

# “Healthy Start.” A National Strategy for Parents With Intellectual Disabilities and Their Children

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*Abstract* Parents with intellectual disabilities, like all other parents, need support with child rearing. Often this support comes from family and friends, but in the case of parents with intellectual disabilities, they are more likely to have to rely on the service system. Research from a number of countries demonstrates that there is limited system capacity to support these parents. There are few appropriate services, and practitioners are generally ill-equipped to meet the parents’ particular learning and support needs. In response, the Australian government has funded a capacity-building model known as *Healthy Start: A national strategy for children of parents with intellectual disabilities*, as part of its Stronger Families and Communities Strategy. This paper presents this model for building systems capacity that, in brief, addresses on the one hand, practitioner commitment, knowledge, and skills, and on the other, the parent education and community development resources needed to support parents with intellectual disability and promote a healthy start to life for their young children. The model involves the development of local leaders and practitioner networks in addition to dissemination of knowledge and innovation to support evidence-based practice. Innovative, cross-disciplinary, and inter-sectoral practitioner networks are at the heart of this capacity-building model. These networks bridge the gap between research knowledge and practitioner knowledge as a basis for planning and coordinating local service development.

*Keywords:* intellectual disability, knowledge translation, parents, prevention, systems

## INTRODUCTION

The foundation for health and well-being is laid down early in a child’s life (Shonkoff & Phillips, 2000). Supporting parents during this critical period is widely regarded as the most effective means of promoting health and well-being in the developing child (UK Department of Health, 2000). This support is least likely to be available for those most vulnerable, such as parents with intellectual disabilities (McConnell, Llewellyn, & Ferronato, 2006). Typically, parents with intellectual disabilities receive limited social support from their family, friends, or the community. In this challenging situation, support from the service system may be critical to their children’s life chances. Health, education, and social services in many countries, however, have been shown to be poorly equipped to meet the particular learning and support needs of parents with intellectual disabilities.

In this paper, we describe *Healthy Start*, a three-and-a-half-year funded quasi-experimental trial of a national strategy in Australia to build capacity in the community service system to

support parents with intellectual disabilities. This project, funded by the Australian government under the Stronger Families and Communities Strategy of the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs, is the initiative of the Australian Supported Parenting Consortium, which is a community–university partnership dedicated to translating research knowledge into policy and practice. The consortium partners are the Parenting Research Centre (<http://www.parentingrc.org.au>) and the University of Sydney-based Australian Family and Disability Studies Research Collaboration (<http://www.afdsrc.org>).

### *An At-Risk Group of Parents and Children*

Children of parents with intellectual disabilities, as a group, are at risk for developmental delay and behavior disorders. Behavior–genetic studies show that general cognitive ability, typically indexed by a total score on a standardized intelligence test (IQ), is approximately 50% heritable (Plomin, 1999; Simonoff, Bolton, & Rutter, 1996). Inherited risk is increased by poor pregnancy and birth outcomes. A recent Australian prospective cohort study found that the odds of preeclampsia was 2.85 times higher for pregnant women with intellectual disabilities, and the odds of low birth weight and admission to neonatal intensive care were,

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respectively, 3.09 and 2.51 times higher for their children (McConnell, Mayes, & Llewellyn, 2004). Children of parents with intellectual disabilities also face environmental risk conditions that may have a multiplier effect. These include family poverty, unsafe and/or unsuitable housing in low income neighborhoods, chronically poor parent health including higher than population levels of depression, anxiety, and stress, social isolation, and unequal access to health, education, and social services (Feldman, 2002; Llewellyn, McConnell, & Ferronato, 2003).

Studies on outcomes for children of parents with intellectual disabilities date back to the 1930s; however, these are few in number and based almost exclusively on small clinical samples. Within these limitations, the findings suggest that approximately 40% of these children demonstrate clinically significant developmental delay and/or behavior disorders. For example, Keltner, Wise, and Taylor (1999) report that 16 of 38 (42%) 2-year-old children were developmentally delayed in a North American study. Similarly in Australia, McConnell, Llewellyn, Mayes, Russo, and Honey (2003) found that between one-third and one-half of their sample of 37 preschool-age children demonstrated delay of at least 3 months in one or more developmental domains. Little is known about outcomes for older, school-age children. One case-control study compared outcomes for 27 6–12 year old children of mothers with an intellectual disability (IQ < 70) with 25 children of mothers without mental retardation. On average, the children of mothers with an intellectual disability had lower scores on measures of IQ, reading, spelling, and math, and 37% met the local school board's criteria for learning disabilities (Feldman & Walton-Allen, 1997).

