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RESEARCH ARTICLE

Do Australian policies enable a primary health care system to identify family adversity and subsequently support these families—A scoping study

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Abstract

Issue Addressed: To determine if Australian policies support a primary health care system to identify family adversity and subsequently support these families.

Methods: Two methodological approaches were used: (i) a scoping review of Australian federal and two states (Victoria and New South Wales) policies related to family adversity (e.g., childhood maltreatment or household dysfunction, such as parental mental illness); (ii) thirteen semi-structured interviews with Victorian Community Health Service (CHS) staff and government policy makers, recruited via snowball sampling to understand the context of policy making and service implementation. Data collected were subsequently discussed in relation to the Stages Model of policy analysis.

Results: One hundred and eighty-eight policies referenced family adversity. Of these, 37 policies met all eligibility criteria including a focus on early intervention within primary care and were included in the review. Most policies were developed within health departments (78%) and included a wide range of adversities, with the majority based within maternal and child health and CHS platforms. Most policy development included consultation with stakeholders. Although most policies received some level of funding, few included funding details and only a third included evaluation.

Conclusions: There are many policies related to family adversity in Australia, with most focused within existing primary care platforms. Given these policies, Australia should be well positioned to identify and respond to family adversity.

So What: More work needs to be done to ensure policies are adequately implemented, evaluated and transparently and appropriately funded. The co-occurrence of adversity should focus policy action; and potentially lead to more effective and efficient outcomes.

KEYWORDS
family adversity, health policy, policy implementation, scalability, scale-up

1 | INTRODUCTION

Family adversity is a broad term that refers to a wide range of circumstances or events that pose a serious threat to a child's physical or psychological well-being.[1] In Australia, family adversity is not distributed equally. For example, compared to their Anglo-European counterparts, children from indigenous and culturally and linguistically diverse backgrounds—when combined with low socio-economic position—are 4–8 times more likely to be exposed to two or more adverse experiences.[2]

Family adversities may include adverse childhood experiences (ACEs) as well as social determinants of health and wellbeing. ACEs include childhood maltreatment (e.g., physical, verbal or sexual abuse) and household dysfunction (e.g., parental mental illness, family substance abuse).[3] These intersect with the broader social determinants focusing on where children and families live, work and play, and include broader community dysfunction (e.g., witnessing physical violence, discrimination) and peer dysfunction (e.g., stealing, bullying) as well as socio-economic deprivation.[4] Family adversity has well-established negative impacts on health[5,6] and, in particular, mental health, increasing the risk of anxiety, internalising disorders, depression and suicidality in childhood and across the life course.[7–10] In addition, family adversities have intergenerational consequences across health and wellbeing in the second generation.[11]

A focus on prevention and early intervention for family adversity is critical, as the cost to the Australian government of not intervening early is significant—$15.2b annually,[12] equating to $1912 per child and young person.[12] Primary health care provides first contact and continuous, comprehensive and coordinated care for families.[13,14] In Australia the primary health care system provides prevention and early intervention opportunities, and a non-stigmatising entry for families into the health and social care system.[15] General practitioners, maternal and child health nurses, allied health professionals and service providers in community health services (CHSs) are well placed to identify and respond to family adversity.[16] Within two Australian states—Victoria and New South Wales, CHS play an important role in providing a coordinated or integrated primary care platform with a remit of proportionate universalism, whereby health actions are universal, but with a scale and intensity that is proportionate to the level of disadvantage, improving the equitable delivery of prevention and early intervention.[17,18] Despite this remit, many CHS lack an integrated approach across health, mental health, education and social services,[19] potentially impacting their ability to effectively detect and respond to family adversity.

Public policy relating to the identification and response to family adversity has not previously been mapped across Australian state or federal departments. Therefore, there is little insight into the policy environment to support better detection and response to family adversity in Australia. Policy scoping, which includes a broad-based inquiry that accommodates grey literature, can assist in producing contextual accounts of the current state of knowledge,[20] providing a valuable means to understand the current policy making process related to family adversity, and the available support for interventions or new ways of working.

