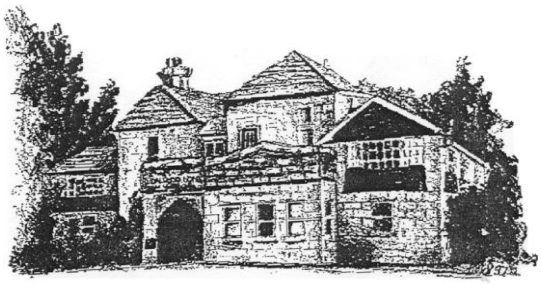


Dalwood Spilstead Service

Centre Of Excellence in Trauma-Informed

Family Intervention and Support

The Spilstead Model and Evidence Base

Dalwood Spilstead Service
21 Dalwood Avenue
Seaforth NSW 2092
Telephone 02 9951 0365
Facsimile 02 9951 0325

Northern Sydney Local Health District

The Dalwood Spilstead Service

Family Intervention and Support Service

Service Description by:

Kerry Gwynne,
Service Manager
Occupational Therapist
Dalwood Spilstead Service

Gabrielle Duffy
Clinical Psychologist
Dalwood Spilstead Service

Bronwyn Dowling
Social Worker
Manager Dalwood Home Support Program

Alison Newman
Teacher
Dalwood Spilstead Service

".. in order to develop normally, a child requires progressively more complex joint activity with one or more adults who have an irrational emotional relationship with the child. Somebody's got to be crazy about that kid. That's number one. First, last and always."

Urie Bronfenbrenner.

Making a difference that will last a lifetime!

Contents

SERVICE SUMMARY

The Dalwood Spilstead Intervention and Support Service functions as a tertiary unit of the Northern Sydney Local Health District (NSLHD) within the Primary and Community Health Service and is supported by external grants as well as the Dalwood Spilstead charitable trusts. The service provides intensive intervention and support for vulnerable families and children at risk (0-17 years) who have been identified by the NSW Department of Communities and Justice (DCJ) child protection service and other professional agencies.

Two modes of service delivery are available:

1. **The "Spilstead Model" Whole Family Service** for client families living in the Northern Beaches and Lower North Shore regions who have been referred by DCJ or other professionals.
2. **Specialist Neuro-sequential Model Trauma Service** providing Neuro-sequential Model (NM) Assessment and Consultation services for families throughout NSW who have been referred by DCJ or other agencies.

1. The "Spilstead Model" of Milieu Intervention for the Whole Family

The single governance "Spilstead Model" (SM) enables a seamless continuum of care for families irrespective of their movement between the standard DCJ child protection streams. IE:

1. Out Of Home Care
2. Intensive Family Support and Restoration service for clients managed by the DCJ child protection service.
3. Comprehensive Family Intervention and Support for families transferred from DCJ.
4. Step Down Family Support

This "one stop shop" Spilstead Model (SM) is unique in ensuring a holistic approach with all services for both parents and children provided under one service umbrella and from the one team. This enables optimum engagement with families and ensures maximum co-ordination and consistency of service delivery. The SM has been designed to integrate a comprehensive range of evidence-based interventions for vulnerable families and children at risk within a trauma-informed and relationally sensitive therapeutic milieu. The SM combines parent support, home visiting, and parent-child attachment interventions with multi-disciplinary centre and home-based education and development programs, in an environment of family centred and strength-based practice.

The service components include:

1) **Family Services:**
    a. Case management, professional home visiting and counselling.
    Including Aboriginal specific support.
    b. Individual NMT (Neuro-sequential Model of Therapeutics) adult assessment, case planning and trauma counselling.
    c. Fathers / Men's Program
    d. Parenting Education Programs
    e. Parent Self-Care and Support programs.
    f. Volunteer Home Support Program
    g. Parents In Action Group and Indigenous Advisory Group

2) **Child and Youth Services (0-17 years):**
    a. Individual NMT child assessment, case planning and trauma counselling.
    b. Home-based Early Childhood Education and Early Intervention, including Infant Supported Playgroups
    c. The Spilstead Therapeutic Preschool Program
    d. Outreach education services to mainstream preschools and schools, including individual tuition.
    e. Emotional regulation and social skills group programs.
    f. Allied Health Therapy Services including Speech Pathology, Occupational Therapy and Clinical Psychology

3) **Parent/Child Interaction Interventions:**
    a. Parent/Child Interaction Groups
    b. Attachment focused Parent/Child Interaction interventions

The Dalwood Spilstead Service (DSS) is cost effectively able to offer comprehensive and intensive intervention and support for vulnerable families via an interdisciplinary team approach. The Dalwood Spilstead Service is now internationally recognised for its unique and highly successful model of care which has been validated via both short term and longitudinal research.

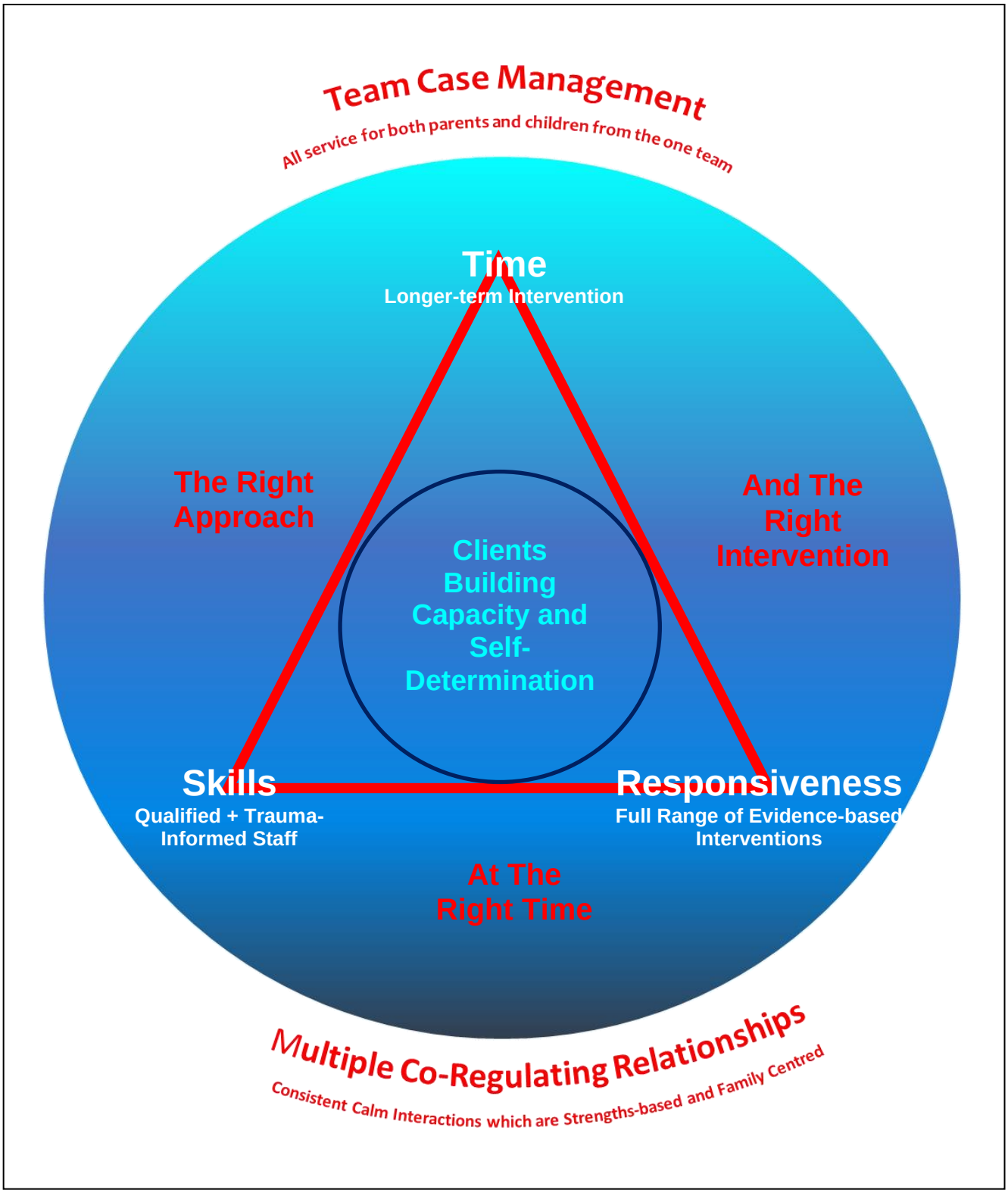
2. Specialist Neuro-sequential Model Trauma Service

Developed by Dr Bruce Perry, Child Trauma Academy, USA, the Neurosequential Model (NM) is a developmentally-informed, biologically-respectful approach to working with at-risk children which provides a way to organize the child's history and interpret current functioning.
The service components include:

    c. Individual NMT (Neuro-sequential Model of Therapeutics) Assessment.
    d. NMT Implementation and Review
    e. Neuro-sequential Model trauma informed practice training for child and family professionals and foster carers.

THE SPILSTEAD MODEL

Of Whole Family Intervention and Support



SUMMARY OF SERVICE EVALUATION AND OUTCOMES RESEARCH

- **10 Year Longitudinal Follow-Up Study 2016 n = 19 families.**
  - 73% of the children who received intervention via the Dalwood Spilstead Service due to significant child risk issues during their early years were found to have sustained the change post intervention and were functioning within the normative range on the Child Behaviour Checklist: Youth Self Report and Teacher Report measure in adolescence.
  - None of the young people had entered the juvenile justice system.
  - Almost 80% of parents reported maintenance of the clinically significant reduction in stress scores at T3 (10 years post) compared to T1 (pre intervention).
- **Service Replication: 2007-2017**
  - The Spilstead Model of whole family services was replicated by The Benevolent Society under the DCJ funded Brighter Futures program from January 2007 – December 2017. All aspects of the service model were replicated at no additional cost. A formal evaluation of the state-wide Brighter Futures program "The Evaluation of Brighter Futures, NSW Community Services" conducted by the NSW University Social Policy and Research Centre (2010) indicated that families receiving service under the SM in Northern Sydney were more likely to leave the programs with goals achieved.
  - Results also indicated that the Dalwood Spilstead Service was able to deliver nearly twice the range of services for a more conservative annual budget.
- **NSW Health Commissioned Independent Service Review 2014**
  - Conducted by Prof. Edward Melhuish, Executive Director, National Evaluation of ***Sure Start,*** Oxford University ***UK.***
  - *Summary* " it currently appears that the Dalwood Spilstead Service is a significant advance in child protection services within NSW..... when the benefits in treatment outcomes that accrue from the Dalwood Spilstead model are considered, there would appear to be a powerful case for extending the Dalwood Spilstead model more widely across NSW, and indeed Australia."
- **Child Developmental Outcomes Audit 2013**
  - An audit of clients referred over a 5 year period 2008-2013 revealed that a total of 68 children under 5 years had been referred to the Dalwood Spilstead Service with an existing diagnosis of a significant developmental disorder
  - On discharge 32 of the 68 children (47%) no longer met diagnostic criteria. 28 children of school entry age were able to commence mainstream school without additional support.
- **Formal Research Evaluation 2005-2006 n = 23 families**
  - Results indicated large effect size changes of between 0.75 – 1.67 ($p<0.01$) in parent/child interaction; reduced parent stress; parental satisfaction; parent confidence; parental capacity; family interactions; child well being; and total family functioning. 71% of children who presented on initial developmental screening with delays in the clinical range, were found to be within the normal range on post testing. 41% moved from the below average range to scores within the normal range in language development. Parents noted improvements in externalising behaviours of large effect size (1.46).

THE SPILSTEAD MODEL WHOLE FAMILY SERVICE

The Spilstead Model (SM) of intervention, has been designed to maximize the benefits of the three primary evidence-based interventions for vulnerable families and children at risk, within a comprehensive integrated and trauma-informed approach. The SM combines parent support, home visiting, and parent-child attachment interventions with multi-disciplinary centre and home-based education and development programs, in an environment of family centred and strength-based practice.

This “one stop shop” program is unique in it’s ability to provide a holistic approach with all services for both parents, youth and children provided under one service umbrella and from the one team. This enables optimum engagement and containment for families and ensures maximum co-ordination and consistency of service delivery.

The Core Components Of The Spilstead Model

- **Single governance** with integrated services provided by the one team.
- **Team Case Management** addressing family Safety, Home, Social, Community, Economic and Empowerment needs.
- Integration of 3 **evidenced based modes of intervention** within a NM trauma informed practice approach. NMT Phase II Certified Service.
    1. Family home visiting and support services supporting parent Health and Education.
    2. Parent / child attachment interventions supporting healthy relationships and parenting skills.
    3. Intensive child developmental focus including individual allied health intervention and therapeutic preschool supporting child development, skills and education.
- Routine outcome measurement regime integrated into clinical practice to review: Family Safety, Home Environment and Economics, Social and Community Participation, Empowerment, Parent and Child Health, Parent and Child Education and Skill Development.

As a tertiary unit of the Northern Sydney Local Health District, the program gives priority to those families with complex parental issues (ie mental illness, substance abuse, domestic violence, social isolation, Aboriginal or refugee background) and children who are experiencing social, emotional or developmental delays/disorders. These families present with a multiplicity of both parent and child risk factors plus early indicators of poor childhood resilience. Families co-design a package of services tailored to meet the individual needs of both parents and children.

The DSS Spilstead **Parents In Action Group** and Indigenous Advisory Group assist in guiding service planning, co-ordination of parent programs and provides parent support.

The Spilstead Model Whole Family Service Description

1. FAMILY SERVICES:

Case Management, Professional Home Visiting and Counselling Services

A Family Counsellor is allocated to each family to provide individual assistance for each parent to plan for their own needs. Services include:

- Individual counselling. Utilizing a strengths-based regarding safety planning.
- Professional home visiting. Utilising a family-centred approach to housing needs.
- Referral, advocacy and assistance with welfare issues.
- NMT Parent assessment and planning.
- Trauma counselling
- Parent physical and mental health support.
- Financial counselling and mentorship.
- Grandparent support group.

Helping families to make closer connections

Fathers / Men's Program

The **"Dads @ Dalwood"** program is designed to maximize engagement and participation for fathers and male carers in the family. A male family counsellor co-ordinates this program which provides dedicated support for men via:

- Ensuring father friendly access and orientation.
- Dads e-mail group and webpage.
- Individual counselling
- Activities afternoons for children and father's
- Dads playgroups
- Evening groups

D@ds Playgroup

This program is supported financially by the Osborne Family.

Parent Self-Care and Support Programs.

Weekly leisure and support group programs are available for parents to build social connections, self-care and regulation skills. Programs include:

- Somato-sensory regulatory activities such as:
  - Pottery
  - Creative Art
  - Yoga
  - Cooking
  - Drumming groups.
- Personal Development Programs:
  - Step Into Work Program.
  - First Aide
  - Budgeting and Money Management
  - Fashion and Beauty
- Support Groups:
  - Parents In Action Group
  - Aboriginal Advisory Group

Parents In Action Group

Parenting Education Programs

Regular parent education and support programs are offered to assist parents to build confidence and skills in areas where they have identified need. ie:

- Child development and activity ideas for home.
- Promoting emotional development and positive behaviour using programs such as:
  - Circle of Security Parenting Program
  - Marte Meo transactional Analysis
- Child safety and first aid.
- Tuning Into Teens program

Volunteer Home Support Services

A team of trained and professionally supervised volunteers provide weekly home visiting services for families who are in need of additional social support. These volunteers visit for 2 hours per week, provide personal support and assist families with a wide range of home or parenting tasks.

Volunteer support

This program is funded by the Dalwood Dog Show.

2. CHILD AND YOUNG PERSON'S DEVELOPMENTAL SERVICES

Each child is offered a full developmental screening assessment. An early childhood educator or teacher is then allocated to each child. Education and multidisciplinary early intervention support is then able to be planned according to the child's age and developmental needs.

Teacher Outreach Services

Children who are managing in mainstream settings or attend school are offered regular consultation services and monitoring of development via school or centre visits. Services include assistance with classroom programming, strategies for individual learning or behavior needs and family advocacy. Services are then reviewed via an annual Individual Education Planning IEP meeting.

Allied health professionals are able to provide school visits and in school services as needed.

Individual remedial tuition is available to school aged children via a team of retired teachers under the Dalwood Spilstead **Volunteer In School Individual Tuition (VISIT**) program. This supplements individual tuition provided by the outreach teacher.

After school groups are provided for school aged children including:

- The Seasons For Growth program
- Emotional Regulation group
- Social skills groups
- Art and leisure groups.

Home-based Early Childhood Education and Early Intervention.

Children under 2 years are offered early education services by an experienced educator via weekly or fortnightly home visits of 1-2 hours.

Services include:

- Individual home visiting play sessions with at least one parent participating in the session.
- Regular monitoring of developmental progress via formal developmental screening.
- Parent education and support to promote parent / child relationship and play stimulation.
- Toy Library resource for parents.
- Provision of home based activity suggestions and resource material.

Getting in early

The Spilstead Therapeutic Preschool

54 children (12 months – 6 years) are able to attend the Spilstead Therapeutic Preschool program 2 days per week

The program provides:

- Ratio 1 teacher: 3-5 children. Plus a trained voluntary aide per group.
- Maximum class sizes of 5 children.
- Annual NMT assessment and planning for each child.
- Attachment based model of service delivery to promote emotional and social development using Circle of Security principals.
- Regular monitoring of developmental progress via formal developmental screening.
- Individualized education programming.
- Highscope curriculum framework with intensive language and literacy focus.
- Preschool environment and activity routine informed by the Neuro-sequential Model of Therapeutics. (Perry 2007).

