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**IMPLEMENTING NURSE HOME VISITING
PROGRAMS: A COMPARISON OF OPPORTUNITIES
AND CHALLENGES IN THE UK AND AUSTRALIA**

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AIMS

This project aimed to assist in the development of an Australian and international evidence base of effective and sustainable home visiting interventions in early childhood and identify the system and workforce capabilities that will be required for these interventions to be widely and equitably implemented. Specifically, the project explored the opportunities and challenges of implementing the Maternal Early Childhood Sustained Home-visiting (MECSH) program in England. The findings of this program of research will have significant implications for the development of early childhood policy and strategy in Australia and internationally.

POLICY CONTEXT

'Acting early to keep our children healthy is one of the most powerful investments our society can make' (National Health and Hospitals Reform Commission, 2009. p. 98). Home visiting services are one way to address the health needs of children born in areas of disadvantage who do not have the same opportunity for good health as those living in more advantaged areas (World Health Organisation, 2008). Over the past decades a series of well-designed randomised controlled trials have demonstrated the efficacy of particular programs of home visiting in the United States, (Astuto & Allen, 2009) and now Australia (Kemp L, et al. 2011, in press). Based on this evidence, governments in Australia and internationally are implementing home visiting programs. How we can best provide these evidence-based interventions (EBIs) equitably, with fidelity and quality, and sustainably to the whole population is now a matter of urgent concern. Research is needed to support the translation of efficacious interventions into equitable, effective, real-world practice.

The Australian and English child health systems are similarly built on a platform of universal public health provision of home visiting and centre-based services by qualified specialist nurses, integrated with the broader child health, development and welfare service system. This project occurred within the rapidly changing context of early childhood service delivery in Australia and England.

IN AUSTRALIA

The National Health and Hospital Reform Commission supports a strong focus on early childhood intervention, and has proposed that the Commonwealth government assumes 'responsibility for the policy and public funding of primary health care services, including existing child and family health services that are funded and provided through state and local governments' (National Health and Hospitals Reform Commission, 2009. p. 99). In addition, the Australian Health Ministers' Advisory Council has commissioned the development of a National Framework for Universal Child and Family Health Services which aims to promote consistency, national standards and performance monitoring across jurisdictions. Within this changing national context, both Commonwealth and State governments are pushing forward with widespread implementation of locally and internationally developed home visiting interventions aimed at improving outcomes for vulnerable children. These national and international initiatives are occurring in a context that provides little guidance, and scant evidence on how to replicate efficacious interventions at sufficient scale to improve outcomes for the overall population (Astuto & Allen, 2009). This is occurring with the context of significant health service reforms that particularly lack clarity regarding the position in the system of non-General Practice (GP) community health services and intersectoral child health and welfare initiatives such as the Keep Them Safe program from NSW Department of Premier and Cabinet, which has made a significant investment in funding NSW Health to roll-out of sustained nurse home visiting in NSW, based on the MECSH program.

IN ENGLAND

The Marmot review *Fair Society, Healthy Lives* (Marmot, 2010), the White Paper *Healthy Lives, Healthy People: Our strategy for public health in England* (Department of Health, 2010a) and the new *Service Vision for Health Visiting in England* (Department of Health, 2010b) are all requiring that government provides an increased response to the needs of vulnerable families. Over the past decades a series of well-designed USA-based randomised controlled trials have demonstrated the efficacy of the Nurse Family Partnership (NFP, known as Family Nurse Partnership (FNP) in England) programme for first-time, teenaged mothers, and the Government will double the capacity of the FNP programme in England.

It is increasingly being recognised, however, that to make a difference to patterns of inequality children's access to positive early experiences needs to be tackled along the whole social gradient, rather than focussing only on specific segments (Marmot, 2010). In response the Government in *Healthy Lives, Healthy People: Our strategy for public health in England* has committed to investigating new approaches to supporting vulnerable families and supporting health visitors to work with families needing additional early intervention (Department of Health, 2010a). This commitment, however, is occurring in a time of health system reform including amalgamations of Primary Care Trusts (PCTs), a return to GP commissioning, fear about loss of NHS funding and staff, and significant loss of senior management staff within the PCTs (see Figure 1).



Figure 1: Health visitors, school nurses and community practitioners protesting the NHS reforms (photo taken at the Community Practitioner and Health Visitor Association (CPHVA) conference, Harrogate UK October 2010).

MATERNAL EARLY CHILDHOOD SUSTAINED HOME-VISITING (MECSH) PROGRAM

The MECSH program was designed to enhance the capacity of universal services to respond to the needs of vulnerable Australian families with a broad range of needs (~20% of the overall population of families) and provides an approach that should be transferable to the English healthcare setting and is consistent with the Healthy Child Programme and the new Service Vision for Health Visiting in England. The MECSH program has two elements:

1. **An intervention for families.** The MECSH intervention is a structured program of sustained nurse home visiting, group activities and broader service system engagement for families at risk of poorer maternal and child health and development outcomes (mothers identified during pregnancy with any of the following vulnerabilities: teenaged, presenting late for antenatal care, psychosocially distressed, low self-esteem, experienced major stressor in past 12 months, mental health issues, abused themselves as a child, drug and alcohol issues, domestic violence). It was developed as an effective intervention for vulnerable and at-risk mothers living in areas of socio-economic disadvantage. The MECSH

intervention is built on and provides a programmatic context for delivery of the Family Partnership Model of strengths-based practice in partnership with their clients. This model was developed by Hilton Davis and Crispin Day in the UK and is core training for child and family health nurses in Australia (www.fpta.org.au).

2. **A system of care** that 'meshes' families with the broader health, development and community services system. The MECSH intervention is delivered as part of a comprehensive, integrated approach to services for young children and their families. The intervention is delivered by child and family health nurses who are embedded within universal child and family health nursing services. The intervention is managed by universal child and family nursing services and embedded within the broader child and family health, development and community services system.

