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SUPPORT FOR NEW PARENTS AND BABIES IN NEW SOUTH WALES

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The case for evidence-based sustained nurse home visiting

A submission to the NSW Parliamentary Committee on Community Services prepared by the right@home partnership

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Summary

The right@home partnership, a collaboration between Western Sydney University (WSU), Murdoch Children's Research Institute (MCRI) and the Australian Research Alliance for Children and Youth (ARACY), has undertaken research to identify the best Australian model of sustained nurse home visiting (SNHV) for parents and children experiencing moderate and significant risk. Within the partnership, the team at WSU leads implementation support for the intervention, providing supervisory advice and support to right@home nurses, monitoring and reporting on program fidelity, and overseeing a community of practice of all clinicians. MCRI leads the research evaluation of right@home, designing and administering follow-up assessments, while ARACY acts as project managers, overseeing funding, governance and reporting.

The right@home model, currently being implemented in 8 sites across Victoria, has been developed and tested through a randomized controlled trial (RCT). It consists of 25 visits delivered from the antenatal period until the child turns 2 and aims to improve outcomes in three key areas: parental care, parental responsivity and the home learning environment. The results of the trial are promising but are not yet publically available; representatives of the partnership would be willing to present this data at the Inquiry's hearing.

In this submission, the right@home partnership outlines the following:

1. Interventions need to address all parents, not just first-time parents.

2. Children and parents experiencing clusters of risk are most in need of antenatal, anticipatory, strengths-based interventions embedded within a system of proportionate universalism.

3. The right@home model achieves this.

The final part of this submission discusses the broader importance of early intervention, particularly in reference to SNHV.

A need to look beyond 'new parents'

The current focus on developing models of care to support first time parents creates an environment in which children of families with more than one child – and their parents – are not provided with the support required to improve their outcomes. The most commonly known evidence-based sustained nurse home visiting (SNHV) model, David Olds' Nurse-Family Partnership, focuses solely on young, first-time mothers. Whilst there is evidence to show that first-time parents are often underprepared to care for their infant, there is strong evidence to suggest that risk increases with the number of children in the family (Lanier & Jonson-Reid, 2014). This includes greater cumulative risk factors, increased caregiver psychosocial disorders including stress and depression, and an increased risk of child maltreatment (Lanier & Jonson-Reid, 2014). By focusing solely on first time parents, the Inquiry is failing to identify models of support for parents and children who have been shown to have equal, if not greater, risk factors as new parents. In addition, it must be noted that each child and context is unique, meaning any parent with a new child – regardless of parity – is, in effect a new parent and therefore may require additional support.

Proportionate universalism

The Strategic Review into Health Inequalities in England outlined that focusing solely on individuals who experience the most extreme levels of adversity will not reduce health inequalities sufficiently (Marmot, 2010). To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of support needed by each individual (Marmot, 2010).

Care for families should be delivered in a manner that is proportionate to their needs. For example, it has been found that those families at moderate risk benefit most from home visiting programs, whereas those groups with either the lowest or highest risk benefit the least (Landy and Menna, 2006, cited in Moore et al., 2012). Quality intervention, therefore, requires effective needs assessment based on carefully constructed eligibility criteria, as well as the development of evidence based packages of care that provide the best support. Certain interventions that work for one set of complexities may not work for others.

By providing additional services that are embedded in the universal system, support for parents can function as a "single, integrated endeavour", removing the costly need for the creation of a separate service (Cowley, Kemp, Day & Appleton, 2012, p.110). Embedded programs draw on and integrate with resources and services in the wider community, and the best functioning services build on people's strengths, increasing their self-efficacy and capacity to meaningfully engage with services (Cowley et al., 2012). A separate service removes the target population from the universal system, thereby emphasising the population's deficits, increasing the likelihood of stigma and learned helplessness and removing the opportunity for them to build their capacity to independently engage with services.

SNHV and the right@home model

When vulnerable families with risk factors or adverse child outcomes are partnered with a qualified nurse, who delivers an intensive and sustained home visiting program from pregnancy until the child is two years of age, child and parent outcomes can be significantly improved over the medium to long term (Moore et al., 2012). The SNHV model is preventative, provides anticipatory guidance and encourages partnership between the nurse and the family to promote child health and family functioning.

Background

Although there has been substantial international literature to support nurse home visiting, there has only been one modest randomized controlled trial of this approach in Australia. Kemp and colleagues conducted the Miller (Maternal) Early Childhood Sustained Home Visiting (MECSH) program in a single, socioeconomically disadvantaged suburb in greater Sydney (Kemp, 2011). The authors aimed to improve family, maternal and child health and developmental outcomes. At 2 years of age, mothers offered the MECSH program provided a more supportive home environment for their children, e.g. were more responsive, provided appropriate play materials, were more involved with their child, and the environment was better organized, than control mothers. Intervention mothers also reported an improved experience of being a mother, and those born overseas breastfed for longer.

The right@home model was created based on MECSH, with additional evidence based modules derived from a series of literature reviews focusing on the features of an SHNV program that are, "likely to bring about improved learning and development outcomes for young children whose families could benefit from greater support" (Goldfeld et al., 2017; McDonald, Moore & Goldfeld, 2012; Moore, McDonald & Sanjeevan, 2013; Moore, McDonald, Sanjeevan & Price, 2012).

