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Family support programs: ensuring a healthy start to life

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Dr Deborah Askew

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Australian Primary Health Care Research Institute
The Australian National University
Acton ACT 0200 Australia

T: 61 2 6125 0766

F: 61 2 6230 0525

E: aphcri@anu.edu.au

W: <http://aphcri.anu.edu.au>

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Introduction and background

This report details the findings of a targeted literature review and discussions in England and New Zealand with researchers and service delivery personnel involved in family support and parent education programs.

BACKGROUND

There is increasing concern in developed countries about factors impacting on the health and psychological wellbeing of children and young people, including child abuse, conduct difficulties, substance use, crime, teen pregnancy, and teen suicide. A common feature of these factors is their disproportionate clustering in children and adolescents who have experienced social, educational, emotional and related disadvantages (Fergusson, Grant et al. 2005; Davis and Day 2010).

As a result of these growing concerns, governments are increasingly investing in programs that aim to ameliorate the impact of these disadvantages. Intensive home visiting programs are one such initiative, as are other parent support and education programs. Parenting support and education programs have the potential to improve long term health and social outcomes for children by influencing parenting practices, children's immediate health status, the quality of the child's home environment, and children's development (Puura, Davis et al. 2005; Eckenrode, Campa et al. 2010). There are a number of different intensive home visiting programs that have been implemented across the world – these programs differ in their eligibility criteria, including age of the mother/parents (participation restricted to younger mothers, or open to all mothers); parity (nulliparous or multiparous mothers); different classification of risk of social disadvantage; the background of the home visitors (nurses only, nurses or social workers, para-professionals), the age of the child when visits commence (antenatal or postnatal), the duration and content of the visits etc (Fergusson, Grant et al. 2005; Bayer, Hiscock et al. 2009; Howard and Brooks-Gunn 2009). However, they all aim to provide parents with sustained emotional support, information, access to other services, and direct instruction on parenting practices (although programs vary in how they achieve these goals and in the relative importance of the goals) (Howard and Brooks-Gunn 2009).

The two home visiting programs that have been most extensively evaluated and report the most positive outcomes are the New Zealand based Early Start program (Fergusson, Grant et al. 2005; Fergusson, Grant et al. 2006) and the US based Nurse Family Partnership (NFP) (Kitzman, Olds et al. 2010; Olds, Kitman et al. 2010). Both of these programs have been evaluated in robust randomised controlled trials, and both have demonstrated positive outcomes. At 36 months, the Early Start program demonstrated small to moderate benefits in areas relating to child health, preschool education improved utilisation of child health services, reduced rates of hospital attendance for injury/poisoning, increased preschool education, increased positive and non-punitive parenting, reduced rates of severe parent/child assaults, and reduced rates of early problem behaviours (Fergusson, Grant et al. 2005). At 12 years, the NFP participants reported reduced children's substance use, reduced internalising of mental health problems, and improved the academic achievement of children. Additionally, at 12 years the mothers participating in the NFP demonstrated improved maternal life course and reduced government spending (Kitzman, Olds et al. 2010; Olds, Kitman et al. 2010).

Current policy context

The Australian Government is taking a whole of government approach to improving Aboriginal and Torres Strait Islander health with the ultimate goal of achieving health outcomes and health services for Indigenous Australians at least as good as that of the general Australian community. Improving child and maternal health is essential if the gap in life expectancy is to be reduced or eliminated. The Australian Government has recognised

the potential benefit of implementing home visiting programs for improving child and adolescent health and psychological wellbeing, and has invested in the Australian Nurse Family Partnership Program (ANFPP), based on the US NFP, which is currently being delivered in four pilot sites: Victorian Aboriginal Health Service, Melbourne; Wuchopperen Health Service, Cairns; Central Australian Aboriginal Congress, Alice Springs; and Wellington Aboriginal Health Service, Wellington (Commonwealth of Australia 2009).

Aboriginal and Torres Strait Islander health services not participating in this project who wish to provide parenting support and education programs must, by necessity, develop their own programs. With the myriad of different programs being implemented nationally and internationally, there are many lessons to be learnt that can aid and guide the development and implementation of parenting support and education programs to meet the needs of individual communities.

Aim

This project aimed to investigate national and international parenting support and education programs, including intensive home visiting programs that aim to improve child health and development outcomes, and improve maternal and familial health and social outcomes. Specifically, the project explored a range of parenting support and education programs developed by the Centre for Parent and Child Support, London, England and the Early Start Program in Christchurch, New Zealand that could inform the development of a parent support and education program for Aboriginal and Torres Strait Islander families to be delivered via an urban Aboriginal and Torres Strait Islander primary health care centre.

Methods

This study combined a targeted literature review and discussions in England and New Zealand with researchers and service delivery personnel involved in family support and parent education programs. The Fellowship was conducted in November and December 2011, and involved a visit to the Centre for Parent and Child Support in England and the Early Start Parent Support Program in New Zealand. The Fellowship built on previously established relationships with the Early Start program, and established a positive relationship with researchers and service delivery personnel in England.

Literature review

A review of published and grey literature describing and evaluating Australian intensive home visiting family support programs.

Site visits

Discussion with international researchers and service delivery personnel involved in family support and parent education programs.

- > Dr Crispin Day, Ms Meagan Ellis, Dr Daniel Michelson, Dr Michelle McGrath and Ms Ros Loxton, Centre for Parent and Child Support (CPCS), Kings College, London & South London and Maudsley NHS Foundation Trust, England

The Centre for Parent and Child Support (CPCS) aims to develop, deliver and evaluate programs to improve outcomes for children, families and wider communities.

- > Mr Jo Harper, Torbay Family Health Partnership, Paignton, Devon.

The Torbay Family Health Partnership is an intensive, sustained home visiting early intervention program that aims to support first time young parents within Torbay, Devon.

- > Professor David Fergusson, University of Otago, Christchurch

Professor Fergusson is the founder and director of the Christchurch Health and Development Study, a 30 year study of a birth cohort of 1265 children born in the Christchurch region in mid 1977 and is the chairman and evaluator of the Early Start programme, which is a Christchurch-based family support programme.