MECSH PROGRAM GOALS

The program goals are:

Improve transition to parenting by supporting mothers through pregnancy. This includes providing support with the mother's and family's psychosocial and environmental issues, supporting the health and development of the family including older children, providing opportunity for discussion, clarification and reinforcement of clinical antenatal care provided by usual antenatal midwifery and obstetric services, and preparation for parenting.

Improve maternal health and wellbeing by helping mothers to care for themselves. Guided by a strengths-based approach, the nurse will support and enable the mother and the family to enhance their coping skills, problem solving skills and ability to mobilise resources; foster positive parenting skills; support the family to establish supportive relationships in their community; mentor maternal-infant bonding and attachment; and provide primary health care and health education.

Improve child health and development by helping parents to interact with their children in developmentally supportive ways. This includes supporting and modelling positive parent-infant interaction and delivery of a standardised, structured child development parent education program.

Develop and promote parents' aspirations for themselves and their children. This includes supporting parents to be future oriented for themselves and their children, modelling and supporting effective skills in solving day to day problems and promoting parents' capacities to parent effectively despite the difficulties they face in their lives.

Improve family and social relationship and networks by helping parents to foster relationships within the family and with other families and services. This includes modelling and supporting family problem solving skills, supporting families to access family and formal and informal community resources and providing opportunities for families to interact with other local families.

THE MECSH INTERVENTION

The MECSH intervention with families has five core elements that are delivered with the MECSH system of care (see Figure 2):

1. **Supporting mother and child health and wellbeing**, including observation and support of child, maternal and family health and development, parent-infant interaction, and provision of primary health care and health education.
2. **Supporting mothers to be future oriented and aspirational** for themselves, their child and family.
3. **Supporting family and social relationships** within the extended family, with the family's communities and with other health and social services.

4. Additional support in response to need including interventions by the MECSH nurse and additional support accessed through the tiered service system.

5. Child development parent education program delivery. This is a structured program of parent education about child development. The MECSH trial used the “Learning to Communicate” (LTC) program.

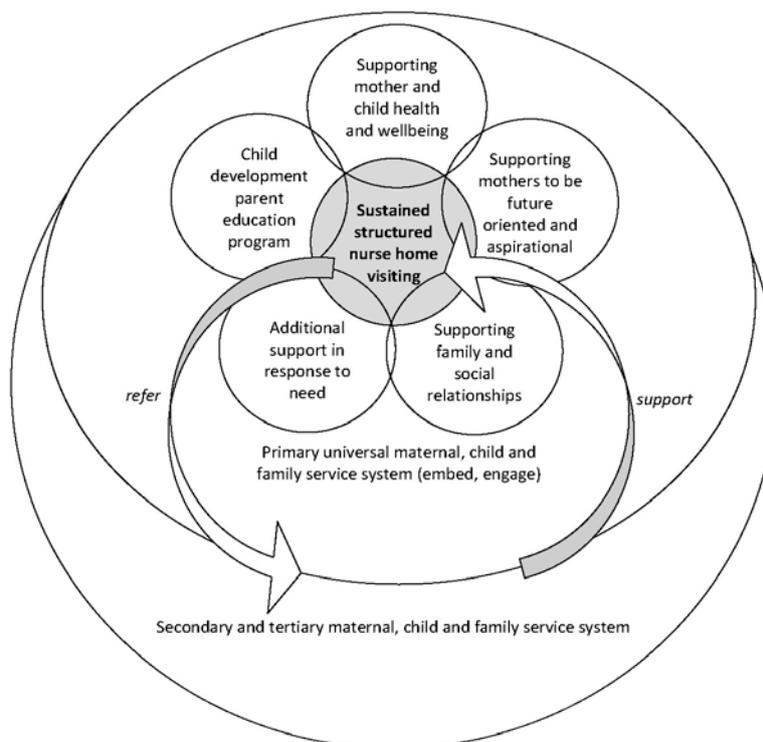


Figure 2. MECSH program model

The MECSH intervention is delivered through three program activities:

1. Home visiting. The home visiting components of the MECSH program intervention consists of at least 25 home visits by the same MECSH program child and family health nurse during the remainder of pregnancy and the first 2 years post birth.

2. Group activities for MECSH families. MECSH groups may be formed around an activity, such as a pram walking group, or be a parent-led group where parents identify the activities, for example craft, cooking, or guest speakers. After attending the MECSH group for a period of time, many families ‘graduate’ to the existing child and family groups in their local community, such as play groups.

3. Engagement with and referral to other services and supports. The MECSH program includes the provision of early intervention through early identification of health and development issues for mothers, infants and their family, and direct and timely access to services through the tiered service structure. Families are also connected to other groups, services and facilities in the local area, for example playgroups, parenting groups, and health and community service providers.

SYSTEM OF CARE

The MECSH program uses a tiered service model as the System of Care. The tiered model encompasses the primary health care and more specialised services that families may need. The tiered service system enables skilled Tier 1 workers and families to consult with, and be

supported by, more specialised Tier, and have timely access to Tier 3 and 4 services for families. This facilitates the provision of effective and efficient support to families, by improving the quality of help available to all families.

Tier 1

Tier 1 services are the 'front-line' service providers. In the MECSH program Child and Family Health Nurses (C&FHNs) are the Tier 1 provider. The role of Tier 1 services is to provide primary health care to families as described above, and identify problems early in their development, offer general advice and pursue opportunities for health promotion and prevention. The bulk of more minor problems can, and should be, identified and handled within the primary care service, supported by Tier 2 and other specialist health and intersectoral services. The Tier 1 C&FHNs in the MECSH program should establish good relationships with the other Tier 1 providers of care for families, particularly midwifery services during the antenatal period and general practice.