Children of parents with intellectual disabilities are more likely than any other group of children to be removed by child welfare authorities (Booth, McConnell, & Booth, 2006). Perceived developmental risk is one contributing factor (McConnell et al., 2006). Studies from a number of different countries and jurisdictions show that in any sample of parents of intellectual disabilities, two out of every five of their children have been removed and permanently placed outside the family home. For example, the first national survey of adults with "learning difficulties" in England found that 48% of the parents interviewed did not have custody of their children (Emerson, Malam, Davies, & Spencer, 2005). In the United States, analysis of the 1994/5 National Health Interview Survey—Disability Supplement data determined that 49% of parents with intellectual or developmental disabilities were not living with their children at that time (Larson et al., 2001). Court studies in the United States, England, and Australia have confirmed that children of parents with intellectual disabilities are overrepresented in child welfare proceedings representing approximately 15 to 25% of all children placed by the courts away from their family home (Booth, Booth, & McConnell, 2005; Llewellyn, McConnell, & Mayes, 2003).

### *Reducing Risk for Parents With Intellectual Disabilities and Their Children*

From the early 1980s, parent and child intervention studies have shown that the risk of poor outcomes for children of parents with intellectual disabilities can be reduced with appropriate support and services. One of the best-known child-level interven-

tion studies is the Abecedarian project. In this study, children were randomly assigned to one of two treatment conditions: a comprehensive educational day care intervention from birth through to age 5 years or a no-treatment control. The children were selected for the study using a high-risk index that included items such as low IQ in the mother and/or father, low income, and history of social service contacts. At the end of the first year, there was no difference between the two groups. At 24, 26, and 48 months, however, a significant difference in general cognitive ability was observed, with an average treatment-related difference of 11 IQ points and a standardized effect size of 1.75 (Campbell, Pungello, Miller-Johnson, Burchinal, & Ramey, 2001; Martin, Ramey, & Ramey, 1990). Follow-up of children at age 21 found lasting intervention effects including an increase in reading and math achievement and increased participation in secondary and post-secondary education.

At the parent level, experimental and quasi-experimental trials have demonstrated the efficacy of parenting programs when designed specifically for parents with intellectual disabilities. In a review of first generation parent training studies, Feldman (1994) noted that "prior to 1983 there were no studies focusing on the training of parents with cognitive disabilities that provided sufficient outcome data to judge the effectiveness of the intervention" (p. 301). By 1993, however, there were 20 suitable studies. These and other more recent studies have demonstrated positive gains across a range of parenting skills. These include basic childcare such as bathing, changing nappies/diapers, and cleaning baby bottles (e.g., Feldman et al., 1992); home safety and emergencies (e.g., Tymchuk, 1990; Tymchuk, Andron, & Hagelstein, 1992; Tymchuk, Hamada, Andron, & Anderson, 1990); recognizing and responding in a timely and appropriate way to symptoms of childhood illness (Llewellyn, McConnell, Honey, Mayes, & Russo, 2003a); parent-child interaction and play (e.g., Feldman, Case, Rincover, Towns, & Betel, 1989; Feldman et al., 1986; Keltner, Finn, & Shearer, 1995); decision-making (e.g., Tymchuk, Andron, & Rahbar, 1988); and responding to common problematic parenting and social situations (e.g., Fantuzzo, Wray, Hall, Goins, & Azar, 1986).

Over the last decade, parent-level interventions have been extended to tackle other risk conditions including the social isolation of parents, and by proxy, isolation for their children. In one British study, Booth and Booth (2003) prospectively evaluated the Supported Learning Program, a group-based intervention designed to enhance the support networks of mothers with "learning difficulties" and foster their self-advocacy skills. Reported outcomes for the 31 mothers included greater personal and practical skills, greater sense of control over their lives, a better self-image and more confidence in their own abilities, greater assertiveness, greater awareness of their own needs and how to get help, and a larger support network. McGaw, Ball, and Clark (2002) report similar findings from their evaluation of a group intervention for parents with mild intellectual disabilities. In their British study, 12 parents were assigned to an experimental parent group and 10 were assigned to a control group. A cognitive-behavioral approach was used to raise social awareness, enhance interpersonal communications, and improve listening in relationships. Major findings included significantly improved self-concept, improved relationships with partners, new friends, and increased confidence in accessing resources for themselves.