The aim of this study is to determine if the policy environment is well positioned for the Australian primary health care system to identify family adversity and subsequently support these families.

2 | METHODS

This study employed a mixed-methods design incorporating (i) policy scoping to identify and prioritise current policies (for the year 2020) related to family adversity within two states—Victoria and New South Wales (NSW), and within federal government, and (ii) semi-structured interviews with state policy makers and CHS staff, to triangulate the policies identified in the scoping review and inform how policies framed the issue of adversity. Utilising the Stages Model,[21] the current policy context informed by policy scoping (i) and semi-structured interviews (ii) was subsequently examined across the stages of policy making, including agenda setting, policy formulation, decision making or policy adoption, policy implementation and evaluation.

2.1 | Policy scoping protocol

Arksey and O'Malley[22] and Levac, Colquhoun and O'Brien's[20] framework was used to conduct a scoping review of government policy documents on family adversity within state—Victoria, NSW and federal governments. The framework for the review was based on four steps.

Step 1. Identifying the research question

The research question was presented to and agreed upon by the authorship group, including research and implementation staff within the Centre of Research Excellence in Childhood Adversity and Mental Health—What state (Victoria and NSW) and national policies support the prevention or early intervention and response to family adversity?

Step 2. Identifying relevant policies

We used two strategies to identify relevant published state and national policies that were current for the year 2020.

The first strategy involved searching for relevant policies through specific policy websites, including the following search engines and websites: Google, Australian Policy Online, Victorian and NSW government department websites relating to the following portfolios—health, education, justice and social services. Australian government department websites, including—Departments of Education, Social Services, Family and Children, Health, Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), Australian Institute of Family Studies (AIFS), Australian Institute for Health and Welfare (AIHW) and Council of Australian Governments (COAG). The second search strategy involved a snowball methodology[23]; whereby reference lists from the policies found through the initial search strategy were used to identify subsequent relevant policies.

The following inclusion criteria were used to identify relevant policies through the abovementioned search strategies:

1. Jurisdiction: State (Victorian or NSW) or federal policies. These two states were chosen as they are the only Australian states that fund and support a model of CHS, which provide an important role in providing a coordinated or integrated primary care platform with a remit of improving the equitable delivery of prevention and early intervention.
2. Timeline: Must be current policies that include the year 2021.
3. Link to adversity/adverse childhood experiences—including the following terms agreed by authorship group: Adverse childhood experiences (ACEs), adversity, adverse childhood experience; child abuse—sexual abuse, physical abuse, emotional abuse; child neglect—physical or emotional neglect; disadvantage—poverty, low socio-economic status, vulnerable; domestic/family violence; parent mental illness—parent mental health, parent mental disorder; parent substance misuse—drug and alcohol abuse/misuse; bullying—bullying at school; incarceration—jail; housing—homelessness, housing support; out of Home Care; parenting—parenting style, parenting support, harsh parenting; child behavioural issues; general Health—health, wellbeing; general vulnerability—vulnerability, disadvantage; educational vulnerability—vulnerability, disadvantage within Education Department policies; child mental health—depression, anxiety, internalising behaviours and externalising behaviours.
4. The policy included children 0–12 years and their families/carers.
5. The policy was focussed on early intervention or prevention within primary care.
6. Policies were defined as a deliberate system of principles to guide decisions and achieve rational outcomes and can include law, regulation, procedure, administrative action, incentive or voluntary practice of governments and other institutions.[24] We included the following types of government policy documents: government funded programs and projects; government statements or intent plans, strategy, proposed action, blueprint, approach, scheme, stratagem, program, guidelines, intentions, theory, line, position and stance.

Step 3. Screening and selection of policies

For the Victorian and national policies two authors (Suzy Honisett, Hayley Loftus) double screened the same 5% of policies. Discrepancies were identified and resolved, and Suzy Honisett independently searched and screened the remaining Victorian and national policies. For NSW policies, Suzy Honisett double screened the same 10% of policies also screened by each of the NSW authors (HueiMing Liu, Denise De Souza and Alicia Montgomery). Discrepancies were identified and resolved, and the NSW authors continued to search and screen policies independently. Double screening of policies compared data collected and the allocation of weighting for each policy.