Tier 2

Tier 2 providers function as a member of the extended MECSH team. Access to Tier 2 providers is through direct contact between the Tier 1 and Tier 2 workers rather than through a formal process of referral. This direct contact may be facilitated through strategies such as regular case review meetings or ad hoc contact between the C&FHN and a designated Tier 2 provider. A key Tier 2 provider within the MECSH program is a Social Worker.

Tiers 3 and 4

The service system for MECSH program should identify relevant Tier 3 and 4 service providers for families and ensure that there are processes for timely referral and access to specialised and tertiary level services.

Services or individual providers may not fall neatly into tiers, but rather, their function will be different. For example, a speech pathologist may function as a Tier 2 provider by providing education, support or advice for the Tier 1 child and family health nurse working with a family concerned about their child's speech and language development. The speech pathologist may also be a provider of a Tier 3/4 service providing specialised treatment for a child with a speech or language disorder.

OPPORTUNITIES AND CHALLENGES

The Marmot review suggests the need to 'test ways of working with a wider range of families as well as exploring alternative models of intensive home visiting, where there is good evidence of effectiveness (Marmot, 2010, p. 97). The MECSH program could provide the opportunity, in Australia and England, to implement an evidence-based model of home visiting that supports a wide range of vulnerable families, addressing the needs of approximately twenty percent of the population of families who are vulnerable to poorer outcomes. MECSH could provide the opportunity to address equity across a wider portion of the social gradient when provided in addition to programs that target specific segments of the population, such as the first-time teenaged mother supported by the Nurse Family Partnership (NFP) program (known as Family Nurse Partnership in England). The following table (Table 1) provides a comparison of key elements of MECSH and NFP.

Implementing the MECSH program, however, would provide a challenge, as the program requires organisations, and practitioners to work differently with families, to truly act on the rhetoric of prevention and early intervention to improve outcomes for some of the most vulnerable families. Implementing the MECSH program requires a change of practice for child and family health nurses to deliver enhanced and reflective practice in child development, social determinants of health, and broader outcomes for individuals and populations; advanced skills in fine observation, anticipatory guidance, negotiating, modelling, supporting experimentation, holistic case management and working in interdisciplinary teams; and attitudinal competence for working "with" families and supporting risk taking by families. The MECSH program also

requires development of, and engagement with a comprehensive universal child and family service system that has sustainable systems to identify and respond to vulnerable families, and provide a broad range of timely supports for families in response to their varying needs.

This project aimed to explore these opportunities and challenges in England, and through that experience, identify issues and options for enhancing the implementation of home visiting programs for vulnerable families in Australia.

Table 1: Comparison of key elements of MECSH and NFP.

Program element	MECSH (Kemp, 2011)	NFP (Olds, 2007)
Target group	Mothers at risk of poorer maternal and/or child health and development outcomes (~20% of mothers)	First-time teenaged mothers who present for antenatal care early in pregnancy (~3% of mothers)
Intervention	25 home visits plus group activities plus engagement with broader service system beginning in pregnancy to child-age 2 years.	~60 home visits beginning in pregnancy to child-age 2 years.
Service system	Embedded in comprehensive universal child, family and community service system	Service delivery separate from universal service system
Primary outcomes	Improved duration of breastfeeding, home environment for child development, child cognitive development (for children of mothers with psychosocial distress in pregnancy)	Improved perinatal health, home environment for child development, child cognitive development (for children of mothers with lower psychological resources in pregnancy)

METHODS

The fellowship was conducted during a visit to the United Kingdom between October and December 2010. The fellowship built on relationships between home visiting researchers in New South Wales and Kings College London that have been developing over the past six years. The fellowship was hosted by Professor Sarah Cowley, Kings College London, who is an internationally recognised leader of health visiting research. Professor Cowley facilitated Dr Lynn Kemp's appointment as a visiting senior research fellow at Kings College London. She also facilitated meetings between Dr Kemp and senior policy makers (including Viv Bennett (Deputy Chief Nurse), Kate Billingham (Family Nurse Partnership)), senior policy influencers (including Prof Mitch Blair (Royal Society of Medicine), George Hosking (CEO Wave Trust)), academics (including Prof Jane Barlow (Warwick University), Crispin Day (Kings College London)), child health service commissioners and Primary Care Trust managers throughout England, practitioners and students. These meetings provided the opportunity for Dr Kemp to explore the opportunities for implementation of the MECSH program in England, and challenges to implementation.

The fellowship activities were framed with the concepts of implementation science. Implementation science, or Type 2 translational (T2) research, systematically 'examines a broad range of factors necessary for successful adoption, implementation and sustainability of EBIs across diverse populations' (Spoth, et al., 2008, p. 4). The importance of such research in early childhood has been increasingly recognised over the past decade, however, to date such research is limited, resulting in 'the paradox of non-evidence-based implementation of evidence-based programs' (Fixsen, et al., 2005, p. 35). Internationally, T2 research is the cutting-edge of intervention research in community child health (Astuto & Allen, 2009; McCall,

2009; Spoth, et al., 2008). 'At a time when experts warn of the fragmented health care system and of a widening "chasm" in access, quality, and disparities, interventions to close these gaps – the work of T2 – may do more to decrease morbidity and mortality than a new imaging device or class of drugs.' (Woolf, 2008, p. 212).

Conducting T2 research requires the application of naturalistic methods and experimental trials, and a collaborative, multi-disciplinary approach involving practitioners, clients and communities, and includes:

- *Translation stage-setting research* that focuses on consumer and provider preferences and acceptance, and feasibility.
- *Institutional or individual adoption research* that focuses on factors influencing decisions to implement EBIs.
- *Effective implementation research*, that is, the systematic study of activities and strategies for successful integration of EBIs in service systems, including the reach, quality and fidelity of program delivery.
- *Sustainability research*, that is, the systematic study of how EBIs are institutionalised long-term and the factors that contribute to long-term implementation.