Despite the significant advances in knowledge about parents with intellectual disabilities and their children, intervention studies have focused almost exclusively on limited parenting knowledge and skills. Interventions have also focused solely on the parent or child, the most basic unit of social organization. Research from the field of public health suggests that interventions targeting organizational and institutional levels of social organization are also needed to complement individual-level intervention programs. One reason is that the health and behavior of individuals is strongly associated with their social position and environment. It is, therefore, difficult to effect lasting change at the individual level without modifying the environment in a way that supports and/or leads to individual-level change. Another reason is that interventions targeting environments, or more specifically organizational and/or institutional change, often produce more sustainable effects than individual-level interventions alone (Swerissen & Crisp, 2004). No study to date has investigated the efficacy of an intervention for parents with intellectual disabilities and their children focused on change at the organizational or institutional level.

### *The Gap Between Research and Practice*

Against this background, there is an apparent gap between the services provided to parents with intellectual disabilities and their children (and the research), which are primarily focused at the individual level and the knowledge that organizational interventions are also needed to effect sustainable change. A steady increase in the referral of parents with intellectual disabilities and their young children for support and protective services is well documented (Bradley, Toft, & Collins, 2000; English, 2000; Genders, 1998; Guinea, 2001; McConnell, Llewellyn, & Ferronato, 2000). Yet services for parents with intellectual disabilities remain scattered, underdeveloped, and of variable quality (Goodringe, 2000), and practitioners lack training and resources (McConnell, Llewellyn, & Bye, 1997; Tarleton, Ward, & Howarth, 2006). For example, in New South Wales, Australia, McConnell et al. (1997) investigated the support needs of parents with intellectual disabilities and service constraints through a combination of interviews with parents, focus groups with practitioners, and a survey of significant others. A number of service constraints were identified including limited time, staff, and funding; lack of suitable parent education resources; insufficient practitioner skills; and negative practitioner attitudes. Practitioners agreed that additional training and resources were needed to effectively support these parents and their young children. Almost a decade later, similar findings were reported in another Australian state when the Victorian Parenting Centre (now the Parenting Research Centre), in partnership with the Office of the Public Advocate, convened a forum that brought together the health, education, and social welfare sectors (see <http://www.parentingrc.org.au>). To overcome the gap between current service approaches and sustainable change strategies, the Parenting Research Centre and the Australian Family and Disability Studies Research Collaboration (University of Sydney) came together as the Australian Supported Parenting Consortium to develop and trial a capacity-building strategy, known as *Healthy Start*, to deliver

evidence-based support for parents with intellectual disabilities and their children at individual and organizational levels.

### *Australian Policy Context*

In 2004, the Australian government released a draft framework for building a National Agenda for Early Childhood. A primary objective of this framework was to forge a whole-of-government approach to investment in the early years. Underpinning this framework was the emerging evidence and growing recognition of the importance of the early years for later development and lifelong health and well-being and of the social and economic benefits of prevention and early intervention, in terms of increased productivity and reduced expenditure in health, justice, and welfare. Guided by this draft framework, the Australian government committed a further AUS\$365 million to its Stronger Families and Communities Strategy (2004–08), of which AUS\$70 million was allocated to the Early Childhood—Invest to Grow initiative. This initiative supports the dissemination of evidence-based prevention and early intervention programs and resources, with funding allocated on a competitive basis. The Australian Supported Parenting Consortium successfully applied for AUS\$2.3 million of Invest to Grow funding to implement *Healthy Start*. Further information about the Early Childhood—Invest to Grow initiative is available through the Department of Families, Housing, Community Services and Indigenous Affairs website (<http://www.ofw.fahcsia.gov.au/internet/facsinternet.nsf/>).