Weighting of policies aimed to identify those policies that offered the greatest influence to support prevention or early intervention and respond to family adversity and associated child mental health outcomes within a primary care setting. The weighting of policies was based on the following criteria: (i) meeting one or more family adversity criteria, (ii) being funded, (iii) being implemented and/or (iv) related to an appropriate primary care platform, such as CHS or maternal and child health service.

Weighting 1: meets all four criteria.
Weighting 2: meets three criteria.
Weighting 3: meets two criteria.
Weighting 4: does not meet any criteria.

Policies with a weighting of one and two were included as a starting point for further assessment. All policy and weighting data were inputted by authors into a RedCap[25] online database for secure storage.

Step 4. Charting the data

Data were extracted from the RedCap online database for policies that met weighting 1 (met all four criteria above). We extracted descriptive data such as: title; type of policy; jurisdiction; timeline; target population; association or link to family adversity; health, education or other existing early intervention platforms policies were linked to for example, CHSs or maternal and child health; funding and implementation details; whether the policy referenced an evidence base; included consultation or co-design; considered equity and, was or planned to be evaluated.

2.2 | Semi-structured interviews

Individual interviews were undertaken with 13 Victorian participants from two stakeholder groups—Victorian Government policy decision makers (PM) from health, education and social service departments and Victorian CHS CEO or Senior Managers. To triangulate the mixed methods data interviewees were asked to comment on the final list of priority policies, established through the weighting process (step 3 of the policy scoping methods outlined above) and comment on whether they felt this policy list reflected the policy environment related to their work. The aim of triangulation was to establish convergence, divergence or complementarity of data from the two methods strands—policy scoping and semi-structured interviews. Through triangulation convergence of data can validate results while divergence can provide an opportunity for supplementary explanations.[26] In addition, interviewees were asked to discuss the terminology used within their workplaces related to family adversity as a means of understanding the framing of family adversity within a policy and implementation setting. All participants were aged >18 years and had sufficient English language to participate and consented to be involved. Investigators Sharon Goldfeld and Harriet Hiscock, both with experience working with the health and government sectors, initially nominated two potential participants working within CHSs and government

policy (e.g., Department of Health). The qualitative methodology of snowball sampling[27] was subsequently used to purposefully identify and recruit further interviewees by asking participants to nominate relevant colleagues to invite to the study.

2.3 | Ethics

Before each interview commenced, participants provided verbal informed consent to take part in the interview. Ethical approval was granted by The Royal Children's Hospital Human Research Ethics Committee (HREC #62129).

2.4 | Data collection

Fifteen potential participants were emailed the Participant Information Statement and invited to take part in the study. Thirteen completed interviews and two policy makers were uncontactable after initially accepting the invitation. Suzy Honisett conducted all interviews during November 2020 and March 2021. Suzy Honisett has a PhD in health sciences and is an experienced public health policy researcher. Each interview took 30–60 minutes. Interviews were conducted using Zoom web video-conferencing platform, and audio recorded and then transcribed verbatim by an external professional company.

Interviews were semi-structured and explored interviewees':

1. Use of terminology and framing related to family adversity.
2. Assessment of the final list of priority policies, established through the weighting process to determine whether they felt this list reflected the policy environment related to their work.

2.5 | Data analysis

Interview transcripts were imported into NVivo Release 1.4.1 for analysis. Suzy Honisett employed inductive and deductive framework analysis to analyse the qualitative data arising from the interviews. Framework analysis is suitable for this applied study because the technique is not aligned with any specific epistemological stance and places the research questions at the forefront of the analysis.[28] The first author developed a draft coding frame with deductive themes based on the research questions (e.g., what language is used in your work environment around the term family adversity?). Inductive content analysis involved close coding to identify content items emerging from the data, and then cross-referencing between all transcripts to develop common content categories, that is, provisional inferences drawn from statements and observations.[29] Suzy Honisett and Teresa Hall independently coded two transcripts, and then met to review and discuss the emergent codes to reach consensus on the coding framework. They subsequently recoded two transcripts and met again to review and discuss codes and reach consensus. Suzy Honisett then applied the revised coding framework to the 13 transcripts.

