported they rarely communicated with GPs but they did not quantify this response. Four said they communicated with GPs between 2-4 times per month, four said it was once every 3 or 4 months. The remainder said it was as required, once a fortnight or every 1-2 months.

Question 9. How do GPs usually communicate with you about a client?

Eight nurses indicated that GPs usually communicate with them by phone. One had received a letter and 17 had not received any communication from GPs'.

Question 10. How often do GPs usually communicate with you?

Thirteen nurses reported that GPs do not communicate with them. Six said the communication was infrequent, six said GPs communicated with them about every 1—2 months.

Question 11. Has communication between you and GPs changed since the introduction of the MoU for the Families First GP Collaboration Project?

Nineteen nurses did not believe communication had changed since the introduction of the MoU. One said it had changes and this nurse noted a slight improvement. Four were unsure if it had changed and one nurse did not answer the question.

Question 12. Overall, how satisfied are you with the effectiveness of the communication you have with GPs?

One nurse was very satisfied with the effectiveness of communication with GPs, six were satisfied, 11 were unsatisfied, three were very unsatisfied and four said the question was not-applicable to them.

Question 13. How might Nurse-GP communication be improved?

Ten nurses did not offer suggestions. The other 15 nurses suggested communication could be improved by:

- Implementing strategies that help child and family health nurses and/or GPs to more clearly understand the services that each can provide for families needing early intervention (n=4)
- GPs' documenting relevant information such as diagnosis or follow-up treatment in babies Personal Health Record n=3
- Providing C&FH nurses with lists of GPs with a paediatric and/or women's health focus
- Encourage use of referral forms (n=5)
- Encourage GPs to contact nurses with patient/client feedback rather than have it come via the patient/client (n=3).

Question 14. Have you read the Parenting Support Guide?

The Parenting Support Guide card is given to new mothers in their Blue Book on the birth of their baby. It offers parenting tips and contact numbers for services that may assist parents having difficulties with their baby or family relationships. The information is intended to support the individual advice given to new parents by GPs, CAFH nurses and the personnel of family service organisations. Nurses were asked if they had read the card and if it could be improved.

Sixteen out of 25 nurses had read the card, nine had not. Four nurses suggested minor improvements to the card. Two nurses from the one area noted an incorrect phone number on the card, which has subsequently been corrected. One nurse recommended it be printed in languages other than English and one had seen few cards in clients' books so recommended that distribution be increased.

Question 15. Do you need more information about the Families First GPs Strategy or services provided by local GPs?

In the final question, 12 nurses indicated they needed further information and 12 did not need it.

Nursing Unit Manager survey

Questions on the Nursing Unit manager survey was similar to the CAFH nurse survey. One nursing unit manager out of three responded to the survey. She had read the Memorandum of Understanding and considered it a useful communication aid. She could not specifically comment whether communication with GPs had improved since the introduction of the FFP strategies as she was not involved in clinical work. As a general suggestion however, she suggested communication could be improved if GPs were reminded about the referral pathways documented in the MoU and nursing staff were reminded of the FFP resources available for this area of practice. She was unaware if her organisation provided information about CAFH (Early Childhood) services to GPs at their

educational meetings and at present, her organisation did not use the local GP newsletter to promote their services.

6. Family Services Organisations

Family Services organisations are the third set of providers of family and child intervention services included in the Families First evaluation. Survey forms were posted to 33 organisations whose contact details were listed on various FFP resources. The survey comprises 12 questions which focus on the usefulness of the resources developed for family service organisations¹⁰ and the modes and effectiveness of communication between family service organisations and GPs. Respondents were invited to make additional comments.

Eight organisations responded to the survey. Four from the Sutherland Divisional area, two from the St George area and two from the South Eastern area. Responses are as follows.

Question 1. Did you receive a "Communicating with GPs Resource Kit", a resource kit to help agencies communicate with GPs?

Two organisations (Number 9 and Number 17) received the Kit.

Question 2. If yes, did you find this kit useful?

Both organisations found the information contained in the kit to be useful.

Question 3. What aspects were the most useful?

The most useful aspects were the general information and examples of Client focussed letters (Organisation Number 9, Organisation Number 17). Organisation 17 also found the general information and contact details for Divisions of General Practice useful.

¹⁰ A Communicating with GPs Resource Kit was developed to explain the aim of the Families First Collaboration project. It comprised information about strategies for communicating with GPs, care plans and case conferencing strategies and examples of feedback letters to facilitate the communication these organisations have with GPs.