- > Ms Hildegard Grant, Ms Jan Egan, Ms Heather Davidson, Ms Michelle Fagan, and Family Support Workers, Early Start Program, Christchurch, New Zealand.

The Early Start Program is a research based fully evaluated long term intensive home visiting service aimed at vulnerable Christchurch families caring for children under 5 yrs of age that commenced in 1995.

Results

This study explored different models of supporting and enabling parents to maximise the health and psychosocial well-being of children and young people. Whilst originally this study aimed to focus on intensive home visitation programs, it became clear during the Fellowship that other, less resource intense approaches also had the potential to positively impact on childhood health and psychosocial outcomes. This chapter of the report will summarise outcomes of the literature review on Australian home visiting programs, discuss a range of parenting education and support programs provided by the CPCS, and describe the Early Start Program including reflections on its strengths and weaknesses.

AUSTRALIAN HOME VISITING PROGRAMS

Three Australian Intensive Home Visiting Programs have been reported in the literature (Appendix 1). As has been found previously in broader literature reviews, these projects reported some positive effects for some, but not all, outcome variables. Additionally, the lack of long term follow-up data means that the lasting impact of these programs is not possible to assess.

The ANFPP is included in this review as it is an existing program that is specifically focused on Aboriginal and/or Torres Strait Islander children, and therefore of extreme relevance to this study. At the time of the Fellowship, there were no evaluation data available, nor was there any specific information about how the program is being implemented at the four sites, other than the inclusion of an Aboriginal Community Worker as a member of the home visiting team.

The three published studies do begin to provide some evidence in the local Australian context about the effectiveness of intensive home visitation programs in Australia. This type of intervention for socially vulnerable families has been successfully trialled in the USA and New Zealand (Fergusson, Grant et al. 2005; Fergusson, Grant et al. 2006; Kitzman, Olds et al. 2010; Olds, Kitzman et al. 2010). But, there are considerable differences between the USA, New Zealand and Australian health and welfare systems, particularly Australia's universal health insurance, and a universally available system of community-based early childhood nursing and other government funded family support. It could be hypothesised that the potential benefits of intensive home visiting programs would be less clear in a system such as Australia, but the UK and these Australian studies have reported that intensive home visiting, against a backdrop of universal home visiting, result in a range of improved child health outcomes (Vimpani 2000).

SITE VISITS

Centre for Parent and Child Support, South London and Maudsley National Health Service Foundation Trust, London

The Centre for Parent and Child Support (CPCS) aims to develop, deliver and evaluate programs to improve outcomes for children, families and wider communities. The CPCS was originally established to develop and evaluate the Family Partnership Model (FPM) (formerly known as The Parent Adviser model). The conceptual framework and methodological approach to working with families inherent to the FPM underpins three programs developed and disseminated by the Centre: Antenatal and Postnatal Promotional Interviewing; the Empowering Parents Empowering Communities (EPEC) project; and the Helping Families Programme (HFP).

Family Partnership Model

The Family Partnership Model (FPM) is an evidenced based, explicit model that demonstrates how:

“the **outcomes** of helping are determined by a set of tasks (**the helping process**) undertaken together by the client and the practitioner in the context of a relationship that is most effective if it is a defined **partnership**. The process, and hence the outcomes, are determined by the **interpersonal skills** and **personal qualities of helpers**, various **client characteristics** and their family context, the nature of the **service context**, and the **construction processes** that determine the psychological adaptation of all those involved in the helping situation (eg. Clients, family members, practitioners, managers/supervisors)” (Davis and Day 2010).

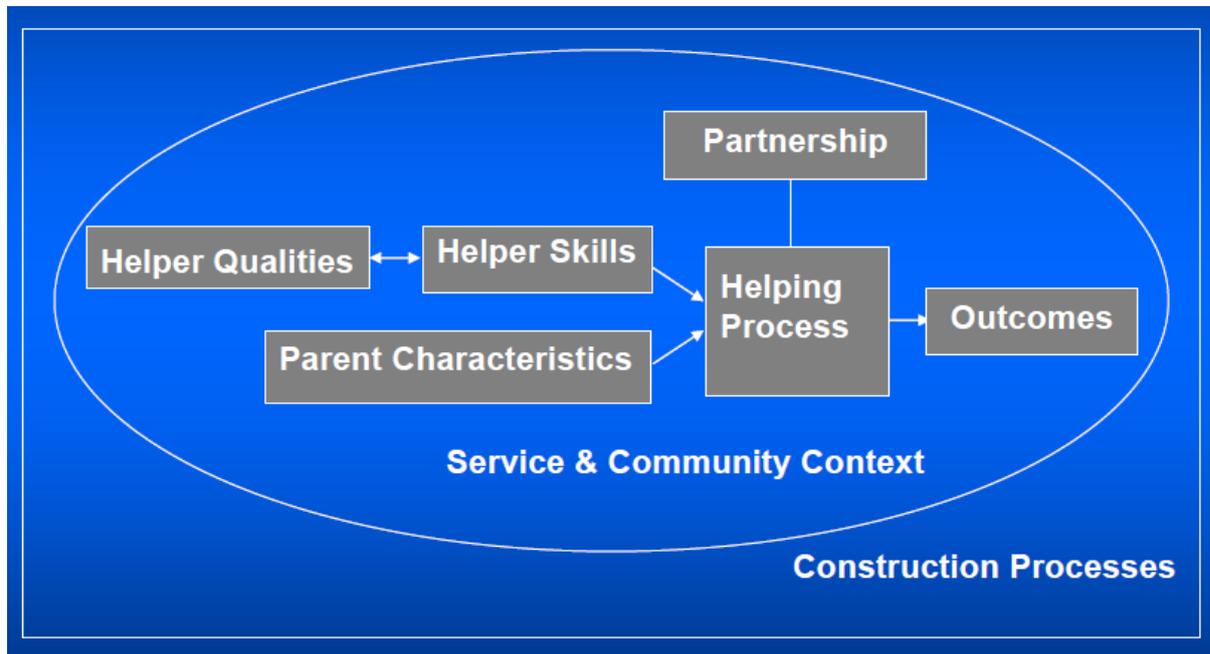


Figure 1: The Family Partnership Model (Davis and Day 2010)

The FPM has identified the series of tasks inherent to the helping process, as described in Figure 2.