### *Healthy Start: A National Strategy for Children of Parents With Intellectual Disabilities*

*Healthy Start* is an organizational-level intervention to reduce risk and promote a healthy start to life for children of parents with intellectual disabilities. The focus of the intervention is on the limited capacity of the service system to deliver evidence-based practice to these parents. *Healthy Start* aims to build system capacity by developing local area networks developed and led by local champions, implementing a national technology-based network, and by actively disseminating knowledge and innovation. The components of *Healthy Start* are described as follows.

**Building capacity** The logic underpinning the *Healthy Start* national strategy is illustrated in Figure 1. Capacity refers to the potential to act, including the will or commitment to act, and the knowledge, skills, and material resources needed to do so effectively (Elliott et al., 2003). The hypothesis is that enhanced capacity will result in evidence-based practice and in turn, that evidence-based practice leads to improved parent and child outcomes. Further, we expect that improved parent and child outcomes will positively reinforce evidence-based practice, and capacity will be strengthened as evidence-based practice becomes routine. Three categories of outcomes, proximal, intermediate, and distal are illustrated in Figure 2. In this model, intermediate outcomes such as increased family capacity and resources are said to mediate the relationship between evidence-based practice and

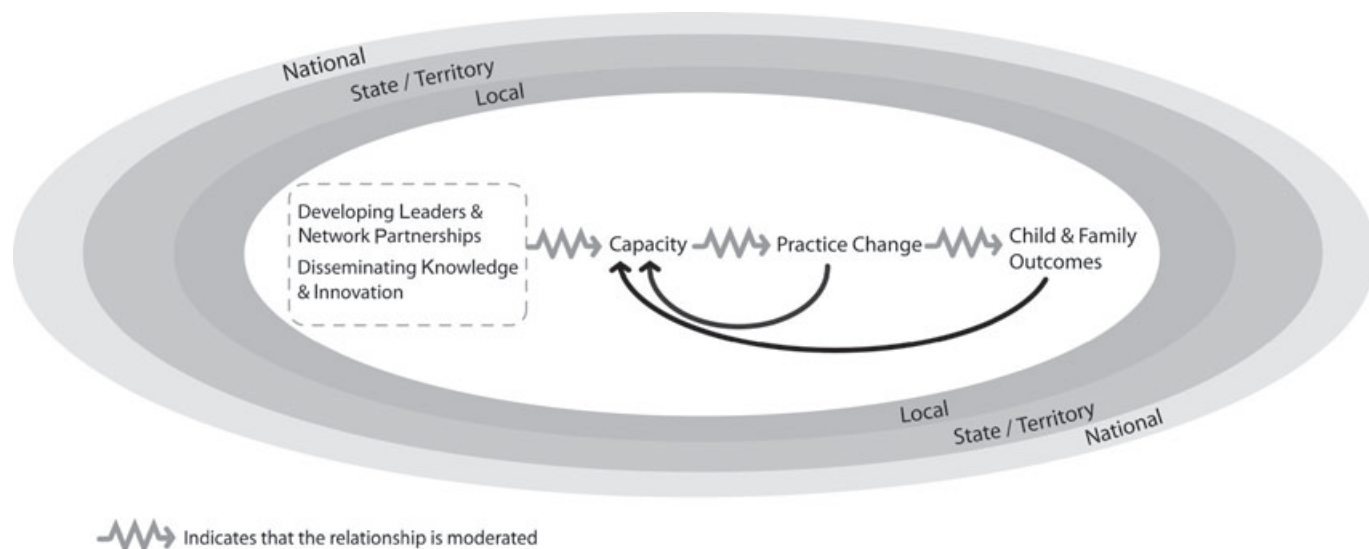


FIGURE 1  
Logic of *Healthy Start*.