Question 4. Have you used this kit to improve your service's communication with GPs?

One organisation has used the kit to improve communication, specifically by using the client focussed letters as a guide for communication. The other had not used it.

Question 5. Has communication between you and GPs changed since the introduction of the "Communicating with GPs Resource Kit" as part of Families First GP Collaboration Project (June 2005)?

Communication had changed for one organisation who said they had subsequently: "Sent more information back to GPs following referral" (Organisation 17)

Question 6. Did you have any response from the GP(s)?

Neither organisation received feedback from GPs.

Question 7 How do you mostly communicate with GPs about clients?

Four organisations answered this question saying the telephone was the mode of communication used for this purpose.

Question 8. How often do you usually communicate with GPs?

Seven organizations out of eight answered this question. Two organizations indicated they occasionally communicated, three said it was monthly for a few patients, one organization communicated with GPs around every three months while for another it was once a fortnight.

Question 9. How do GPs usually communicate with you about a client?

Respondents were asked to identify the usual modes of communication from a list. They could identify more than one option if desired. Six organisations answered this question and two did not respond. Four organisations said GPs communicated with them by phone and three said it was by letter

Question 10. On average, how often do GPs usually communicate with you?

Three organisations indicated GPs communicated with them occasionally, (a few times per year). For two organizations it was once to twice a month and three did not indicate the frequency of communication.

Question 11. Overall, how satisfied are you with the effectiveness of the communication you have with GPs?

Three organisations were satisfied with the effectiveness of the communication with GPs, two were very unsatisfied and three did not respond to the question.

Question 12. Additional comments (optional)

Respondents said:

- "We still do not receive many referrals from GPs- I am not sure why".
- "We are about to do a new mail out particularly for our Care management program"
- "We would appreciate access to the resource kit to streamline communication with GPs" (Three commented to this effect)
- "We always contact a referring GP when there is a referral letter. However, most clients who are referred by GPs are referred verbally only. There are the occasional exceptions".

Fax-back survey

Eight family services organisations responded to the above 12 question survey reported above. Only two of them had the *Communicating with GPs Resource Kit* survey. Subsequently, a three question survey was posted to 33 family service organisations to determine whether they had heard of the project, received the kit or wanted a kit. Organisations were asked to fax their survey form to the St George Division of General Practice.

Sixteen organisations replied to the Fax-Back survey. Only one organisation which responded to the 12 question Family Services Organisation survey also responded to Fax-Back survey. This data was included in the Fax-Back analysis because the response provided by this one organisation to the same question on the separate surveys was different. The fax-Back survey asked:

Question 1. Have you heard of the Families First GP Collaboration project?

Eight organisations had heard of the project and eight had not.

Question 2. Did you get a Communicating with GPs Resource Kit?

None of these organisations received the kit. This question was asked in the Families First survey and the Fax-Back survey. It was this question that was answered differently by the one organisation. This result is important because it suggests that information dissemination through out the organisation was incomplete and it has implications for the improvement of the Families First initiatives.

Question 3. Would you like us to send you a copy?

All sixteen organisations were interested in obtaining a *Communicating with GPs Resource Kit*.

7. The Parenting Support Guide

The primary aim of the Families First initiatives is to improve the support available to 'at risk' young families. Resources were developed to assist health professionals and support service organisations to achieve this goal and the Parenting Support Guide was compiled for new parents. The guide provided parenting tips and information about the support services and was distributed to new parents via the "Blue Book" across the maternity units of seven hospitals in the South East Sydney area. These included Royal Hospital for Women, Prince of Wales Private, St George, St George Private, Hurstville Community, The Sutherland and Kareena Private Hospitals.

The final component of the evaluation aimed to determine whether the guide was a useful resource for new parents. No attempt was made to distinguish between first time parents and parents who had other children as the relevant point was whether clients had read the information on the guide and whether it was considered useful.

Survey participants were canvassed from CAFH within the South East Health as this former area health service was affiliated with Eastern, South Eastern, St George and Sutherland Divisions of General Practice. One hundred and seven parents were invited to participate in the survey. Eighty one parents (76%) completed a survey form. Twenty four of the 107 parents (22%) invited to participate had not received the Parenting Support Guide so could not complete a survey. Another two declined the invitation.

Forty eight parents from centres within the Sutherland Division catchment completed a survey. Twenty two parents from centres in the South Eastern and Eastern Divisions' catchment participated and 11 parents from within the St George catchment participated.