The activities that were undertaken during the fellowship, in support of each of the above research types as detailed in Table 2 (see Appendix A for detailed weekly diary of activities).

Table 2: Activities undertaken.

Type of research	Activities	Involving
Translation stage-setting	Presentations and workshops	Practitioners Practice Teachers Managers and commissioners Office of the Chief Nurse
	Review of policy documents	<i>Service vision for Health Visiting in England</i> Public Health White Paper <i>Healthy Lives, Healthy People: Our strategy for public health in England</i>
Institutional or individual adoption	Meetings and joint agenda setting Review of current programs	Department of Health England
Effective implementation	Planning meetings	Department of Health England
Sustainability	Presentations and workshops	Practice Teachers Family Partnership Model developers (Crispin Day)
	Development of local training capacity to support sustainable implementation	Practice Teachers Health Visiting academic staff Family Partnership Model developers (Crispin Day)

KEY FINDINGS

The engagement with all groups in England suggests that *prima facie* MECSH would be an appropriate model to meet the gap in service provision for vulnerable families, that builds upon the capacity and investment that has been made in England in building a comprehensive child health, development and welfare service system. The processes for transferability and effectiveness of MECSH and its generalisability in international contexts will however, require testing.

OPPORTUNITIES FOR MECSH IN ENGLAND

The MECSH program has high *prima facie* validity with the English service system as both an intervention program and with a service system. There are high levels of enthusiasm for implementation of the MECSH program and improving services for vulnerable families. This enthusiasm, however, is tempered by anxiety regarding capacity and organisational arrangements in the context of health system reform. This is particularly an issue for programs like MECSH that are embedded in and build on the universal child health, development and welfare system.

The Department of Health England is investing in 4200 extra health visitors over the next 4 years, and have developed a new vision for health visiting that clearly articulates the differing levels of family need and the general service response (see Figure 3). However, more specific articulation of the evidence-based responses at each level is needed. The MECSH program is seen as an equity response addressing the needs of “Some families all of the time” because of the broad target group of vulnerable families, and so is seen as response to the call by the Marmot review for interventions for a broader range of vulnerable families, a policy direction also articulated in the recently released Public Health White Paper Healthy Lives, Healthy People: Our strategy for public health in England.

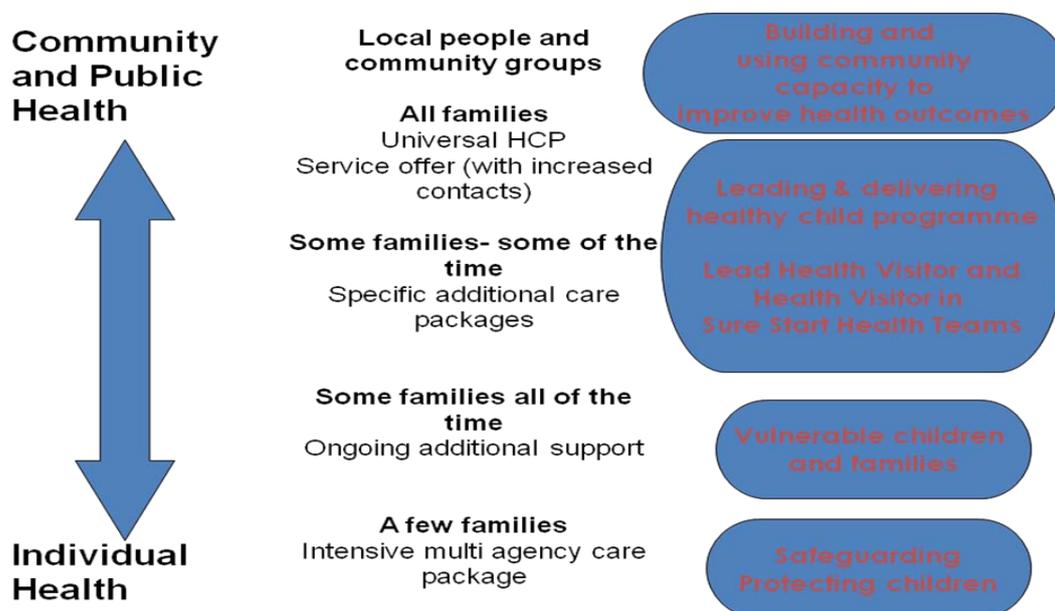


Figure 3. Service Vision for Health Visiting in England (Department of Health, 2010b)

There will be, however, a number of challenges for implementation of MECSH in England. Firstly, health visiting in England has become ‘polarised practice’ providing minimalist universal service for most of the population and high intensity ‘safe guarding’ (child protection) services for a small number of families, with minimal responsiveness for families with differing levels of need. Implementing MECSH would thus need considerable investment in health visitor (re)training; local service system capacity building; commitment by practitioners, managers, commissioners and policy makers to provision of evidence-based programs for vulnerable families; and resources for sustainable implementation of MECSH. There is an opportunity to build MECSH into Family Partnership Model training which would provide UK-based training capacity, as well as enriching Family Partnership Model training in Australia. Translation of MECSH into the English context may be helped over time by the Department of Health England’s high level of commitment to implementing evidence-based programs with fidelity, both at national policy level and in local decision making.

IMPLICATIONS FOR MECSH IN AUSTRALIA

The engagement with local stakeholders in England revealed a number of challenges and opportunities in the English context that have implications for the further development of the MECSH program within the Australian policy context.