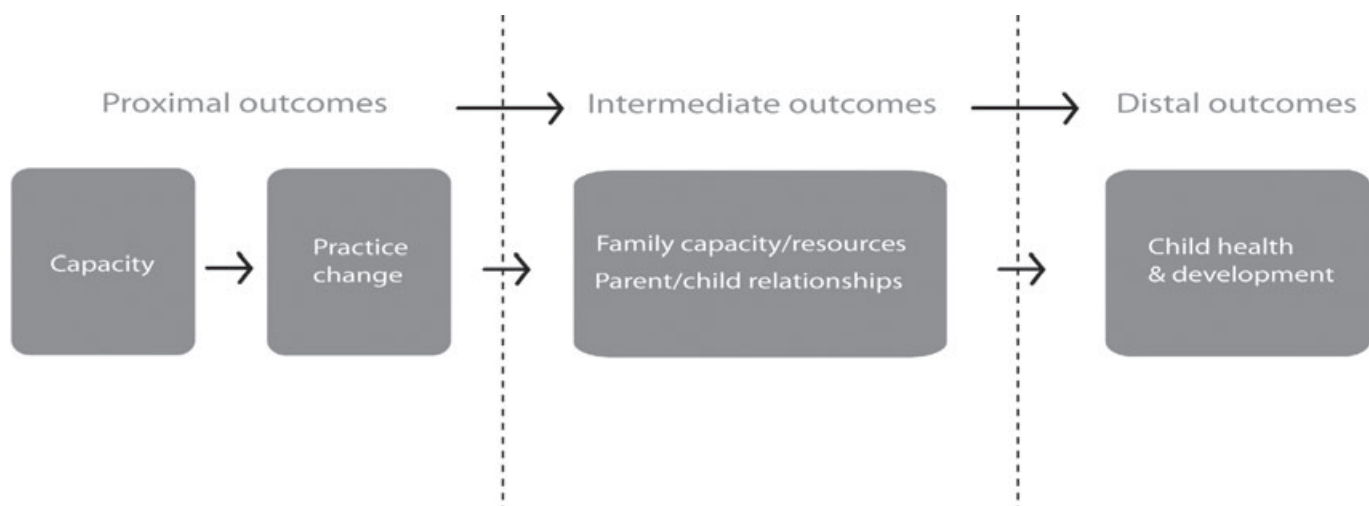


FIGURE 2  
*Healthy Start* outcomes.

outcomes for children. The overall strategy is designed to build system capacity within the limits of existing organizational funding.

Crisp, Swerissen, and Duckett (2000) identify four different approaches to capacity building, briefly summarized in Table 1. These approaches are not mutually exclusive: rather, a combination of approaches is usually required (Elliott et al., 2003). *Healthy Start* integrates network partnership and bottom-up

approaches to capacity building. The network partnership approach is based on two premises. One premise is that opportunities for the two-way flow of knowledge between practitioners and organizations can lead to partnerships through which the resources required to plan and implement new initiatives may emerge (Crisp et al., 2000). The other is that social interactions between practitioners facilitate knowledge dissemination and diffusion of innovation (Berwick, 2003). This premise comes from

TABLE 1  
Approaches to capacity building<sup>a</sup>

Approach	Focus	Strategies
Top-down organizational	Organizational policy and infrastructure changes	Decentralizing services Redistributing resources Establishing clinical guidelines
Bottom-up organizational	Enhancing staff knowledge and skills	Workshops/training Local leadership & innovation
Network partnerships	Strengthening relationships between organizations	Inter-agency coalition Online networks
Community organizing	Involvement and leadership of community members	Open community forums Local community boards

<sup>a</sup>Adapted from Crisp et al. (2000).

social science research showing that individuals vary in terms of their readiness to adopt innovations, and the rate of spread of an innovation depends in part on opportunities for interactions between early and late “adopters” (Rogers, 1995). The bottom-up organizational approach is also based on two premises. One is that investing knowledge and skills in individual staff members increases the capacity of organizations to plan and implement new initiatives and reduces their reliance on external expertise (Crisp et al., 2000). The other is that the spread of knowledge and innovation is not simply a matter of adoption: practitioners are not empty vessels to be filled with knowledge and skills. Rather, the spread of knowledge and innovation from research usually involves adaptation or simplification by practitioners and organizations before it is applied in a particular practice setting (Berwick, 2003).

