NSW Child and Family Health State-wide Services Network

RESPONSE TO:
PRODUCTIVITY COMMISSION DRAFT RESEARCH REPORT – EARLY CHILDHOOD DEVELOPMENT WORKFORCE

Introduction

The NSW Child and Family Health State-wide Services Network (NSW CAFH SWS Network) is a peak forum for advocacy and leadership in regards to Child and Family Health Services across NSW health service agencies. The committee brings together senior child and family health service managers and clinical leaders to

- Promote and advocate the role of Child and Family Health Services at National, State, Area Health Service and Local levels
- Identify National, State, Area Health Service and Local level issues for collaborative action and response
- Participate in the development, implementation, monitoring and evaluation of relevant policies and programs
- Promote practices that positively influence the social determinants of health for all children and families
- Facilitate networking and the promotion of innovative practice models of Child and Family Health Services

The NSW CAFH SWS Network has developed the following response to the Productivity Commission Draft Research Report – Early Childhood Development Workforce to provide additional information to government officials and health service planners. In particular, this discussion paper aims to describe the vital role of community child health services and their role in ensuring quality care is provided to children and families across the continuum of care.

Issues of concern contained in the Productivity Commission Draft Research Report

The report fails to reflect the complexity and comprehensive nature of the services provided by Community Child Health. Chapter 12, page 215 of the report discusses the

‘regular checks’ provided by Child Health Services however this does not identify the broad role of Community Child Health services in promoting and addressing health and psychosocial issues impacting on the wellbeing of the child, parents and family as a whole. The following paper will describe in more detail some of these services, vital to the health and wellbeing of children, families and the community.

It should also be noted that the report discusses Child Health Workforce only in terms of Child Health Nurses and Aboriginal Health Workers. This does not reflect the reality of the experienced and skilled clinicians across a range of health disciplines including allied health and medicine working in this sector. Likewise, reference to these two groups on pages 219 & 220 does not reflect the true nature of the workforce.

Page 216 notes a focus on universal primary care services aimed at child and families, stating that other health services for children are generally provided in hospital or by medical practitioners. This is incorrect. In the community child health, very complex health and social problems are identified and addressed with very few of these children requiring hospitalisation. Clinicians in community child health have a high level of expertise in the health needs of children who are at risk for complex problems. One of the key components of community child health is to address the needs of vulnerable populations in order to improve child health outcomes. As can be seen in the following discussion, health services including health promotion, prevention and early intervention are provided throughout community child health services by teams of clinicians across a range of disciplines.

The draft report does not mention social workers or psychologists, although it does say that physios, OTs and speech therapists are employed in the early childhood development workforce. This needs to be redressed as social workers and psychologists who are placed in these services play a vital role in supporting families through the sometimes difficult transition of bringing a new baby home. For example, in the case of social workers, these professionals provide support and counselling around parenting, developmental and relationship issues as well as being pivotal in the teams they are employed in identifying and responding to child protection concerns including domestic violence. Social workers have skills in group work and often run these to assist families with such issues as anxiety and depression, younger parent education and support and managing changing relationships.

Page 216 provides a description of Child Health Nurses from the ANF. Please find attached to this document a copy of the NSW Health 'Child and Family Health Nursing Professional Practice Framework 2011 – 2016'. This document was recently released by NSW Nursing and Midwifery Office and contains on page 8 (Section 4) a description of the 'Scope of Practice in Child and Family Health Nursing Practice' and pp. 9-11 (Section 5) an outline of the 'Core Knowledge and Skills' required by nurses working in this specialty area. In relation to the comment on p. 222 of the Productivity Commission draft report regarding the child health workforce should 'not be seen to judge', please note point 5.5. (page 10 of the Framework) which describes the model of Working in Partnership with Families. NSW Health, as have some other jurisdictions across NSW, have implemented Family Partnership Model (Davis, Day & Bidmead, 2002) as the model for working with families to identify and build upon strengths and capacity to address the health needs of their families. The framework document also outlines the elements for professional development and support which is of relevance to the content of the draft report (p. 232). These elements (see Sections 6 & 7) include reflective practice self-assessment, clinical practice consultancy, clinical skills assessments / learning activities, and Clinical Supervision.

