Early intervention – from evidence to implementation: The policy-maker’s tale

A case study

Diana Hetzel

Occasional Paper Series No. 4

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National Library of Australia Cataloguing in Publication entry

Hetzel, Diana.
Early intervention : from evidence to implementation : the
policy-maker's tale. A case study.

Bibliography
ISBN 0 7308 9235 2.

1. Children - Health and hygiene - South Australia - Adelaide.
2. Children - Medical care - South Australia - Adelaide.
I. Glover, John, 1945- . II. Public Health Information
Development Unit (Australia). III. Australia. Dept. of Health
and Ageing. IV. Title. (Series : Occasional paper series
(Public Health Information Development Unit (Australia)) ; no. 4).

362.198920009423

Public Health Information Development Unit, The University of Adelaide

This case study was produced by the Public Health Information Development Unit (PHIDU), The University of Adelaide, South Australia in July 2002. The views expressed in this paper are solely those of the author and should not be attributed to the Department of Health and Ageing or the Minister for Health and Ageing.

Suggested citation:

Hetzel D. (2003) *Early intervention – from evidence to implementation: The policy-maker's tale. A case study*. Occasional Paper Series No. 4. Public Health Information Development Unit, Adelaide.

Enquiries about or comments on this publication should be addressed to:

PHIDU, The University of Adelaide, South Australia 5005
Phone: 08-8303 6239 or e-mail: PHIDU@publichealth.gov.au

This and other publications are available from the PHIDU website (www.publichealth.gov.au).

ISSN 1447-8803 Occasional Paper Series

Abstract

Implementing evidence from research, into policy, and then practice, is a challenging task, glistening with opportunities and fraught with practical difficulties and political realities. This case study describes a process of taking research evidence, embedding it into policy and then implementing and making it happen ‘on the ground’, as a ‘live’ early intervention program in South Australia.

Evidence on the level of disadvantage of people living in particular geographic locations in metropolitan Adelaide, and research on effective early intervention programs for disadvantaged families with infants were used to support policy directions and to gain funding to establish a pilot program. A community development approach was adopted, and strategies used to ensure the participation of those communities in the design and establishment of the program are also discussed. A number of key criteria were identified to support the successful transition from research, to policy, to planning and practice, and these are reviewed in the light of experience.

This is a sobering tale, with exciting outcomes but a number of important lessons, which may be helpful to others seeking to ensure the successful implementation of early intervention programs for children and their families in Australia.

Preface

This is a tale of a personal journey and thus the reflections and the views are my own. It is a story of things that worked well and also one of disaster and disappointment, and I want to share it because I believe that often we learn more from the mistakes we make than from our successes. There are a number of things that I have been interested in which led me on this journey, and these too are my biases, which should be explicit from the beginning. These interests have often been in the ‘non-traditional areas’ of medicine – such as childhood trauma, interpersonal violence and abuse, marginalised populations, health inequality, attachment and infant mental health, social health, and children’s rights. I have also spent much of my working life with people from many other disciplines, cultures and communities who have helped me understand a wider range of viewpoints and ways of looking at the world. To all of them as teachers, I remain deeply indebted.

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The Tale begins …

Implementing evidence from research, into policy, and then practice, is a challenging task, glistening with opportunities and fraught with practical difficulties and political realities. This tale tells of some of my experiences in such a process, one of taking research evidence, embedding it into policy and then implementing and making it happen ‘on the ground’, as a ‘live’ early intervention program in South Australia.

In the mid to late 1980’s, I was working part time in the area of child protection, as a practitioner and then in developing new child protection services, practice guidelines and policies, particularly for the health sector. I became increasingly aware of our inability as a system to engage the small proportion of very marginalised families with young children and to provide services effectively that they needed. These families were the ‘hardest to reach’ for all agencies; often having had previous negative experiences with institutions and authorities, which had led to low trust and poor expectations, and likely to be burdened with poor physical, mental and emotional health. Their lives were fraught with other disadvantages: low income, unstable housing, difficult or transient relationships, isolation (both geographic and social), violence, unemployment, discrimination and racism. Literacy and poor education were also common difficulties, and their own experiences as children were often unhappy and traumatic. Many of these families were resilient in spite of the challenges they faced, and many had survived countless hurdles and setbacks. However it was clear that they deserved better support from the society in which they lived and better access to early intervention resources, which would assist them and their children to make it through.