Empirical studies of capacity building for health promotion have identified a number of conditions influencing the rate of the spread of knowledge and innovation and the success of efforts to build systems capacity (Berwick, 2003; Bowen & Zwi, 2005; Elliott et al., 2003; Hawe, Noort, King, & Jordens, 1997; Miller & Shinn, 2005; Rogers, 1995). Preconditions or contingencies include the perceived need and benefit of the knowledge, innovation, or strategy by individuals, organizations, and government. How and when knowledge and innovation is taken up often depends upon the political agenda and ideology of the government of the day (Bowen & Zwi, 2005). In the case of *Healthy Start*, these conditions are, at least to some extent, in place. A “Healthy Start to Life” is an Australian national research priority area, and as previously described, practitioners are calling for training and resources to support parents with intellectual disabilities and their young children. Other conditions influencing the rate of spread of knowledge include leadership (Dobbins, 2002; Miller & Shinn, 2005), access to knowledge and innovation (Berwick, 2003; Bowen & Zwi, 2005), peer networking or opportunities for social interactions and a two-way flow of information between practitioners (Rogers, 1995; Waisbord, 2006), and adaptability or local adaptation to community context (Berwick, 2003; Schroeder, Van de Ven, Scudder, & Rolley, 1986). By integrating network partnership and bottom-up approaches, *Healthy Start* is designed to create these optimal conditions for knowledge dissemination and

capacity building. *Healthy Start* strategies and the conditions they are designed to address are displayed in Table 2.

**Leadership and managerial support** Leaders, particularly individuals who will champion new knowledge and innovation, and managerial leaders who provide support are central to the success of capacity-building efforts. *Healthy Start* addresses this condition for success at multiple levels. *Reference groups* have been established at state level. These advisory groups are comprised of senior managers from the government and non-government sectors. One role of these groups is to advise on the most appropriate implementation strategies in their home state. Another important role is to champion *Healthy Start* within their agencies. *State and territory leaders* have also been appointed. State leaders have the support of their agency and funding from the *Healthy Start* initiative to recruit and provide ongoing support at the local level where practitioners across agencies come together to form a learning hub. The third strategy involves recruiting and developing *learning hub conveners* at the local level in communities across the country. Learning hub conveners promote *Healthy Start* in their own local areas, and bring practitioners together, from various disciplines and across sectors, to create local *Healthy Start* learning hubs. The fourth leadership strategy involves *local learning hub members* actively championing within their agencies the knowledge and innovation disseminated through *Healthy Start*. The final strategy involves leadership and support from the *Healthy Start* national team, available by telephone and e-mail to all *Healthy Start* practitioners.

**Access to knowledge and innovation** To counterbalance the traditional and rather slow dissemination of evidence from research by publication, *Healthy Start* uses active diffusion of knowledge and dissemination strategies. One strategy is an *information-rich website* (<http://www.healthystart.net.au>). The website contains a searchable database of abstracts from more than 400 articles on the topic of parents and parenting with intellectual disabilities and a set of Practice Points guidelines summarized from the research literature. A second strategy is an *online graduate-level unit of study* from the University of Sydney on parents and parenting with intellectual disabilities. This

TABLE 2  
*Healthy Start* capacity-building strategies

Strategies	Leadership/ managerial support	Access to knowledge and innovation	Peer networking	Adaptation to community context
State-based reference/advisory groups	X	X	X	X
State leaders	X			
State-leader forums			X	
Online graduate course of study for learning hub conveners	X	X	X	X
Biannual learning hub leader forums	X	X	X	X
Local area learning hubs—asset mapping and local action plans	X	X	X	X
Guide to developing a learning hub		X		
Regular meetings			X	
Community asset mapping protocol		X		
Dissemination of information			X	
Workshop training		X		
Implementation of local action plans			X	
Information-rich website		X		
E-newsletters		X		
<i>Healthy Start</i> Listserv			X	

14-week semester-long unit of study is provided for all learning hub conveners and requires participation in online discussions, completion of assignments, and the development of a local area action plan in consultation with their learning hub members. The third strategy is *parent education workshop training* for learning hub members on two evidence-based parenting programs, *Healthy and Safe: An Australian Parent Education Kit* (Llewellyn, McConnell, Honey, Mayes, & Russo, 2003b) and *Parenting Young Children* (Mildon, Wade, & Matthews, in press).