Participants were asked seven questions. Six had a tick box response. Question 7 required a brief written response.

Question 1. Around how long have you had the card?

Seventy two out of 81 participants had been in possession of a card for a period of ranging between several weeks to 7 months. One parent did not answer this question (Table 12).

Table 12: Length of time parent had card (n=81)

Length of time	No. of responses
Less than one week	8
Less than one month	18
About 1 month	25
About 2 months	13
About 3 months	5
More than 3 months	11
No response	1

Question 2. Have you read the information on the card?

Thirty five had read all the information on the card. Thirty two had read some of it and 14 had not read any of it.

Question 3. Was the information on the card easy to find?

Fifty participants reported the information was easy to find, 17 said some of it was easy to find and 14 had not read it so could not comment.

Question 4. Was the information on card easy to understand?

Fifty four indicated that all the information was easy to understand and for 13, some of it was easy to understand.

Question 5. Have you used the information on the card?

Thirty three participants had used the information, 34 had not used it.

Question 6. Overall, how useful is the information on the card?

Forty eight said the information was useful, 17 said it was partly useful.

Question 7. How could the card be improved?

Seventeen participants suggested improvements for the card, 13 recommended a magnetic strip be applied to the card to permit attachment to the refrigerator.

Other suggestions were that:

- information about the Breast Feeding Association include more details on the services (n=1)
- the card be larger (n=2)
- the telephone numbers of the support services be listed on a fridge magnet (n=1).

Seven participants offered general comments which were mainly positive. They said that:

- "The card covers all of the questions and feelings of being a parent for the first time"
- "I think the card is great, very helpful"
- "Good information, easy to read and very accessible"

- “Very informative”
- “Very handy and easy to carry when needed in an emergency”

Two others said:

- “Have someone point out the card as a resource”
- “We receive so much info when we have a baby. I tended to read more what I felt was an absolute necessity. No reason I didn’t read yours”.

Summary

This section of the report presented information from Divisional records and results comprising interview and survey data from each of the three groups of health service providers and the users of those services – patients/clients. The next section of the report discusses these results.

Discussion

The purpose of this study was to evaluate the Families First GP initiatives that were implemented across the Eastern, South Eastern, St George and Sutherland Divisions of General Practice between 2005 and 2006. It evaluated the effectiveness of the Families First GP strategies and identified areas for improvement. This section of the report discusses the dissemination of Families First information to target groups and reports their perceptions of the effectiveness of the strategies and resources designed to support these strategies. The project targeted GPs, CAFH nurses, specific groups of midwives, personnel in family support service organisations and the parents of children up to the age of 5 years.

Data was obtained from personal communiqués with the South East Health Families First Registration Officer, Divisional records held by the Families First Project Coordinator, surveys of family service organisation personnel, CAFH nurse and midwives. GPs were interviewed or asked about Families First initiatives as part of the Annual GP survey. The questions were brief due to space limitations but the four GPs interviewed for the evaluation provided additional detail.

Resources were developed for each target group to increase their knowledge of the strategies available to support early assessment and intervention for families 'at risk' of social and emotional problems. The following discussion addresses the extent to which project information was disseminated; target groups' perspectives on the various resources and about the strategies that may be required to further support the FFP initiatives.

1. Dissemination of information to GPs'

Results from the Annual GP surveys of St George, Sutherland and South Eastern Divisions of General Practice indicate different awareness levels of the project across divisions. Fifty nine percent of St George Division respondents had heard of the Families First GP initiatives, 56 % of Sutherland Division respondents had heard of it and 34% of respondents from the South Eastern Division had heard of the initiatives. Information about the Families First strategies was distributed to GPs through various modes including CPD meetings, academic detailing at practice visits, mail-outs to surgeries and in Divisional newsletter articles.

The number of CPD meetings where Families First information was addressed varied from 2 to 9. St George Division has the largest number of members and it provided 9 meetings. South Eastern and Eastern Divisions combined for these educational meetings and held 2 meetings and Sutherland, with the smallest number of members, also held two meetings. A short presentation was usually given by the project officer at educational meetings to explain the purpose and mechanics of the project and to demonstrate the various project resources.

Forty three GPs across the four Divisional areas were informed of the project through academic detailing provided by the Families First Project Officer. With this method of information dissemination the project officer personally visited GPs' surgeries to explain the strategies and how to use the resources to best effect. This approach is effective but costly in terms of human resources and time.