Caring Classrooms

Meeting Individual Needs

Therapy Services

Children who demonstrate delays in their development are provided with specialist therapy intervention according to their needs. Services include individual, group and classroom programs and can be offered flexibly throughout a range of settings. A multidisciplinary team approach is provided including the following specialist interventions:

- Speech Pathology, Occupational Therapy, and Play Therapy
- Clinical psychology diagnostic assessments and individual intervention for 0-17 years.
- Regular consultation by a special education teacher.
- Medical consultation with a Paediatrician.

Speech Pathology and Clinical Psychology services are funded by the Child's Play Sponsorship project under the auspice of the Rotary Club of Balgowlah.

Infant Supported Playgroups

Children under 3 years are offered participation in a weekly infant playgroup facilitated by an Early Childhood Educator.

The Home-based Early Childhood Education program is also supplemented by a weekly playgroup involving all parents with children in this age group.

3. PARENT/CHILD INTERACTION INTERVENTIONS

Trained staff are available to work intensively with parents and children when needed in order to promote attachment and positive parent/child relationships.

One of the following evidence-based interventions may be provided:

- Parent/Child Interaction Therapy (PCIT).
- Watch, Wait and Wonder
- Circle of Security individual program.
- Mart Meo video feedback program.
- Theraplay Dyadic Therapy

Parent / Child Thematic Playgroup programs involving a parent information session followed by a parent/child play session focusing on a specific theme further promote:

- Promoting child development and play skills.
- Parent and child attachment and interaction.
- Practical parenting skills via short-term targeted programs covering:
  - specific areas of child development
  - child-lead play
  - home-based play and development activities.
  - behaviour support and positive parent leading skills.
- Parent support via parent discussion and feedback.

Promoting "Parent" Play!

4. FAMILY STEP-UP PROGRAM

In order to provide a gradual transition and exit from the service at the family's own pace the service also offers an opportunity for parents to continue to receive support and some services at a less intensive level.

This program has been designed to ensure some ongoing support and intervention for families who have confirmed with their Family Counsellor that they no longer need intensive Family Services including regular family counselling.

Parents in the Step-Up program often find that they are in a great position to be able to offer support and mentorship to other parents in greater needs.

Opportunities to support others include:

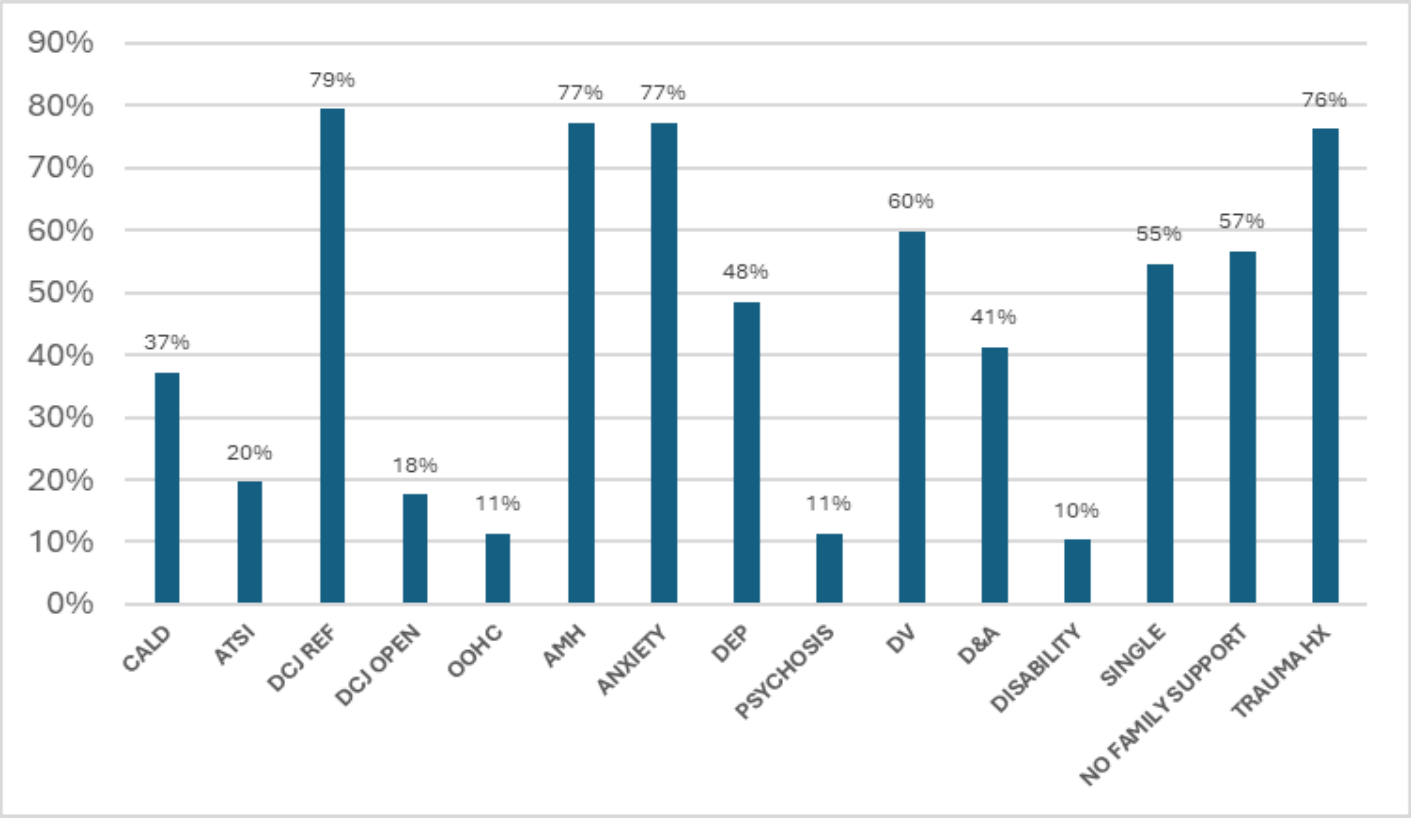
- Participation the Dalwood Spilstead Parents In Action Group (PIAG)
- Becoming a Dalwood Spilstead volunteer
- Mentorship and peer support for others in need

Volunteering!

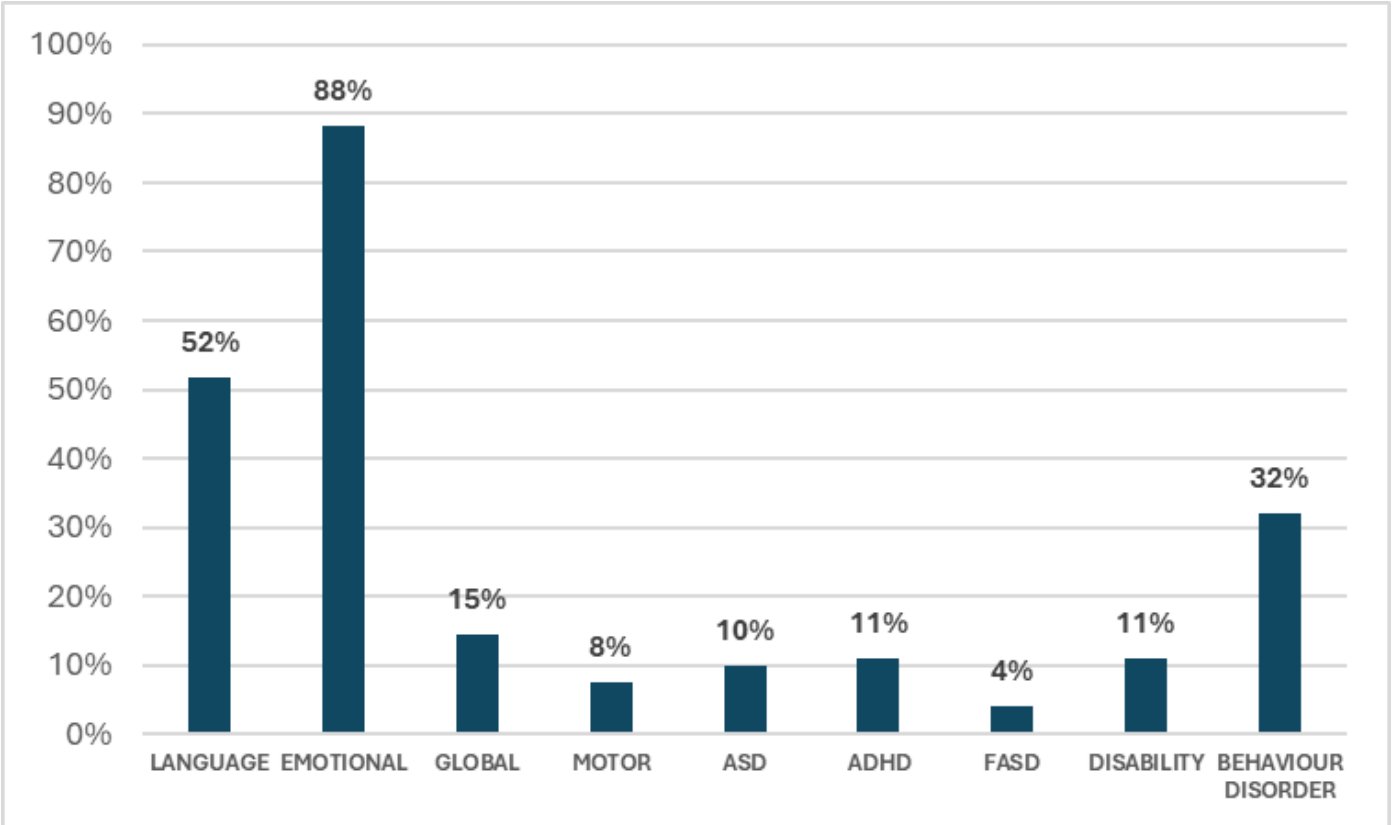
Sharing Skills!

Whole Family Service Caseload Profile 2023

Parent and Family Presentation N = 97 Families



Child / Youth Developmental Issues N = 172



Referral Data 2022 - 2023

Total Referrals		**44**
Referrals Source		
• **DCJ CSC**		**39** (83%)
○ DCJ Brighter Futures	29 (66%)	
○ DCJ CP / OOHC	10 (23%)	
• **D&A / Adult Mental Health**		**1** (2 %)
• **Other**		**4** (9%)
Referral Outcome		
• **Offered services**		**43** (86%)
• **Unable to contact**		**0** (7%)
• **Assessed and referred to secondary tier service**		**0** (2.3%)
• **Assessed as Ineligible by BFAU**		**1** (5%)
Engagement Rate of Eligible Referrals		**40 (93%)**
Average Total Caseload		**85 families**
Average Length of Participation		**2.8 years**

DCJ Funded "Brighter Futures" Data Last Full Contract 2018 - 2021

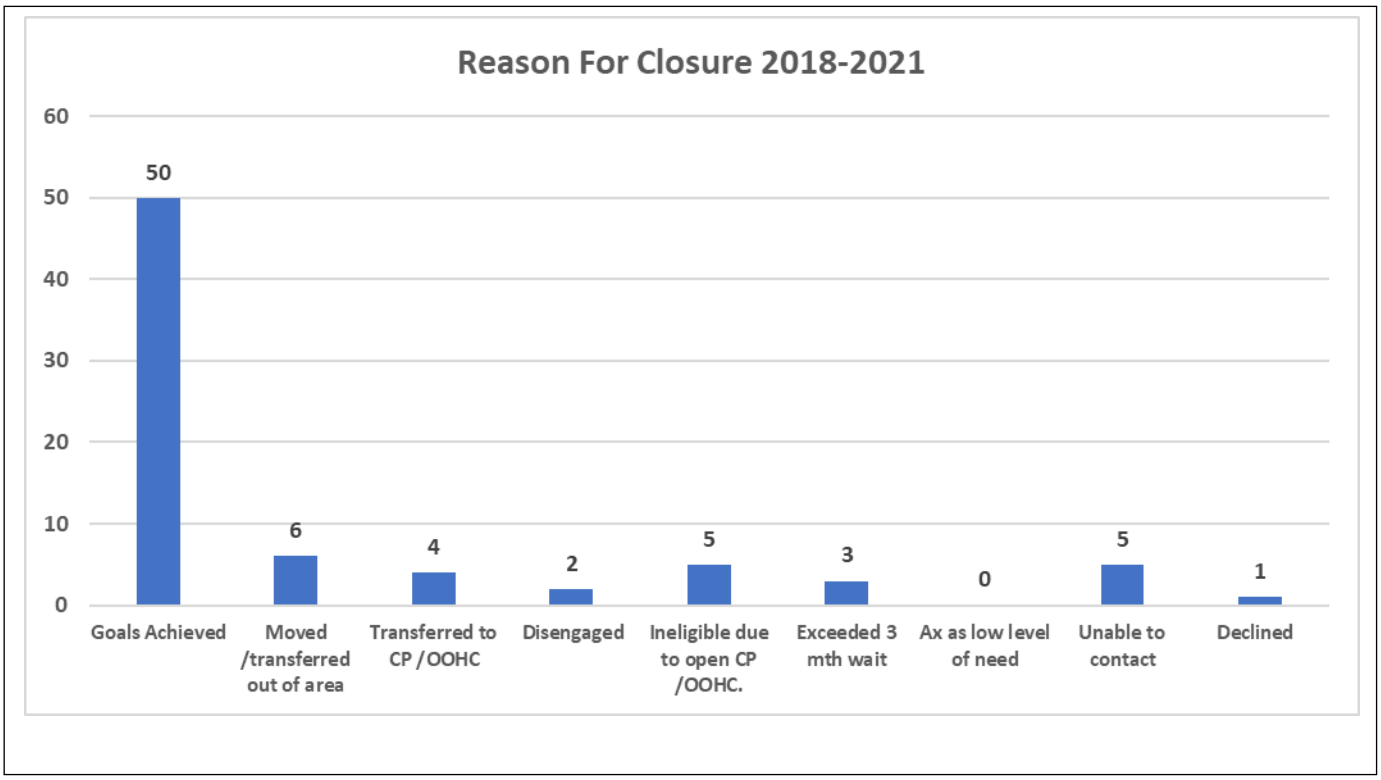
1. **2018-2021 Contract Referral Summary.**
   - **Total ROSH Referrals**
     1. CP Transfer — 71 (92%)
     2. Transfer from Triage — 6 (8%)
     3. **Total** — **77 (81%)**
   - **Total Community Referrals** — **18** (19%)
   - **Total Referrals** — **95** (2.6 per month)

2. **2018-2021 Engagement**

   - Total Referrals Ax By BFAU — 95
     1. BFAU Ax Pending — 0
     2. Total Assessed as Eligible by BFAU — 90 (95%)
     3. Total Assessed as Ineligible — 5
     4. Community Eligibility List — 3
     5. Total Families Offered Services — 87 (92%)

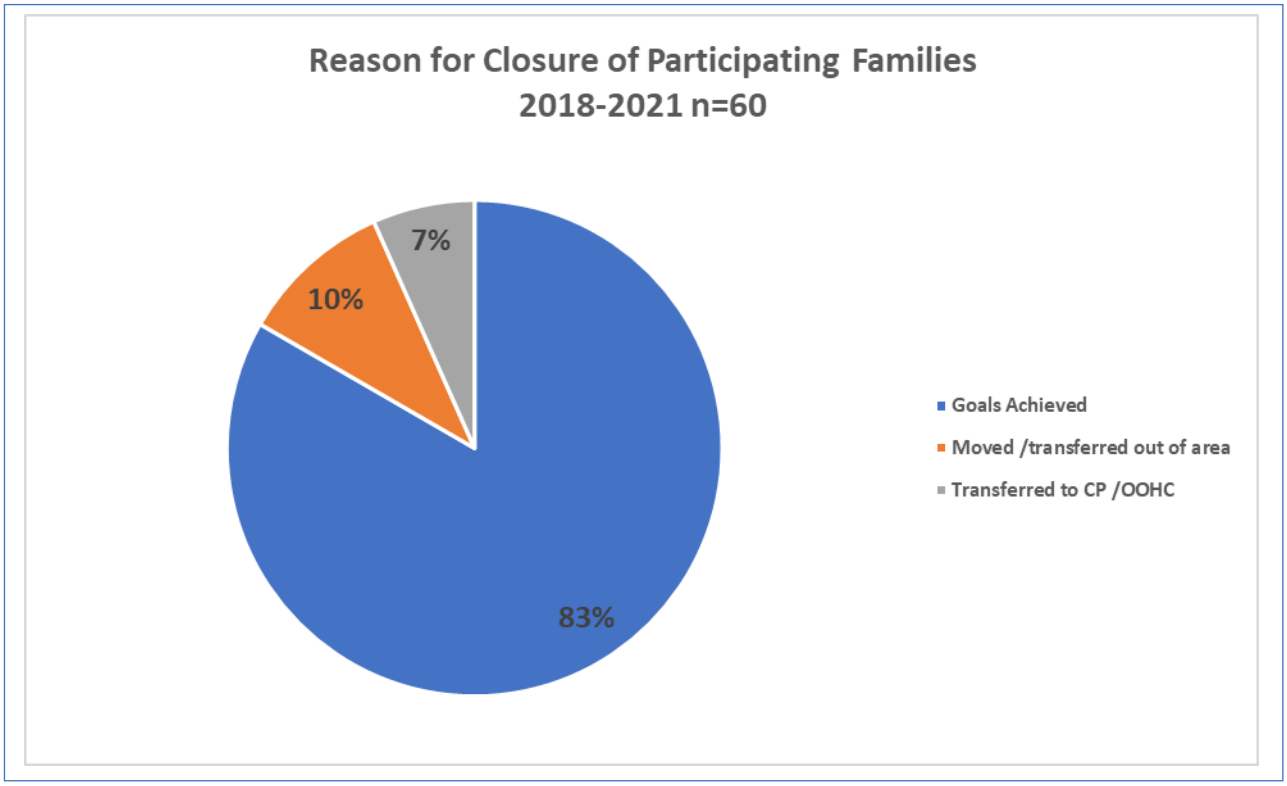
3. 2018-2021 Closed Cases

1.	**Total Closed Cases**	**76 (2.2 per month)**
2.	BFAU Ineligible	5 (7%)
3.	Declined	1 (1%)
4.	Transferred Out Of Area	7 (9%)
5.	Transferred to OOHC/CP	4 (5%)
6.	Unable to Contact	5 (7%)
7.	Exceeded Eligibility Period	3 (4%)
8.	Disengaged	2 (3%)
9.	Goals Achieved	49 (65%)