**Peer networking** Peer networking between agencies and their practitioners is crucial to coordinating the actions and resources necessary to underpin the spread of knowledge and innovation. *Healthy Start* incorporates a number of strategies and opportunities for peer networking at multiple levels. At the first level, the reference groups bring together the senior managers of government and non-government agencies in each state. At the second level, *Healthy Start* state leaders are brought together annually in face-to-face meetings to share experiences, exchange ideas, and promote innovation and change. A third level is the bringing together of learning hub conveners online as students in the unit of study: Using an online asynchronous discussion facility, learning hub conveners come together to reflect on the knowledge gained and application into evidence-based practice. Learning hub conveners also come together twice a year for face-to-face meetings at which innovative solutions and challenges are shared and resources distributed. The fourth level brings learning hub members together as practitioners in their local community from their different disciplines, sectors, and agencies. While these meetings are convened according to a mutually acceptable sched-

ule, there is also instant access to peer networking for all involved in *Healthy Start* via the website and listserv, with the listserv functioning as a clearinghouse for practitioner questions, answers, sharing resources, announcing events, and generating new ideas and actions.

**Adaptation to community context** Translation of research to practice occurs when new knowledge or innovation finds meaningful application in any given context. The goal of *Healthy Start* is to facilitate organizational and practitioner adaptation of knowledge and innovation to meet local community-specific needs and interests. Adaptation is a primary role of local learning hubs. Learning hub conveners receive training and resources on how to undertake community asset mapping and develop a local area action plan. Local action plans are developed collaboratively by members of the learning hub to integrate knowledge and innovation from research with local service strengths to address local service development needs. Examples of local action include the establishment of volunteer home-visiting services and parent-peer support groups, and the development of information/tip sheets and a training package for local health clinics, early childhood education, and social service providers.

#### NATIONAL HEALTHY START EVALUATION STRATEGY

Evaluation is a requirement of Stronger Families and Communities projects. The *Healthy Start* evaluation is a pre-post comparison with parallel case study design. Mixed methods are employed to obtain qualitative and quantitative data. One focus of the evaluation is the factors influencing capacity building and

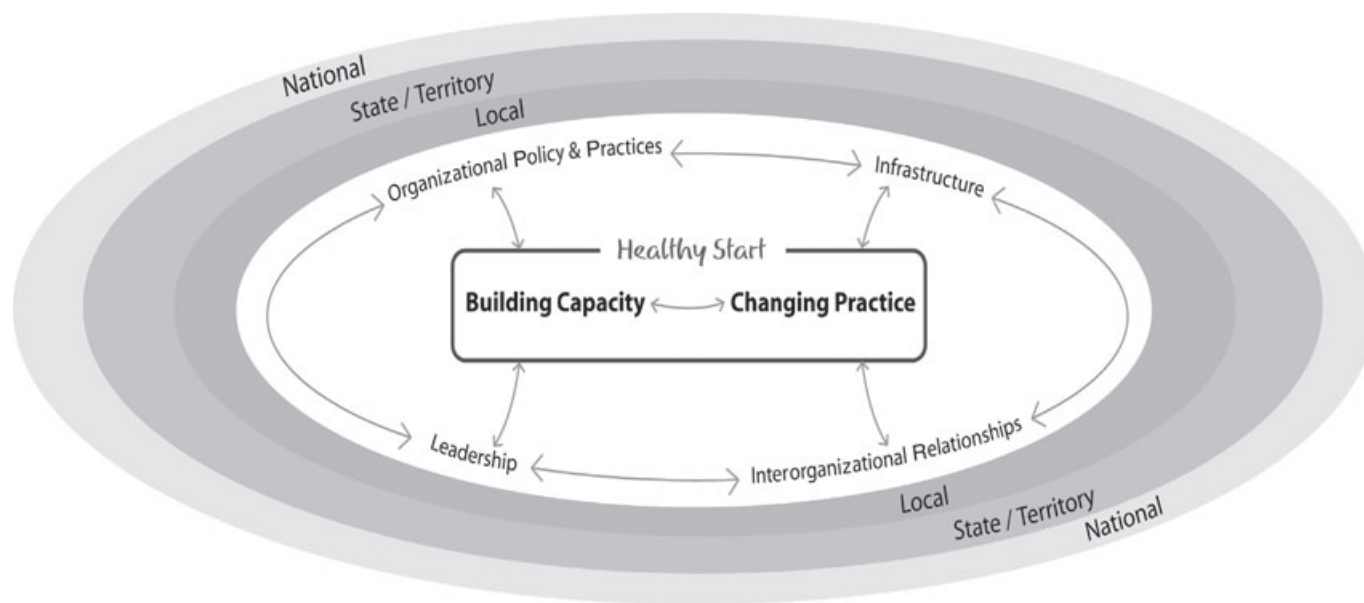


FIGURE 3

Factors influencing the processes of capacity building and practice change.