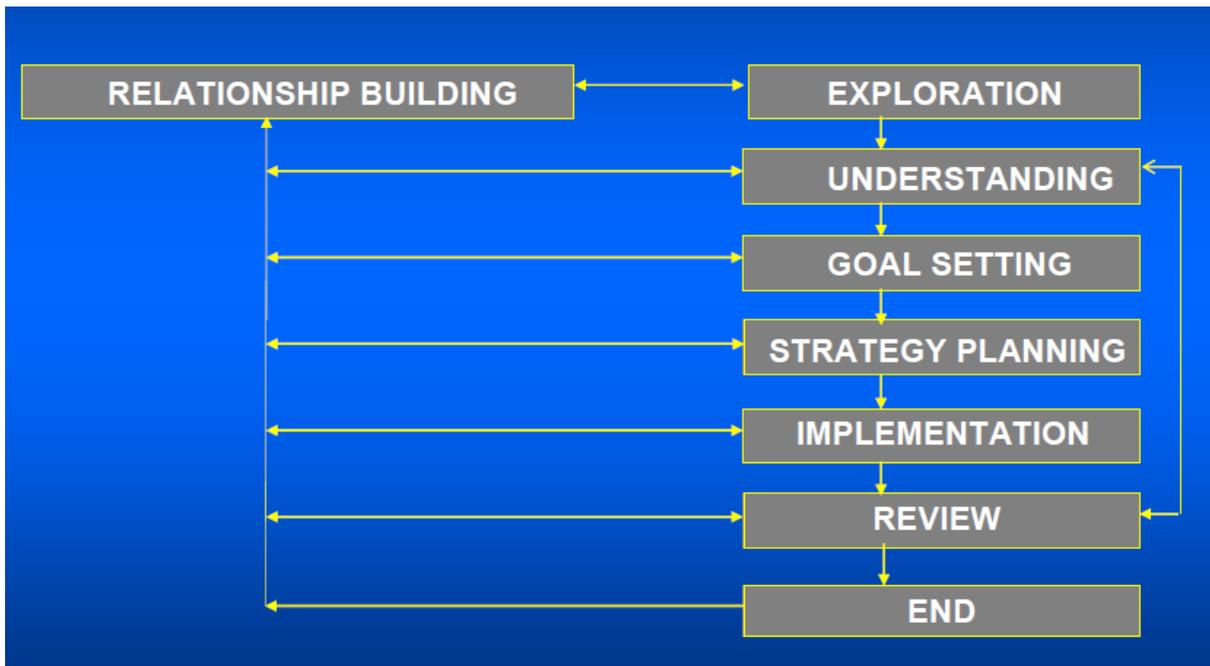


Figure 2: The Helping Process (Davis and Day 2010)

From the perspective of the FPM, the intended outcomes of helping include:

- > Doing no harm
- > Helping parents and children to identify and build on strengths
- > Helping to clarify and manage problems
- > Fostering resilience and problem anticipation
- > Fostering children's development and wellbeing
- > Facilitating social support and community development
- > Enabling service support
- > Compensating where necessary
- > Improving the service system.

The FPM provides the theoretical and structural basis for a range of preventive and early intervention services developed by the CPCS, in addition to services across the UK, Europe and Australasia, including intensive home visiting programs such as the Miller Early Childhood Sustained Home-visiting (MESCH) programme (Kemp, Harris et al. 2011).

Antenatal and postnatal promotional interviewing

Policy context

The UK Department of Health released its National Service Framework for Children, Young People and Maternity Services in 2004. Since then, it has been developed and refined, with the latest best practice guidelines being released in 2009, the *Healthy Child Programme – Pregnancy and the first five years*. In summary, the

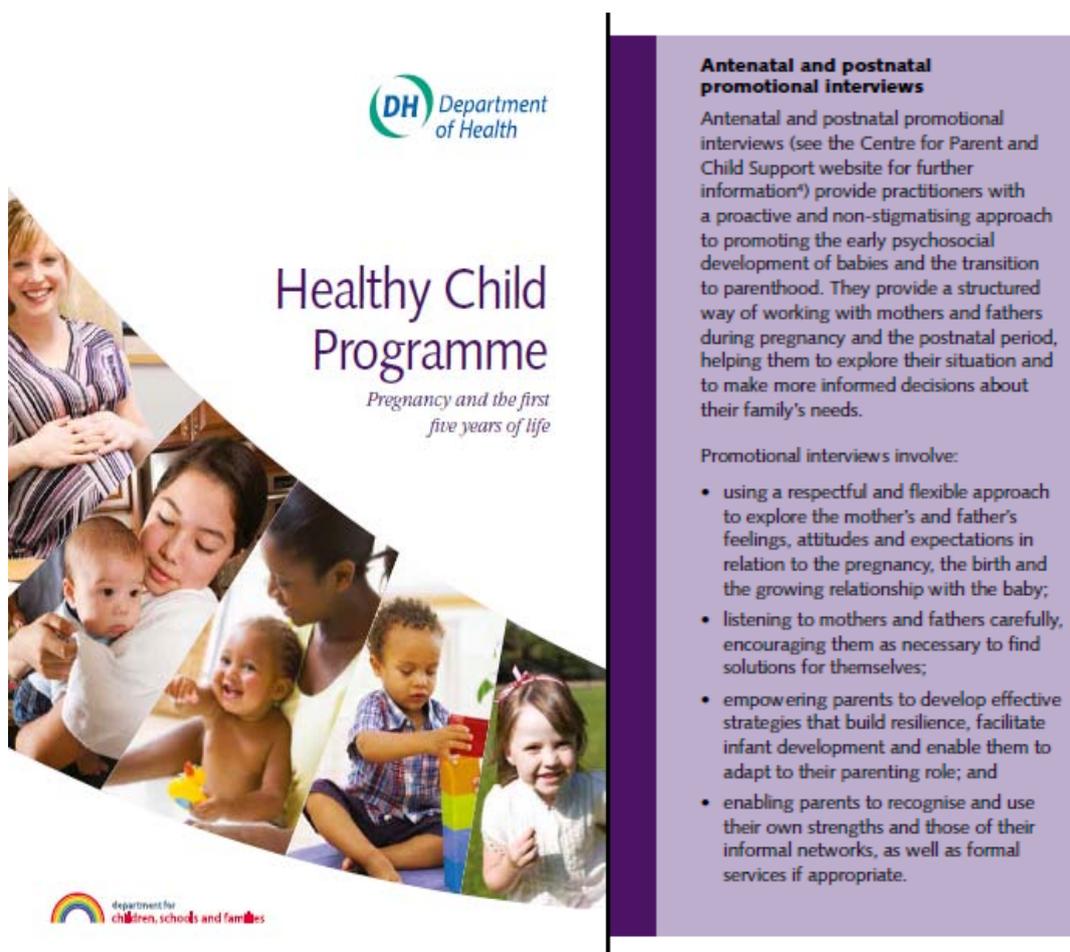
“Healthy Child Programme (HCP) is the early intervention and prevention public health programme that lies at the heart of our universal service for children and families. At a crucial stage of life, the HCP’s universal reach provides an invaluable opportunity to identify families that are in need of