4. 2018-2021 Closure Reasons for Participating Families

1.	**Total Closed Cases**	**60 (1.8 per month)**
2.	Transferred Out Of Area	6 (10%)
3.	Transferred to OOHC/CP	4 (7%)
4.	Goals Achieved	50 (83%)



5. 2018 -2021 Participation

- Total No. Of Families participating to Date 121
- Total No. ASTI 19 (16%)
- Total No. CALD 50 (41%)

6. Average achievement of caseload targets per month for 2018- 2021 contract = 101%

7. 2018-2021 Engagement Rates

- **Total No. Of Referrals = 121**
- **Total Ineligible or Unable to Contact = 13**
- **Total Engageable Referrals = 108**
- **Total Declined = 1**
- **Total Referrals Engaged = 107**

- **Therefore 2018-2021 Engagement Rate = 99%**

DCJ Funded "Brighter Futures" Program Comparative Data 2019-2020

NSW Sate-Wide Brighter Futures Data Dashboard

Released 2.10.2020, Department Of Communities and Justice,
NSW Family and Community Services

1. Overview

Full year 2019-20
(July 2019 - June 2020)

Contracted Places and Vacancies

Contracted places	Families in Brighter Futures (daily average)	Vacancy rate
2,706	2,155	20%

Allocation and Intake

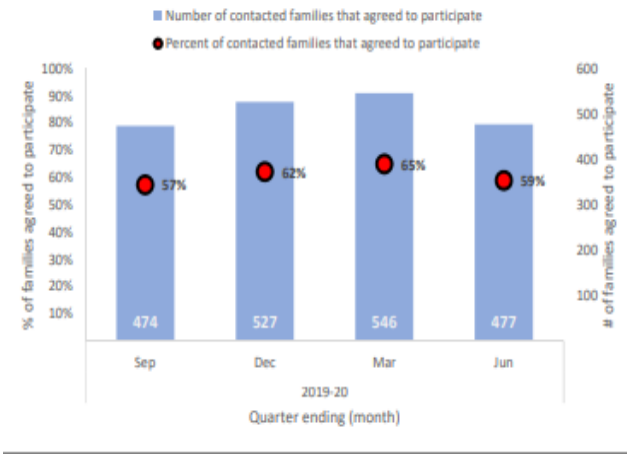
Families allocated to Brighter Futures	Families contacted by providers within 28 days	Percent of families contacted by providers within 28 days
3,351	2,973	89%

Contacted families that Agreed to Participate	Percent of contacted families that Agreed to Participate	Average days to contact
2,020	63%	15

Program Delivery and Outcomes

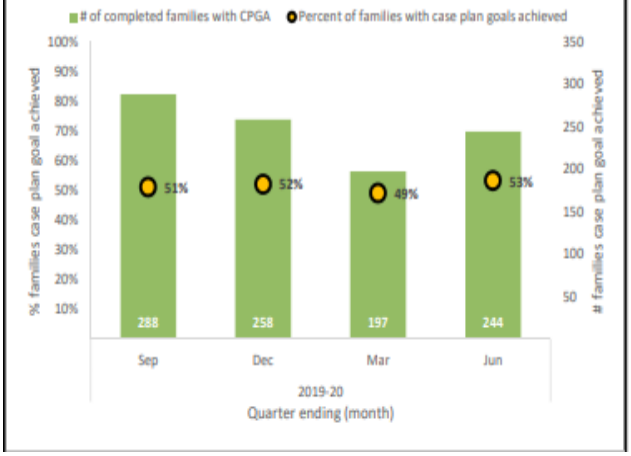
Participating families that exited the program	1,739
Participating families that achieved case plan goals	926
Percent of participating families that achieved case plan goals	53%

Of the families contacted, how many agreed to participate?



4. Program Outcomes

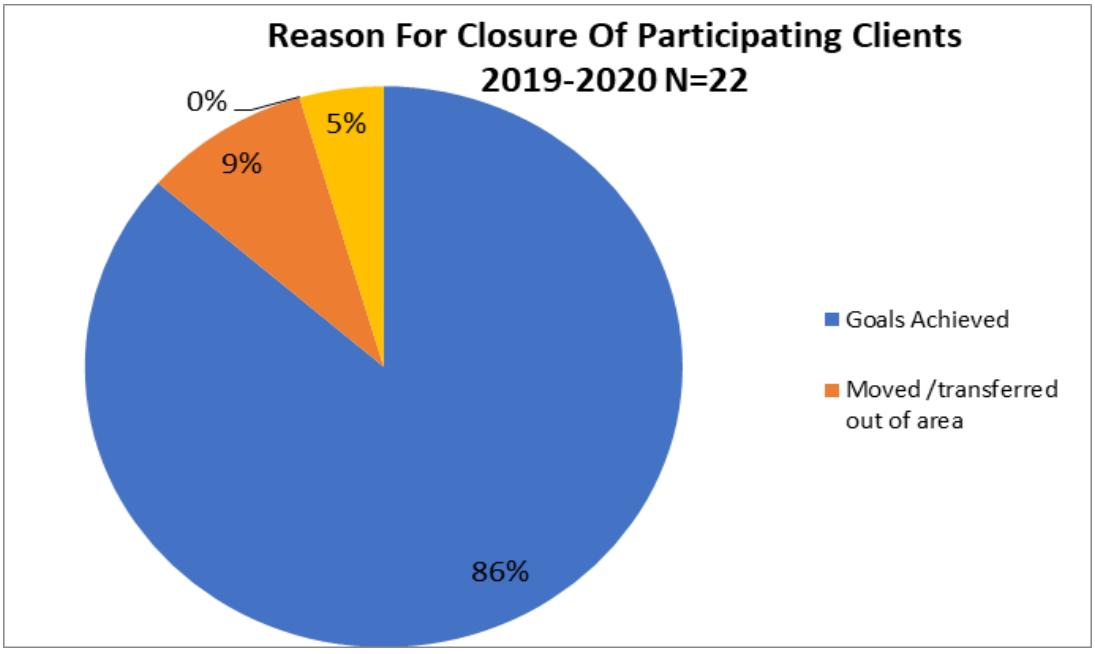
For families that participated in the program, how many have achieved their case plan goals?



Dalwood Spilstead Brighter Futures Data 2019-2020:

- **Total No. Of Referrals = 72**
- **Reason For Closure Of Eligible And Contactable Clients**

1. 69 cases deemed eligible by DCJ and contactable.
2. 22 cases closed
    - **19 (86%) completed program with Goals Achieved.**
    - 2 (9%) moved / transferred out of area.
    - 0 (0%) disengaged from the program.
    - 1 (5%) were transferred to FACS CP / OOHC services.
3. 46 yet to complete program.

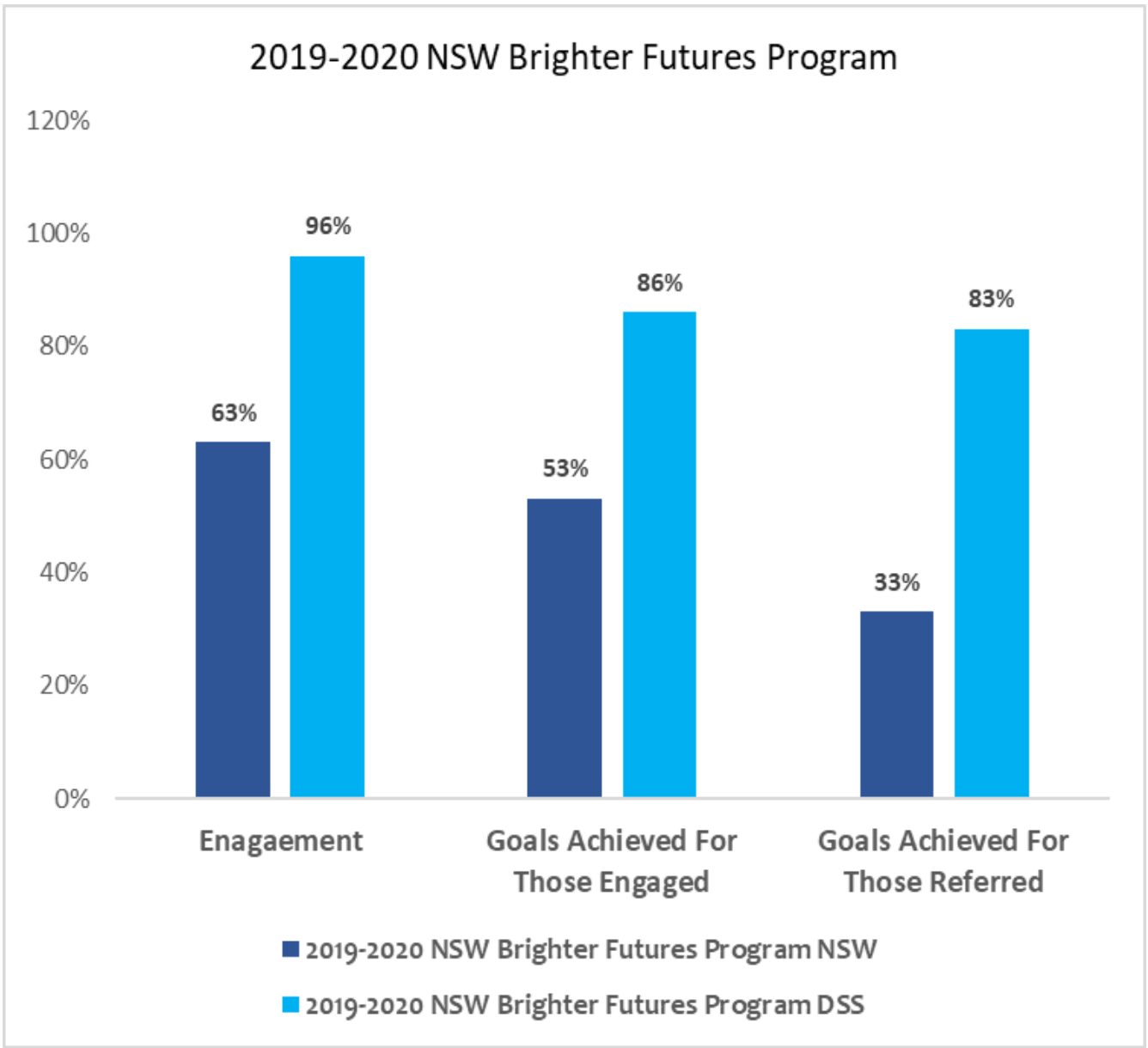


2019-2020 Engagement Rates

- Total No. Of Client Referrals = 72
- Total Ineligible or Unable to Contact = 3
- Total Engageable Referrals = 69
- Total Declined = 0
- Total Referrals Engaged = 69
- **Therefore 2019-2020 Engagement Rate = 96%**

Dalwood Spilstead Brighter Futures Data 2019-2020 continued:

This data from the 2019-2020 contract period indicates that the Dalwood Spilstead Service (DSS) had a 96% engagement and participation rate with families referred via the Brighter futures program, 33% higher than the 63% state-wide average. Of the families who participated in the DSS version of Brighter Futures, 86% of families completed the program with family goals achieved, 33% more than the state average of 53 %. These higher participation and achievement rates indicate that 83% of the families referred to the Brighter Futures service provided by the DSS completed the program with goals achieved compared to the state average of 33%.



Brighter Futures Contract Data Jan 2007 - June 2023

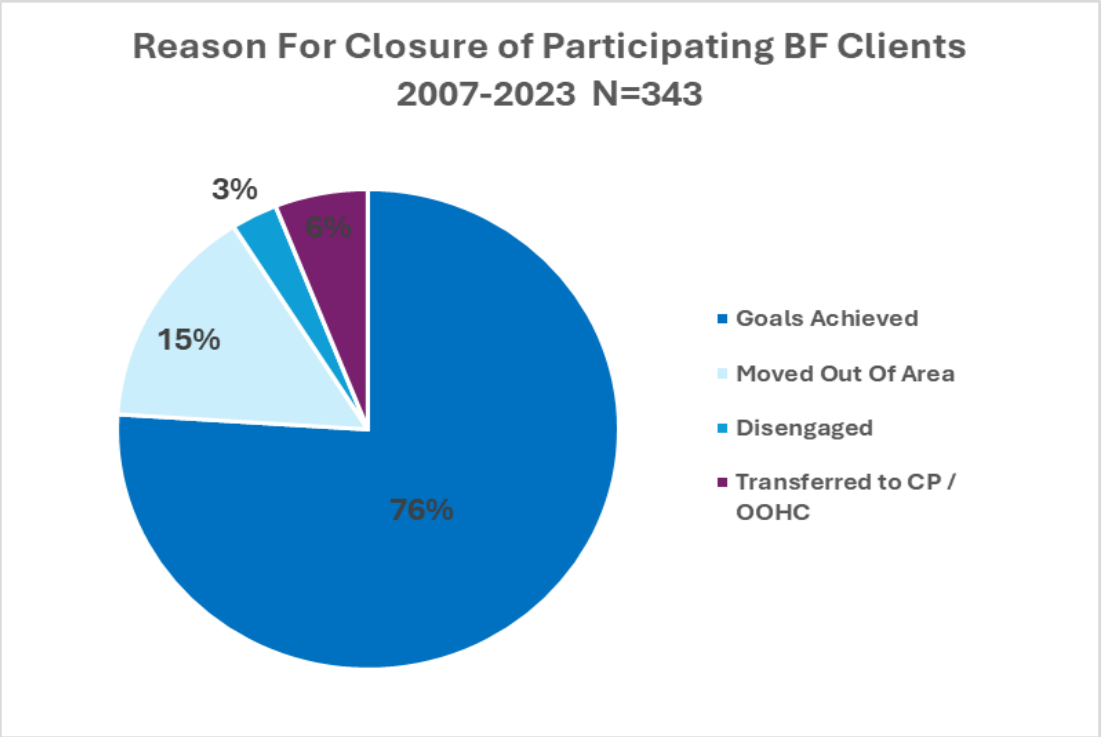
Full Contract Data 2007-2023:

- **Total No. Of Referrals = 545**
- **Reason For Closure Of Eligible And Contactable Clients -2007-2023: n = 412**

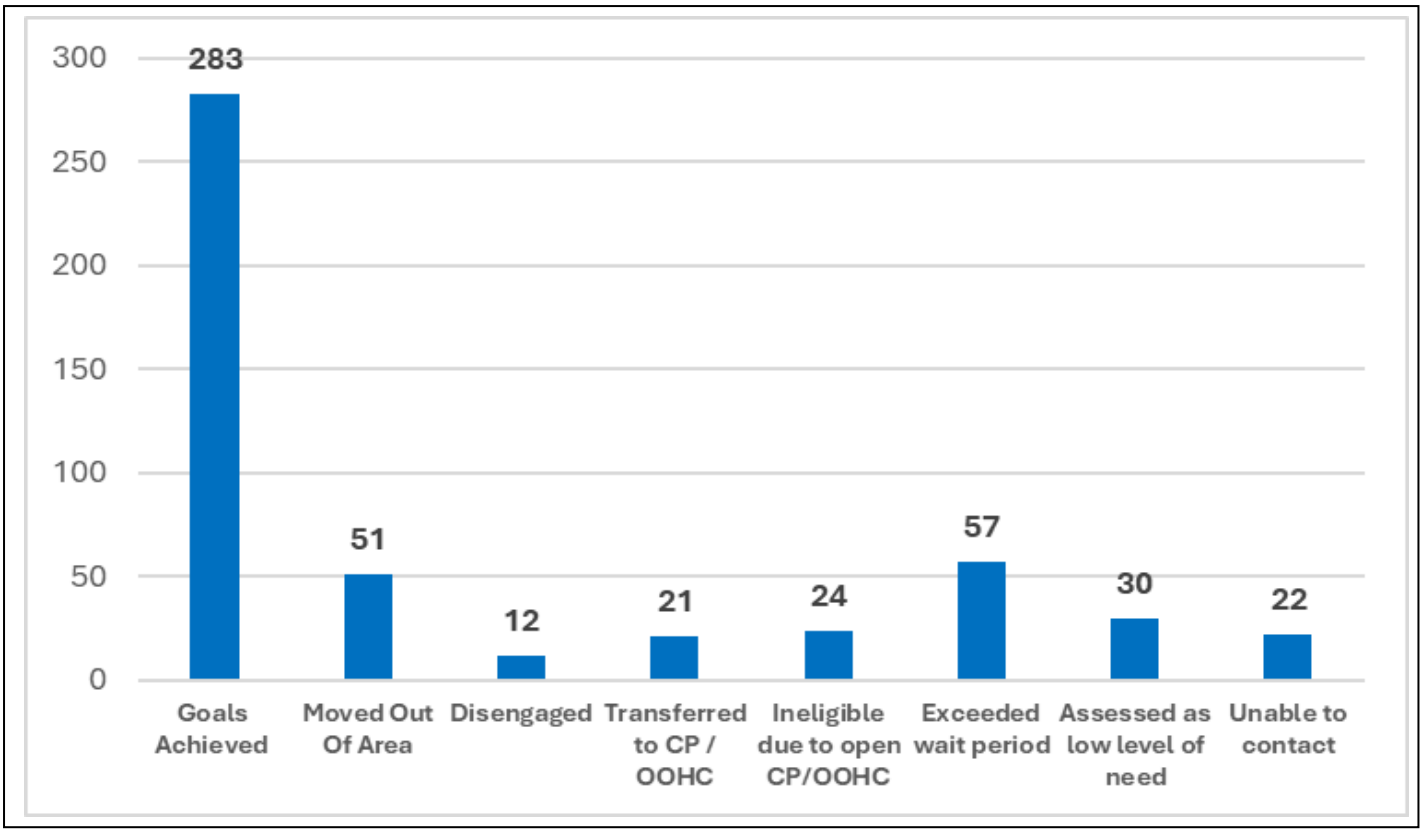
1. 412 cases deemed eligible, contactable and ready to participate.
2. 367 cases closed
    1. **283 (77%) completed program with Goals Achieved.**
    2. 51 (14%) moved / transferred out of area.
    3. 12 (3%) disengaged from the program.
    4. 21 (6%) were transferred to FACS CP / OOHC services.
3. 45 yet to complete program.