3 | RESULTS

3.1 | Number and scope of policies

In total, 188 policies were identified that had varying links to family adversity including 44 federal policies, 97 Victorian and 47 NSW policies. Once policies were prioritised, the number of policies that were weighted 1 and 2%–39% of the total policies, are shown in Table 1.

Note Priority One policies are those considered to be of highest importance to family adversity. Priority Two policies are of secondary importance to the issue of family adversity.

Due to the high number of policies being weighted Priority One and Two, the following data relate to only those policies weighted priority one, as listed in Appendix S1.

Interviewees were asked to verify their use and reference to priority one policies within their work, this allowed triangulation of end user expectation and the policy environment as defined by the weighting of policies through the scoping process. There was alignment between the priority one weighting of policies by investigators and those policies identified as important by interviewees.

Most policies were published by health departments (67.6%). However, other departments that were involved in these policies exclusively, or in collaboration with health departments were social (24.3%), whole of government (18.9%), education (10.8%) and justice (5.4%).

The primary target populations for Priority One policies were children (n = 19, 52.8%), parents (n = 15, 41.7%), families (n = 12, 33.3%), services (n = 13, 36.1%) and to a lesser extent whole of population (n = 7, 19.4%), women (n = 6, 16.7%), indigenous (n = 6, 16.7%) and multicultural (n = 3, 8.3%) populations. There could be more than one selection of main audience for each policy and therefore this data represents counts or frequency.

Most policies (75%) included some level of consultation with external stakeholders or members of the public; however, detail as to the level of consultation or the strategies for consultation were often unclear.

3.2 | Framing of family adversity

Equity was an important principle in most policies (32, 86%), either directly mentioned or implied via the policy focusing on creating greater supports for those most vulnerable or targeting the most vulnerable populations in the community.

Interviews with CHS and PM stakeholders discussed the terminology used within their workplaces related to family adversity. Many participants stated the term vulnerable children or vulnerability was used frequently, rather than terms such as adversity or childhood adversity (relating to adversities that relate specifically to the child/children within the family), as stated below by two stakeholders.

> Vulnerable children or vulnerable families has probably been commonly used or disadvantaged… adversity would not be the first term that we would use. (CHS 5).

TABLE 1 Number of policies related to family adversity and their ranking of importance.

Total policies mapped		Priority 1	Priority 2	Total of priority 1 and priority 2
National	44	8	9	17
Victorian	97	21	17	38
NSW	47	8	12	20
Total	188	37	37	74

> I have not commonly heard childhood adversity, although I would have thought that's very helpful. We've used vulnerable children in the past and we continue to use that… Equity has got a lot of resonance in our department. (PM 11).

3.3 | Types of family adversities represented in policies

A broad range of family adversities were represented within policies, particularly childhood maltreatment (abuse and neglect [n = 18, 48.6%] and sexual abuse [n = 15, 40.5%]) and household dysfunction (family violence [n = 17, 45.9%], parent mental illness [n = 12, 32.4%], parenting [n = 11, 29.7%], drug and alcohol misuse [n = 7, 18.9%] and out of home care [n = 7, 18.9%], child behavioural issues [n = 3, 8.1%]). Broader social determinants focusing on where children and families live, work and play, as well as socio-economic deprivation were also represented in many policies, particularly general vulnerability (n = 24, 64.9%) and to a lesser degree vulnerability within an educational setting (n = 6, 16.2%), poverty (n = 6, 16.2%), housing (n = 5, 13.5%) and incarceration (n = 3, 8.1%). There could be more than one selection of main audience for each policy and therefore this data represents counts or frequency of adversity.

Many policies included more than one element of adversity, as shown in Table 2. Childhood maltreatment (abuse, neglect and sexual abuse) was often included in policies with family violence. Policies that included parent drug and alcohol misuse, incarceration, poverty, housing issues and out of home care included reference to indicators of childhood maltreatment and household dysfunction, whilst also referencing other broader social determinants of health.