additional support and children who are at risk of poor outcomes”
(Department of Health 2009).

Key features of the updated HCP include:

- > commissioning of a universal core programme, plus programs and services to meet different levels of need and risk (progressive universalism);
- > distinguishing between three levels of need: low, moderate and high;
- > a greater focus on parenting support, preparation for parenthood, as well as surveillance and health promotion;
- > the proactive promotion of attachment and the prevention of behavioural problems;
- > an increased focus on pregnancy, with routine antenatal care including screening, lifestyle advice, introduction to resources, services and choice;
- > involvement of fathers, including non-residential fathers, as well as mothers; and
- > Health Visitors having a lead role in implementation of the HCP.

The HCP promotes Antenatal and Postnatal Promotional Interviews as a proactive and non-stigmatising approach to promoting the early psychological development of babies and the transition to parenthood.



http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118525.pdf

Figure 3: The Healthy Child Programme document, with excerpt discussing promotional interviews.

The antenatal and postnatal interviews

Early childhood is a critical time for ensuring and promoting healthy psychological and physiological development. The nature of children's interaction, experiences and relationships with important adults influences how a baby's brain develops, with experiences of adversity having a significant and lasting impact on mental and physical health that endures into adulthood. The Antenatal and Postnatal Promotional Interviews (PIs) provide a proactive and non-stigmatising approach to promoting the early psychological development of babies and young people, and assisting the transition to parenthood. They provide a mechanism to foster an understanding relationship between parents and health visiting staff and act as a flexible, structured guide so practitioners can help parents explore their pregnancy, baby and adaptation to parenthood so together they can make better decisions about their family's needs. Health visitors trained to use the interviews have been found to be better at identifying needs than those not using the interviews (Davis, Dusoir et al. 2005). Furthermore, at 24 months, participation in the PIs had a positive impact on the mothers' ability to maintain positive interaction with their children (Puura, Davis et al. 2005).

The Antenatal PI occurs after the 28th week of pregnancy. It helps to explore the changes occurring in all areas of the parent's lives in relation to the forthcoming birth, helps parents identify possible challenges that might negatively impact on their ability to parent, and importantly, it helps them to consider strategies they can implement to manage those challenges, using their own strengths as well as support from formal and informal networks and services. It focuses on the following 10 areas:

- > The mother and father's feelings about their pregnancy
- > Expected family and other support
- > Anticipated changes in family life and relationships
- > Self perception of the pregnant mother
- > The pregnant mother's current perceptions and anticipation of her unborn child
- > The mother's and father's anticipation of becoming parents
- > Anticipation of labour, delivery and birth
- > Anticipation of feeding, caring and looking after their baby
- > Current finances and housing
- > Life events

The Postnatal PI occurs six to eight weeks post-birth, and takes account of the parent's experiences and meaning of the birth process, their new baby, the interaction and relationship between the new parents and their young baby, and the parent's changed circumstances. Ideally, it is conducted at home, with the baby present and awake so that the interaction between the parents and their baby can be carefully observed. It explores the following 10 topics:

- > The labour, delivery and birth
- > The mother's and father's psychological health and well-being
- > Response and support from family
- > Mother's and father's concern for their baby's development and well-being
- > The mother's and father's perception of their baby
- > Parent-infant interaction and care
- > Parent-infant communication

- > Mother's emotional resources for her baby
- > Current finances and housing
- > Life events

After each PI a checklist is completed of key risk and resilience factors predictive of future parent and infant psychosocial distress. This checklist is not used as a means of rating a family, but rather as an aide to clinical and parent decision making using information from the PIs and other sources. It is also a means of identifying families most at risk, and requiring additional resources or support.

However, incorporation of the PIs into standard Health Visitor requires support. There needs to be appropriate training of the Health Visitors that incorporates the theoretical underpinnings of the PIs with opportunities to practice the PIs and discussions with peers about their use. Health Visitors will also have adequate opportunities to practice the PIs in the field, ideally with experienced practitioners providing on-the-ground support to novice practitioners. Supervision of Health Visitors will provide formal opportunities to discuss, reflect on and monitor use of PIs at the individual Health Visitor level, and enable monitoring of PI use, implementation and adaptation by area.

The full potential of the PIs can not be realised without Health Visitors being appropriately and adequately trained and supported and senior management endorsing the PIs as a core component of health visitors workload, with concomitant restructuring and/or amending Health Visitors' work load to ensure sufficient time is available to conduct the interviews, complete the check list, and follow-up as necessary. This need for adequate and appropriate training and support is equally true in the Australian context.

Empowering Parents, Empowering Communities

Empowering Parents, Empowering Communities (EPEC) is a community-based program developed by clinicians in South London and Maudsley NHS Foundation Trust and supported by SureStart Children's Centres in the inner London Borough of Southwark. EPEC trains local parents in basic psychology so they are then qualified to deliver parenting groups in their own communities, and aims to provide cost-effective and accessible help for families whose child/ren are experiencing behavioural difficulties. The EPEC parenting program "*Being a Parent*" was specifically developed for use by "peer facilitators", based on the assumption that parents would find it less stigmatising and more supportive to attend parenting groups run by local parents in similar circumstances to themselves (Day, Michelson et al. 2012).