I started to look for possible early interventions that might support these families, their young children and the communities in which they lived.
The tale unfolds here … and it has some of its beginnings in a conversation I had with Professor Richard Krugman in 1991. He was in Australia to speak at a national conference, and I was interested in the extensive review of child protection that had been undertaken for the US Federal Government, by the US Advisory Board on Child Abuse and Neglect, of which he was the Chair. The Board had examined the available knowledge and research in the area of prevention, and determined that universal home visiting services for families of infants was the best documented strategy for preventing child maltreatment. His strongly felt view to me was that home visiting as a service delivery strategy for all families of newborn infants offered promise in the USA, a country where there was no publicly funded universal health service for children and families. I believed such a strategy could also provide some support for those families in South Australia who currently were not accessing available early intervention services.

I went in search of evidence myself, spending time examining research information across many domains - medicine, psychology, sociology, nursing, early childhood education, anthropology, welfare, social work literature and so on - and looking at evaluations of existing programs that might assist the particular families in which I was interested. Home visiting as a way of supporting women and infants has existed for a long time in many parts of the world. A great number of models have been described and the research evidence was sometimes conflicting, often inconsequential and occasionally impressive. Each country had developed its own set of programs, to fill gaps or to support existing systems of home visitors, and the diversity of approaches was overwhelming. I remained convinced though that home visiting as a strategy, innovatively applied, could assist those families who were seriously disadvantaged and isolated.

In 1993, I had the opportunity to contribute quite late to the development of the SA Health Commission’s child health policy, Strategic Directions in Child Health. The consultation processes were almost completed when I was asked to comment and I was interested to see that child abuse and neglect were missing as significant issues concerning the health of South Australian children. This was not surprising as we had been working hard to increase the understanding of mainstream health decision-makers that child abuse and neglect were public health concerns, not just areas for which welfare was deemed responsible. A quick submission later and the reduction of child abuse and neglect was included as a key strategy for the next three years. This was rather serendipitous, but the inclusion of home visiting as one of the strategies in the policy proved to be important later on. The Commission endorsed the Strategic Directions document and hundreds of copies were printed and distributed. No one ever commented on the inclusion of the home visiting strategy nor adopted it as part of their organisational business, and it was never cited as part of a service agreement with any health agency. And so it is with many policy interventions … unless someone is particularly interested, an idea can languish and fade away.

By March 1994, I had finished my review of the research and had corresponded with a number of people overseas. I developed a set of key criteria that I believed was supported by good evidence, and that I could use to guide the development of a program for very marginalised families. To be effective, it was clear that programs should be based on ecological models, where influences on child and family health are viewed in terms of systems of material, social, cultural, behavioural and emotional factors rather than single influences. Programs must therefore address simultaneously the psychological and emotional needs of the parents (especially their sense of mastery and competence); the parental behaviours that influence maternal, fetal and infant development; and the situational stressors and social supports that can either interfere with or promote the adaptation to pregnancy, birth and the early care of the child.

The key criteria were:

- A community development approach was the most effective strategy for development and implementation that I believed would work for these families;
- The program had to sit within a universal framework of services in order to avoid stigmatising families – the health sector appeared most promising;
- It was crucial not to link the program with child abuse prevention at any stage and not to include child abuse prevention or reduction as a desired outcome;
- The program had to be piloted, adequately funded, independently evaluated and evolve over time as a result of the lessons learned;
- The program had to be flexible and responsive to all the needs of the family, and not focus solely on services for the child and / or the mother, but also include the father and other family members, if available;
- The program had to be based in a geographical area where there were significant levels of disadvantage;
- Engaging families antenatally was preferable, and the selection and matching of visitors to families would be critical to the success or otherwise of the program.

I identified three models that I believed were worthy of further examination – the Elmira Study of Olds et al. in Rochester, New York; the Healthy Start program in Hawaii; and Newpin from the UK. I met with the Director of Primary Health Care in Metropolitan Health Services Division who I knew was also interested in improved access for disadvantaged populations. After discussion, he agreed that detailed planning of an appropriate strategy for piloting in the northern metropolitan region of Adelaide could commence. The northern region was selected on the basis of significant socioeconomic disadvantage (it was the second most disadvantaged metropolitan area at the time in Australia on the ABS SEIFA score), the number of births at the Health Service and the fact that a number of government agencies were already operating in the region. Two other factors were crucial for this to proceed: the inclusion of home visiting as a key strategy in the SAHC Child Health Policy and home visiting as a preferred program in the prevention of child abuse and neglect identified by the National Child Protection Council in October 1993.