Subsequently, it was not possible for the project officer to access vast numbers of GPs with this method.

In keeping with common information distribution practices in Divisions, information was periodically posted to GPs in their practices either as a discrete information package or included with other Divisional information. GPs were also exposed to Families First items, which were published in the newsletters of the participating Divisions between August 2004 (project inception) until September 2006. Twenty three items appeared in the newsletters in this period.

Topic coverage was comprehensive including issues such as prevention and early intervention strategies, services for families with acute, chronic or complex care needs, postnatal depression groups, peri-natal mental health services, child protection and CAFH services specific to divisional areas.

A little over 50% of respondents to the Annual GP Survey for St George Division recalled seeing the Families First items in the newsletters. A little over 40% of respondents to the Sutherland Division GP Survey recalled them and 30% of South Eastern Division respondents to the survey recalled the items. This means that in two out of three divisions a majority of respondents did not recall them. Why were the items not better recalled by survey respondents?

One possible explanation suggested by interview data from GP 4 is that GPs have suffered information overload in recent years and some at present cannot readily assimilate additional information. The GP suggests there is a need to incrementally deliver this information to GPs in a way that meets their individual need for information at a particular time. This recommendation reflects a principle of adult learning that proposes adults learn most effectively when they are given information which they perceive they have a specific need to know (Knowles 1984). It is an important result because it has implications for how FFP information might be conveyed in the future.

Despite lower than expected GP recall of Families First Newsletter items, the majority of GPs who did recall them indicated the items were informative or useful. One hundred and forty nine GPs out of a possible 345 GPs answered this question in the GP Survey and the majority said the items were beneficial in some respect. Although information overload situation was a problem for some GPs, it was generally agreed by GP interviewees that newsletters effectively distributed information because it reached large numbers of GPs at any one time.

It appears too, that some GPs attach a high priority to reading the Divisional newsletter because it contains information of local relevance. Consequently,

distributing information via the newsletter still appears to be an appropriate information dissemination strategy.

2. Target group perspectives on resources

Nine resources were developed to assist GPs, CAFH nurses and personnel in family support service organisations to assess and manage psycho-socially vulnerable families. For GPs these are the *Memorandum of Understanding GP Referral*; the *Helping Families GP Resource*; and the *Levels of Care for Families- GP referral options*. For CAFH nurses the resources are a *Memorandum of Understanding, including the Feedback to GP form* and the *Consultation Request to GP form*. The *Communicating with GPs Kit* which included proformas for *client focused letters* (in essence, a feedback form to GPs) was developed for family service organisation personnel while a *Parenting Support Guide* was developed for parents. The perspectives of the target groups regarding different aspects of the program, mainly the resources, were canvassed.

GP resources

GP resources comprised the *GP Resource Kit*, the *Memorandum of Understanding between South East Health and Divisions of General Practice (GP Central Referral form* and the *Levels of Care for Families- GP referral options)*. The GP Referral aimed to streamline and expedite the referral process. It was intended that the GP would complete the referral, fax it to the Registration Officer who would forward it to a CAFH Centre in the vicinity of the patient/client's suburb of residence. The CAFH nurse would then act on the referral. .

To close the communication loop, the CAFH nurse or family service organisation was to provide the GP with patient/client feed-back letters, a proforma for which was included in the *Memorandum of Understanding* given to the CAFH nurses.

To learn more about GPs experiences with these resources interviewees were asked if they had used the GP Referral and the Central referral pathway and whether it had been effective for them. This question was based on the assumption that they

had a copy of the form. This assumption was shown to be incorrect when one GP indicated her referral form was misplaced (GP 4)¹¹. GP 2 had not used the Central Referral Pathway either but this was because she already had an effective system in place. GP 1 and GP 3 had used the Pathway and said it worked reasonably well for them. Neither GP however received follow-up information from CAFH to which the patient had been referred so they followed it up independently. In one case it took a few days and a few faxes before the GP received confirmation that the matter had been addressed by the appropriate CAFH centre. Reasons for such delays need further investigation as there are a number of factors which impact on timeliness including out of area clients, delays in being able to contact the family.

To form an impression about the utilisation rate of the central referral pathway more broadly, GPs answering the FFP questions in the Annual GP Survey were asked if they had received a copy of the form and if so whether it had been useful. One hundred and seventy six GPs answered this question, 113 of them had a referral form and 63 did not or could not recall it? More GPs from the St George Division had a copy than GPs in the Sutherland and Southern Eastern Divisions¹². Of the 113 GPs who had the referral form, 67 had used it and most said it was moderately useful. Some however, indicated it was slightly or highly useful.