Full Contract Engagement Rates

- **Total No. Of Referrals = 545**
- **Total Ineligible or Unable to Contact = 133**
- **Total Engageable Referrals = 412**
- **Total Declined / Withdrew = 12**
- **Total Referrals Engaged = 400**
- **Therefore 2007-2023 Engagement Rate = 97%**



Reason For Closure Of All Clients: 2007-2023 N=500



Service Cost and Sources of Funding 2022-2023

DCJ FUNDED "BRIGHTER FUTURES" / "FAMILY PRESERVATION" PROGRAM COSTS – 45 FAMILIES

NSW State-wide Brighter Futures Per Family Cost	**=**	**$ 23,300 pa**
22/23 Per Family Brighter Futures Cost	**=**	**$ 22,902 pa**
22/23 Total DSS Brighter Futures Cost @ 45 families	**=**	**$ 1,030,576 pa**

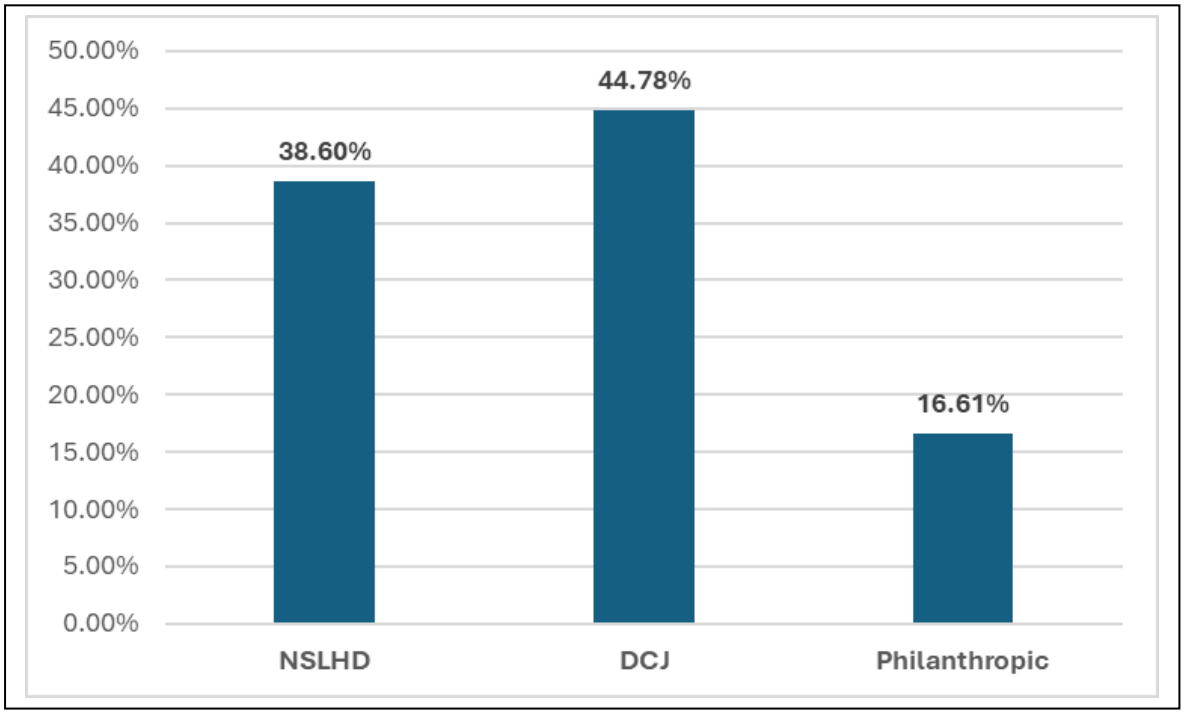
INTENSIVE PROGRAM FOR HIGHER NEED FAMILIES – 52 FAMILIES

22/23 Per Family Cost	**=**	**$ 24,436 pa**
22/23 Total High Need Caseload Cost	**=**	**$ 1,270,674 pa**

TOTAL SERVICE COSTS – 97 FAMILIES

22/23 TOTAL SERVICE COST	**=**	**$ 2,301,250 pa**
22/23 Total Per Family Cost @ 97 Families	**=**	**$ 23,724 pa**
22/23 Total Per Client Cost @ 257 Clients	**=**	**$ 8,954 pa**

FUNDING SOURCE 2023



SPECIALIST NEURO-SEQUENTIAL MODEL TRAUMA SERVICE

Background - The Neuro-sequential Model Of Therapeutics

Research has indicated that the common denominator for families presenting to child protection service is early childhood trauma. Neuro-science is now dictating that these families receive a "trauma informed" approach which is able to target the neuro-biological causes of dysfunction.

Developed by Dr Bruce Perry, trauma expert from the Child Trauma Academy,USA, the world's best practice Neurosequential Model (NMT) is a developmentally-informed, biologically-respectful approach to working with at-risk children which provides a way to organize the child's history and interpret current functioning. "The NMT integrates several core principles of neurodevelopment and traumatology into a comprehensive approach to the child, family and their broader community. The NMT process helps match the nature and timing of specific therapeutic techniques to the developmental stage of the child, and to the brain region and neural networks that are likely mediating the neuropsychiatric problems." www.childtrauma.org. (see Perry, 2006; Perry and Hambrick, 2008; Perry, 2009).

The Dalwood Spilstead Service has been fortunate to be able to train with the Child Trauma Academy as one of the few organisations in Australia now Phase II certified in the NMT clinical online assessment tool and treatment approach. This approach has proven to be of immeasurable value to those children in greatest need who were previously the most difficult to treat due to their background of severe abuse and neglect. NMT is able to expand the benefits of conventional therapy by prescribing "therapeutic" interventions which can be implemented throughout the child's day and across various settings. It is clear that NMT has great potential to also assist all children from vulnerable backgrounds.

Services

A Neuro-sequential Model of Therapeutics assessment and consultation service is provided for children and young people from across NSW. Children identified with a history of significant trauma by government and non-government agencies (NGOs) are offered a comprehensive NMT assessment and individual intervention program. Referrals have been received from NSW DCJ as well as several NGOs including the Benevolent Society, Anglicare and Phoenix Rising. These NGOs have indicated a high demand for the NMT assessment and intervention recommendations. Clinicians are offered a 1 day training program providing background re the NMT approach to trauma-informed practice plus information re the assessment and consultation service prior to making a referral.

The NMT assessment and consultation includes:

- Collation of all background information, norm-referenced assessments conducted plus interviews with carers, case workers and teachers.
- Clinic visit – 2-4 hours:
    - Comprehensive carer and OOHC agency interview
    - Psychometric cognitive assessment if not already conducted.
    - Clinical Observation of Postural Behaviour, J. Ayres. Screening of neurological soft signs plus resting and activity heart rate and ocular-motor functioning.
    - 1.5 hour play observation and regulation session in the sensory gym
    - Completion of Play or Adolescent Activity Preference Checklist.
- Completion of NMT metrics on-line and NMT Metric report
- Completion of comprehensive assessment report.
- Tele-conference or face to face feedback session to case workers and carers:
    - Feedback re assessment results.
    - Finalisation of intervention plan focussed on a bottom-up approach to address neuro-developmental needs following the **Regulate, Relate and Reason** hierarchy:
        - **Regulate**: addressing the sensitized stress response and developing regulation via a combination of:
            - Routine: a familiar structured routine supports regulation.
            - Relationship: consistent predictable unconditionally co-regulating care.
            - Rhythm: patterned repetitive somato-sensory activities.
        - **Relate**: enhancing relational health via increased contact and support from therapeutic adult relationships and mentors.
        - **Reason**: enhancing language and learning strategies.
- Further telephone consultation as needed to support implementation of intervention plan.
- 6 month follow-up via tele-conference.
- Full assessment review at 12 months if required.

Professional Training

Professional training in the NM approach to trauma-informed practice is also provided via regular open workshops for professionals working in the sector with children, young people and adults. Seminars and professional supervision us also tailored for individual agencies and organisations as requested.

These services are provided on a fee for service basis.

Formal Research Evaluation 2005-2006

The Spilstead regime of outcome measurement is administered routinely for each family receiving Dalwood Spilstead services and complimented with additional assessments where appropriate.

This comprehensive evaluation incorporates measures addressing global family functioning, parental stress, parenting confidence, parent/child interaction as well as specific measures of child development with a particular focus on language and social and emotional competency.

Evaluation of the service's ability to meet the family's goals over a medium term of intervention was also considered.

The battery of clinician rated and parent rated evaluation measures, which demonstrated strengths in both reliability and validity included:

- The Parent Stress Index , PSI-4 S, Abedin, R, 2012
- The Being A Parent Scale, Johnston, C. & Mash, E.J. 2001
- The Child Behaviour Checklist (18mths – 5 years), Achenbach, T. and Rescoria, L. 2001
- The Brigance Developmental Screen-III, Brigance, Albert H. 2017
- The Northern Carolina Family Assessment Scale. Kirks, R and Reed Ashcraft, 2020
- Norm-referenced language Assessments
- Goal Attainment Scaling, TJ Kiresuk, A Smith, JE Cardillo, 2014

A report of the service pilot outcomes measurement project was published in 2009. Ref. Gwynne KD, Blick B, Duffy G, *"Pilot evaluation of an early intervention program for children at risk."* Journal of Paediatrics and Child Health, 2009, Vol 45. Issue 3. pp 118-124. Please see attached.

The following is a summary of this pilot n = 24.
Collection of standardised measures of child and family functioning was attempted for each family. The resultant sample size for each measure was small however due to the following factors.

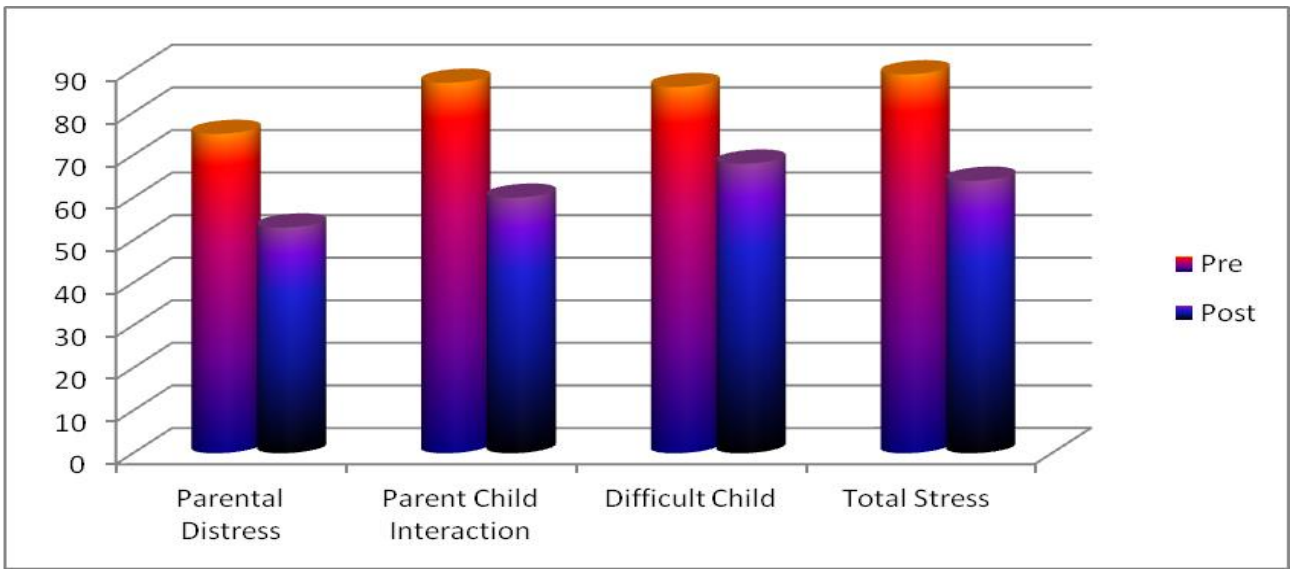
- 5 clients commenced later in term 1 and did not complete pre measures.
- ESL difficulties invalidated some test results.
- 3 clients failed to complete all post measures.
- 2 families left prior to the end of the year.

Table One: Results on Measures of Family Functioning: Parent-Rated Scales.

The Parent Stress Index (Abidin, R, 1995) measure of parent stress has strengths in both validity and reliability. The Being A Parent Scale (Johnston & Mash, 1989) is a parent rated tool which assesses parent's sense of satisfaction and their confidence in their role as parents.

Measure	Subscale	Sample Size (n)	Mean Pre Standard Score	Mean Post Standard Score	Effect Size	T Test Sig. Level
PSI – SF (Parent Stress Index - Short Form)	Parental Distress	21	74.43	52.92	0.73	P < 0.01
	Parent Child Interaction		87.24	60.05	1.38	P < 0.01
	Difficult Child		86.14	68.10	0.77	P < 0.01
	Total Stress		88.95	64	1.03	P < 0.001
Being A Parent Scale	Parental Satisfaction	16	3.24	4.47	1.099	P < 0.001
	Parent Sense of Efficacy		4.14	5.36	1.204	P < 0.001

Figure Three: Results reported on the Parent Stress Index



Effect Size:	Moderate 0.73 (p<0.01)	Large 1.38 (p<0.01)	Moderate 0.77 (p<0.01)	Large 1.03 (p<0.001)

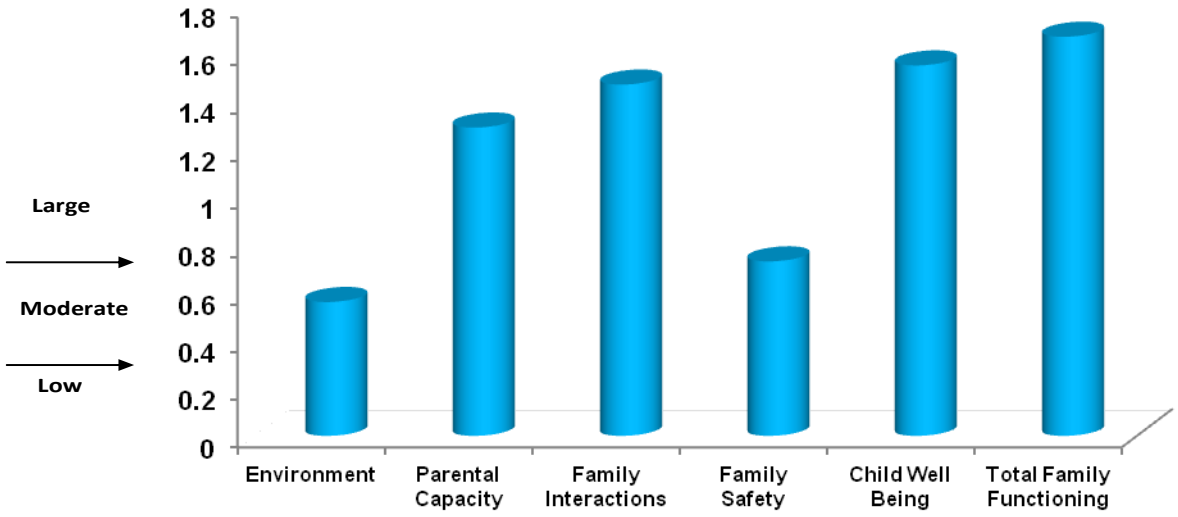
Table Two

Results on Measures of Family Functioning: Clinician - Rated Scale.

The Northern Carolina Family Assessment Scale

Measure	Subscale	Sample Size (n)	Mean Pre Standard Score	Mean Post StandardScore	Effect Size	T Test Sig.Level
Northern Carolina Family Assessment Scale	Environment	21	0.62	1.143	0.56	P < 0.001
	Parental Capacity	21	2.33	3.62	1.29	P < 0.001
	Family Interactions	21	-0.57	0.57	1.47	P < 0.01
	Family Safety	21	0.66	1.24	0.73	P < 0.001
	Child Well Being	21	-0.95	0.53	1.55	P < 0.001
	Total Family Functioning	21	-0.76	0.38	1.67	P < 0.001

Figure Four: Effect Size (Cohen's D) On The Northern Carolina Family Assessment Scale: Clinician's Measure of Family Functioning (p<0.001)



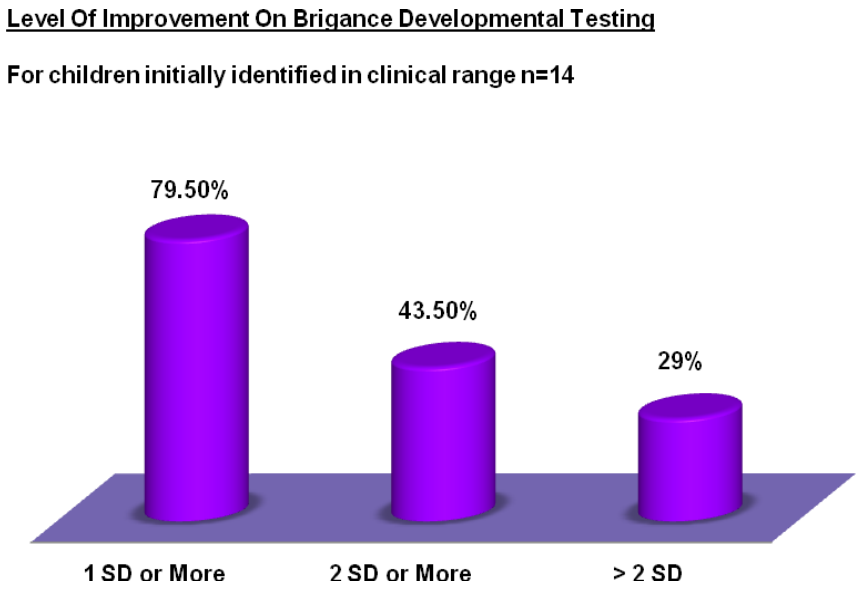
Large Effect Size, ES changes were evident in Parenting Capacity, Family Functioning, Child Well Being and Total Family Functioning.