Peer facilitators are selected from the parents attending the *Being a Parent* groups. Potential facilitators participate in a semistructured interview that assesses their capacity to self-reflect, understand and empathise with the difficulties of others, and aptitude for and understanding of the tasks involved in facilitating parenting groups. Parents who successfully complete the Peer Facilitator Training receive an accredited qualification from the Open Learning Network.

With administrative support from the CPCS, EPEC runs approximately 15 *Being a Parent* groups in Southwark each year and by July 2010, 24 Southwark parents had been trained and accredited as parenting group facilitators. EPEC is currently expanding to other London Boroughs including Lambeth and Greenwich and has received funding to roll out the program in Tasmania.

A research program to evaluate the EPEC program included a wait-listed randomised controlled trial which evaluated the clinical effectiveness and acceptability of EPEC parenting groups. A number of measures were used to assess child behaviour (Concerns About My Child (CAMC), Strengths and Difficulties Questionnaire (SDQ), and the Eyberg Child Behaviour Inventory (ECBI)), parenting stress (Parenting Stress Inventory (PSI)), parenting style (the Arnold O'Leary Parenting Scale), and satisfaction (Training Acceptability

Scale). Significant improvements ($p < 0.05$) were observed within the intervention group on all measures. A relatively low drop out rate (15%) was observed, and parents reported a high level of satisfaction with the program. These results suggest that EPEC is effective in reducing problem child behaviours, increasing positive parenting and engaging parents (Day, Michelson et al. 2012).

A qualitative study of peer facilitators experiences has also been conducted, investigating their views on the barriers and enablers for the delivery of EPEC, their supervision needs, their attitudes to training compared to their experiences in delivering the program in the “real world”, and the wider impact of their involvement in EPEC on their own parenting and on their life in general. Data from this study are still be analysed, but preliminary results suggest that the peer-facilitators like the supervision and co-facilitation they receive by qualified trainers from the CPCS; the administrative support provided by the CPCS in organising the parenting group; and the manualised approach of the *Being a Parent* course as it provides both credibility amongst their peers and the support of a structure program that they deliver. For some peer facilitators, it appears that the program has transformed their aspirations for themselves and their children.

Helping Families Programme

The Helping Families Programme (HFP) is an innovative parenting intervention developed for multi-stressed families living in complex social circumstances with primary school aged children who experience severe and persistent conduct problems. It aims to help the parents address their children’s immediate behavioural difficulties, and as a consequence help parents bring up their children safely, lovingly and with confidence that they are doing the best by their children. It focuses on reducing children’s conduct problems to reduce family harm and increase resilience in the parents and the entire family. To achieve these outcomes, it aims to facilitate improvement in five key risk domains that evidence shows contribute to, and reinforce severe child behavioural difficulties (Day, Kowalenko et al. 2011). Specifically, the programme aims to:

- > Improve interpersonal conflict management by increasing parent’s ability to interact positively, build and maintain relationships and reduce conflict with their child/ren, partner, family and/or key professionals
- > Improve mood stability and regulation by increasing parents’ ability to be tolerant, feel calm, happy and satisfied
- > Improve supportive social and family networks by increasing the frequency and availability of constructive parental support that reinforces resilience and buffers against risk
- > Reduce the harmful effects of drugs and/or alcohol by working towards cessation or harm minimisation
- > Strengthen instrumental and emotional coping by increasing adaptive problem management and improving emotional regulation and distress tolerance in relation to problems that cannot be immediately managed (Day, Kowalenko et al. 2011).

This program has developed through a research collaboration led by the UK National Academy for Parenting Research and two universities in Brisbane, Australia (The University of Queensland and Griffith University), and the development, implementation and evaluation is being led by the CPCS. The intervention uses the FPM (Davis and Day 2010) as the basis for manualised core practice tasks which provides the practitioner with the process and strategy to deliver the intervention. The intervention modules combine a range of evidence-based strategies and techniques that draw on cognitive behavioural, social learning, relational, attachment and systems theories to develop structured, but non-sequential, individualised implementation plans. Contact between the family and practitioner occurs over a minimum of 20 weeks, with the possibility of multiple contacts each week, and

is delivered in the family home or other community locations (ie. the practitioner comes to the family and works with the family in the family's environment) (Day, Kowalenko et al. 2011).

Between May 2010 and March 2011, the HFP was piloted with 10 families. Evaluation data are positive, with 80% of parents and 70% of teachers reporting improvements in their child's conduct problems, and all parents reporting improvements in the index child's skills and behaviour at school and in their own overall wellbeing and goal achievement. No parent missed a session with their practitioner without prior arrangement. Parents reported feeling calmer, more in control, feeling more connected with their child, and observed positive changes in their child's conduct (Day, Kowalenko et al. 2011).

More research is needed to accurately evaluate the effectiveness of the program compared to usual care, and to determine the sustainability of the improvements demonstrated in this pilot project. The families that HFP is targeting have multiple, complex and high needs who are typically much harder to engage and treat, have significant and enduring safeguarding concerns, are a high cost to services and resources, and remain an important priority group. Changing outcomes for these families is a means of addressing intergenerational disadvantage and poor family outcomes.

Early Start Project, Christchurch, New Zealand

(<http://www.earlystart.co.nz>)

Early Start is an intensive home visiting service targeting vulnerable families in Christchurch, New Zealand. Families can be referred to Early Start from six months before the birth of a child up to one year after the birth. Early Start uses a planned, focussed and systematic approach to working with families, and aims to enable enrolled families to:

- > Learn and apply nurturing parenting practices
- > Discover personal strengths and abilities
- > Develop new skills and practices
- > Challenge negative and destructive life habits.

Although the advent of Early Start precedes the wider national Family Start program, it is now part of the Family Start network of 32 sites across New Zealand offering intensive home-based support services for the 15% of families with high needs and most at risk of poor life outcomes to ensure their children have the best possible start in life. Family Start is funded and managed by the New Zealand Government Department of Family and Community Services¹.