I also sought the support of the Child Health Council of SA who wrote to the SAHC, endorsing the approach. A brainstorming workshop was held in June 1994 involving all the key service agencies in the region to determine the features that should be included in the strategy. Two additional models, both using volunteers were also discussed, but it was agreed that the Healthy Start program had worked well with those families who were the most similar to the marginalised families that we wished to serve. A small planning group was chosen to continue the planning process. In July 1994, I arranged for the Director of the Healthy Start program in Hawaii to visit Adelaide. She was here for less than 24 hours, but she met with the planning group for almost a day and a dinner was organized for her to present the program to the senior funders and decision-makers within the health and welfare sectors.

The Healthy Start program used paid, non-professional workers to support families who were selected, specially trained and supervised by a professional worker. There were caseload limits for each worker and ongoing training and support for them was an essential element of the program. The program had operated successfully in Hawaii since 1975, and its model was being trialled elsewhere in the USA. I was aware that using paid, non-professional workers would be seen by some as a radical move away from the more traditional approaches of using nurses, but there was considerable support for this alternative approach among the stakeholders and the local community members and it was the view of many local service providers that this would be more acceptable to families. We were keen to use some of the features of the Hawaiian program, but recognised from the beginning that this would need to be a program developed by the community in which it was to operate, rather than be a ‘transplanted’ operation from overseas.

By the end of the year, a formal proposal was ready to put to the funders. A team of visitors would be drawn from the same geographic area as the families of the firstborn infants. The team would reflect the ethnic mix of the community. These people would have completed their own primary parenting roles successfully and would have a broad understanding of the challenges that face new families in their community. The key attributes sought would be their compassion, their willingness to work with a family in a tolerant and non-judgmental way and their ability to advocate on behalf of a family for access to needed resources. Intensive training and supervision would be provided to equip the workers with additional knowledge and skills in their new role.

A smaller number of interviewers would be trained to talk with parents, preferably before or around the time of the baby’s birth, in order to identify those parents who might best benefit from the program because of the special challenges that confronted them. The semi-structured interview would be used to identify those families who were over-burdened and likely to benefit from a voluntary scheme that could offer additional supports. All families from the area would be interviewed and all families offered services according to need. Those in the highest need category would be offered the program. Thus the program would be targeted but delivered within a framework of universal service delivery.

For those families to whom the services were offered, a home visitor would be selected to match a family and visiting would begin at least weekly. As the family strengthened, the frequency of visiting would reduce to fortnightly and so on but always with the aim of family independence and self-sufficiency. For those families who declined the offer of the program, there would be a persistent approach to continue to offer the program for three months. The range of services would depend on the individual needs of the family, but would include fostering of positive attachments between parent and child, skilling parents to meet the developmental and learning needs of their children, access to well baby and developmental checks, linking with a family medical practice, and assistance in accessing community services such as support groups for parents or employment or housing. For some parents, referral to therapeutic and counselling services would be facilitated.

The home visitor would be available to the family on a 24-hour basis initially, with guidelines agreed by both parties. Frequent feedback from the families would be sought to ensure that the visitors were satisfactorily meeting their needs. It was also envisaged that the visitors would require the ability to access services quickly and effectively on behalf of families. To this end, interagency agreements of a special and unique type were envisaged in order to fulfill the practical needs of the families. Critical to the success of the program was the linking of families to services in the community, particularly to group support programs, playgroups and other social networks for young families. It was agreed that the SA Health Commission would manage the program via the state child health organisation but would contract with a community services sector agency for the operation of the service.

In February 1995, I presented the research evidence, the policy context and the proposed pilot to the Executive of the SAHC, who agreed to a period of more detailed planning for 6 months, the establishment of a pilot, which would be evaluated and allocated funding of $1 million that was sought. I presented the proposal to the Minster for Health the next day, and he supported the approach for a pilot, but also wanted to assess cost-effectiveness. So far, so good …

The planning process proceeded, with a consultant chosen by the SAHC Executive to lead the community development process in the northern metropolitan region. A Steering Committee was formed as well as an Interagency Group and visits to a wide range of agencies were undertaken, outlining the program and seeking their support for working together for the families in the region who were to be participants in the program. A number of consultations were held with people from the local community, with many of the participants being older women and young mothers. Initially we talked about the sort of service that would be most useful to families of new babies in the area; in subsequent sessions, we discussed the sort of people that they thought would be best as home visitors in their community and people reflected often on their own experiences. A clear preference for non-professional workers was expressed on many occasions, and for the workers to be available when the family needed support, not scheduled into an appointment system. Other issues such as difficulties with housing and transport, accessing other services, social and geographic isolation and domestic violence were also raised. Specific consultations were also held with the Aboriginal community and with communities where English was not the first language spoken.

We continued to discuss the program's development widely within the community and reached the point of drafting job descriptions, evaluation tenders and had outlined a training program content which we hoped could be provided by and accredited at the local TAFE College.