Despite 67 GPs *indicating* they thought the referral form was useful, approximately only one third of that number used the referral form, based on the referrals processed through the Families First registration officer. This number peaked at 16 referrals across the four Divisions in 2006. Apart from not having or recalling a referral form, what other reasons might account for the low utilisation rate of the Central Referral Pathway?

¹¹ This response subsequently prompted the inclusion of the first FFP question of the GP Survey.

¹² This may have been because the project officer for Families First was based at the St George Division and there was ready access to other project staff were able to distribute FFP information in their mail outs to GPs.

Interview data suggests several possibilities, including lack of need for this type of program in some practices because clientele are predominately older than this age bracket (GP 3); lack of skill in identifying patients with these vulnerabilities (GP 2) and GPs' pre-conceptions that their patients are not the type to need support services (GP 2).

Results indicate the Central Referral Pathway strategy has not markedly, if at all, improved the effectiveness of communication between GPs and other health personnel involved in early family interventions. This was also the observation of the GP interviewees, one of whom said GPs probably need to foster good communicative relationships with local service organisations and personnel rather than communicate through a central system.

The second resource to be evaluated was the *Levels of Care for Families- GP referral options*. Interviewees had not used the referral options guidelines, mainly because it did not offer new information. The Annual GP Survey asked GPs if they had the guidelines, whether they had used them and if so, how useful the guidelines had been. One hundred and sixteen GPs had the guidelines. Eighty had used them. Four did not think they were useful. The other 76 GPs rated them between slightly and highly useful with almost half the sample rating them as moderately useful. There was no opportunity in the survey question, due to space restrictions, for GPs to explain why the guidelines were not useful to them but possibly their reasons are similar to the interviewees' reasons.

The third resource to be evaluated was the *Helping Families – GP Resource* booklet. None of the interviewed GPs' had this resource. Two of them had received but misplaced the booklet. The other two GPs had not received a booklet. Both had seen the booklet however at some time and were familiar with at least some of the content.

One of them suggested it would be advisable to discuss the psycho-social assessment questions on page 2 of the booklet with GPs at educational meetings as some of these questions could be considered confronting if expressed as stated in the booklet. These questions could be examined at CPD to determine ways to ask them unobtrusively.

The survey too enquired about the booklet. GPs were asked if they had the *Helping Families* booklet and how useful it had been. One hundred and three GPs had it, 72 had used it. Sixty eight said it was useful, with most of them rating it as moderately useful.

Several survey respondents also supplied additional comments, suggesting for example that the resources were difficult and time consuming to apply or they had not been followed up. These comments suggest that some GPs' need additional information about how to apply project resources. A few indicated they had not used the resources which raises the question of why were the resources not used? For example, do some practices have no patients with these needs, perhaps due to age factors or were the resources not used because they could not be found when required? If the latter is a reason then there may be a need to consider how this problem could be overcome.

Generally however, FFP resources were reported as useful by a majority of survey respondents. Due to space limitations GPs in the survey could not be asked if the resources had increased their awareness of where to access information and/or to refer mothers and children for services, however, this question was asked of the interviewees.

Two of the four GPs judged the resources to be useful. However, another GP with extensive knowledge and experience in this area already, found the resources told her nothing new. The fourth interviewee had misplaced the resources.

Other issues this evaluation considered were program sustainability and ways to facilitate greater GP involvement in the program. Interviewees believed GPs generally supported the program even if it was just theoretically. Impediments were perceived however, that could limit their capacity to execute the early intervention role. Insufficient time was the main impediment but the FFP GP resources were seen at least by one GP as a means of reducing that problem because all the information required is listed in the resources. Impediments that were a little more difficult to ameliorate included a possible lack of confidence in some GPs to handle psycho-social and family related issues; lack of opportune time for a psycho-social assessment when both mother and baby are physically and/or emotionally fatigued; inadequate GP remuneration for the service; sub-optimal quality of some services and in contrast, high demand on high quality facilities which cannot be accommodated in all instances.

To increase GPs' involvement in the program interviewees suggested that the impediments to greater participation be redressed as far as possible. CPD meetings for example could examine common concerns regarding psycho-social assessments in an effort to increase GPs confidence in handling these cases. Workshops could investigate patterns of work organisation that better suit the needs of mothers and babies. GP 2 for example suggests these patients be given the first appointments of the session and that staff should let the GP know if the babies are getting restless so that they can be slotted in at the next convenient moment.