Early Start Family Support Workers work with families using a collaborative, problem solving and solution focussed approach, to ensure a balance between a deficit-based approach that focuses on family limitations and problems, and a strengths-based approach that may fail to address family deficits. The program aims to improve child health, reduce child abuse, improve parenting skills, support parental physical and mental health, encourage family economic and material well-being, and encourage stable positive relationships. It uses a social learning model with the following essential elements:

- > Assessment of family needs, issues, challenges, strengths, and resources
- > Development of a positive partnership between the family support worker and client
- > Collaborative problem solving to devise solutions to family challenges

¹ <http://www.familyservices.govt.nz/working-with-us/programmes-services/early-intervention/family-start/index.html>

- > The provision of support, mentoring and advice to assist client families to identify and use their strengths and resources
- > Involvement with the families throughout the child's preschool years (Fergusson, Grant et al. 2005).

The first families were enrolled into the Early Start Program in 1995. Following an initial field trial during which the intervention was further developed, refined and evaluated, a randomised controlled trial was undertaken to determine if families involved in Early Start showed improved outcomes of child health, pre-school education, welfare services use, parenting, rates of child abuse and neglect, and early behavioural adjustment. Between January 2000 and July 2001, 220 families were randomised to receive the Early Start program and 223 were randomised to the control group to receive usual care. Assessments occurred at trial entry, and again at 6, 12, 24 and 36 months. Compared with children in the control group, children participating in Early Start had:

- > improved health care and health outcomes (greater use of GPs; higher rates of well-child checks; fewer hospital attendances for accidents, injuries or poisoning; and greater use of preschool dental services)
- > increased exposure to early childhood education and greater use of community services
- > increased exposure to positive parenting practices (positive parenting attitudes and non-punitive parenting)
- > lower rates of parental report of severe physical assault
- > reduced rates of problematic child behaviour (externalising and internalising behaviour problems) (Fergusson, Grant et al. 2005).

However, there were no differences between intervention and control groups in the areas of maternal health and well-being; family stability; family relationships and family violence; family economic and material well-being; and family exposure to stress and adversity. In summary, the Early Start program had a positive impact on child-related outcomes but had no impact on maternal and family outcomes (Fergusson, Grant et al. 2006). Furthermore, evaluation conducted at 9 years reveals that the benefits of the intensive home visiting program diminish over time suggesting that the influence of the family support workers weakens without the constant reinforcement provided by ongoing contact and as other influences overtake the family (personal communication, Prof David Fergusson).

Despite the lack of impact on the maternal life course, the positive impact of the Early Start Program on child outcomes means that the program is achieving one of its central aims. In discussion with both management and staff of the program a number of key elements became apparent that contribute to its success:

- > Careful staff selection, a lengthy and detailed orientation program, and a buddy support system for new family support workers that continues for 18 months.
- > Regular, formalised, structured supervision of family support workers by clinical supervisors, and structured supervision of the clinical supervisors by the clinical manager.
- > Supportive management and a "team charter" that unites all staff in the organisation under a shared vision and agreed code of conduct. Staff are proud of the difference they can make in people's lives.
- > Structured compulsory program to focus the visits, ensure all families receive consistent messages and sufficient "dose" of the program to maximise the potential of the program achieving its desired outcomes
- > Programmatic delivery of structured, evidence based parenting support programs: Partners in Parenting Education (PIPE) in the first 2 years of service delivery; Positive

Parenting Program (Triple P) delivery in 3rd year of service delivery; and Getting Ready for School in the 4th and 5th years of service delivery. In addition, there are sessions on health and safety, child development, nutrition, oral health and fire safety throughout the five years of the program.

Discussion

Early childhood is a critical time for the development of healthy, socially adapted children and adults. Parents or primary care givers have a critical role in supporting their infant's development, and less than optimal parenting can have a serious and lasting negative impact. Consequently, a range of parenting support and education programs has been developed to assist and support parents, some of which have been discussed in this report.

The UK is using the concept of “progressive universalism” to underpin their *Healthy Child Programme* which ensures that some support is available to all, but more support is provided to those who need it most. Tools such as the Antenatal and Postnatal Interviews and the associated needs assessment check list discussed in the previous section conducted with all families are a means of identifying families in need of more intensive support over a prolonged period of time, such as intensive home visiting programs.

However, evaluation of intensive home visiting programs reveals a lack of consistent benefit in some child health outcomes and particularly in maternal and family related outcomes. Programs that do show benefit in child health outcomes such as the Early Start program and the NFP are programmatic, systematic, consistent and ensure each family receives a minimum dose of the core components.

A number of potential reasons for the lack of impact on maternal life course have been hypothesised, as have been potential adaptations to intensive home visiting programs that may impact on maternal health and wellbeing. Early Start Family Support Workers predominantly have nursing or social work backgrounds, but they do not provide specialist services from within their own or other disciplines. Rather, they act as family mentors and advocates to support and assist the family in addressing day-to-day problems in addition to providing home based parent education programs. Consequently, Early Start is reliant on the quality and accessibility of therapeutic services in the community to address problems such as maternal depression, substance abuse, smoking, and budgeting and finance problems. A suggested solution to this problem is to integrate a home visiting service within a comprehensive service to ensure that the intervention can include therapy as required by either the parents or the children.

Intensive home visiting programs are very resource intensive, and their reach is therefore limited. For example, although the New Zealand wide Family Start Program targets the 15% of the population most at risk of poor life outcomes, individual program sites aim to engage at least 5% of this group into the program. This gap between intended and actual reach may be due to difficulties engaging the target families in the program, but is likely to be compounded by resource constraints that limit the number of families that can be enrolled. No information is available about the target and actual reach of the ANFPP, but it would be safe to assume that the number of families has to be capped due to resource limitations. Consequently, families that could benefit from parenting support and education programs are not able to access these programs, and therefore remain at risk of poor health and developmental outcomes.