Table Three

Norm-Referenced Measures of Child Development. The Brigance Developmental Screen

Measure	Sample Size (n)	Mean Pre Score (Percentile Ranking)	Mean Post Score (Percentile Ranking)	Effect Size	T Test Sig. Level
Brigance Developmental Screen	23	21.6	44.44	0.75	P < 0.001
CELF / PLS-4 Receptive Total	17	8.765	18.58	0.565	P<0.02
CELF / PLS-4 Expressive Total	16	13.88	18.94	0.25	P<0.03
CELF / PLS-4 TOTAL	17	10.35	15.94	0.33	P<0.03

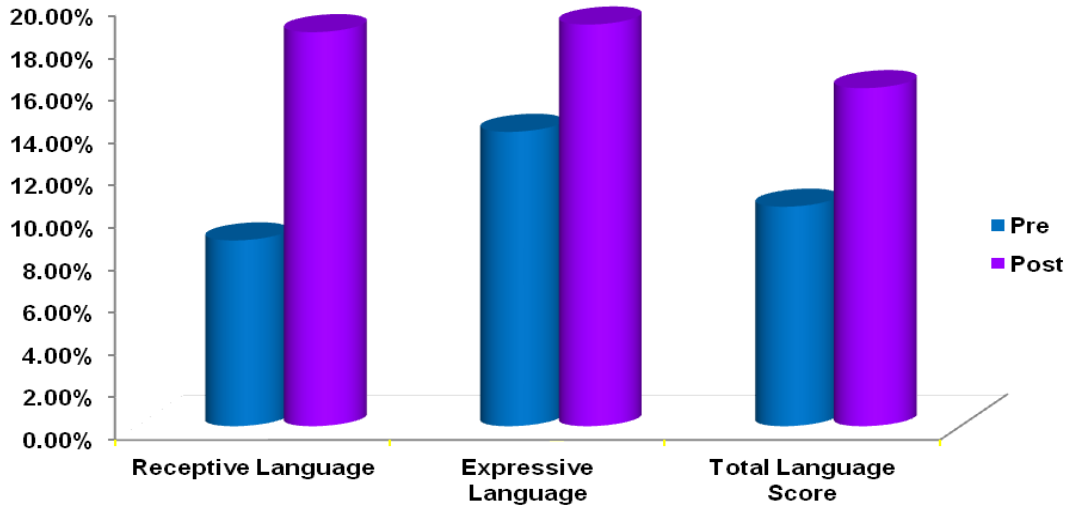
Figure Five



Of the 14 children who presented on entry to the program with skills in the clinically delayed range, 29% were found to have improved by more than 2 standard deviations on post-testing. 43% had improved by 2 or more standard deviations and 79% had improved by at least 1 standard deviation.

Figure Six: Speech And Language Assessment Results In Percentile Rankings

Utilising CELF-Preschool / PLS-4 Measures. Initially Identified in the Clinical Range of Delay n=17.



53% improved by at least 1 standard deviation.

41% progressed from the clinically delayed range to the normal range. ($p<0.02$)

Table Four

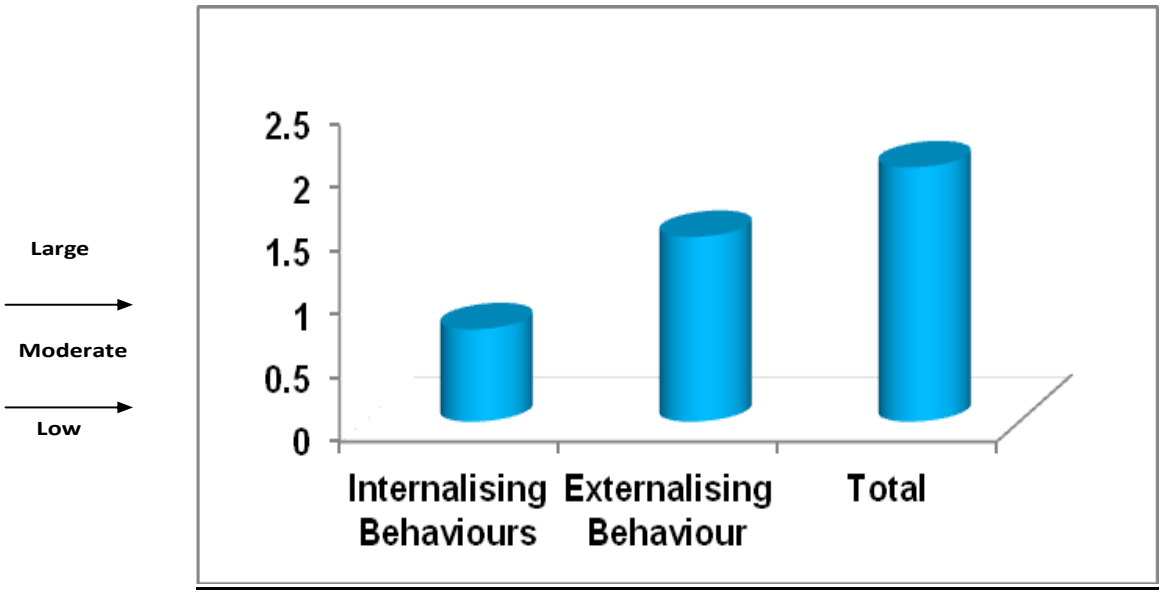
Results on Child Development Measures: Parent-Rated Scale.

The Child Behaviour Checklist (Achenbach l and Rescoria T, 2000) is a comprehensive parent rated scale of child social and emotional development.

Measure	Subscale	Sample Size (n)	Mean Pre Score	Mean Post Score	Effect Size	T Test Sig. Level
Achenbach Child Behaviour Checklist Empirical Scales	Reactive	21	61.5	58	0.52	P < 0.05
	Anx. / Depression		58	55	0.26	P < 0.1
	Somatic		54.7	54.2	0.09	P < 0.05
	Withdrawn		65.6	58.4	0.82	P < 0.001
	Sleep		58.7	54.7	0.53	P < 0.01
	Attention		62.9	53.5	1.37	P < 0.001
	Aggression		67	55.3	1.26	P < 0.001
Achenbach Composite Scores	Internal		61	54.5	0.73	P < 0.001
	External		65.7	52.5	1.46	P < 0.001
	Total		64.5	47	2.01	P < 0.001

Figure Seven

Effect Size (Cohen's D) On Child Behaviour Checklist Results: Parent Rating of Behaviour (p<0.001)



Results indicated statistically significant improvements in both externalising and total behaviour scores (p<0.001) with the size of the change noted to be large in each index.

Table Five

Goal Attainment Scaling Results Goal Attainment Scaling was attempted with 2 standardised child goals established and 2 standardised family goals established for each client family.

GAS	Sample Size	No of Goals Measured	Standard Score	Significance of Goal Setting	Significance of Goal Attainment
Child Goals	23	2	60.65	High	High
Family Goals	21	2	55.76	High	High

Speech and Language Assessment

Specific Speech Pathology measures are utilised to assess the children's individual speech and language skills. The following is a summary of Speech Pathology outcome data collated over the past two years.

Standardised Assessment Results

Assessment Index	Percentage of Children in Clinical Range of Delay on Service Entry	Percentage of Children in Clinical Range of delay Post Therapy (Time 2)
Receptive Language	67%	20.4%
Expressive Language	58%	28%
Total Language Skills	40%	18%

Average therapy period = 1.5 years.

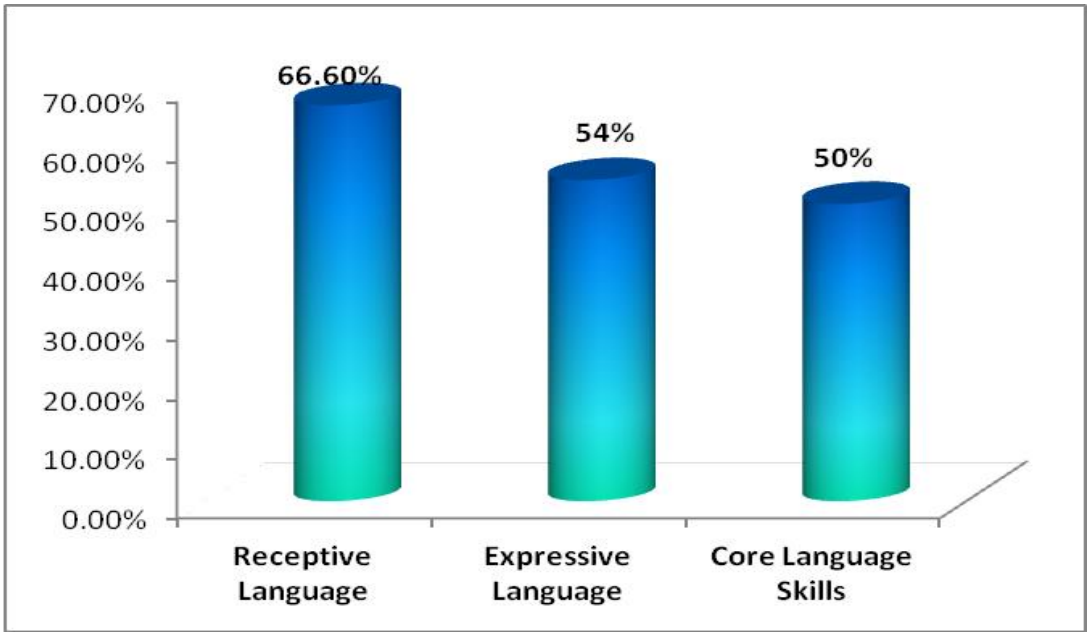
Percentage of Clinical Sample who Improved from Clinical range to Normal Range

Receptive Language **66.6%**

Expressive Language **54%**

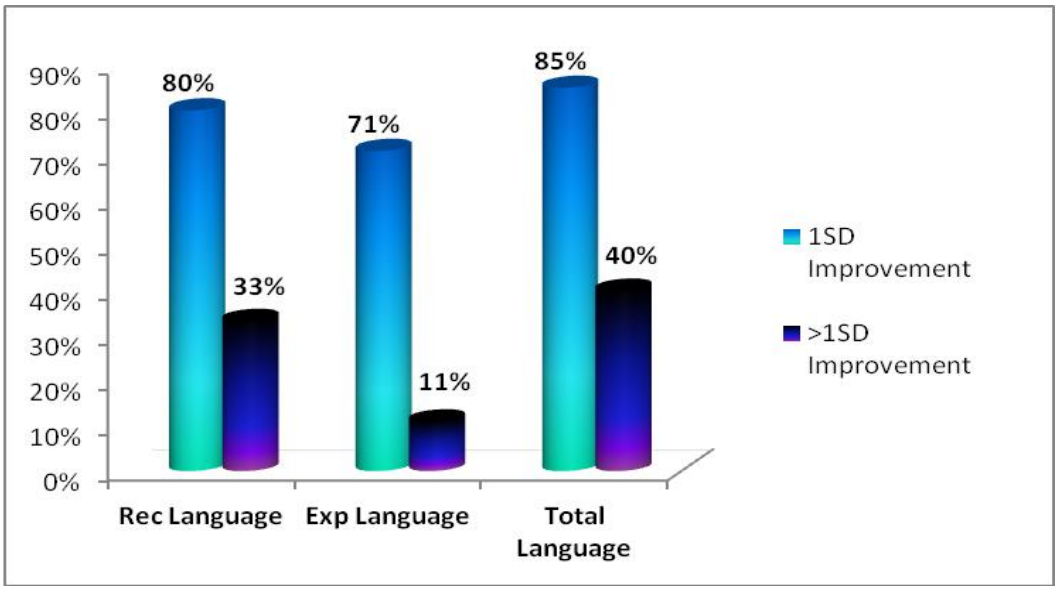
Core Language Skills **50%**

Figure Eight **% of Clinical Sample who Improved by 1 or more Standard Deviations.**



	1SD Improvement	>1SD Improvement
Rec Language	80%	33.3%
Exp Language	71%	11%
Total Language	85%	40%

Figure Nine: Improvements in Standard Deviations



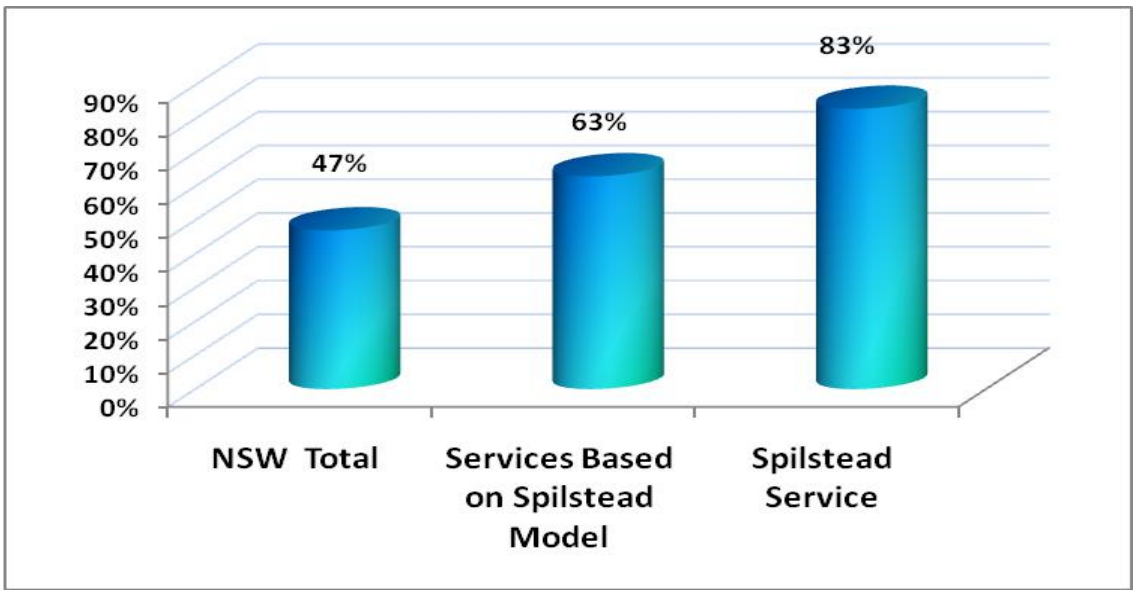
Statistical Significance and Extent of Change 2010-2012 Cohort n=49

	Effect Size	Interpretation	
Rec Language	**0.88**	Large	P<0.0001
Exp Language	**0.47**	Moderate	P<0.0001
Total Language	**0.73**	Moderate	P<0.0001

Independent Brighter Futures Evaluation 2010

Results from "The Evaluation of Brighter Futures, NSW Community Services' Early Intervention Program: Final Report, September 2010" and "The Brighter Futures Early Intervention Program Final Report prepared for The Benevolent Society, Jan 2011" Conducted by the University of NSW Social Policy Research Centre

Attrition Rates: Percentage of Clients who Completed the Brighter Futures Program with Case Plan Goals Achieved NSW 2007-2009.



Cost per Family Per Annum: Services Provided and Cost per Annum in NSW 2007-2009

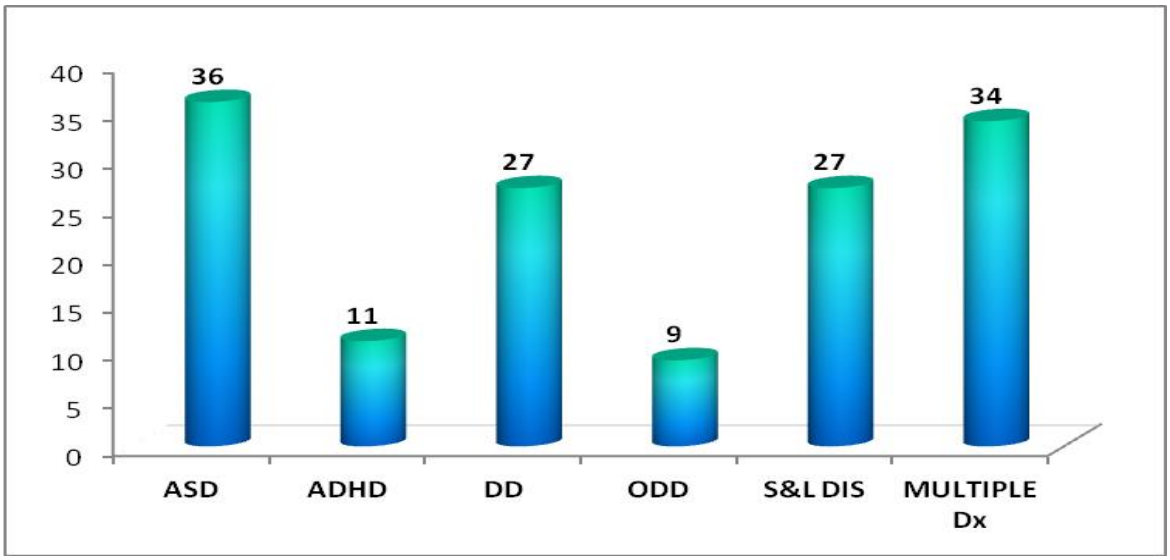
Spilstead Services	Brighter Futures Consortium Model Services
Case Management	Case Management
Professional Counselling	Parenting Programs and Playgroups
Professional and Paraprofessional Home Visiting	Home Visiting
Parenting Programs	Mainstream Child Care
Parent / Child Interaction Interventions	
Therapeutic Preschool	
Intensive Allied Health	
$20,000 per family pa	**$22,000 - $31,000 per family pa**

Results of the SPRC independent evaluation indicated that the Dalwood Spilstead Service was able to deliver a broader range of services for a more conservative annual budget.