In order to maximise policy and decision-makers, managers and practitioners understanding and commitment to implementing MECSH in Australia, the way MECSH works as both a program and a service system needs to be more clearly articulated. The practice and theoretical underpinnings of the intervention program in MECSH home visiting program and the 'meshed' way of working within the comprehensive service system have been challenging to both describe and implement in the Australian context. The importance of the MECSH program intervention and service system as an equity intervention that targets families needs within a universal service system, and the need to maintain the MECSH program's broad target group needs to be more strongly articulated. This unique contribution of the MECSH program within the range of home visiting programs developed internationally needs to be highlighted, against a background of tension between universal and targeted approaches to families in need. Specifically the local and Australian workforce and system underpinnings and assumptions in the program need to be more clearly described order for the program to be understood internationally.

The capacity and organisational context for MECSH and other child health and development services is similarly impacted by health system reforms in both England and Australia. The review of the new Service Vision for Health Visiting in England, however, allowed articulation of a comparable vision of the levels of health visiting response in Australia (Table 3), which can inform a national understanding of responses for families with differing needs.

NSW, like England, also has polarised practice due to policy attention to the first (single) visit by the child and family health nurse and increased pressure from 'Keep them Safe' for nurses to be managing child protection issues. This is an issue from an equity perspective as noted by Marmot (Marmot, 2010), as services are only providing a minimalist universal response, or highly targeted specialist services, rather than addressing the needs of families across the social gradient. This is also occurring in England in a service context with higher ratios (almost double the number) of health visitors to the number of children under 5 than in NSW. The hypothesis that emerged in discussions in England is that the polarisation of practice results from policy that dictates the engagement with high and low need families, lack of policy requiring engagement with families 'in the middle' (see Table 3, levels 1 and 2) and lack of evidence-based responses for families with differing needs. This hypothesis needs testing in both the English and Australian service systems, within the context of the MECSH program provision for families with a range of vulnerabilities and development of the service system.

The evidence-base for MECSH also provides a challenge in taking MECSH to scale in the international context. Conducting experimental design research on complex interventions in Australia is a challenge due to small/low density populations (in comparison to other OECD countries), jurisdictional differences, service capacity and lack of availability of research funding. These factors limit the ability to conduct large efficacy or effectiveness trials in Australia, particularly longitudinal trials where long-term follow-up is needed. Obtaining support for such trial is also hampered in the Australian context where fidelity to evidence and use of evidence in local decision making does not appear so embedded in the community child health, development and welfare sector in Australia as it is in England.

Finally, resources are needed to support taking the MECSH program to scale. Questions that need to be considered when building those support systems include: What elements of the MECSH program need intellectual property protection? Which elements of the program are adaptable for local implementation and which are not?, What is the 'right' balance between maintaining engagement with services using of the MECSH program and building local capacity? What feedback or data should be gathered centrally in order to continue to build an evidence base for MECSH in Australia and internationally?

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Table 3: Service scope, level of vulnerability and recommended service responses.

Service scope	For whom	Response	Child and family health service role	Example
Population health	Local community	Community development and capacity building	Engager	The child and family health service is connecting with the local Aboriginal community through attending community events.
Universal services	All families (Level 0/1)	Universal child and family health nursing service core child health contacts	Provider	Karen and new baby Shae are doing well with good family support. Karen and Shae are provided with the core 'blue book' child health and development checks by their child and family health nurse (CFHN).
	Some families some of the time (Level 1)	Universal child and family health nursing services, with periodic additional support for specific needs	Provider, referrer for community-based support	Jenny has been doing well, but now is having some problems with introducing solids. Jenny is provided with a couple of extra home visits by her CFHN to help with weaning Alicia. Liz is having difficulty managing 3-year-old Stephen's behaviour. Liz is advised by her CFHN to join the parenting group provided by a local non-government organisation for support.
Targeted services	Some families all of the time in the early years (Level 2)	Family psychosocial issues: MECSH sustained structured nurse home visiting program	Key provider, with support of the tiered service model (see MECSH Program Description)	Sue is identified antenatally as having some psychosocial issues that may impact on her parenting. Sue is provided with the MECSH program to support her during pregnancy and the first two years of her baby's life.
		Child physical health/growth issues: Inpatient, outpatient and community-based child health and paediatric services	Provider of universal service, referrer for targeted support	Mary's baby James was premature and small for dates. Mary receives the support of her child and family health nurse, general practitioner and paediatric services to monitor and support James' health, growth and development.
Specialist services	A few families (Level 3)	Child protection issues: Intensive, multi-agency services	Provider of universal service, referrer for specialised support	Marina has issues with drug addiction which is resulting in her having significant parenting difficulties. The DoCS Brighter Futures Program is providing Marina support.
		Child disability issues: Disability services	Provider of universal service, referrer for specialised support	Raye's son Mitch was born with cerebral palsy. Raye receives the support of disability services from DADHC and non-government providers to meet Mitch's needs.

OUTCOMES AND FUTURE ACTIVITIES

The fellowship had benefits for both the Australian and English collaborators (see Appendix D for report by Professor Cowley to Kings College London) and identified a clear opportunity to develop an international research agenda supporting the implementation of the MECSH program and development of universal child and family health service systems in both countries. The following program of ongoing collaborative international research will be developed to support exploration of feasibility and implementation of MECSH in England (Table 4).

Table 4: Program of research around MECSH: three overlapping spheres.

Practice and commissioning questions	Frameworks	Processes	Implementation
Underpinning issues	Equity, focusing on pregnancy and early childhood, families	Practice theory Salutogenic approaches: developing capacity and resilience	Workforce: Delegation (skillmix), referrals, collaboration Organisation of services Professional education
Key theory base	Bronfenbrenner's ecological theory Rose's epidemiology – distribution of need Social capital and well-being	Family Partnership Model Health as process: developing resources for health	Tiered model of provision Organisational climate
Research collaboration	PREview (understanding risk and need profile of families with young children) COGS-2 (commissioning generic health visiting services for children under 2 years old) Understand fluctuating need across universal provision	Feasibility RCT of MECSH Exploration of evidence-based responses across the continuum of need.	Research collaboration with University of NSW, Kings College London, Department of Health England, Dartington Social Research Centre, Warwick University, Birkbeck

A number of specific activities will be undertaken over the next 12 months to support the development of the research program and policy development in both Australia and England, as outlined in Table 5.