3.4 | Platforms for early intervention policy implementation

As shown below in Figure 1. The main care platforms referenced in policies were maternal and child health nurses (45.9%), and CHSs (43.2%).

The majority of policies related to the platform of maternal and child health were in Victoria (70.6%), compared to NSW (17.6%) and Commonwealth (11.8%). MCH policies across all jurisdictions focused on broad health and wellbeing issues such as general health and general vulnerability (11, 64.7%); however, issues such as poverty (1, 5.9%), housing (1, 5.9%), incarceration (0, 0.0%), were not well represented within the MCH platform.

The majority of policies related to the CHS platform were in Victoria (56.8%) compared to NSW (21.6%) and Commonwealth (21.6%). These policies across all jurisdictions focused on general health (13, 35.1%) and vulnerability (24, 64.9%), however, there was also a clear focus of this platform on childhood maltreatment (abuse and neglect [18, 48.6%], sexual abuse [15, 40.5%]) and household dysfunction (family violence [17, 45.9%], parent mental illness (12, 32.4%], drug and alcohol misuse [7, 18.9%], out of home care [7, 18.9%) and parenting [11, 29.7%]). Housing (5, 13.5), poverty (6, 16.2%), incarceration (3, 8.1%) and child behavioural issues (3, 8.1%) were less well represented within this platform.

3.5 | Support for policy implementation

Most policies were funded or referenced funding for implementation (33, 89%). Of those policies referencing funding, most were government plans (8, 24.2%), frameworks (7, 21.2%) or service guides (9, 27.3%). However, 65% of priority policies (weighted 1) provided no information about the specific amount of funding available for that policy. This may be due to no additional funding being provided or a lack of information about funding within the policy documentation.

Many policies indicated being implemented (59%), however, it is difficult to ascertain what level of implementation had occurred with policies. Twenty-seven percent of policies were only partially implemented due to staged roll out.

Of the priority one policies identified, nearly a third included information about their evaluation (10, 34.5%), nearly a third were either not evaluated or provided no information or reference to an evaluation (9, 31.0%) and only 17% (5) included information on process evaluation or monitoring of policies meeting key performance indicators.

No information was collected on workforce training and support to assist policy implementation and sustainment of changes.

4 | DISCUSSION

We set out to determine if Australian policies support a primary health care system to identify family adversity and subsequently support these families. The results of this study identified many (188) Australian state (Victorian and NSW) and federal policies that reference family or childhood adversity or vulnerable families, with close to

TABLE 2 Inclusion of multiple adversity issues within policies.

The number of policies that reference adversity		Additional adversity issues represented in policy (note that more than one adversity can be represented in a policy, therefore numbers and percentages below are based on counts or frequency of adversities)													
Category of adversity	(n = total number of policies)	Childhood maltreatment		Household dysfunction				General health/Vulnerability				Other social determinants of health			
		Abuse and neglect	Sexual abuse	Family violence	Parent Mental illness	Parenting	Drug and Alcohol	General health	General vulnerability	Educational Vulnerability	Child behavioural issues	Poverty	Housing	Incarceration	Out of home care
Childhood maltreatment	Abuse and neglect (18)														
	Sexual abuse (15)														
Household dysfunction	Family violence (17)														
	Parent mental illness (12)														
	Parenting (11)														
	Drug and alcohol (7)														
General health/ vulnerability	General health (13)														
	General vulnerability (24)														
	Educational vulnerability (6)														
	Child behaviour (3)														
Other social determinants of health	Poverty (6)														
	Housing (5)														
	Incarceration (3)														
	Out of home care (7)														

Note: The percentage of policies that include multiple adversities are shown incrementally via colours: represents 0%–25%, represents 26%–50%, represents 51%–75%, represents 76%–100%. Black squares represent the same policies and are therefore, not considered.