Child Development Outcomes Audit 2013

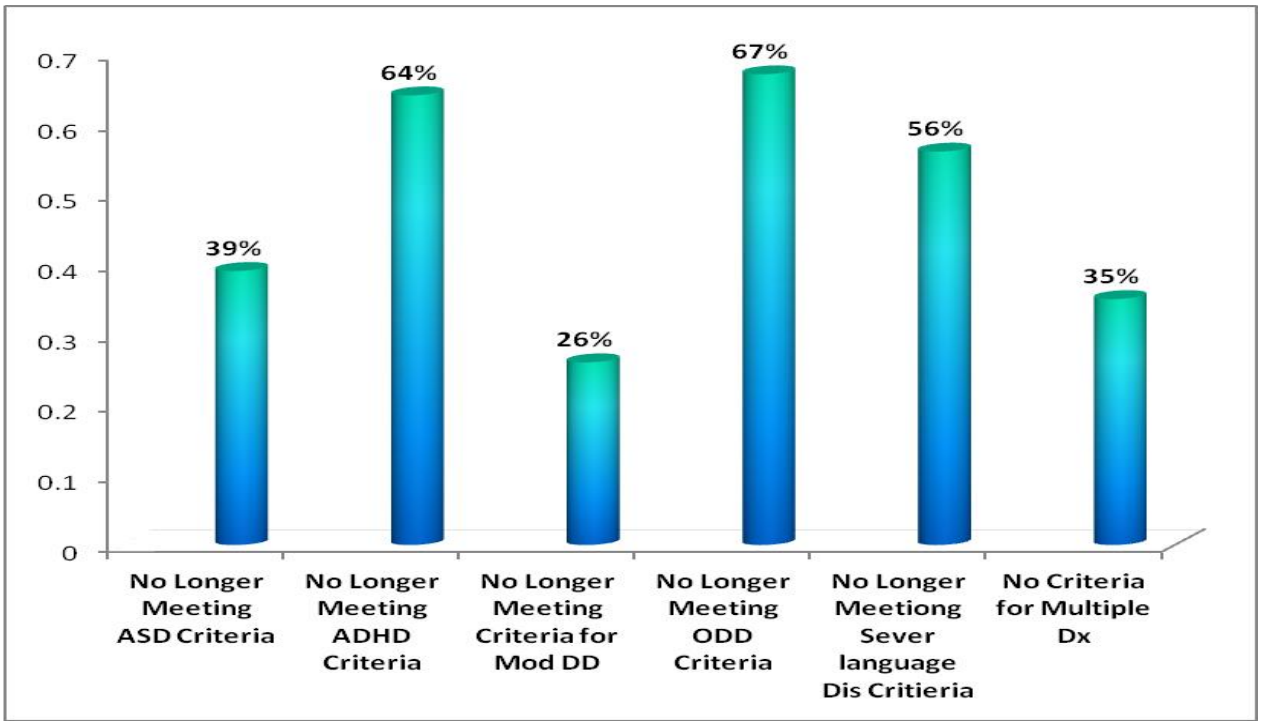
An audit of clients referred over a 5 year period 2008-2013 revealed that a total of 68 children had been referred to the Dalwood Spilstead Service with an existing diagnosis of a significant developmental disorder including Autistic Spectrum Disorder, Attention Deficit Disorder, moderate – severe global Developmental Delay, Oppositional Defiant Disorder, Severe Speech and Language Disorder. 34 of these children had multiple diagnoses on referral.

Figure One: **Diagnosis of Significant Developmental Disorder on Referral 2008-2013 n= 68**



On discharge 32 of the 68 children (47%) no longer met diagnostic criteria. 28 children of school entry age were able to commence mainstream school without additional support.

Figure Two: Percentage of Children No Longer Meeting Diagnostic Criteria on Discharge



Independent Service Review 2014

A formal service review was commissioned by NSW Health in 2014 and conducted by Prof. Edward Melhuish, Executive Director, National Evaluation of *Sure Start,* **Oxford University** *UK.*
Professor Melhuish surmised:

Of the range of child protection services that exist, the Dalwood Spilstead model is worthy of special attention. The "Spilstead Model"(SM) was developed in 2004 to align the service with world-wide research and best practice, maximising the benefits of three modes of intervention within an integrated centre-based approach. It combines parent support and professional home visiting with parent-child attachment interventions together with a centre-based early childhood development program.

There is substantial evidence now existing for the long-term benefits of early education for both the general population and children in vulnerable circumstances, (e.g., Melhuish, 2011a,b; Sylva et al., 2010; Reynolds et al., 2011). Hence it is likely that the high quality early education in the Dalwood Spilstead model is enhancing longer-term outcomes for the children of the vulnerable families participating. In addition there a range of other components within the Spilstead model that the staff have found useful, but for which hard evidence has yet to be accumulated. With such an evidence-based approach to early intervention with vulnerable families and children it might be anticipated that good results may accrue.

Indeed the available evidence from the research conducted by the service to date indicates that the degree of improvement illustrated resulting from the Dalwood Spilstead model would be a good bet for extending in order to improve prevention of child abuse and neglect more extensively across NSW.

Thus it currently appears that the Dalwood Spilstead service is a significant advance in child protection services with NSW. I understand that the costs of treatment for the families referred because of the child being at risk of abuse or neglect is in the range of 20-25 thousand AUD per family, within New South Wales. Dalwood Spilstead costs appear to be in the same range, and hence choosing between Dalwood and other service models cannot be justified on cost grounds. However when the benefits in treatment outcomes that accrue from the Dalwood Spilstead model are considered, there would appear to be a powerful case for extending the Dalwood Spilstead model more widely across NSW, and indeed Australia.

10 Year Longitudinal Follow-up Study 2016

The following is a summary of the longitudinal follow-up study conducted in 2016 for the children who participated in the 2005-2006 pilot study n = 19.

Aims:

- 10 year longitudinal follow up to investigate whether improvements were maintained.
- To investigate whether there is sound evidence to support the extension of the Spilstead Model.

Hypotheses:

- Hypothesis 1: Levels of parental satisfaction, self-efficacy, and family functioning (including environment and child wellbeing) will be significantly higher 10 years post intervention compared with pre-intervention, and levels of parental stress will be significantly lower.
- Hypothesis 2: Parental reports of their child's social, emotional and behavioural problems will be significantly lower 10 years post intervention compared with pre-intervention.
- Hypothesis 3: At 10 years post intervention the social, emotional and behavioural functioning of the young people will be within the average range of normative comparison groups, based on parent, teacher and self-reports.
- Hypothesis 4: A small percentage of the young people at 10 year post intervention will have repeated school grades, been suspended from school, been charged with a criminal offence, or have required ongoing special education.

Method

Collection of standardised measures of child and family functioning was attempted for each family.
Data collection

- Family functioning.
- Social, emotional and behavioural functioning
- Multiple informants
- Questionnaires and a semi-structured interview.
- Measured changes from pre-intervention to 10 years post-intervention.

Results

Table One: The Sample

Risk Factor	**Percentage**
parent with a mental illness	43%
parent with a mental illness	57%
parent with a current or recent drug and alcohol problem	30%
experienced recent or current domestic violence	43%
single parent families	43%
parent with an intellectual disability or learning difficulty	13%
severe parenting difficulties	91%

Participants

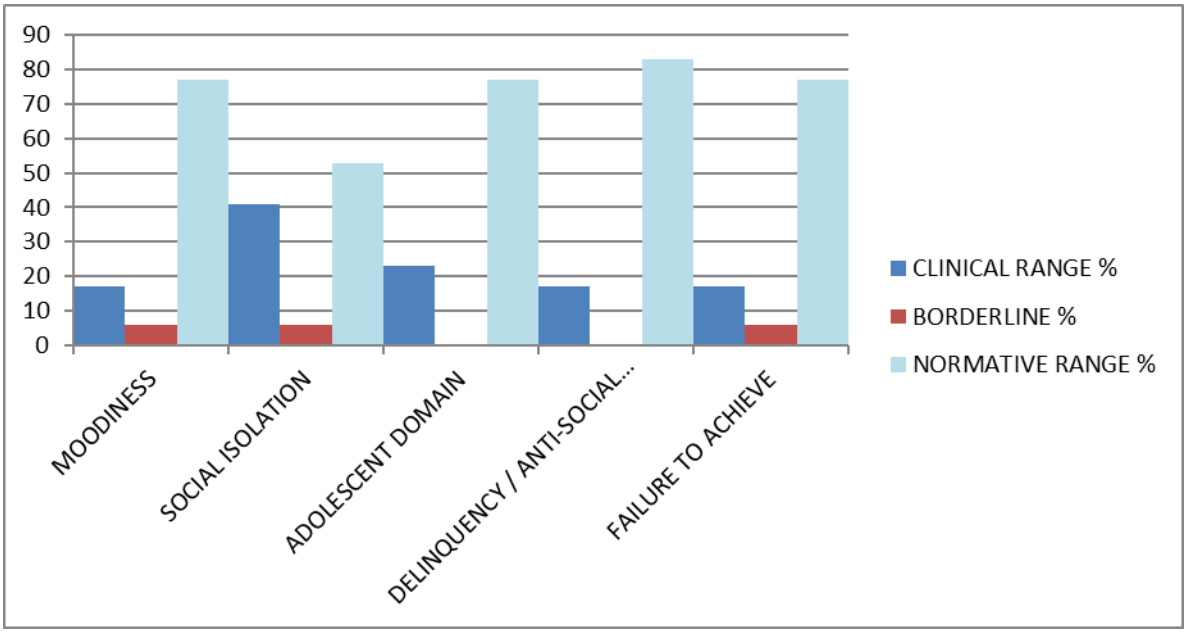
- 79% of the 24 new clients of the DSS from 2005
- 19 young people aged 12 - 15 years
- 13.21 years mean age.
- 4 families unable to be located.
- 1 parent was unable to participate due to illness.

Statistical Analysis

<u>Hypothesis 1 – Supported</u>

- Levels of parental satisfaction, self-efficacy, and family functioning (including environment and child wellbeing) will be significantly higher 10 years post intervention compared with pre-intervention, and levels of parental stress will be significantly lower.

Figure One: Results from the Stress Index for Parents of Adolescents n = 19



Almost 80% of parents reported clinically significant reductions in stress scores at T3 (10 years post) compared to T1 (pre intervention).
Similar results were found for scores related to the relationship between the parent and the child or young person. Clinically significant improvements in the relationship between individual parents and their child from T1 to T3 were also found for almost 70% of participants

Hypothesis 2 – Supported

- Parental reports of their child's social, emotional and behavioural problems will be significantly lower 10 years post intervention compared with pre-intervention.

Figure Two: Social, Emotional and Behavioural Functioning (Achenbach CBCL): Externalising Problems

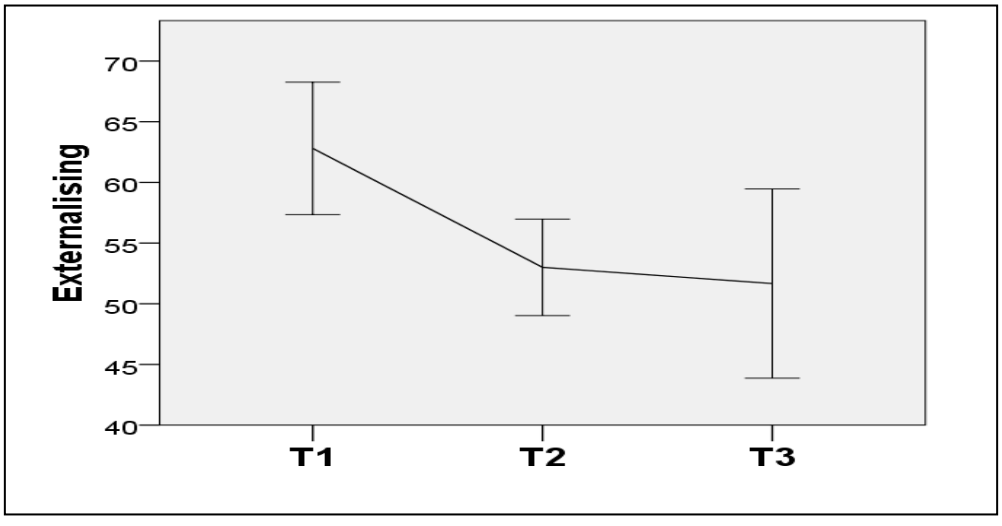
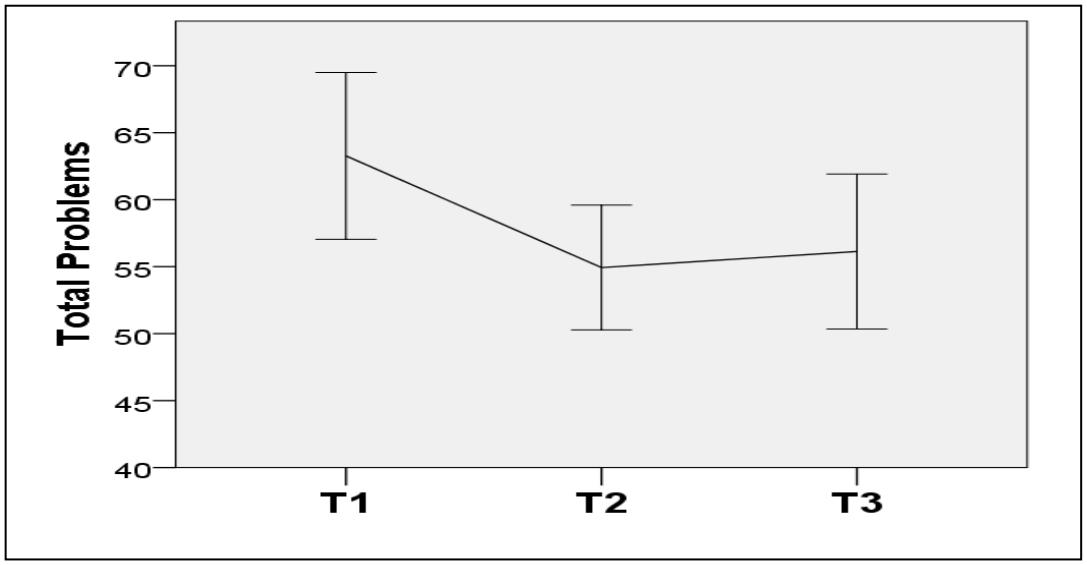


Figure Three: Social, Emotional and Behavioural Functioning (Achenbach CBCL): Total Problems



Hypothesis 3 – Supported

- At 10 years post intervention the social, emotional and behavioural functioning of the young people will be within the average range of normative comparison groups, based on parent, teacher and self-reports

Figure Four: Results from the Child Behaviour Checklist, Youth Self Report and Teacher Report Form Norm Referenced Assessments n = 19

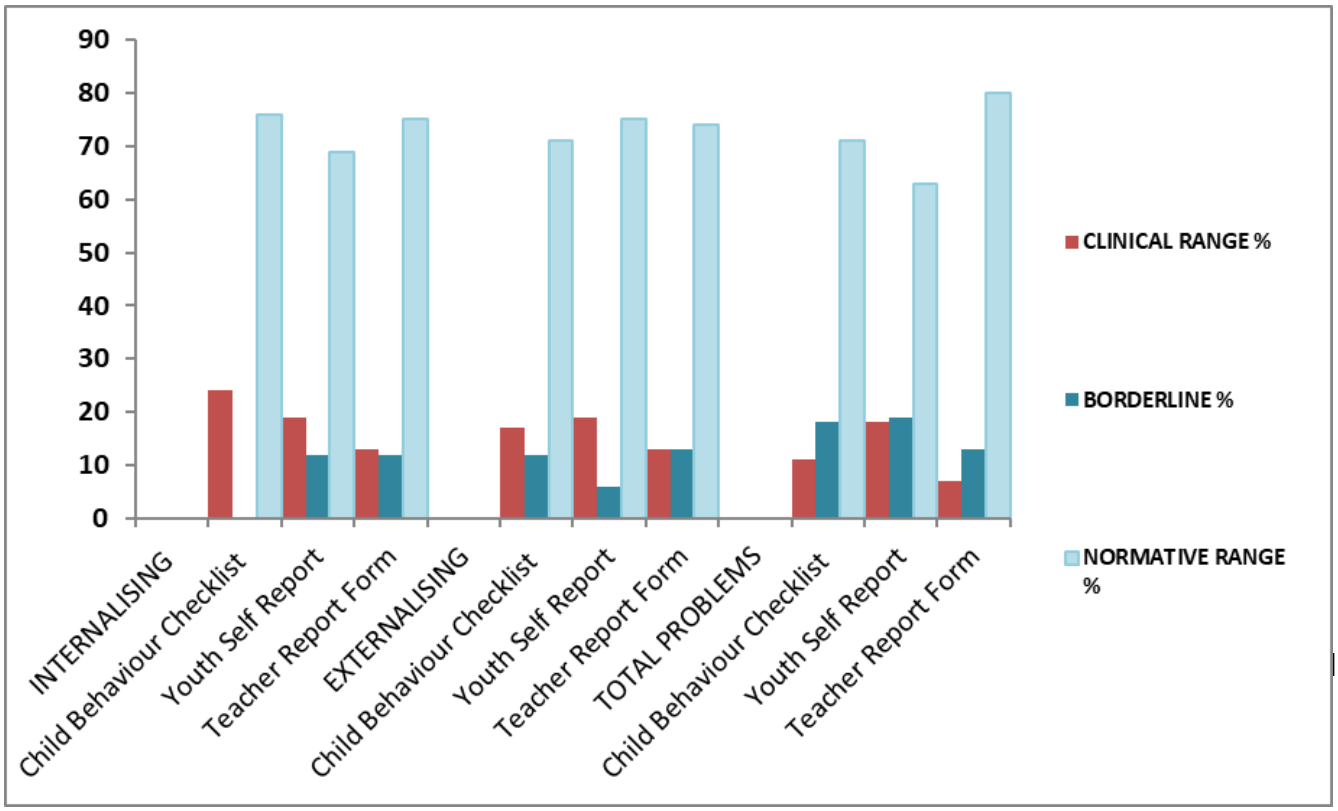


Table Two: Educational and Behavioural Outcomes based on Parent and Teacher Report

Repeated a grade	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
	2	10.53						
Special education	None		Brief		1-3 years		All of Schooling	
	7	36.84	6	31.58	1	5.26	5	26.32
Suspended from school	Never		Once or twice		3 or more times			
	13	68.42	4	21.05	2	10.53		
Arrested or charged	0	0.00						
Involvement with Juvenile Justice	0	0.00						
Use of drugs or alcohol	0	0.00						

Results Summary

- Results reflected a consistent pattern of group and individual improvements over time on measures of child wellbeing, parenting stress, the parent-child relationship, externalising and total problem behaviours.
- There were also trends of improvement on measures of parent efficacy and the family environment; however the pattern of results was less consistent.
- No significant changes were found on measures of parent satisfaction or internalising behaviours of the young people.
- The majority of individuals were found to be currently functioning within normative ranges on all measures.