Table 5: Future activities

Future activity	Timeline
Invited paper for Journal of Research in Nursing on challenges of conducting trials on programs and systems (draft abstract Appendix B)	Abstract submitted, paper due June 2011, publication November 2011
Ongoing monitoring of the impact of health service reform on the provision of child health and development services is needed. Include the consideration of the context of health system reform impacts in current research into the frameworks for universal child health services, currently being conducted in Australia (ARC Grant LP100100693 (CHoRUS study))	Further discussion during 2011. ARC grant 2010-2012
Proposed replication effectiveness trial of MECSH in England. Exploration of opportunities for further trials of MECSH in Australia.	Further discussion in England and Australia February 2011
Revised MECSH manual suitable for international dissemination	April 2011
Discussions with NSW Health regarding clearer articulation of service response to families with differing needs. Future research in England on understanding levels of need and response in universal services including further development of MECSH data collection tool for universal use. Include the vision as a framework for analysis in current research into the frameworks for universal child health services, currently being conducted in Australia (ARC Grant LP100100693 (CHoRUS study))	February 2011 Further discussion May 2011 ARC grant 2010-2012
Preparation of paper for publication on the MECSH program in the local and international context. Key note address in preparation for presentation by Professor Sarah Cowley at International Conferences in Community Health Nursing Research Biennial Symposium 2011 May 4-6, 2011 Edmonton, Alberta, Canada.	June 2011 May 2011
Future research in England on understanding levels of need and response in universal services including further development of MECSH data collection tool for universal use. Exploration of similar research program for Australia.	Further discussion May 2011 September 2011
Future work may include trialling in NSW and Australia processes used in England that foster evidence based child service system decision making, for example, the Dartington Social Research Unit's 'Common Language' methods to support investment in evidence based programs for children.	Further discussion May 2011
Discussions with local MECSH team regarding licensing of MECSH program for international dissemination.	March 2011
Revised Family Partnership Model training to include MECSH.	July 2011

POLICY OPTIONS

Three areas of learning were identified that have impacts for Australian child health policy. These impacts and accompanying recommendations are presented below.

IMPACT OF HEALTH SYSTEM REFORMS

Discussion and workshops in England made clear that the many educators, practitioners and academics felt that child health, and particularly the delivery of universal child preventive health services in the context of a comprehensive child health, development and welfare system, was poorly understood by the political and bureaucratic systems driving reform. The problems in universal preventive child health services that needed addressing by reform and the gains to be had from reform were unclear, particularly as the drivers for reform are based in the acute care system. It was also unclear how universal child health services would be funded and managed post reform. The levels of uncertainty and anxiety were very high in England during this project (see Figure 4). Universal preventive child health services in Australia seem to be similarly positioned in relation to the current Australian health system reforms.

POLICY RECOMMENDATION 1

The implications of health system reforms for universal preventive child health services need to be identified. In particular:

- How will current levels of investment in preventive child health be protected and enhanced?
- Who will manage child and family health nursing services?
- Who will be in control of and accountable for the level of funding?
- Who will monitor the quality and fidelity of service provision?

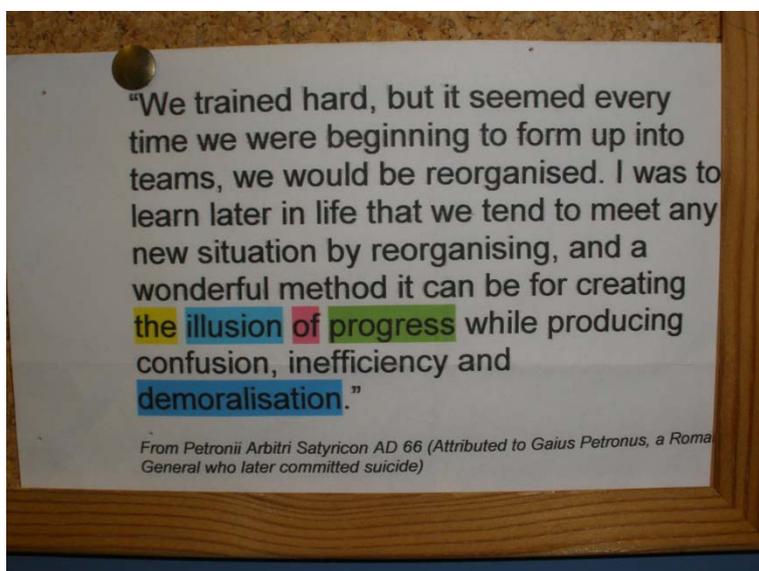


Figure 4:
Commentary on effects of constant reform on notice boards at Kings College London.

POLICY INVESTMENT IN EVIDENCE BASED PROGRAMS FOR CHILDREN

Department of Health England and local authorities and services providers who were engaging in discussions and workshops regarding MECSH had high levels of commitment to investment in evidence based programs and implementation of programs with fidelity, including development of processes to support evidence-based decision making regarding resource investment for

children. Over recent years in Australia policy makers and practitioners in some jurisdictions have been adopting decision-making support tools like Health Impact Assessment (Harris, 2007), however, these have yet to be 'institutionalised' into program planning. Tools to support decision making by child health service commissioners have been developed and resourced in England, such as the Commissioning Support Program (www.childrenstrustcommissioning.com) and the Child and Maternal Health Observatory (www.chimat.org.uk), however, equivalent resources are not available in Australia.

POLICY RECOMMENDATION 2A

Evidence-based decision making support tools should be developed, trialled and supported in Australia to improve the capacity of government and civil society to identify effective programs for investment.

POLICY RECOMMENDATION 2B

Policy makers and service managers should commit to delivering effective interventions with fidelity to improve the health of Australian children.