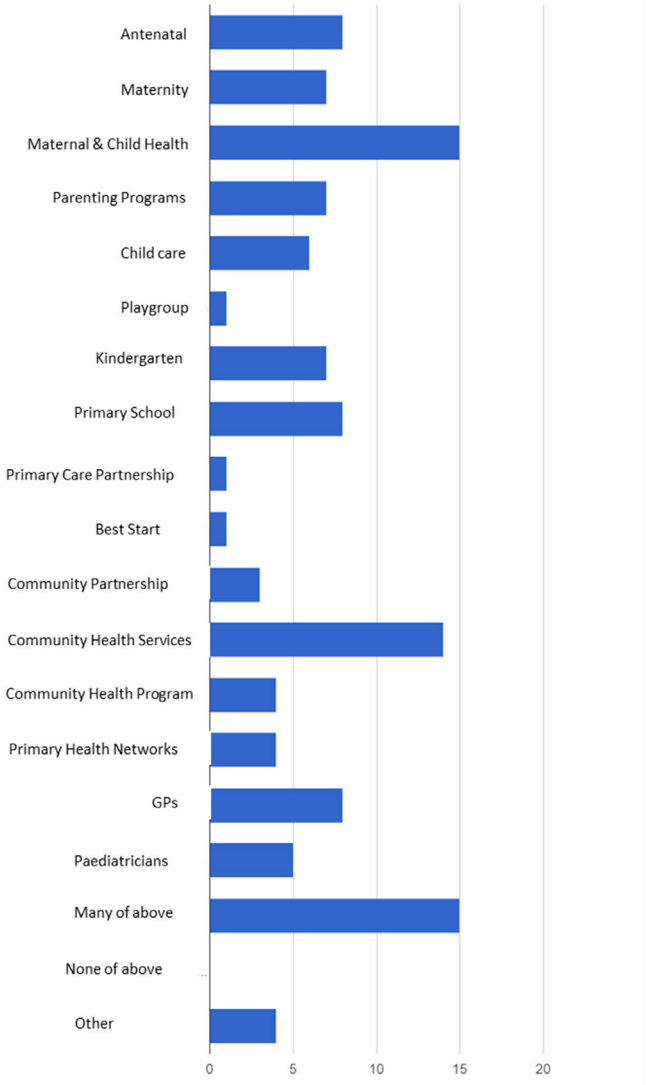

FIGURE 1 Primary care platforms referenced and utilised within state and national policies.

40% of these policies focused on early intervention or prevention within primary care. These results broadly indicate a receptive policy environment to intervene early to address family adversity through existing primary health service platforms, such as maternal and child health and CHSs. This is the first policy scoping article to focus on family adversity in Australia and provides insights into the policy context for this important issue.

4.1 | Framing the issue throughout the stages of policy making

Issue framing is the process of shaping the interpretation of a social problem[30] and is relevant to each stage of policy development. The way a problem is framed can influence its prioritisation on the policy agenda the types of solutions that are proposed.[31] Family adversity is a term not widely used in policies, as identified in interviews by policy makers and those implementing policy (CHS staff); however, it is a term that is closely linked with vulnerability and individual adversities,[32] such as drug and alcohol misuse or child abuse and neglect and provides an important focus for governments to drive equity. This commitment to equity was supported by the explicit and implicit use of the term within most (86%) priority policies within this scoping review. The wide and synergistic reference to the terms vulnerability and equity, suggests a social justice frame of the issue of adversity by governments. This not only identifies the importance of social responsibility to address the issue from a policy perspective, but also governments' responsibility to create a supportive environment to promote equal chance for people to be healthy. However, given the focus on equity, it is interesting to note that broader determinants of health, such as housing and poverty which provide a foundation for equity, were not well represented across policy documents. This may be due to the complexity and perceived intractable nature of these issues within the community leading to a dearth of effective or affordable policy solutions.

4.2 | Agenda setting

Agenda setting refers to getting an issue on the formal policy agenda to be addressed by government.[31] Within any level of government there are limited resources, including time and finances; therefore, choices must be made between competing issues. According to Kingdon's Multiple Streams Framework[33] influencing the government's agenda involves three separate but parallel streams (i) recognition of the problem to be addressed, often but not always supported by data, (ii) possibilities for policy action and inaction that are ideally based on evidence to be identified, analysed and prioritised to few feasible options and (iii) a political imperative where there is potential for commitment, also termed political will. If these three separate streams come together at a critical time, a policy window is likely to open and influence the agenda setting process. It is instructive to consider how these three streams of agenda setting emerged in this research about family adversity.