Conclusions

"The current study lends support for the role of comprehensive early intervention services in improving the trajectories for vulnerable families and children at risk. It extends the sparse Australian literature base in this area and may provide guidance for future early intervention models of care if consolidated by future research." (Angel, 2016).

The results of this study further supports the value of the Spilstead Model of early years intervention for vulnerable families. As expressed by Professor Edward Melhuish, Executive Director, National Evaluation of *Sure Start,* Oxford University: "when the benefits in treatment outcomes that accrue from the Dalwood Spilstead model are considered, there would appear to be a powerful case for extending the Dalwood Spilstead model more widely across NSW, and indeed Australia."

Literature Review

The negative impact of early childhood adverse experience on long term life outcomes is well understood (Amaya-Jackson, 2016; Felitti et al., 1998; Felitti, 2009; Gilbert et al., 2010; Gilbert, Breiding, Merrick, Thompson, & Ford, 2015; Zarnello 2018;). There is now a large body of evidence that has consistently confirmed Felitti's (2009, p.131) statement that "what happens in childhood—like a child's footprints in wet cement—commonly lasts throughout life. Time does not heal; time conceals" (Anda et al., 2006; Brown et al., 2010; Clarkson Freemen, 2014; Flaherty et al., 2013; Lambert, King, Monahan, & McLaughlin, 2017; Oh et al., 2018; Shonkoff et al., 2012). Children who are exposed to Adverse Childhood Experiences (ACEs) including social disadvantage, maltreatment, parental mental health problems, substance abuse or domestic violence are more likely to develop both physical and psychological problems later in life (Amaya-Jackson, 2016; Anda et al., 2006; Brown et al., 2010; Clarkson Freemen, 2014; Felitti et al., 1998; Felitti, 2009; Flaherty et al., 2013; Gilbert et al., 2010; Gilbert et al., 2015; Lambert et al., 2017; Oh et al., 2018; Shonkoff et al., 2012; Zarnello 2018). They are pre-disposed to disease, neuro-developmental disorders, school failure, conduct problems and psychiatric illness (Anda et al., 2006; Briggs-Gowan, Carter, Bosson-Heenan, Guyer, & Horwitz, 2006; Brown et al., 2010; Clarkson Freemen, 2014; Filippo et al., 2012; Flaherty et al., 2013; Gilbert et al., 2010; Gilbert et al., 2015; Lambert et al., 2017; Mayo et al., 2017; Oh et al., 2018; Shonkoff et al., 2012.)

Advances in neurology, epigenetics and behavioural science have further provided an understanding of the aetiology and neurobiological mechanisms underlying this developmental emergency in terms of the impact of early stress and disrupted attachment on the infant's brain architecture (Bucci, Marques, Oh, & Harris, 2016; Fox, Levitt, & Nelson, 2010; Gaskill & Perry, 2012; Hambrick et al., 2020; Lupien, 2009; Perry, 2005; Shonkoff et al., 2012; Shonkoff, 2012;). Studies of toxic stress indicate that antenatal and early childhood trauma can alter multiple neurological circuits and systems including the Limbic-Hypothalamus-Pituitary-Adrenal Axis, the Amygdala mediated fear response and the neuro-endocrine immune circuitry (Bucci et al., 2016; Hambrick, Brawner & Perry, 2019; Meaney, 2010; Perry, 2009;). Indeed, Shonkoff et al suggest that "many adult diseases should be viewed as developmental disorders that begin early in life" (2012, p.232).

The evidence-base in relation to effective early intervention for children at risk is equally robust (Liming & Grube, 2018). Targeted support for vulnerable families via professional home visiting is widely recognised as effective in improving both parent and child wellbeing (Doyle, 2017; Heckman, Holland, Makino, & Rosales-Rueda, 2017; Howard & Brooks-Gunn, 2009; Lowell, Carter, Godoy, Paulicin, & Briggs-Gowan, 2011). The Nurse-Family Partnership (NFP) program which has now provided services to more than 200,000 families in 43 states across the U.S. is the most cited program with proven benefits. This research has demonstrated positive changes with regards to home environment, parenting attitudes, and maternal mental health for parents of both boys and girls at age two years. Improved cognitive skills for both boys and girls, enhanced early socio-emotional skills for girls at age six years and sustained social-emotional improvements particularly for boys to age twelve years have also been recorded (Heckman et al., 2017). Specific programs targeting the parent-child relationship such as Parent Child Interaction Intervention (PCIT) have also demonstrated proven

benefits for vulnerable children aged two to seven years in terms of social/emotional development. A meta-analysis including 23 studies and 1144 participants found PCIT to have large effect size outcomes across multiple measures including parent-related and child-related stress as well as child behaviour (Thomas, Abel, Webb, Avdagic, & Zimmer-Gembeck, 2017).

The most profound and long-lasting benefits however have been associated with programs which offer centre-based early childhood education interventions, rather than home-visiting or case-based services (Wise, Da Silva, Webster, & Sanson, 2005). The High Scope Perry Preschool Project (PPP), implemented in Ypsilanta Michigan in 1962, provided 58 preschool children from low SES families who had IQ scores between 70-85, with intensive small group early education plus weekly teacher home-visits (Schweinhart, 2000; Schwienhart et al., 2005; Schweinhart & Weikart, 1990; Schweinhart & Weikart, 1997). Analysis of 35 years of data following participants to the age of 40 years has indicated that although the program did not mitigate sustained gains in IQ, highly significant and lasting changes were effected in "character skills" resulting in reduced aggressive, antisocial and rule-breaking behaviour (Heckman, Pinto, & Savelyev, 2013). These improvements in social/emotional development had positive impacts on education, economic, health and social outcomes with a resultant annual return on investment of between 7 and 10 % (Heckman, Moon, Pinto, Savelyev & Yavitz, 2010; Nores, Belfield, Barnett, & Schweinhart, 2005;). Similarly, the Abecedarian project in Chapel Hill North Carolina from 1972 to 1977, offered disadvantaged children an educational day-care intervention between the ages of 6 weeks and school entry (Campbell et al., 2012; Campbell, Ramey, Pungello, Sparling & Miller-Johnson, 2002). Experimentally evaluated "life-cycle benefits" of the program have indicated exceptional and sustained benefits in education, earnings, general adult health and reduced crime for participants in their mid-30s with a baseline rate of return at 13.7% (Campbell et al., 2014; Garcia, Heckman, Leaf, & Prados, 2017).

Further, the evidence suggests that the most effective approach to early intervention is integrated service provision (Oberklaid, Baird, Blair, Melhuish & Hall, 2013). Shonkoff and Phillips (2000) reported that "programs that combine child-focused educational activities with explicit attention to parent-child interaction patterns and relationship building appear to have the greatest impact" (p. 244). Carrey, Curran, Greene, Nolan and McLuckie, (2014, p.3) observe that "even the most rigorously tested programs with high fidelity (Nurse-Family Partnership) must be part of a comprehensive approach". Several factors including poor continuity of care across developmental phases, lack of "two generation models" with parallel services for parents and children as well as inconsistent staff qualifications and training have been noted as hinderances to the provision of quality integrated care (Carrey et al, 2014).

Finally, a trauma-based approach is considered essential in the management of families where there are multiple risk factors and intergenerational stress (Amaya-Jackson, 2016; Hambrick, Brawner & Perry, 2019; Perry, 1995; Perry, 2009; Shonkoff et al., 2012; Zarnello, 2018). The Neurosequential Model (NM) is a neurobiology-informed approach to clinical problem solving which is developmentally sensitive. The model, developed by Perry (2006; 2013; 2014) is not designed as a specific therapeutic technique or intervention but rather a tool to inform case planning for clients who have experienced early childhood trauma and their families. Evidence has emerged regarding the value of this "bottom-up" approach which focusses directly on the client's neuro-developmental

organization starting from the lowest level of identified impairment then informs the progression of intervention following an appropriate neuro-developmental sequence. (Hambrick et al., 2018; Hambrick et al, 2020; Perry, 2015; Perry & Dobson, 2013).

Despite these strong indications that comprehensive integrated care across multiple domains of early intervention is best practice, there continues to be surprisingly limited research conducted evaluating programs offering this model of care. The Centre for Independent Studies highlighted the scarcity of evaluations which examine the impact of intervention via standardised outcome measurement and the absence of long-term program evaluation. It was noted that this makes it impossible to "determine which programs are effective, let alone generate benefits in excess of their costs" (Jha, 2016, p. 19). McLuckie et al (2019) identified "5 pillars of direct practice for children 0-5 at risk for experiencing mental disorders" (p. 12) each with similar aims for children, parents and families however noted limited efforts toward integration or co-ordination of these programs and interventions.

The Dalwood Spilstead Service (DSS) functions as a tertiary unit of the Northern Sydney Local Health District (NSLHD), in Sydney Australia. In response to international evidence the Spilstead Model (SM) of early intervention, was designed in 2004 in order to maximize the benefits of the three primary evidence-based interventions for vulnerable families and children at risk, within a comprehensive, integrated and trauma-informed approach. The SM combines parent support including distinct father services, home visiting, and parent-child attachment interventions with multi-disciplinary centre and home-based early childhood education and development programs, in an environment of family centred and relational practice. This "one stop shop" (French et al, 2005; Hetrick et al,2017; Jha, 2016.; Ovretveit, 2011) program is unique in its ability to provide a holistic approach with all services for both parents and children provided under one organisation and one team. This enables optimum engagement with families and ensures maximum co-ordination and consistency of service delivery. In addition, the single team model enhances the creation of a therapeutic milieu of predictable, co-regulating and relational care for both children and families (Mahoney, Palyo, Napier, Giordano, 2009; Thomas, Shattell & Martin, 2002; Walker, 1994).

The DSS is certified at the advanced Phase II (Train The Trainer) level in the Neuro-sequential Model Network (NMN) through the Child Trauma Academy USA (Gwynne, Duffy, Dowling, & Howitt, 2020). NM of Therapeutics (NMT) assessments are offered for both parents and children in order to inform case management and the provision of the most relevant bottom-up approaches to trauma and the development of self-regulation.

The independent evaluation of the NSW Brighter Futures program conducted by the Social Policy Research Centre in 2010 further identified the SM in Northern Sydney as achieving superior results in family engagement and retention, family goal achievement and cost effectiveness with a greater range of services provided at a lower cost (Hilfery et al., 2010). The cost benefits of this integrated single governance approach have persisted. A review commissioned by the NSW Ministry Of Health and conducted by Oxford University concluded that the SM represented an advance in child protection services in NSW, and that it should be extended more widely across NSW and Australia (Melhuish, 2014).

References

1. Agostinis, A., Morley, S. J., & Dowzer, C. N. (2008). The Leeds Reliable Change Index Calculator (v. 1). Retrieved from http://medhealth.leeds.ac.uk/downloads/file/2140/ rci_for_groups.
2. Amaya-Jackson, L., (2016). The Adverse Childhood Experiences Study and Beyond. *Journal of the American Academy of Child & Adolescent Psychiatry,* 55: Oct. no.10 . doi:10.1016/j.jaac.2016.07.700
3. Anda, R.F, Felitti, V.J, Bremner, J.D, Walker, J.D, Whitfield, C. Perry, B.D, Dube, S.R, & Giles, W.H. (2006). The enduring effects of childhood abuse and related experiences: a convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatric and Clinical Neuroscience*, 256 (3), 174 – 186.
4. Barnett, W.S & Masse, L. (2007). Comparative benefit–cost analysis of the Abecedarian program and its policy implications. *Economics of Education Review*, 26: 113–125.
5. Briggs-Gowan, M. J., Carter, A. S., Bosson-Heenan, J., Guyer, A. E., & Horwitz, S. M. *(2006).* Are infant-toddler social-emotional and behavioral problems transient? *Journal of the American Academy of Child and Adolescent Psychiatry, 45(7), 849 858. doi: 10.1097/01.chi.0000220849.48650.59*
6. Brown, D.W., Anda, R.F., Felitti, V.J., Edwards, V.J., Malarcher, A.M., Croft, J.B., & Giles, W.H. (2010). Adverse childhood experiences and the risk of lung cancer a prospective cohort study. *BMC Public Health*. 10:20.
7. Bucci, M., Marques, S.S., Oh, D., & Burke-Harris, N., (2016). Toxic stress in children and adolescents. *Advances in Pediatrics,* 63(1):403-28. https://doi.org/10.1016/j.yapd.2016. 04.002.
8. Campbell, F. A., & Ramey, C. T. (1995). Cognitive and school outcomes for high-risk African-American students at middle adolescence: Positive effects of early intervention. *American Educational Research Journal,* 32(4), 743-772. doi: 10.2307/1163334
9. Campbell, F. A., Ramey, C. T., Pungello, E., Sparling, J., & Miller-Johnson, S. (2002). Early childhood education: Young adult outcomes from the Abecedarian project. *Applied Developmental Science*, 6(1), 42-57. doi: 10.1207/S1532480XADS0601_05
10. Campbell, F. A., Pungello, E. P., Burchinal, M., Kainz, K., Pan, Y., Wasik, B. H., Barbarin, O.A., Sparling, J.J., Ramey, C.T., & Ramey, C. T. (2012). Adult outcomes as a function of an early childhood educational program: An Abecedarian project follow-up. *Developmental Psychology*, 48(4):1033-43. 10331043. doi: 10.1037/a0026644
11. Campbell, F., Conti, G., Heckman, J.J., Moon, S.H., Pungello, E., Pan, Y. (2014). Early Childhood Investments Substantially Boost Adult Health. *Science,* Volume 343 , issue 6178 , pages 1478-1485.
12. Carrey, N J., Curran, J A., Greene, R., Nolan, A., & McLuckie, A., (2014) Embedding mental health interventions in early childhood education systems for at-risk preschoolers: an evidence to policy realist review. *Systematic Reviews.* 3:84, pp. 1-7.
13. Chomycz, S., & Schmidt, F. (2015). Practice guidelines for the assessment of clinically significant treatment outcomes in the children's mental health system. *Journal of Evidence-Informed Social Work*, 1-13. doi: 10.1080/23761407.2015.1031417

14. Clarkson Freeman, P.A., (2014). Prevalence And Relationship Between Adverse Childhood Experiences And Child Behavior Among Young Children *Infant Mental Health Journal* 35(6) 544-554 doi: 10.1002/imhj.21460
15. Cohen, J. (1969). *Statistical power analysis for the behavioral sciences*. New York: Academic Press.
16. Cohen, J. (1988). *Statistical power analysis for the behavioral sciences (2 ed.).* New York: Academic Press.
17. Doyle, O. (2017). The First 2,000 Days and Child Skills: Evidence from a Randomized Experiment of Home Visiting. *Human Capital and Economic Opportunity Global Working Group Working Paper 07-054*, University of Chicago, 1126 E. 59th Street Box 107. Chicago IL 60637.
18. Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., & Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine,* 14:245–258.
19. Felitti, V., (2009). Adverse childhood experiences and adult health. *Academic Pediatrics*, 9:131-132.
20. Flaherty, E.G., Thompson, R., Dubowitz, H., Harvey, E.M., English, D.J., Proctor, L.J. & Runyan, D.K. (2013) Adverse Childhood Experiences and Child Health in Early Adolescence. *JAMA Pediatrics*. Jul; 167 (7):622-629.
21. Fox, S.E., Levitt, P., & Nelson, C.A. (2010). How the timing and quality of early experiences influence the development of brain architecture. *Child Development,* 81(1):28-40, doi.org/10.1111/j.1467-8624.2009.01380.x.
22. French RS, Coope CM, Graham A, Gerressu M, Salisbury C, Stephenson JM; One-Stop Shop Evaluation Team. One stop shop versus collaborative integration: what is the best way of delivering sexual health services? *Sex Transm Infect*. 2006 Jun;82(3):202-6. doi: 10.1136/sti.2005.018093. PMID: 16731668; PMCID: PMC2564738.
23. Garcia, J.L., Heckman, J.J., Leaf, D.E., & Prados, M.J. (2017). Quantifying the Life-cycle Benefits of a Prototypical Early Childhood Program. IZA Institute of Labor Economics. Discussion paper. IZA DP No. 10811. http://ftp.iza.org/dp10811.pdf
24. Gaskill, R. L., & Perry, B.D. (2012). **Child sexual abuse, traumatic experiences and their effect on the developing brain.** In P. Goodyear-Brown, (Ed) *Handbook of Child Sexual Abuse: Identification, Assessment and Treatment*. (pp. 29-49). Wiley, New York
25. Gilbert, L.K., Breiding, M.J., Merrick, M.T., Parks, S.E., Thompson, W.W., Dhingra, S.S., & Ford, D.C., (2015). Childhood adversity and adult chronic disease: An update from ten states and the District of Columbia. *American Journal of Preventive Medicine,* 48(3):345-9.
26. Gwynne, K., Blick, B. A., & Duffy, G. M. (2009). Pilot evaluation of an early intervention programme for children at risk. *Journal of Paediatrics and Child Health*, 45(3), 118-124. doi: 10.1111/j.1440-1754.2008.01439.x
27. Gwynne, K., Duffy, G., Dowling, B., & Howitt, C. (2020). *The Dalwood Spilstead Service: Early Years Intervention and Support*. Sydney: Northern Beaches Child and Family Health Service. www.dalwodspilstead.com