POLARISED PRACTICE IN EARLY CHILDHOOD

Policy ensuring that universal preventive health services are available for all families with young children and the policy impacts of the heightened attention to child protection issues have resulted in practice that have become 'polarised'. Policies in both England and NSW maintain that all families are expected to receive at least one visit by a health visitor/child and family health nurse soon after birth, and all health visitors/child and family health nurses are mandated to respond to children at risk of significant harm from child abuse and neglect.

There are however, no stated policy expectations regarding the provision of additional services for families with needs other than risk of child abuse and neglect. These are being developed in England in the Service Vision for Health Visiting in England and the NSW Supporting Families Early policy, however, service and program specificity is lacking. For example, whilst the Service Vision for Health Visiting in England provides a framework that includes provision of 'specific additional care package' (see Figure 3, page 11 above), these additional care packages have not been specified. Similarly, an Australian practitioner wishing to provide 'periodic additional support for specific needs' (see Table 3, page 13 above) does not have ready access to information to allow them to choose the best evidence-based support for the family. In the absence of guidance, information and support, provision of effective interventions for families with varying needs is unlikely to occur.

POLICY RECOMMENDATION 3

Evidence-based programs for use by practitioners working with families with varying vulnerabilities and needs in their local communities should be identified, promoted, made readily available, resourced and supported by policy in order to improve the outcomes of all families with young children.

CONCLUSION

The engagement with English policy makers, practitioners and academics resulted in a number of learnings and outcomes relating to the MECSH program in particular and the early childhood policy context more broadly. Firstly, there was a high level of enthusiasm for adoption of the MECSH program in the English health system from practitioners, providers, commissioners and policy makers in early childhood. An ongoing international collaboration and program of research will result, which will be of benefit to both England and Australia. Secondly, there were both many similarities and some differences between the child health context of England and Australia, for example both had polarised practice in the context of differing levels of workforce resources, . These similarities and differences facilitated reflection on the early childhood policy

context in Australia, resulting in three recommendations to support improvement of the context and practice of child health. In particular, the English commitment to identifying and supporting evidence-based programs and practice for families in policy decision making provides a strong platform for the trialling and implementation of effective programs, and Australia would benefit from mirroring such practice. Child and family health services for vulnerable families with varying needs in both countries, however, lack a clear and easily accessed evidence base to inform practice and lack of policy support for services for families across the social gradient. The international collaboration cemented during the fellowship should support both English and Australian policy makers and practitioners to identify, support and implement evidence-based programs to improve outcomes for all families with young children.

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APPENDICES

APPENDIX A: WEEKLY TRAVEL DIARY

Week start	Monday	Tuesday	Wednesday	Thursday	Friday
18 th Oct	Conference preparation Harrogate	Meet with Sarah Cowley, Mary Malone and Suzanne Watts at some point in conference	CPHVA conference, Harrogate	CPHVA conference, Harrogate	CPHVA conference, Harrogate
25 th Oct	Kings College London 12.30pm Sarah Cowley	Kings College London 3.30pm, Prof. Jane Sandall at JCMB room 4.32	Kings College London JCMB: 11.30am Karen Whittaker 3.30pm. Prof Debra Bick	Kings College London	Kings College London
1 st Nov	Kings College London 10am Liz Plastow phone call 4pm Sarah Cowley	Kings College London 10-11am, Public health module (Suzanne Watts co-ordinating, 45 students) (equity and access) JCMB G14	Kings College London 12-1pm, Seminar Stephanie Brown Room 2.40 FWB	Kings College London 1-4pm Specialist Practice Teachers (Mary Malone co-ordinating) (MECSH)	Crispin Day 10.00am Munro Centre Guy's Hospital 4pm Mitch Blair Royal Society of Medicine,
8 th Nov	Kings College London 11am Jane Sandall JCMB room 4.32 1.30pm, Viv Bennett, Deputy Chief Nursing Officer, Richmond House, Dept Health	Kings College London 12.30pm, lunch with Sarah Cowley, Christine Bidmead JCMB	Kings College London 9.30am. Women's Health Research Group (WHRG) Venue Capital House 1.00-2.30 pm School Seminar: Title: Sustained nurse home visiting for vulnerable families 2.30. Sarah Cowley	Prestons, Lancashire 09.30-11am Lynne Braley and children's service manager, Central Lancs; 11.30-1pm Chi Centre, Burnley; 2-4pm Larkhill Health Centre Blackburn with Darwen PCT Karen Whittaker co-ordinating	University of Sheffield Alicia O'Cathain 3.00-4.45pm Home visiting programs in Australia - progress, fidelity and evaluation (40mins)