4.2.1 | Recognition of the problem

Family adversity incorporates a complex and multi-dimensional set of issues and as a result is likely to draw many stakeholders, otherwise known as actors, to advocate for their issue and proposed policy solutions on the government agenda. The breadth of actors, available data on prevalence of adversity, and the well-established evidence of the negative health and economic impacts of adversity are likely to elicit some degree of power, important when influencing whether an issues gets on the policy agenda.[34] The current policy scoping shows a relatively high number of policies from a variety of government departments that reference family adversity or more commonly vulnerability. In addition, the breadth of adversities included in current policies indicates the issue of family adversity is acknowledged to be

of public interest, although, as previously mentioned, not generally termed as family adversity. Although this article does not have the capacity to fully assess the mechanisms of agenda setting for family adversity, we can see that there has been some level of success with getting family adversity and issues related to adversity recognised as important issues for government to address.

4.2.2 | Proposed solutions

Actors often advocate for issues and proposed solutions to be placed on the agenda; however, government policymakers must become engaged in the process for an issue to be formally addressed through policy.[30] Governments utilise several procedural tools within the agenda setting process to manage the range of issues and proposed solutions presented, including advisory groups, public submissions and citizen juries.[35] These different forms of consultation seek to build consensus between actors and policy makers as to the policy problem, and the range of solutions that seem credible.[30] Within this policy scoping 78% of priority policies described some degree of consultation; however, a limitation of this review is that details of consultation, including the type, level and length of engagement with actors and public was not collected. In addition, a lack of consultation information included in published policy documentation may not represent whether consultation occurred.

Given the high number of policies that reference adversity or vulnerability and the broad range of issues included within the term family adversity, it is likely that the range of solutions proposed would also be broad, potentially diluting a coordinated and strategic primary care approach to the issue. Although, this scoping review did not assess the range of solutions or interventions, there were two key platforms used for implementation of many policies—maternal and child health nurse visits and CHS. Two states (Victoria and NSW) do have funding and support for both platforms, which have a remit of proportionate universalism, improving the equitable delivery of prevention and early intervention. A focus on these platforms will be an important solution option to identifying and supporting family adversity, however there is presently no national strategy for these two platforms.

4.2.3 | Political will

There are several current state and federal policies suggesting that there is already political will and an authorising environment for the formulation of policy related to early intervention for family adversity. These policies include Victoria's Roadmap to Reform,[36] Victorian Community Health Reform Plan,[37] state government budget allocated to recommendations within the Royal Commission into Victoria's Mental Health System (Victorian),[38] NSW The First 2000 days Framework,[39] NSW Building Strong Foundations Program Service Standards,[40] Integrated Prevention and Response to Violence, Abuse and Neglect Framework,[41] National Children's Mental Health and Wellbeing Strategy (Commonwealth).[42] These policies are important as they often link with a range of other existing policies and hold government accountable to their actions.

The current interest in child mental health as demonstrated by two new state and federal government policies[33,37] potentially reflects political will to the issue. This issue is likely to be further highlighted as the child mental health burden increases as a result of the COVID pandemic and associated isolation measures.[43] This potentially shows a convergence of the three streams of agenda setting, as outlined in Kingdon's Multiple Streams Framework,[28] leading to a policy window being open for further policy development relating to family adversity. However, more concise policy solutions aligned between actors are likely to assist this process needed for progress to policy formulation.

4.3 | Policy formulation

Policy formulation refers to the development of effective and acceptable courses of action for addressing what has been placed on the policy agenda.[27] As previously mentioned, although there are many policies that focus on single or a number of co-occurring issues, such as child abuse and neglect and family violence, broader policies that focus on vulnerability and equity provide an opportunity to bring all adversities together as a combined issue rather than separate issues thereby recognising the co-occurrence across the breadth of issues in family adversity.