And then in September 1995, disaster struck! Having been very careful to ensure that the program was not identified as a child abuse prevention program, we saw to our horror that the daily SA newspaper had written a page 3 story about the program, identifying it in the headlines as just that! It appeared that this eventuated as a result of a dispute between the paper and the Minister's office about an un-related matter, but the Minister became increasingly unhappy and in spite of numerous ameliorative activities on our part, he pulled the plug on the program and it ceased operation within the month. This led to uproar and disbelief within the local community and there was considerable discussion about the withdrawal of resources from a significantly disadvantaged community. A local opposition politician joined the fray, and the Minister's unhappiness increased.

At this point, I received a number of disparaging comments from some members of the SAHC Executive for the embarrassment 'my program' had caused the Minister. In desperation, we argued for the money to be salvaged and to be used for its intended population. We met with the CEO on a number of occasions, and eventually he agreed for the program to be re-vamped and re-named, the funding halved and the location to be changed to another area of significant disadvantage in the western suburbs. This area is the third most disadvantaged metropolitan area nationally on ABS SEIFA score. The remainder of the funding went to two other small projects, which were also focused on support for mothers of new infants. After much debate, he decided that the program should be auspiced by a SAHC agency that would be prepared to commit a small amount of funding and administrative support for the program. The agency which was keenest to auspice it was the Women's and Children's Hospital. And so, we began again …

In April 1996, I presented the research evidence, the policy context and the proposed pilot to a Grand Medical round and to a Nursing Forum at the Women's and Children's Hospital, and to a group of agencies in the western suburbs. There was much support and commitment to the program and with a member of the Hospital's Executive and the CEO of the state child health agency, we started a new community development process. In May 1996, the Commonwealth's audit of Home Visiting programs was released, and it confirmed that we had already addressed many of the recommendations of the audit in the work done to date. We started our planning and had difficulty initially in recruiting a Program Director, but finally in November, one was appointed. An Executive Support Group was formed and the community development approached proceeded. Special groups were established to develop the initial interview and processes within the hospital, the training program for the visitors and the evaluation brief for tender. These processes ensured that research and practice continued to underpin the program's development and also helped to build credibility and support for the program.

By July 1997, the planning had been completed, evaluation and training briefs developed and tendered and the budget approved by the SAHC. Premises were found, staff appointed, training began and the program commenced operation in January 1998. Throughout the next few months as I had done previously, I continued to send emails to the SAHC CEO and other Executive members, informing them of the program's progress. I also advocated for the program within the central office of the SAHC whenever there was an opportunity. The program was now in the hands of a very skilled and committed Director who developed and supported the program through its infancy to a mature and effective service. My involvement was limited to membership of the Executive Support team and the Advisory Group to the program.

In December 1998, I approached the CEO with a request to present to the Executive once again on the progress of the program, to which he agreed. It was an occasion to demonstrate that research evidence can be applied to policy and successfully implemented, even if the path is strewn with obstacles. I also felt that it was important for them to understand that the strategy was working now well and was something with which they could be pleased.

The program's evaluation was conducted by independent evaluators and was completed in November 2000. The results confirmed that the program was effective, very acceptable to the families, had not induced dependency in the families, was culturally acceptable to Aboriginal and Indo-Chinese families, had engaged very marginalised families successfully, was well regarded by the other agencies operating in the area, had not resulted in duplication of services and had resulted in community-capacity building – and at a final cost of $2517 per family per year (for an average 3.2 family members). The cost of the program was initially criticised by some as being too expensive. My own view was that these families were among the most disadvantaged in the community, and I was aware that many of them could use more resources than this in one 'crisis' situation. In fact, this represents the cost of a visit to an A& E Department for a child, a hospital admission and one outpatient visit (DRG Costing $2500) in South Australia. I also believed that there was an ethical dimension to be considered, in that there is a moral obligation to provide adequate support to these families based on their specific needs, rather than 'sheep-dipping' them through a program designed more broadly which they may not be prepared to access anyway.

Lessons learned and some personal reflections

Reflecting now on the guidelines for development of the program, there are a number of lessons that are apparent.

- Review the evidence and assess its strength, and continue to review;

This has remained an important element and the dissemination of new research to interested people is important too.

- Ensure endorsement by senior funders and decision-makers;

Clearly this is necessary, but if you lose it, try hard to re-build it.

- Commitment at a political level;

Again, this is very important, but politicians are keen to promote the work of their Departments and there needs to be consultation about the ways in which early intervention programs are publicised in order to avoid stigmatising communities. Sometimes it is better simply to undertake good work quietly.