The first literature review focused on successful processes and strategies for working with families experiencing adversity, concluding that whilst only a limited amount is known about what makes an effective program, those that are most effective:

- Are delivered by a professionally skilled workforce,
- Commence in the antenatal period,
- Are offered over a longer period of time,
- Are targeted to those populations experiencing greatest complexity and who would benefit from most support (Moore, McDonald, Sanjeevan & Price, 2012).

The second literature review looked at what makes an effective SNHV program (McDonald, Moore & Goldfeld, 2012). It concluded that successful programs, "involve a partnership between the family and nurse, focus on goals that parents prioritise, build competencies, be non-stigmatising and maintain continuity of care" (Goldfeld et al., 2017).

As outlined in the right@home protocol paper:

> The third review went on to investigate specific evidence-based interventions that focused on this trial's primary outcome areas and had the potential to enhance the effectiveness of SNHV programmes. The outcome areas were derived from reviewing the early childhood evidence which highlighted the importance of the home learning environment, parent responsivity and language development and the differential effect of adversity on executive functioning and therefore self-regulation. All of these areas are considered necessary precursors for optimising children's learning and development trajectories. (Moore, McDonald & Sanjeevan, 2013, cited in Goldfeld et al., 2017).

The right@home model

The right@home model is targeted at families experiencing risk or adversity, identified through a set of eligibility criteria derived through a pilot study in 2013 (Goldfeld et al., 2017). These risk factors are outlined in the Table 1. The program aims to improve the three primary outcome areas identified in the literature.

Table 1: Risk factors

Eligibility for the research trial ≥2 risk factors	
Young pregnancy (maternal age <23 years)	Health problem or disability that limits daily activities
Smoker	Anxious mood
Global health = poor/fair/good	Education < Year 12
Not living with another adult	No one in household currently has paid work
No support through pregnancy (e.g. financial, emotional, practical)	Participant has never had a job

right@home commences in the antenatal period and continues until the baby is 2 years old. In Victoria, the program is delivered by Maternal & Child Health nurses working in multidisciplinary teams alongside a social worker. Whilst it is based on the MECSH program, it also incorporates the Key Ages and Stages framework as detailed in the Maternal and Child Health Service Practice Guidelines (Department of Education and Early Childhood Development, 2011) and incorporates focus modules tailored to the Australian context. In this way, right@home provides a universal service with additional support to families that may require it.

The right@home program is comprised of 25 visits, which includes three antenatal visits and high frequency visits in the early weeks of the child's life. This frequency reduces over the course of the program, which encourages the development of parental independence and self-efficacy. It involves an evidence-based individual and group focused curriculum that addresses nutrition, sleep, safety, responsivity, the home learning environment (particularly focused on language and communication development) and social supports. It follows a flexible structure, with the nurse able to adapt their application of the program depending on the specific needs of the mother. This includes a flexible definition of 'home', which allows the visit to take place at a location that best suits the mother's context, such as a park, a café or even a clinic.

The flexible structure, diminishing visit frequency, strengths based partnership approach and context-specific focus modules are designed to ensure optimal implementation fidelity at scale and support the development of parental self-efficacy and capacity in relation to the primary outcome areas. right@home has a detailed quarterly quality monitoring and feedback system, including parent reported experience and impact measures, that results in very high retention and dose and content fidelity, which differentiates it from most other SNHV programs. Outcomes data from the trial, are not yet publicly available, but initial results look promising. Data will be available in the coming weeks and representatives of the right@home partnership are able to give witness at any future hearing related to the Inquiry.

The right@home trial

A randomized controlled trial was conducted to assess the effectiveness of the right@home model. The right@home trial was a community-based randomised control trial (RCT) involving 722 families conducted at 7 sites in Victoria and Tasmania; the largest RCT of SNHV in Australia and one of the largest in the world. The RCT commenced in 2012 and data collection for the 2 year outcomes concluded in 2016.

Participants were recruited from maternity hospital waiting rooms using a screening survey; mothers with 2 or more risk factors were invited to join the trial. The primary outcomes it aimed to improve were parental responsivity, parental care, and the home learning environment. Data were collected in person at enrollment, at 6 weeks, at 1 year and at 2 years, and collected by phone at 6 and 18 months.

The program is now being implemented across 8 sites in Victoria as a voluntary service offered to mothers demonstrating 3 or more risk factors or who have been identified by a service provider as in need of added support.

Specific areas of disadvantage or challenge in relation to health outcomes for babies – the case for early intervention through SNHV programs embedded in a proportionate universal service

The first 1000 days

The first 1000 days of a child's life, from pregnancy to age 2, involve rapid development of the brain and biological systems. This period lays the foundations for future linguistic and social development, emotional wellbeing, physical and mental health and self-regulatory capacities, while also impacting children at the genetic level, with environmental factors moderating gene expression (Moore, Arefadib, Deery, Keyes & West, 2017; Shonkoff & Fisher, 2013; Woolfenden, Goldfeld, Raman, Eapen, Kemp & Williams, 2013). Consequently, "developmental experiences and the social context in which they occur have the capacity to become biologically embedded (that is, have the capacity to alter human biological and developmental processes), with lifelong impacts on health and other outcomes" (Moore et al., 2017, p.6).