4.4 | Policy implementation

According to Hudson, Hunter and Peckham[44] 'policies do not succeed or fail on their own merits; rather their progress is dependent upon the process of implementation'. A myriad of factors influences policy implementation that are complex, multifaceted and multileveled,[45] with two key factors being funding and implementation support, such as capacity building. Although this scoping review did not examine the complete range of factors that may influence policy implementation, funding for policies was investigated. This scoping review identified most policies had some level of funding associated with policy implementation; however, for nearly two-thirds of these policies there was no information available in the published policy documents about the amount of funding or how this was allocated to the policy implementation, creating a lack of transparency in the policy implementation process. Government support provided for policy implementation in addition to funding, including but not limited to training, leadership and governance, are important considerations to reduce the likelihood of policy failure.

4.5 | Policy evaluation

Efficient and effective public policy must be informed by solid evidence about what works, for who, under what circumstances, and at what cost. Policy evaluation will inform and improve the ongoing development of policy, its adoption, implementation and effectiveness,

and builds the evidence base for further policy interventions.[46] Given the importance of policy evaluation, it is surprising that only a third of policies in this scoping review included information about their evaluation, while a third were either not evaluated or provided no information or reference to an evaluation. The lack of publicly available reports on policy evaluation undermines the notion of government accountability and creating public value, outlined by Moore.[47]

4.6 | Limitations

This scoping review provides an overview of the policy environment related to family adversity within two Australia states (Victoria and NSW) and federally. Therefore, the outcomes of this review may not be representative of other Australian states and territories. In addition, this review did not have the capacity to delve into the detail of a full policy analysis. Important information relating to policy development and implementation, such as the type of consultation with stakeholders, training and infrastructure supports to policy implementation, and evaluation methodologies were not able to be analysed in full detail. Finally, interviews with stakeholders to verify their use and reference to priority one policies within their work was undertaken only with Victorian stakeholders. As such, the list of NSW policies has not been verified.

4.7 | Implications

This study is a component of research within the Centre of Excellence in Childhood Adversity and Mental Health (CRE). The broad aims of the CRE are to develop and evaluate an integrated child and family hub model of care positioned within CHSs and co-designed with families and local service providers, to improve children's mental health by early detection and response to family adversity. The study outlined in this article was conducted as part of the formative research phase and seeks to address the gap in evidence relating to the current policy environment to detect and respond to children and families experiencing adversity. This information will inform state-wide knowledge translation activities to support the scale and sustainment of the child and family hub model.

5 | CONCLUSIONS

The policy environment related to adversity and vulnerability includes many policies across a range of adversities; with the co-occurrence of adversities often (but not always) considered. Given the number and breadth of policies focused on existing primary care platforms, it suggests there is an authorising environment for addressing adversities, especially when framed within a social justice perspective. It will be important to utilise this opportunity to move beyond policy rhetoric to accelerate our response to family adversity and create accountable and measurable action.

AUTHOR CONTRIBUTIONS

Suzy Honisett was involved in study design and concept development, data collection, data analysis and drafted the manuscript. Hayley Loftus was involved data collection for Victoria, interpretation of the findings and manuscript preparation. HueiMing Liu, Alicia Montgomery and Denise De Souza were involved in data collection for NSW, interpretation of the findings and manuscript preparation. Teresa Hall was involved in coding and analysis of stakeholder interviews and manuscript preparation. John Eastwood, Harriet Hiscock and Sharon Goldfeld were involved in study design, concept development and interpretation of the findings and manuscript preparation. All authors read and approved the final manuscript.

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CONFLICT OF INTEREST

The authors declare that they have no competing interests.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

Ethical approval was granted by The Royal Children's Hospital (RCH) Human Ethics Research Committee (HREC # 62129). Participants provided written informed consent to take part in semi-structured interviews. Participants provided separate consent for quotations to be used. All methods were performed in accordance with relevant guidelines and regulations stipulated by the RCH Human Ethics Research Committee and the Australian National Health and Medical Research Council.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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