28. Gwynne, K., Duffy, G., Dowling, B., Prowse, K., Mercutt, P., & Howitt, C. (2019). *The Spilstead Model and Evidence Base:* Northern Sydney Local Health District, Primary and Community Care. www.dalwodspilstead.com
29. Hambrick, E.P., Brawner, T.W., Perry, B.D., Wang, E., Griffin, G., DeMarco, T., Capparelli, C., Grove, T., Maikoetter, M., O'Malley, D., Paxton, D., Freedle, L., Friedman, J., Mackenzie, J., Perry, K.M., Cudney, P., Hartman, J., Kuhl, E., Morris, J., Polales, C., & Strother, M., (2018). Restraint and Critical Incident Reduction Following Introduction of the Neurosequential Model of Therapeutics (NMT) *Residential Treatment For Children & Youth*, Vol. 00, No. 00, 1–22 https://doi.org/10.1080/0886571X.2018.1425651
30. Hambrick, E.P, Brawner, T.W., & Perry, B.D., (2019) Timing of Early-Life Stress and the Development of Brain-Related Capacities. *Frontiers in Behavioural Neuroscience.* Vol 13:183. https://doi.org/10.3389/fnbeh.2019.00183
31. Hambrick, E.P., Brawner, T.W., Perry, B.D., Brandt, K., Hofmeister, C., & Collins, J.O. (2020). Beyond the ACE score: Examining relationships between timing of developmental adversity, relational health and developmental outcomes in children *Archives of Psychiatric Nursing Article* In press 2020.
32. Heckman, J.J., Moon, S.H., Pinto, R., Savelyev, P.A., & Yavitz, A. (2010). The Rate of Return to the High/Scope Perry Preschool Program. *Journal of Public Economics,* Volume 94 , issue 1-2 , pages 114-128.
33. Heckman, J., Pinto, R., & Savelyev, P. (2013). Understanding the Mechanisms Through Which an Influential Early Childhood Program Boosted Adult Outcomes. *The American Economic Review*, *103*(6), 2052-2086.doi:10.1257/aer.103.6.2052
34. Heckman, J.J., Holland, M.L., Makino, K.K., Pinto, R., & Rosales-Rueda, M. (2017). An Analysis of the Memphis Nurse-Family Partnership Program *National Bureau of Economic Research Working Paper No. 236.* JEL No. C5,H5,I1, 1050 Massachusetts Avenue Cambridge, MA 02138.
35. Hetrick, S.E., Bailey, A.P.,Smith, K.E., Malia, A., Mathias, S., Singh, S.P., O'Reilly, A., Verma, S.K., Benoit, L., Fleming, T.M., Moro, M.R., Rickwood, D.J., Duffy, J., Eriksen, T., Illback, R., Fisher, C.A., McGorry, P.D., (2017) Integrated (One Stop Shop) Youth Health Care: Best Available Evidence and Future Directions. *The Medical Journal Of Australia,* Vol. 207(10), S5-S18.
36. Hilferty, F., Mullan, K., Van Gool, K., Chan, S ., Eastman, C., Reeve, R.D., Heese, K., Haas, M.R., Newton, B., Griffiths, M., & Katz, I. (2010). *The evaluation of Brighter Futures, NSW Community Services' early intervention program: Final report.* Social Policy Research Centre. University Of NSW. http://hdl.handle.net/10453/17583
37. Howard, K., & Brooks-Gunn, J. (2009). The role of home-visiting programs in preventing child abuse and neglect. *The Future of Children* 19 (2), 119–146.
38. Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, 59(1), 12-19. doi: 10.1037/0022-006X.59.1.12
39. Jha, T., (2016). Early childhood intervention : assessing the evidence *National Library of Australia Cataloguing-in-Publication Data*: Research Report 19 (RR19) • ISSN: 2204-8979 (Printed) 2204-9215 (Online) • ISBN: 978-1-922184-73-3 www.cis.org.au

40. Lambert, H.K., King, K.M., Monahan, K.C., McLaughlin, K.A. (2017). Differential associations of threat and deprivation with emotion regulation and cognitive control in adolescence. *Developmental Psychopathology*, Aug; 29 (3): 929-940.
41. Liming, K.W., & Grube, W.A., (2018). Wellbeing Outcomes for Children Exposed to Multiple Adverse Experiences in Early Childhood: A Systematic Review. *Child and Adolescent Social Work Journal*, 35: 317–335.
42. Lowell, D.I., Carter, A.S., Godoy, L., Paulicin, B., & Briggs-Gowan, M.J. (2011). A randomized controlled trial of Child FIRST: a comprehensive home-based intervention translating research into early childhood practice. *Child Development* Jan-Feb;82(1):193-208.
43. Lupien, S.J. (2009). Effects of stress throughout the lifespan on the brain, behaviour and cognition. *Nat Rev Neurosci*. 10(6):434-45. https://doi.org/10.1038/nrn2639.
44. Mahoney, J.S., Palyo, N., Napier, G., Giordano, J., (2009). The Therapeutic Milieu Reconceptualized for the 21st Century, *Archives of Psychiatric Nursing,* Volume 23, Issue 6, Pages 423-429, ISSN 0883-9417,https://doi.org/10.1016/j.apnu.2009.03.002.
45. Mayo,D., Corey,S., Kelly,L.H., Yohannes,S., Youngquist,A.L., Stuart,B.K., Niendam,T.A. & Loewy ,RL. (2017). The Role of Trauma and Stressful Life Events among Individuals at Clinical High Risk for Psychosis: A Review. *Frontiers in psychiatry*, 8: 55. doi:10.3389/fpsyt.2017.00055
46. McLuckie, A., Landers, L.L., Curren, J.A., Cann, R., Carrese, D.H., Nolan, A., Corrigan, K., & Carrey, N.J. (2019). A scoping review of mental health prevention and intervention initiatives for infants and preschoolers at risk for socio-emotional difficulties. *Systematic Review* 8:183 pp. 1-19.
47. Meaney, M.J. (2010). Epigenetics and the biological definition of gene x environment interactions. *Child Development*. 81(1):41-79.
48. Melhuish, E. (2014). *An appraisal of the Dalwood Spilstead model for preventing child abuse and neglect.* Report prepared for NSW Kids and Families. NSW Health.
49. Nores, M., Belfield, C.R., Barnett ,W.S., & Schweinhart, L. (2005). Updating The Economic Impact Of The High Scope Perry Preschool Program. *Educational Evaluation and Policy Analysis*. 27(3): 245-261.
50. Oberklaid, F., Baird, G., Blair, M., Melhuish, E., & Hall, D. (2013). Children's health and development: Approaches to early identification and intervention. *Archives of Disease in Childhood*, 98(12), 1008-1011. doi: 10.1136/archdischild-2013-304091
51. Oh, D.L., Jerman, P., Silvério Marques, S., Koita, K., Purewal Boparai, S.K., Burke Harris, N., & Bucci, M. (2018). Systematic review of pediatric health outcomes associated with childhood adversity *BMC Pediatrics*, 18:83 (1).doi:10.1186/s12887-018-1037-7
52. Ovretveit, J., *Does clinical coordination improve quality and save money? Volume 1: A summary review of evidence*, London: Health Foundation, 2011. Available at: www.health.org.uk or http://public.me.com/johnovr
53. Perry, B.D., Pollard, R., Blakely, T., Baker, W., & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation and 'use-dependent' development of the brain: How "states" become "traits'". *Infant Mental Health J*, 16 (4): 271-291.
54. Perry, B.D. (2005). *Maltreatment and the developing child: How early childhood experience shapes child and culture.* The Inaugural Margaret McCain lecture (abstracted); McCain Lecture series, The Centre for Children and Families in the Justice System, London, ON.

55. Perry, B.D. (2006). Applying Principals of Neurodevelopment to Clinical Work with Maltreated and Traumatised Children. In: Boyd N. *Traumatised Youth in Child Welfare.* New York: Guildford Press.
56. Perry, B.D. (2009). Examining child maltreatment through a neurodevelopmental lens: clinical application of the Neurosequential Model of Therapeutics. *Journal of Loss and Trauma* 14: 240-255.
57. Perry, B.D. & Dobson, C. (2013) The Neurosequential Model (NMT) in maltreated children. In (J. Ford & C. Courtois, Eds) *Treating Complex Traumatic Stress Disorders in Children and Adolescents*, pp 249-260. Guilford Press, New York
58. Perry, B.D. & Dobson, C.L. (2013). Systemic Approaches to Treatment: The Neurosequential Model of Therapeutics. In *Treating Complex Traumatic Stress Disorders in Children and Adolescents: Scientific Foundations and Therapeutic Models.* Edited by Ford, JD. Guilford Press, New York, pp 249-260
59. Perry, BD. (2014) Applications of a developmentally sensitive and neurobiologically informed approach to clinical problem solving: The Neurosequential Model of Therapeutics (NMT) in young maltreated children. *In Infant and Early Childhood Mental Health Core Concepts and Clinical Practice.* Edited by BrandtK, Perry B D, Seligman S, & Tronick E, American Psychiatric Publishing, Washington DC, pp 21-5.
60. Perry, B.J. (2015). The Neurosequential Model of Therapeutics as Evidence-based Practice. https://childtrauma.org/wp-content/uploads/2015/05/ NMT_EvidenceBasedPract_5_2_15.pdf
61. Schweinhart, L. J., & Weikart, D. P. (1990). The High/Scope Perry Preschool Study. *Prevention in Human Services,* 7(1), 109-132. doi: 10.1300/J293v07n01_06
62. Schweinhart, L. J., &Weikart, D. P. (1997). The High/Scope Preschool curriculum comparison study through age 23. *Early Childhood Research Quar*terly, 12(2), 117-143. doi: 10.1016/S0885-2006(97)90009-0
63. Schweinhart, L. J. (2000). The High/Scope Perry Preschool study: A case study in random assignment. *Evaluation and Research in Education*, 14(3-4), 136-147. doi: 10.1080/09500790008666969
64. Schweinhart, L. J., Monte, J., Xiang, Z., Barnett, W. S., Belfield, C. R., & Nores, M. (2005). The High/Scope Perry Preschool study through age 40 summary, conclusions and frequently asked questions. Ypsilanti, MI: High/Scope Press. Retrieved from http://www.highscope.org/file/Research/PerryProject/specialsummary_rev2011_02_2.pdf.
65. Shonkoff, J.P., Phillips, D. (Eds.). (2000). *From Neurons to Neighbourhoods: The Science of Early Childhood Development.* Committee on Integrating the Science of Early Development. Washington DC. National Academy press.
66. Shonkoff, J.P. (2012). Leveraging the biology of adversity to address the roots of disparities in health and development. Proceedings of the National Academy of Sciences of the United States of America. 109. Suppl 2:17302-7. doi.org/10.1073/pnas.1121259109.
67. Shonkoff, J. P., Garner, A. S., Siegel, B. S., Dobbins, M. I., Earls, M. F., Garner, A. S., McGuinn, L., Pascoe, J. & Wood, D. L. (2012). The Lifelong Effects of Early Childhood Adversity and Toxic Stress. *Pediatrics*, *129*(1), e232-e246. doi:10.1542/peds.2011-2663

68. Shonkoff, J.P. et al. (2014). Excessive Stress Disrupts the Architecture of the Developing Brain: *National Scientific Council on the Developing Child. Working Paper 3.* http://developingchild.harvard.edu/resources/wp3.
69. Thomas, R., Abell, B., Webb, H.J., Avdagic, E., & Zimmer-Gembeck, M.J., (2017). Parent-Child Interaction Therapy: A Meta-analysis. *Pediatrics,* Sep; 140 (3): e20170352-e20170352.
70. Thomas, S.P., Shattell, M., Martin, T., (2002) What's therapeutic about the therapeutic milieu? *Arch Psychiatr Nurs.* Jun;16(3):99-107. doi: 10.1053/apnu.2002.32945. PMID: 12037795.
71. Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., Read, J., Van Os, J., & Bentall, R.P. (2012). Childhood Adversities Increase the Risk of Psychosis: A Meta-analysis of Patient-Control, Prospective- and Cross-sectional Cohort Studies. *Schizophrenia Bulletin Advance Access,* 1-11.
72. Walker, M., (1994) Principles of a therapeutic milieu: an overview. *Perspect Psychiatr Care.* Jul-Sep;30(3):5-8. doi: 10.1111/j.1744-6163.tb00432.x. PMID: 7862519.
73. Wise, S., Da Silva, L., Webster, E., & Sanson, A. (2005). The Efficacy of Early Childhood Interventions. A Report for the Australian Government of Family and Community Services. *AIFS Research Report No. 14.*
74. Zarnello, L., (2018). The ACE effect - A case study of adverse childhood Experiences. *Nursing* Apr; 48 (4):50–54.

Resources

Approximately 40% of funds are provided by community bequests, sponsorship and donations.

The program is further supported by:

- 30 preschool aide volunteers
- 36 home visiting volunteers
- 6 retired teacher volunteer tutors
- Regular donations of equipment and materials from the Dalwood Auxiliary

Hooray! We've got a new playground!

Benefactors

The Spilstead Service is grateful to a large number of individual and organisational benefactors for their commitment and regular support including:

- The Dalwood Auxiliary
- The Rotary Club of Balgowlah
- The Dalwood Dog Show Committee and Pedigree Community
- The Balgowlah RSL Club
- The Osborne Family
- Norman Disney and Young
- The Roth Charitable Foundation
- The Sabemo Trust
- The Ainsworth Foundation
- The Skal Club of North Sydney
- The Fairbridge Foundation
- The Manly Warringah Leagues Club
- The Dee Why RSL
- The McLean Foundation
- The Forestville RSL
- Ruach Ministries
- The Wiles Family
- The Copp Family
- The Lane Family
- Manly Council Staff
- Myer, Warringah Mall Staff
- The Warringah Mall Club
- The Thomas Family
- The St George Foundation
- The GIFT Group
- The Balgowlah Sisterhood
- The HG Foundation

Awards and Presentations

Awards

1. Northern Beaches Health Service Carer Awareness Award, 2009
2. NSW Health Award: Improving primary health and care in the community for “The Spilstead Model of Early Intervention for Children at Risk", 2011
3. NSW Health Volunteer Award, 2016
4. Northern Sydney Child Protection Award, 2017
5. Nominated for NSW Premier’s Award – 2018.

Invited Addresses

- Invited co-presentation with Dr Bruce Perry during his 2015 Australian Speaking Tour: “Applying the Neurosequential Model of Therapeutics (NMT) Master Class”, Melbourne 19th Oct 2015 and the NSW FACS hosted seminar “Transforming Childhood Trauma” Sydney 30th Oct 2015.
- Inaugural Early Start Conference, Wollongong 28th September 2015 “Trauma-Informed Practice in the Early Childhood Education Setting”.
- Keynote presentation, New Zealand National Symposium, "Making A Difference Early On: early intervention, self control, and life course outcomes." April 2011.
- Invited presentation "The Spilstead Model of Early Intervention" and discussion panellist for the Royal Australian Council of Physicians Conference Melbourne Feb 2010.

Recent Conference Presentations

- NM Symposium June 2018 Invited Address: “Integration of the NMT within a Milieu approach to Early Childhood Mental Health.”
- NM Symposium June 2018 Invited Address: “Which activity, when and why?” An OT Activity Analysis Approach to Assist the Tailoring of Individual NMT-Informed Interventions.
- WAIMH May 2018 Oral Presentation: “Trauma-Informed Practice: A Long-term, Multi-faceted, Relational Approach”
- WAIMH May 2018 Poster: “Integration of the NMT within a Milieu approach to Early Childhood Mental Health”
- International Childhood Trauma Conference August 2018 Oral Presentation: “Trauma-Informed Practice That Works: A 10 Year Follow-up of a Multi-faceted, Relational Approach”
- International Family Therapy Conference, November 2018.
- International Childhood Trauma Conference, Melbourne Australia, August 2022

"THE TRUE MEANING OF SPILSTEAD"

Time has passed so quickly,
but memories shall always stay,
Of a place that helped our children,
To grow in every way.

A place that taught them laughter,
Respect and honesty,
Caring, kindness and understanding,
and the importance of being free.

Free from any fear they feel,
Free form any pain,
To be themselves, to grow, to learn,
To never be ashamed.

Through education, imagination,
laughter, fun and tears,
You taught our children, no trepidation,
But ways to confront their fears.

Change became so obvious,
As time progressed each day,
their learning became insidious,
Through the act of simple play.

As parents we were taught to hope,
To eliminate "fear of failure".
We were listened to, we were understood,
and we modified our behaviour.

For what chance is there for any child,
If a parent cannot see,
It is us that they look up to,
It is us that set them free.

For our children are the seeds we planted,
Through a simple act of love,
In the hope that one day...their spirit will grow,
Like the essence of, a peaceful dove.

Mrs D. Leckie 201

4.