- Health as the lead agency worked well, but the building of broad intersectoral support is essential;

Health services are universally available and widely accepted by the community generally; alternatives such as a welfare setting would not have been acceptable to the client families. Involvement and support of other agencies was critical and supported by the fact that many of the families were 'clients-in-common'.

- Community development approaches are essential;

This was one of the most important elements in building the program, and in gaining community support. Parent representatives on the Advisory Group also helped to guide the program's development. This is not a model with which many professional practitioners are familiar, nor necessarily comfortable.

- Gather support from a wide group of stakeholders, particularly those from the local area;

This helped to develop the network of services around the families, improve communication and allowed opportunities for staff from different agencies to support each other across agency boundaries.

- Development of the details of the program design will be the responsibility of many, but the key criteria from research are important;

It was critical to stay with the key criteria, which were drawn from the research evidence, even when there was pressure from some agencies to change them – for example, to alter the geographic region or to include other families with older children. We were evaluating a pilot and keeping to the original agreement was important. The desire of other agencies to include additional families indicated their recognition that the program was working effectively and was needed in other locations and for other families.

- Independent evaluation of program, and informal evaluation of the progress of the process;

Independent evaluation was necessary to demonstrate program outcomes, although there was much discussion of the eventual design and many ethical, methodological and practical issues to resolve. It would have been helpful to have had someone alongside to evaluate the process of the development of the program from the beginning. More lessons might have emerged.

- Ensure that the program is 'marketed' positively, if at all;

This was crucial and almost the undoing of the project. There was constant pressure from the Welfare Department to include the program under their list of child abuse prevention, families-at-risk etc. We resisted this and our welfare colleagues eventually respected this approach. We were careful not to 'launch' the program but had a quiet opening with a barbecue with the families, which the CEO and the Minister attended, without the media.

- Ensure adequate funding for the pilot and its evaluation from the start;

I do not believe in beginning projects unless they are adequately funded. I knew we had to 'prove our case' initially and that was why we only received money for a limited time. There was an agreement that if the program were successfully evaluated, then other sites would be rolled out. Unfortunately, the CEO changed and the Department was re-structured and the program has had to fight for its survival since. As part of that process, it is clear that more advocacy should have been undertaken and the particular strengths of the program explained to the new decision-makers.

- Embed in a policy context and ensure the strategy is 'kept in mind' by decision-makers;

This worked while there was someone in the central office policy area who could undertake the role. Unfortunately in the last two years, this central support has been *patchy and some decision-makers are not well-informed about the details of the program and some of its unique characteristics. Recently decisions have been taken that I believe will weaken the program's efficacy.*

- Expect opposition, do not take it personally and deal with it as it emerges – ensure that evidence is there to support your view or else modify it;

There was opposition from a number of places, much of it came to my attention informally and only occasionally was I in a position to respond formally to the criticisms being made. Some of it related to inadequate or inaccurate information, disappointment that the auspicing arrangement had not been made with another agency, some of it was a response to decisions that were not mine but made at an executive level, and once it was based on a mis-representation of available research evidence. Each time I was made aware of difficulties, I attempted to address the concerns as well as I could. I believe that in many ways negative reaction is a healthy sign of an active democracy and part of working in a complex system. In most cases, it led to greater reflection on my part and firmed my view that we were being effective.

- Assess the timeliness of progress regularly;

I was often disappointed at the slow rate of progress, particularly on my part. Unfortunately I was working only part-time and I had a number of other major projects to manage. It would have been preferable to be able to work only on it or to have been able to hand it over to someone else. Once the Program Director was appointed, it was heartening to watch the pace of development increase.

- Accept you will not control every eventuality – 'complexity theory' predominates, so learn from every setback;

There were many lessons from the 'roller-coaster ride', but the outcomes were well worth the journey and the wait. Persistence was essential – never give up on a good idea! The program came to fruition because of much effort and commitment from a large number of people – and one person could never have managed it on their own.

- Keep focused on the needs of the communities you aim to serve and involve them as partners in the process.

This started as the motivator and remains so for me. Highly disadvantaged families require support and a commitment to 'walk with them' for the longer-term. It is the only way to build trust and a relationship, and after all, that's what it is all about.

The opportunity as a policy-maker to take on the differing roles of reviewing the research evidence, determining the policy, identifying the strategy, working with practitioners and the community in implementing the program, and overseeing the evaluation of the program is a very unique one, and one that is unlikely to come my way again. It was a challenging but ultimately highly satisfying process and made more so, by its successful outcomes for a very marginalised and disadvantaged community. The lessons were significant and have been described here for those who might also undertake such a journey. And so, my tale ends.