Strategies could also be implemented to engage GPs' more deeply with the project aims and processes and the program should continue being promoted through the usual means resource distribution, education, newsletter articles and so on.

It was also important, they said for GPs to be informed of services which have terminated or amalgamated with others so that they are not in a position of referring a patient to a non-existent service. To have the name of a contact person for the various services was also seen as a means of facilitating communication with family service support organisations.

All GPs agreed the early intervention assessment service should be provided by GPs because they are the point of first contact for many patients and many GPs and patients have a long standing professional relationship with established rapport that facilitates psycho-social assessment. Other health professionals, such as CAFH nurses could also be appropriate in some cases as some mothers possibly relate more readily to the nurse.

Sustainability of this program depends to a large extent on maintaining GP knowledge and interest in this aspect of medicine. At present it attracts no additional financial incentive payment so sustainability will depend on ensuring Families First initiatives have a high profile in the general practice domain. This might be achieved by developing web access to resources, continuing to present newsletter items and incorporating the Families First initiatives and resources into other programs such as ante-natal share care, neo-natal and paediatric programs and the inclusion of Families First information into CPD presentations. Greater emphasis needs to be placed however, on clarifying the links between the resource information and how it should be applied. There should also be greater emphasis on networking between GPs and other service providers to establish personal connections that will foster professional communication. It was also suggested that having Division specific Families First liaison officers might facilitate communication as it was envisaged that GPs wanting information could contact this liaison officer who would have a current knowledge of local support services.

Resources for Child and Family Health nurses

The second professional group involved in the Families First GP strategy were the CAFH. The nurses provide wide ranging clinical and advisory services to mothers of children up to the age of 5 years. They often have well established rapport with the mothers as well as expert local knowledge of the support services available within a local area. A total of 25 registered nurses most of whom worked part-time participated in the survey. Around half of them worked in different suburbs but at the one centre. The others worked in as many as three centres during the working

week. Their perspectives are based on extensive professional experience in this area of health practice.

Resources for the CAFH nurses and maternity nurses included the Memorandum of Understanding (MoU) which explains the communication process to be used between health service providers and GPs. In addition, it comprises a Consultation Request to GP that maternity and CAFH nurses can complete when they identify client issues that need follow-up with a GP. It also has a Feedback to GP form on which the nurses can document the support services the patient will use.

Despite the proformas designed to expedite communication, the level of communication between this group of nurses and GPs was low. Over half the nurses (60%) had read the MoU but only one believed communication had subsequently improved. Nineteen nurses said GPs had either not communicated with them or that it was infrequent. The other six received communiqués from GPs around every 1—2 months. GP communication with nurses when it did occur was normally by phone (n=8), occasionally by letter (n=1). Occasionally nurses received GP referrals (n= 11).

Similarly, nurses (n=14) indicated they seldom communicated with GPs. Nurse communication with GPs was generally by phone (n=19), letter (n=8) and occasionally through the patient. The Feedback to GP Form and the Consultation Request to GP form was sometimes used.

Thirteen nurses from two divisions said their service had referred clients to GPs using the Consultation Request form at different times. Twelve nurses had not used the form.

Over half the nurse sample was unsatisfied with the level of communication between themselves and GPs. A smaller proportion was satisfied (28%). The remainder said the question was non-applicable to them. These respondents also

reported little or no communication with GPs so this experience possibly determined their response to the level of communication question.

Nurses said communication between GPs and themselves might be improved by implementing strategies that help each group to more clearly understand the services that the other provides for psycho-socially vulnerable clients. This might be achieved for example by organising educational or social meetings where GPs and CAFH nurses have an opportunity to meet each other. It was also suggested that GPs' document more information about a baby's diagnosis or follow-up treatment in the Personal Health Record as this was an information conduit between the GP and nurse; that greater use be made of referral forms; that GPs contact nurses with client feedback rather than send it via the client and that nurses be supplied with up-dated lists of GPs with a paediatric and/or women's health focus.

Resources for Family Service organisations

The third group of service providers integral to the Families First project are the allied health personnel in family support service organisations operating within the catchment areas for the Eastern, South Eastern, St George and Sutherland Divisions of General Practice. These include organisations such as the Australian Breastfeeding Association, Backstop Family Support Service, Bondi Beach Cottage Family Support, Botany Family Support, Botany Migrant Resource Centre, Centacare, Engadine Community Centre, Interrelate, Karitane Family Care Cottage, Learning Links, Mascot (Deli) Family Support Service, Relationships Australia, Southern Sydney Multiple Birth Association and Sutherland Early Support Service.