Invoking the concept of progressive universalism, all families would be provided with some support to ensure the best possible health and development outcomes for the children, mothers and families. Those families at most risk of poor life outcomes would receive intensive and sustained home visiting that combined parenting education and support with a

therapeutic service. Varying levels of support would be provided for families, according to their level of need. Furthermore, parent education programs such as EPEC. Communities have reach beyond the family unit to also address social determinants of health through the provision of education qualifications and upskilling of parents as peer facilitators.

POLICY OPTIONS

The following policy options are written within the context of improving Aboriginal and Torres Strait Islander child health outcomes as a core component of Closing the Gap in life expectancy between Indigenous and non-Indigenous Australians.

1. **Progressive Universalism:** Provision of high quality early childhood services to all Aboriginal and Torres Strait Islander people, and provision of higher levels of support to those families most in need has the potential to improve child and maternal health outcomes, and long term health and social wellbeing. However, implementation of the context of “progressive universalism” to early childhood care will have resource and workforce implications that will need to be thought through carefully prior to the incorporation of this concept into policy and practice.
2. **Antenatal and Postnatal Screening:** Antenatal and Postnatal Promotional Interviews are an evidence based, proactive and non-stigmatising approach to promoting the early psychological development of babies and young people, and assisting the transition to parenthood that could be used as a screening tool for all families as part of the implementation of “progressive universalism”. Suitably trained and supported Aboriginal Health Workers or child health nurses could conduct the interviews either in a primary health care service, in families’ homes, or in other suitable community locations. However, the full potential of the PIs can not be realised if health practitioners conducting the interviews are not appropriately and adequately trained and supported. Additionally, senior management must endorse the PIs as a core component of the health practitioners’ workload, with concomitant restructuring and/or amending existing work load to ensure sufficient time is available to conduct the interviews, complete the check list, and follow-up as necessary.
3. **Evidence based parenting support programs:** Not all Aboriginal and Torres Strait Islander families require intensive support programs to address parenting deficits and improve child and maternal health outcomes. Evidence based, culturally safe and locally appropriate interventions of varying levels of intensity that aim to increase participants’ parenting skills and improve health and development outcomes need to be developed, trialled, implemented and evaluated to ensure that all Aboriginal and Torres Strait Islander families are provided with the appropriate and necessary level.
4. **Intensive Home Visiting Parenting Support Programs:** Critical success factors of intensive home visiting support programs include well trained and supported staff that deliver a culturally safe, structured, programmatic, consistent program in sufficient dose to enable, support and reinforce parental behaviour change. Ideally, a home visiting support program for Aboriginal and Torres Strait Islander families would be integrated with primary health care and community services to enable delivery of a therapeutic intervention in addition to parental support and mentoring.

Appendices

APPENDIX 1

Summary of Australian Parent Support Home Visiting Programs

Study	Aim of Program	Participants	Program Description	Outcomes
Quinlivan et al, 2003 (Quinlivan, Box et al. 2003)	To reduce adverse neonatal outcomes (death, non-accidental injury, non-voluntary foster care) and improve knowledge about contraception, vaccination schedules & breastfeeding	Teenagers <18yrs attending public hospital antenatal classes. 136 randomised (65 intervention and 71 control); 124 completed 6 month follow up (62 in each group)	Structured home visits by nurse-midwife, at 1 week, 2 weeks, 1 month, 2 months and 4 months post birth, plus 6 month assessment visit. Midwives could also contact obstetrician if urgent advice needed. All participants had access to routine postnatal support, counselling and information services provided by hospital, including access to routine domiciliary home-visiting service.	11 adverse events at 6/12: 2 in intervention group and 9 in control group (p=0.04) Intervention group improved knowledge and effective use of contraception at 6/12 (p=0.007) No difference between groups in completed vaccination schedules or breastfeeding duration
Kemp et al, 2011 (Kemp, Harris et al. 2011)	To improve: <ul style="list-style-type: none"> > transition to parenthood; > maternal health and wellbeing; > child health and development; > parents' aspirations for 	Mothers living in socioeconomically disadvantaged area in Sydney, with ≥1 risk factor for poor maternal or child outcomes: <ul style="list-style-type: none"> > maternal age <19yrs > psychosocial distress 	Sustained and structured home visits commencing antenatally and continuing until child's 2 nd birthday, delivered by child and family health nurses embedded within the universal child and family health nursing services.	Intervention group mothers more emotionally and verbally responsive (p=0.02) No differences in other measures of home environment (avoidance of restriction and punishment; organisation of environment; provision of appropriate play

