Building Blocks for Reflective Practice

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Professor and Director, Translational Research and Social Innovation (TReSI)
When 12-year-old Jessica Burns was asked what she wanted from her future, she answered: “a good job, like where you get like heaps of money. I’d be like a decent mum, like a husband with no violence and everything, so it could be a happy family, you know, but like that would never happen...”
Current investment pattern

- Direct (one-to-one) primary support
- Indirect (group) primary support
- Broader resource system
- Personal resource

Level of investment:
- Low need
- Very needy

All families vs. Crisis management
What is health?

• “a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity.” (WHO 1946)

• “health, as the ability to adapt and to self manage” (Health Council of the Netherlands 2009)
FROM

Respond
Inefficient services

TO

Anticipate
Better outcomes
The problem with prevention is there is nothing to fix!
**Pathogenic View**
Start Point = Disease or Problem

- Works to eliminate risk factors

  - Reactive
    - Reacts to signs, symptoms, and indications of disease

  - Wants to help avoid or prevent a person from being pushed backwards (falling further down a hole)

- Outcome = absence of problem

**Salutogenic View**
Start Point = Health Potential

- Works to create health (salutary) factors

  - Proactive
    - Create conditions of physical, mental and social well-being

- Wants to help or enhance a person’s ability to move forward (get out of the hole)

- Outcome = presence of gain
Well known gradients in child health

parent/family risk

child outcomes
Halfon, 2015. Adapted from Halfon et al., 2014
Ecological model


What is health?

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Well known way to fix it?

lower/remove parent/family risk

better child outcomes
Disclosing risk

“Well if I’m already asking for help it’s because I’m an unfit mum. So she [nurse with whom she had a long term relationship] was just sort of reassuring me that that’s not the case...Yeah, because I think it was more a confirmation that it’s okay to feel how I feeling and it’s okay to get help.” (Cathy).

- 46% families - violence not disclosed until relationship established
- 77% families – disclosed a serious risk factor (violence, drug/alcohol, major mental health issue in context of relationship

Changing risk

- Up to 20% of perinatal risk ‘emerges’ in the period between the first antenatal midwifery visit and the first postnatal child and family health nurse visit. In most cases this risk was not identified (UK audit).
- Depression on entry 14%; depression developed/disclosed 39%
“parenting effectively despite”

赤いマーク

- Can not prevent all the changes, instability and difficulties families face
- Developing child can not wait for family to be ‘cured’
  (“Understanding these mechanisms [how supportive parenting plays a role in child hippocampal development independent of income] is key to the design of more targeted interventions, providing a feasible alternative to changing psychosocial status itself, a much more challenging goal that vulnerable rapidly developing young children do not have time to await” Luby et al 2013)

緑のマーク

- Can intercept detrimental parenting processes that may be triggered by these difficulties (protection, buffering (Shonkoff))
- Can support families to “parent effectively despite” the difficulties they face

Parent effectively despite

• Contain the ‘despite’s’
  – Acknowledge the despite and its impact

THEN ASK
– Is this something that can be changed?
– Does this need to be changed today?

THEN (if can be changed)
– Make plan for change (engage the broader support system)
Quality home environment despite family functioning

Comparison Group

Intervention

\[ r^2 = -0.52 \quad p < 0.001 \]

\[ r^2 = -0.31 \quad p = 0.01 \]
Quality home environment despite depression

Comparison Group

Intervention Group

$r^2 = -.30 \ p = .04$

$r^2 = -.11 \ p = .39$
Family Partnership Model

- Helper Qualities
- Helper Skills
- Characteristics of Parents and Children
- Partnership
- Helping Process
- Outcomes

Service & Community Context
The Helping Process

Partnership Relationship (Engage & Sustain)

- Exploration
- Understanding
- Goal Setting
- Strategy Planning
- Implementation
- Review
- Ending
(Fisher's Personal Transition Curve)
Ability to adapt and self manage

Families can identify:

• The elements of their current life and support that makes the ground away from the top of the hole secure and stable.

And demonstrate:

• Strategies to avoid falling back down the hole
• Strategies for recognising future ‘holes’ the family may face
• Strategies for avoiding or not falling so deep into future holes
• Strategies for getting out of future holes
Confronted with a stressor, the person with a strong sense of coherence will:

- wish to, and be motivated to, cope (meaningfulness);
- believe that the challenge is understood (comprehensibility);
- believe that resources to cope are available (manageability).
Sense of Coherence

Comprehensible
Life is structured, predictable and explainable

It makes sense to me

Manageable
Personal and external resources are available

I have what it takes to do this

Meaningful
Fits with sense of self

It’s worth it!

“You help me with my struggles and to get things out. I can talk things out about my relationship or being a mum when I don’t have people to tell. As an outsider, it helps to talk about what’s going on and get support. You get my emotional things and because I trust you and you listen, even about the hard stuff, you are a huge emotional support. You let me know I’m not crazy because you are like the friend with a degree. You don’t ever say I have to fix it, you just put a positive spin on it and help me figure my own stuff out. That has helped because generally I feel more confident in myself because I feel I’m not failing. My emotions are validated and it’s ok. It helps because I’m not holding it all in and holding on to it or losing my mind and not telling anyone. You let me clear it all out and start again.”
Sense of coherence varies from person to person and situation to situation

- *what* gives one a sense of meaningfulness;
- *which* type or style of resource one thinks is appropriate to apply to a given problem;
- *in whose hands* the resources are, as long as they are in the hands of someone 'on my side';
- *how much* information one thinks one needs to comprehend.