practice change at the local community level, including but not limited to leadership, organizational policies and practices, infrastructure, and interorganizational linkages (see Figure 3) (Anderson, Cosby, Swan, Moore, & Broekhoven, 1999; Crosswaite & Curtice, 1994; Elliott et al., 2003; Riley, Taylor, & Elliott, 2001). The primary strategy for evaluating this is a series of in-depth and prospective case studies of learning hubs nationwide. Another focus is the *Healthy Start* proximal, intermediate, and distal outcomes illustrated in Figure 2, with the relevant repeated measures documented in Table 3. Enhanced system capacity, vital for sustainability as noted by Crisp et al. (2000, p. 103), that "if capacity building is successful it produces fundamental and lasting changes in how organisations and communities address health issues without the need for ongoing funding," is being evaluated by a combination of strategies. One is a purpose-designed systems capacity questionnaire completed by each learning hub in the early and late stages of *Healthy Start* implementation, approximately 2 years apart. Another is the extent to which *Healthy Start* resources such as workshop participation, accessing the website resources, and implementation of the two-parent education programs are utilized over the life of the project. Data on intermediate and distal outcomes are obtained pre and post for all families who participate in one or both of the two-parent education programs taught in the parenting education workshops.

#### PROGRESS TO DATE

*Healthy Start* has been enthusiastically received by organizations and practitioners across the country. The *Healthy Start*

national network now includes some 1,737 individuals (including members and nonmembers of local learning hubs). A total of 69 learning hubs have been established, with hubs in every Australian state and territory. These hubs now involve more than 400 organizations and over 900 practitioners. The *Healthy Start* strategy has invested knowledge and resources in these learning hubs. All have access to the information-rich website. This website has recorded more than 82,000 sessions to date. In addition, knowledge has been invested through a graduate-level unit of study on parents with intellectual disabilities completed by hub conveners and the dissemination of two evidence-based parenting programs, involving workshop training of 464 practitioners Australia-wide. Local learning hubs are now implementing a range of innovative plans to build capacity to support parents with intellectual disabilities and their young children in their own local areas, bringing together knowledge from research with knowledge of local area needs. Descriptions of these local initiatives are accessible to all on the *Healthy Start* website (<http://www.healthystart.net.au>).

#### CONCLUSION

*Healthy Start* aims to effect change at the organizational level by building system capacity to reduce risk for parents with intellectual disabilities and their children. *Healthy Start* integrates network partnership and bottom-up organizational approaches to build systems capacity. Through the *Healthy Start* initiative, active cross-disciplinary and inter-sectoral networks of practitioners have been established across the country. These networks are the foundation for the active dissemination of knowledge and

TABLE 3  
*Healthy Start* outcomes evaluation

	Outcomes	Key result areas	Measures
Proximal	Systems capacity Practice change	Will/commitment to act Practitioner knowledge, skills, and educational resources Links between organizations	Systems capacity questionnaire Interviews with hub conveners Resource utilization
Intermediate	Family capacity and resources Parent/child relationships	Parent knowledge and skills Parent warmth and responsiveness Safety of home environment	Family questionnaire Home inventory Home dangers & Precautions inventory Health knowledge and skills checklist Goal attainment scales
Distal	Child health Child development	Prevent illness and injury Appropriate and timely response to illness and emergencies Language and communication skills	Family questionnaire

innovation nationwide via an information-rich website, an online course of university study, practitioner workshop training, and the leadership support of state leaders and a national team. The 2-year evaluation of *Healthy Start* will determine in the first instance the effectiveness of this model in building capacity and outcomes for parents with intellectual disabilities and their young children. Of equal interest will be the identification of influences on the processes of capacity building and practice change. Both will provide insights to help inform and strengthen the design and implementation of future capacity-building initiatives to support vulnerable families in the Australian community.

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