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IMPLEMENTING NURSE HOME VISITING PROGRAMS: OPPORTUNITIES & CHALLENGES IN ENGLAND & AUSTRALIA

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POLICY CONTEXT

Over the past decades a series of well-designed randomised controlled trials have demonstrated the efficacy of programs of home visiting for first-time teenaged mothers in the United States. The Australian-developed Maternal Early Childhood Sustained Home-visiting (MECSH) program is a home visiting intervention and service system designed to enhance the capacity of universal services to respond to the needs of a broader range of vulnerable families. 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.

This project explored the opportunities and challenges of implementing the MECSH program in England to improve the population reach of effective home visiting programs to families with varying vulnerabilities (~20 per cent of the overall population of families). 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. The MECSH program provides an approach that should be transferable to the English health care setting and is consistent with the Healthy Child Programme and the new Service Vision for Health Visiting in England.

KEY FINDINGS

The MECSH program has high **prima facie** validity with the English service system as both an intervention program and 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 MECSH program is seen as an equity response addressing the needs of the broad target group of vulnerable families who are in need of additional support all of the time, and so is seen

as response to the call by the Marmot (*Fair Society, Healthy Lives: The Marmot Review*, 2010) for interventions for a broader range of vulnerable families.

There will be, however, a number of challenges for implementation of MECSH in England that also mirror challenges in Australia. Firstly, health visiting in England and NSW 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 other varying levels of need. This polarisation is occurring in England in a service context with higher ratios (almost double the number) of health visitors to the number of children under five 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' and lack of evidence-based responses for families with differing needs. Implementing MECSH to fill this service gap would thus need considerable investment in practitioner (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.

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, jurisdictional differences, service capacity and lack of availability of research funding. Obtaining support for such trials 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.

POLICY OPTIONS

Three areas of learning and recommendations were identified that have impacts for Australian child health policy.

IMPACT OF HEALTH SYSTEM REFORMS

Many educators, practitioners and academics in England 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. 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?

INVESTING 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 and resources 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 has 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. 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.

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, senior policy influencers, academics, 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.

For more details, please go to the full report

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