	<p>themselves and their children;</p> <p>> family & social networks and relationships</p>	<ul style="list-style-type: none"> > lack of emotional & practical support > late antenatal care (>20 wks gestation) > major stressors in past 12/12 > current substance misuse > current or history of mental health problem or disorder > history of abuse in mother's childhood > history of domestic violence. <p>Recruitment through local public hospital antenatal clinic. N=208 (111 intervention & 97 control); 107 completed 24 months followup (63 intervention & 44 control)</p>	<p>Postnatal child development parent education programme (Learning to Communicate) delivered in child's 1st year.</p> <p>Access to secondary and tertiary early childhood services, volunteer home visiting services and family support services in area</p> <p>Group activities and links with parenting group, walking group and other community activities.</p>	<p>materials; maternal involvement with child; variety in daily stimulation)</p> <p>1st time intervention mothers more emotionally and verbally responsive, more involved with child, and provided more appropriate play materials</p> <p>Overseas born intervention mothers and mothers with >1 risk factor more emotionally and verbally responsive</p> <p>Intervention mothers psychosocially distressed antenatally were more emotionally and verbally responsive, more organised environments, provided more appropriate play materials, and more positive experience as a mother</p> <p>Mental development of children of mothers with antenatal psychosocial distress was poorer in the control sub-group</p> <p>No difference in parent-child interaction and child development outcomes</p> <p>No differences in child, maternal and family outcomes (birth weight,</p>
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				preterm, child illness and immunisation, maternal and household smoking) Overseas born intervention mothers breast fed for longer than their control group counterparts
Armstrong et al, 2000 (Armstrong and Morris 2000)	Home visiting program designed to: <ul style="list-style-type: none"> > build trusting relationships among professional home visitors and the family > promote maternal-infant attachment > improve parental adoption of health promoting behaviours > promote positive parenting practices > reduce parental stress and improve maternal mood > reduce potential of child abuse > promote the use of community and neighbourhood support systems to assist families. 	Inclusion based on self reported presence of ≥ 1 Tier 1 and/or ≥ 3 Tier 2 risk factors. Tier 1 risk factors include: <ul style="list-style-type: none"> > Physical forms of domestic violence > Childhood abuse of either parent > Sole parenthood > Ambivalence to the pregnancy (sought termination, no antenatal care) Tier 2 risk factors include: <ul style="list-style-type: none"> > Maternal age <18yrs > Unstable housing (≥ 3 moves in last 2 yrs, homelessness) > Financial stress > <10 yrs maternal education > Low family income 	Program designed as a prevention and early intervention for mediating the risk for child abuse and neglect by enhancing family adjustment to the parenting role. Clinicians from medicine, nursing and social work delivered the program. The Home Visitors were nurses; a home based social work intervention was provided for families where parental conflict or maternal ambivalence was reported or where parents requested counselling for issues relating to their own abusive childhood. Parent aides provided intensive assistance for families about parenting. Weekly case conferences were held. Home visits occurred weekly	Child health outcomes at 4 month follow-up: <ul style="list-style-type: none"> > higher rates of full immunisation > lower rates of self-reported injuries and bruising > lower rates of maternal smoking and smoking in the house > no difference in rates of use of medical services or breastfeeding Parent and family function at 4 month follow-up: No difference in: <ul style="list-style-type: none"> > post-natal depression > parental depression > social isolation > relationship with spouse > parental health Intervention group reported: <ul style="list-style-type: none"> > feeling less controlled and

		<p>(<\$16000 / annum)</p> <ul style="list-style-type: none"> > Social isolation > History of mental health disorder (either parent) > Alcohol or drug abuse > Domestic violence other than physical abuse. <p>181 participants recruited Jan – Sept 1996 (90 intervention & 91 control) in public ward following birth of child; 160 participants (80 intervention & 80 control) completed 4 month follow-up</p>	<p>until infant was 6 weeks; fortnightly until infant 3 months; and monthly until infant 12 months old.</p>	<p>dominated by infant's demands and needs</p> <ul style="list-style-type: none"> > improved range of child management skills > greater emotional responsiveness > more accepting of child's behaviour > organised home environment in a manner more conducive to infant safety and development > more positively involved with child > provided more appropriate play material
<p>Australian Nurse Family Partnership Program (ANFPP) (www.anfpp.com.au)</p>	<p>ANFPP aims to improve pregnancy outcome by helping women improve their own health while they are pregnant, and then to improve the child's health and development through the provision of parenting support and education and by helping parents develop a vision for their own future, including education or work.</p>	<p>ANFPP is available for women who are less than 28 weeks pregnant with an Aboriginal and/or Torres Strait Islander child.</p>	<p>ANFPP is based on the NFP home visiting model developed by Professor David Olds in the USA, and is part of the Australian Government's commitment to "Close the Gap" in Indigenous life expectancy. Nurses and Family Partnership Workers (local Aboriginal and/or Torres Strait Islander Health Workers) visit mothers and fathers in their own homes during the antenatal period and until the child turns 2 years of age. The program is</p>	<p>An evaluation of the ANFPP is being conducted but had not been published at the time of preparing this report.</p>

			currently being delivered at the Victorian Aboriginal Health Service, Melbourne; Wuchopperen Health Service, Cairns; Central Australian Aboriginal Congress, Alice Springs; and Wellington Aboriginal Corporation Health Service, Wellington.	
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APPENDIX 2: WEEKLY TRAVEL DIARY

Week start	Monday	Tuesday	Wednesday	Thursday	Friday
7 th Nov, 2011		Centre for Parent and Child Support (CPCS), Kings College, London & South London and Maudsley NHS Foundation Trust. Megan Ellis, Assistant Director, CPCS. Introduction to CPCS family support & parenting education programs	Waltham Forest (Nth London) Day 1, Foundation Training Course, Family Partnership Model.	Kings College London Institute of Psychiatry, Child and Adolescent Mental Health Services Research Unit. Dr Crispin Day (Head of Unit and Director, CPCS). Overview of family support & parenting education research programs	Centre for Parent and Child Support
14 th Nov, 2011	Torbay Family Health Partnership, Paignton, Devon. Jo Harper, Partnership Supervisor.	Institute of Psychiatry, King's College London. Daniel Michelson, Senior Clinical Research Associate (CAMHS Research Unit). Discussion about the various family support & parenting education health services research projects.	Implementing the Healthy Child Programme Training, Oswestry, Shropshire. Training provided by A/Prof Angela Underdown (Warwick University) and Ms Ros Loxton (CPCS)	Centre for Parent and Child Support. Dr Crispin Day and Ms Megan Ellis	Centre for Parent and Child Support. Dr Crispin Day and Ms Megan Ellis.
28 th Nov, 2011	Christchurch, New Zealand Prof David Fergusson, University of Otago,	Early Start Program Hildegard Grant, General Manager: A general overview of	Early Start Program Accompany a Family Support Worker on a home visit.	Early Start Program Discussion with panel of Family Support Workers about the role	Early Start Program Hildegard Grant, General Manager: staff selection, recruitment,

	<p>Christchurch. David is chairman and evaluator of the Early Start Programme, a Christchurch based family support program.</p>	<p>Early Start Jan Egan, Clinical Manager: Structured Compulsory Curriculum Heather Davidson, Clinical Supervisor: Supervision and structure of a home visit</p>	<p>Felicite Jardine, General Manager, Shirley Hub Early Intervention Center and using the Family Partnership Model</p>	<p>of the Family Support Workers, the positive and challenging aspects of the role, and graduating parents/families from the Program Jan Egan, Clinical Manager: child safety in Early Start Program</p>	<p>organisational development strategies, critical success factors for Family Support Workers Michelle Fagan, Clinical Supervisor: Parenting programs – PIPE (Partners in Parenting Education), Triple P, and Getting Ready for School.</p>
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