Ensuring that services are available, responsive and proportionately universal is crucial to supporting positive outcomes in the first 1000 days, particularly for children experiencing clusters of risk who are more likely to have poorer outcomes (Christensen, Taylor and Zubrick, 2017). In particular, a greater number of risk factors experienced over a longer period of time has a greater developmental impact and can lead to increased risk factors later in life (Center on the Developing Child, 2010; Toumbourou, Hall, Varcoe & Leung, 2014). Significantly, these snowball risk trajectories, "tend to be disproportionately clustered within disadvantaged geographic communities and schools" (Toumbourou et al., p.5). It has been suggested that programs delivered in the context of a service system with a more comprehensive approach have added value to families (Azzi-Lessing, 2009). As noted by Daro, "When problems do develop, they do not stay neatly in one "silo," and a continuum of services is necessary in order to deploy the one that will provide the type of help that is needed when it is needed" (2009, p.2).

The importance of parenting

A child's interactional experiences drive their development, and the timing and quality of early experiences combine to shape brain architecture (Center on the Developing Child at Harvard University, 2010). Responsive interactions, both at home and in early learning contexts outside the home, are vital for children's development of language, cognitive, and socio-emotional skills (Center on the Developing Child at Harvard University, 2010; Degotardi, 2010; Melhuish, 2016). In the first three years in particular, children need warm, reliable adult support and sensitive, stimulating, and reciprocal interactions (Degotardi, 2010; Melhuish, 2016). The effect of parenting in the early years is significant enough to positively impact child development, regardless of income or social and emotional disadvantage (Fox et al., 2015; Luby et al., 2013). However, the impacts of poverty, such as financial strain, can impact parental attention and self-control, "and this can impact responsive parenting and sensitivity to children's cues even among parents with good intentions" (Gennetian, Darling & Aber, 2016, p. 20).

Early intervention to build capacity

A key finding is that antenatal recruitment has proven benefits, particularly in relation to birth, child behaviour, and parenting outcomes (McDonald, Moore & Goldfeld, 2012). Holistic antenatal intervention programs with early needs identification, a focus on building parental capacity, and strengths-based mental health programs to support social and emotional family wellbeing have been identified as the "three key preventative areas" to improve child wellbeing outcomes (Fox et al., 2015, p. 5). These work best when utilising a combination of universal, targeted, and proportionately universal strategies (Fox et al., 2015).

Anticipatory guidance and 'parenting effectively despite'

Programs that educate parents about the importance of the first 1000 days and help them develop the skills necessary to provide nurturing environments and experiences are essential (Moore et al., 2017). Programs should work to build the self-efficacy of parents and support them to 'parent effectively despite' potential negative influences such as place-based disadvantage, or poor mental health. This education and empowerment involves anticipatory guidance, where the service provider prepares the client for an anticipated development. In the case of support for new parents this would involve building awareness about key risk and protective factors and enhancing parental capacity to provide an environment that promotes optimal developmental outcomes (Dosman & Andrews, 2012). Areas of focus include supporting parents to anticipate problems and manage behaviours associated with crying, feeding or sleeping, and "improving parents' understanding of their baby's emotional needs and abilities to respond with sensitive, skilled care" (NHMRC, 2017, p.2).

Family Partnership Model

This model works best when service providers have a trusting relationship with parents. These relationships need to be consciously constructed and involve a dynamic where the service provider works with and supports family members. This can be seen in the Family Partnership Model (McDonald, O'Byrne & Prichard, 2015), which focuses on building parental capacity and empowerment, developing a supportive relationship with parents, and taking a holistic approach to understand families. This is embedded in a context of shared expertise and active collaboration. This relationship building has been found to work best when interventions draw on a primary provider who represents and receives team and community support, therefore ensuring continuity of trust and care (Rubenstein, 2017).

Concluding remarks

A service embedded within the universal system that aims to build carer capacity to parent effectively despite their risk factors is a key strategy to enhance outcomes for children experiencing risk. There is a need to ensure that such a service recruits antenatally, and is holistic, purposeful, evidence-based, non-stigmatising, and based in a relationship of trust between the provider and the client. In addition, it should involve a detailed feedback system to ensure high retention and content fidelity. Furthermore, it is imperative that the service is provided to those populations who will benefit most; this includes parents with previous children, as increased number of children increases a variety of risks.

right@home is an evidence-based model specifically designed for the Australian context. It supports carers to build the self-efficacy needed to parent effectively, as well as building their capacity to access universal services, thereby reducing potential strain on the targeted system. The implementation of the model across numerous sites in Victoria indicates its ability to be replicated with fidelity at scale. The NSW well-child health platform has been shown, through Sustaining NSW Families and implementation of MECSH programs, to have the infrastructure required to provide an embedded SNHV service. There is the potential for right@home to be a fitting evidence-based SNHV model for the state's vulnerable families.

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