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

Week start	Monday	Tuesday	Wednesday	Thursday	Friday
15 th Nov	Plymouth Janet Richardson Totnes: meetings with University of Plymouth Child Health colleagues 50 minute Presentation to South Hams District Council and discussion	Plymouth Plymouth: 11am – 12.30pm Short (30 minute) presentation to Preventive and Supportive Care Research Group followed by discussion with the group about research interests.	Plymouth Plymouth: Meet with Public Health Development Unit (NHS Plymouth) colleagues 50 minute Presentation at the University	Kings College London 9am skype Sigg 12.30-2.30pm Kate Billingham at DoH Wellington House 133-155 Waterloo Rd Waterloo	Kings College London
22 nd Nov	Kings College London 11.30am Anne Marie Rafferty – Head of School JCMB 3.27	Kings College London 12.30pm Sarah Cowley	Kings College London 5pm Seminar Institute of Psychiatry De Crespigny Park London	Kings College London 10.30am Crispin Day 4-6.30pm Meeting with HV managers re MECSH	Kings College London 10am Nottingham Kate Billingham and Anne Rowe
29 th Nov	Kings College London	Kings College London 2pm Sarah Cowley 3.15pm East Lancashire PCT, The Commonwealth Club Westminster Davina Gittins 10.30pm skype staff day	Kings College London	Kings College London 12.24-1.45 Seminar Title: Universal for whom? Equity and access issues in child and family health Dept PH & PHC 6th floor seminar room, Capital House 2.30pm Meeting re caseload Sarah's office	Kings College London
6 th Dec	Kings College London 4pm Liz Plastow and Kathy Branson SE England	11.30-12.30 Lewisham Beulah Lewis (tbc) Kings College London COGS-2 Research meeting 2-4pm JCMB	Jersey re MECSH	Kings College London Research meeting 11-1 JCMB 3.26a 1pm Sarah Cowley 2pm George Hosking (East Croydon)	Blackburn & Darwen meeting @ Prestons 10am Visit Fiona Haigh and Impact Liverpool
13 th Dec	Coventry Jane Barlow Warwick University	9-1 South Lewisham Health Centre, Health visiting with Mary Shea 2.30pm research meeting with FNP Wellington House Waterloo	Kings College London	Kings College London 10-12 Thorne Room C'wealth Club – presentation by Clay Yeager - taking programs to scale seminar 2.30pm Sarah Cowley	Kings College London

APPENDIX B: ABSTRACT FOR JOURNAL OF RESEARCH IN NURSING

Title

The challenges of establishing and researching a sustained nurse home visiting programme within the universal child and family health service system.

Abstract

Over the past decades a series of well-designed randomised controlled trials have demonstrated the efficacy of the Nurse Family Partnership programme for first-time, teenaged mothers. It is increasingly being recognised, however, that to make a difference to patterns of inequality children's access to positive early experiences needs to be tackled along the whole social gradient, rather than focussing only on specific segments. Our challenge is to establish effective intervention programmes to meet the broad range of needs of families with young children, within the existing services systems through a combination of targeted and universal interventions that ensure that those most likely to benefit from the service receive it. Health visitors in the United Kingdom have always worked with families with a broad range of vulnerabilities, however, a robust research base for interventions provided by the universal health visiting service for the wider group of vulnerable families has been lacking.

In Australia the Maternal Early Childhood Sustained Home-visiting (MECSH) is a complex intervention, which is embedded in the universal health visiting service, for the broad range of families (20-25% of the population) who are at risk of poorer maternal and child health and development outcomes and who have been shown to benefit from the intervention. MECSH works by providing a structured programme of 25 home visits plus group activities, commencing antenatally and continuing to child-age 2 years, within a system of care approach that requires that local healthcare organisations develop integrated service structures within a organising framework for the delivery of high quality early intervention services to vulnerable families.

The randomised control trial of MECSH in Australia showed significant improvements in mothers' confidence, knowledge and experience of being a mother, children's health and development and a positive environment for children's development for vulnerable families. We found no evidence that the MECSH intervention was only effective with first time or teenage mothers.

Establishing the intervention within the service system and conducting the research trial simultaneously presented many challenges. The intervention required a substantial shift in nursing practice (from being the expert to providing expert support), establishing support structures to prevent "burn out" and isolation, and widening referral links to other services. In conducting the trial the researchers also needed to address the technical and ethical problems of conducting a trial of a complex intervention embedded within universal services including, for example, controlling the impact of the improved service system and health visitor practice on control group families, and responding ethically to child and family needs identified through research processes and measures.

This paper will 1) outline the MECSH program and service system, 2) briefly describe the outcomes of the trial conducted in Australia, 3) discuss the challenges and strategies used to conduct the MECSH randomised trial of a complex intervention for vulnerable families that includes both programmatic and service system components, and 4) suggest the processes and policies needed to support future trials of nursing interventions for vulnerable families conducted within the universal child and family health service system.

APPENDIX C: REPORT BY PROFESSOR COWLEY TO KINGS COLLEGE LONDON

Dr Lynn Kemp, University of New South Wales,

Director of Centre for Health Equity, Teaching Research and Evaluation

Visiting Senior Research Fellow, Florence Nightingale School of Nursing and Midwifery, King's College London

Appointed for one year; in England from 25-10-10 to 18-12-10

Funded through an Australian Primary Health Care Research Institute (APHCRI) 2010 Travelling Fellowship

Dr Kemp's aims in visiting England/King's College were:

to explore the potential for the Maternal and Early Childhood Sustained Home visiting program (MECSH) in the UK, as an option for services who would prefer to implement a sustained structured home visiting program that is embedded in the universal child and family health service system.

to work with international researchers and policy makers on areas related to Australian national health reform, specifically in terms of work with early childhood and disadvantaged families.

to explore the opportunity to develop research based on the MECSH programme, and extend existing links between King's and Australian scholars working in the field of early childhood support.

During this period Dr Kemp has fulfilled an extremely busy schedule, travelling extensively, meeting policy makers, senior researchers, government nurses and local practitioners, managers and service commissioners, as well as both attending and providing seminars and teaching sessions in house (two public seminars - a third was cancelled due to snow - two lectures to SCPHNS) and elsewhere.

- *At least three service areas, including one local link area in London, have 'signed up' to participate in a pilot/feasibility RCT of MECSH*
- *A collaboration of leading researchers are interested in joining a trial of MECSH led from King's/FNSNM*
 - first drafts of a proposal have been prepared
 - further meetings planned
 - target HTA programme or similar for funding source
- *There is interest from DH, who are examining the potential of MECSH:*
 - to support the 'new health visiting service' vision being developed for the government's planned expansion of health visitors,
 - for inclusion in the Healthy Child Programme; further meetings are planned, along with a return visit to UK next year (May, to be confirmed).

Overall, this has been an extremely successful visit, sowing the seeds for a very fruitful future collaboration and preparing the ground for specific research to be developed in 2011.

Sarah Cowley

17-12-10