What matters is that one has had the life experiences which lead to a strong Sense of Cohesion; this, in turn, allows one to 'reach out', in any given situation, and apply the resources appropriate to that stressor. (Of course there can be mistakes and failures; but the person with a strong Sense of Cohesion learns from these, and is not doomed to repeat them.)

Antonovsky (1996)
Programme components

- Supporting mother and child health and wellbeing
- Supporting mothers to be future oriented and aspirational
- Child development parent education program
- Additional support in response to need
- Supporting family and social relationships

Primary universal maternal, child and family service system (embed, engage)

Secondary and tertiary maternal, child and family service system

Refer

Support
Key elements of MECSH and its implementation

• MECSH is:
  – a structured, evidence based (HomVEE approved) program of sustained home visiting, group work and service connection provided by Child Health Nurses from pregnancy or early postnatal engagement up to child-age 2 years.
  – integrated into the child and family health service.
<table>
<thead>
<tr>
<th>Program theory</th>
<th>MECSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health as the ‘ability to adapt and self-manage’; Salutogenesis</td>
<td>Comprehensive programme focussed on developing family ability to adapt and self-manage and ‘parent effectively despite’: focus on aspiration and potential, rather than fixing problems</td>
</tr>
<tr>
<td>Risk is not static</td>
<td>Mothers at risk of poorer maternal and/or child health and development outcomes (~20% of mothers) not restricted by age, parity or gestation and up to 6-8 weeks post parenting</td>
</tr>
<tr>
<td>Working in partnership; relationship based</td>
<td>‘Soft entry and exit’ to programme based on helper and family relationship. Purposeful engagement.</td>
</tr>
<tr>
<td>Program theory</td>
<td>MECSH</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Proportionate universalism</td>
<td>Embedded in universal services and delivered by CHN as part of their caseload: deliberate ‘spill over’ effect to whole service and community</td>
</tr>
<tr>
<td>Solution focussed and building sustainable capacity</td>
<td>Purposeful engagement. Increasing duration between visits to allow families time to develop confidence in solving their own problems and continuing the changes made</td>
</tr>
<tr>
<td>Ecology: integrated ‘ME[C]SH’ed families, community and services</td>
<td>Focus on connecting families with their community and needed services: group work integral: promotes service and community integration</td>
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</tbody>
</table>
Supporting family ability to adapt and self manage

In essence I feel challenged, liberated and also rewarded working as a MECSH practitioner. It requires “unlearning” as well as juggling best timing for providing maternal child health practice and expertise. It’s been great to witness the benefits of holding back / sitting on my hands / withholding well-meant advice. I continue to marvel at the multiple benefits of this newfound game of patience. It’s also as rewarding for me to observe the reluctant mother unearthing her own ability to best manage things as it must be for her to discover her capabilities. The thrill is in her taking responsibility and feeling confident to take charge in the next situation.
Program outcomes

• Children
  – More engaged
  – Improved development

• Mothers
  – Less birthing intervention
  – Improved health
  – Longer time breastfeeding
  – Improved confidence
  – Improved use of services

• Families
  – Improved home environment

• Community
  – Fewer vulnerable children at school entry

Primary outcomes Phase 1

- **parent care**: Parent’s ability to provide a consistent and regular environment for their child

- **parent responsivity**: Parent’s ability to tune in to their child’s needs and to respond appropriately

- **home learning environment**: Building a strong home learning environment through structured developmental promotion activities focusing on language

Goldfeld S, et al. (2017) "right@home": A randomised controlled trial of sustained nurse home visiting from pregnancy to child age 2 years, versus usual care, to improve parent care, parent responsivity and the home learning environment at 2 years. BMJ Open, 7 (3) e013307; DOI: 10.1136
Somerset Trial

- Enablement

![Graph showing mean scores for PEI Baby, PEI Parent, and PEI Total across MECSH and Comparison sites.]

- MECSH sites
- Comparison sites
Zapart S, Knight J, Kemp L (2016) ‘It was easier because I had help’: mothers’ reflections on the long-term impact of sustained nurse home visiting. Maternal and Child Health Journal 20(1)196-204.
<table>
<thead>
<tr>
<th>DOMAIN OF DEVELOPMENT</th>
<th>MEAN PROPORTION OF CHILDREN VULNERABLE IN THE DOMAIN AT SCHOOL ENTRY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TRIAL COMMUNITY</td>
</tr>
<tr>
<td>Physical health and wellbeing</td>
<td>6.8</td>
</tr>
<tr>
<td>Social competence</td>
<td>7.0</td>
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<tr>
<td>Emotional maturity</td>
<td>6.5</td>
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<tr>
<td>Language and cognitive skills (school-based)</td>
<td>4.3</td>
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<tr>
<td>Communication skills and general knowledge</td>
<td>11.5</td>
</tr>
<tr>
<td>vulnerable on 1 or more domains</td>
<td>21.6</td>
</tr>
<tr>
<td>vulnerable on 2 or more domains</td>
<td>9.0</td>
</tr>
</tbody>
</table>

Thank you

Program research and implementation teams

Supporting services

Project funders

Participating families

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