The *Communicating with GPs Kit* was developed for such organisations. This resource provides general information about Divisions and proformas for client focussed letters. It describes communication strategies and care plans and conferencing approaches that might assist them when communicating with GPs.

The perspectives of family service organisation personnel were sought about their level of communication with GPs and the usefulness of the *Communicating with GPs Kit* in facilitating their communication with GPs. The response to the survey was low

with only eight out of 33 surveys completed and returned but the results were informative.

Results showed that only two organisations had received the kit. The organisations who had the kit said it contained useful information. One organisation that has used the client focused letter proformas indicated it had changed their style of communication with GPs because they now gave GPs more sharply focused information.

The survey asked family service organisations how they usually communicated with GPs about clients. The four organisations who answered this question said the telephone was the usual mode. The frequency of communication varied. For some it was occasional, for others every 3 or so months while others communicated more frequently, often once or twice a month.

Six family service organisations said GPs usually communicated with them about clients by phone or letter. Some said communication was occasional, for others it occurred every 3 or so months or at the most, once or twice a month. One organisation indicated they received few referrals from GPs and no organisation had received feedback from GPs about any clients. Some organisations were satisfied with this level of communication but others were dissatisfied.

Results from the survey suggested that a number of family service organisations may not have received the *Communicating with GPs Resource Kit* but were interested in receiving a copy. To examine this possibility further a three question Fax-Back survey was sent to family service organisations to determine whether they had (1) heard of the project, (2) received the kit or (3) wanted a kit.

Sixteen organisations replied to the Fax-Back survey. One organisation which responded to the 12 question Family Services Organisation survey also responded to Fax-Back survey. This data was included in the Fax-Back analysis because the

response to one question on the 12 question survey differed to the same question asked on the Fax-Back survey.

Eight organisations out of the 16 responding to the Fax-back survey had heard of the Families First GP Collaboration project. None of them had received the *Communicating with GPs Resource* kit. It was this question that was answered differently by the one organisation who responded to both surveys. The result is important because it suggests there may be an information dissemination glitch in the organisation which needs addressing. It has implications for the improvement of the Families First initiatives as this may have been an issue for other organisations too. All sixteen organisations were interested in obtaining a copy of the Kit.

Resources for parents – the Parenting Support Guide

A Parent Support Guide was developed to provide new parents with tips on difficulties such as settling the crying baby and strengthening family relationships. The guide also has information and contact details for family support services such as those dealing with issues like domestic violence and post natal depression.

This guide is distributed in the “Blue Book” given to new mothers across seven hospitals in the area; Royal Hospital for Women, Prince of Wales Private, St George, St George Private, Hurstville Community, Sutherland and Kareena Private Hospitals. Its’ usefulness was evaluated with the assistance of 81 parents from across the four divisions.

Most parents who completed a survey had the guide for approximately one month or more. Most of them (n= 67) had either read all of it or some of it and information on the guide was generally considered easy to find and understand. A little over 40% of the sample (n= 33) had used the information and 65 parents said the information was useful or partly useful.

Seventeen parents suggested improvements for the card. The most popular recommendation was to attach a magnetic strip to the card so it could be attached

to the refrigerator. It was also suggested that more information be included about the Australian Breast Feeding Association; that the guide be enlarged and that the telephone numbers of the support services be listed on a fridge magnet.

Several parents said the guide was a useful parenting aid. Another commented that mothers' receive a lot of information when their baby is born and there is a tendency only to read what they perceive to be the most important information which for one mother, did not include the guide. This comment suggests some mothers might not realize how soon they could need the information in this guide. This issue could be partially ameliorated if the presence of the guide in the baby's Blue Book was drawn to the mother's attention, as suggested by one parent.

Midwives and CAFH nurses are the likely candidates for this task as they see mothers in the hospital or the community setting. Over viewing information on the guide with the mother ensures they are at least aware of the contents of this resource.

In summary, this section of the report discussed the implications of the results from the Families First project evaluation for the Eastern, South Eastern, St George and Sutherland Divisions of General Practice. The evaluation examined the usefulness of the resources developed for the providers of early intervention services for young families and for the parents of young families.

The resources were generally considered useful by those who received them but distribution was patchy across the Divisions, consequently, a considerable number of GP's indicated they did not receive the resources. It was beyond the scope of the evaluation to determine whether this is fact or misconception. It is possible however, that FFP information posted to GPs may have been inadvertently discarded or misplaced by practice staff leaving the GP with no knowledge or recollection of its' receipt.

The central referral pathway appears to have been the least successful FFP strategy, whether that is because GPs prefer a more direct approach to the process or because they were unsure how to implement the process should be investigated to determine whether it worthwhile persevering with this strategy.

The final section of the report has recommendations for the project.

Conclusions and recommendations

The Project was coordinated by a project officer whose brief was to develop and implement strategies that would reach over 800 GPs in four Divisions of General Practice (St George, Sutherland, South Eastern Sydney and Eastern Sydney); and, with the help of the Families First Unit Coordinator (Northern & Central Networks), reach nurses, family service organisation personnel and patients, within a two year time frame.

This evaluation focused on the effectiveness of resources developed for the project. Nine high quality resources were developed to assist the implementation of this project across the four Divisions of General Practice. They were distributed through various methods but evaluation results indicate the coverage was incomplete such that a proportion of GPs in each division for example did not know about the project and/or had not received resources to support their participation. Most family service organisations were in a similar position. CAFH nurses were aware of the project but a reasonable proportion had not read the MoU which detailed how the communication process for the project was to be executed.

The key element of the project was a Central referral pathway. GPs however, did not appear to use the system and the GP Referral form as per the project design. This could have been because they did not understand how the system was intended to work or they believed the referral exercise could be executed more expeditiously if they sent the referral directly to the CAFH Centre or an appropriate family service organisation. Other forms developed to facilitate communication between GPs, nurses and allied health personnel appear to have been under-utilised to various extents and for different reasons.

In addition, neither GPs nor the maternity and C&FH nurses in a number of instances, appeared to have an adequate understanding of each other's role in the project and overall, they continued to communicate with each other, albeit infrequently, using the traditional modes of communication- phone, letter and patient/client.

This project has resulted in the development of nine high quality, useful resources. Information dissemination has begun but needs to be continued until all target group members have access to the resources. Information dissemination needs to be followed up with additional information and education sessions that discuss how to use the resources to best effect. Sessions should aim to provide all target groups with an understanding of how the different parts of the program fit together as an integrated system providing coordinated care optimises the potential for a good patient/client outcome.

Recommendations for the project

The following recommendations have been made as a result of this evaluation:

1. Strengthen communication systems:
 - a. More widely investigate specific reasons for the low usage of the central referral pathway. Consider abandoning the approach if GPs prefer a local referral approach.
 - b. Forge stronger local communication links between GPs, nurses and family service organisation personnel by building on existing relationships and traditional patterns of communication between all health personnel involved in the project.
 - c. Appoint area specific liaison officers to facilitate communication between the GPs and other services. GPs wanting information could contact this liaison officer who would have a current knowledge of local support services.

2. Improve service promotion:
 - d. Continue distributing information (eg articles on early prevention and prevention strategies relevant to GPs; research about early life, information on activities relevant to the target group (supported playgroups, etc). to the target groups members through existing communication mediums eg. Division newsletters.
 - e. Develop web-based access to appropriate information (see above) in Divisions where this option is not already in place.
 - f. Continue to provide follow-up information and education sessions to **all** target groups. CPD and in-service education activities are possibly the most time effective methods.

- g. Incorporate appropriate information (see above) into established Divisional programs such as Antenatal Shared Care, paediatric programs and neonatal programs and ensure it is attracts CPD points.
 - h. Request coverage of prevention and early intervention topics at paediatric conferences.

- 3. Abandon academic detailing as a means of follow-up education. Given the number of GPs in the area and duration of project, academic detailing was not a time efficient strategy.

- 4. Continue the distribution of Parenting Support Guide Cards or similar consumer-friendly resources.

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Appendices

1. "Level of Care for Families" guidelines
2. "Helping Families" GP Resource and referral form
3. Divisional Newsletter items
4. Memorandum of Understanding (MoU) between GPs and Area Health Services
5. "Communicating with GPs Resource kit"
6. Parenting Support Guide – Z card
7. Strategic plan
8. GP Interview questions
9. GP survey questions
10. Childhood and family health nurses (CAFH) survey
11. CAFH Nursing Unit Managers survey
- 12.. Non-government Family Service Organisations survey
13. Fax-back survey- Non-government Family Service Organisations
14. The Parenting support guide card survey