Page 221 of the draft report discusses universal services in terms of centre-based services and does not reflect the universal health home visiting conducted in NSW. Home visiting is only noted in the section on targeted health services as sustained health home visiting. The statement in Box 12.2 on p. 224 regarding no evidence of the efficacy of such home visiting within an Australian context is incorrect and researchers need to seek information regarding the Miller Early Childhood Sustained Home-visiting (MECSH), a randomised controlled trial conducted in Sydney, which has been widely published (please contact the study primary investigator Dr. Lynn Kemp and visit the following website http://notes.med.unsw.edu.au/cphceweb.nsf/page/MECSH).The writers of the report should also refer to the NSW Health *Families NSW* 'Supporting Families Early Package', with particular reference to the 'Maternal and Child Health Primary Health Care Policy' (NSW Health, 2009) which describes service delivery models in NSW to provide comprehensive care to the infant and mother.

The statement about the New Directions Mothers and Babies program in the last dot point on p. 224 gives a very limited description of what this program delivers. Ongoing work with

the families, health checks by paediatricians, health promotion and education with families and the community are also important factors which involve the full range of child health clinicians.

Role of Community Child Health

Child and family health services can be described as a range of preventative, assessment and early intervention based services that address the health, development and social well being of children, their families and carers. Community child health covers a range of disciplines such as medical, nursing and allied health and using this multidisciplinary approach, has the ability to identify and address the needs of vulnerable families early. This enables staff to actively plan and facilitate early intervention strategies and make appropriate referrals for improved health outcomes for the children and families of our communities. They also liaise frequently with professionals from other organisations/agencies such as education, disability services, housing and those involved with particular vulnerable groups. This type of model, in which different professionals closely interact, is recognised as best practice in the field of community child health. Community child health services enable families to develop their protective factors and build resilience, promoting parenting confidence, self-efficacy, social networks and supports. By using evidence based developmental strategies and tools, they are able to identify and address the health needs of the child and their families through comprehensive assessment and provision of appropriate interventions.

The speciality of community child health has specific knowledge, skills and training in caring for children and families, and staff are well placed to identify and consider their health needs at an individual child, family and population level. It is recognised as a field of speciality paediatric practice by the Royal Australasian College of Physicians and Child and Family Health Nursing is a post graduate degree available to Registered Nurses in Australia.

Community child health specialists work with a family centred focus to enhance parents, families and carers confidence to build on their capacity to develop skills in the parenting role. They promote wellbeing, preventing illness and disease by identifying early those children and families that need extra supports enabling timely access to appropriate

services. They also work in partnership with families to build on strengths in the family. They are advocates for equitable access to services and addressing the social determinants of health. They are essential in informing policy in improving child health and well being and in conducting research and evaluations of child health and child health services.

What services are provided?

Community Child Health provides population and community based non-acute services for children and adolescents and their families. Health professionals work collaboratively with colleagues, multidisciplinary health care teams and other service providers to provide comprehensive health care to children. Strategies targeting child, youth and family health focus on health promotion, and illness prevention from a community health perspective. The most gains for child and family health can be achieved through a systematic and coordinated approach across the health sector with a equitable continuum from universal to acute care as required.

Child and family health services are delivered within the context of the Families NSW philosophy, which recognises that supporting families and children in the early years of life will have a lasting health and social impact. Many authors have described research conducted on programs aimed at parents and children, especially as the scientific evidence regarding the importance of early experience on brain development has never been stronger or more compelling (Centre for Parenting and Research Service System Development, 2007; Shonkoff, J. P. 2003; Hertzman, C. 1999; Olds, Sadler and Kitzman, 2007; National Program on Early Childhood Program Evaluation, 2007). Services are also closely linked with other policy directive programs such as Keep Them Safe, Out of Home Care strategy, Supporting Families Early, Disability Action Plans and many early intervention programs.

Child and family health services encompass a range of service modalities including Aboriginal Infant Maternal Health, Child and Family Health Nursing, Specialist Paediatrics, Speech Pathology, Occupational Therapy, Physiotherapy, Orthoptics, Dietetics, Audiometry, School Health, Counselling and Therapy Services, Mental Health, Sexual Assault Services, Genetic Counselling, Domestic Violence Programs and appropriate family support services.

Community child health is part of an established network of government funded health services and NGO's working in partnership to provide a range of preventative, assessment and early intervention based services that address the health and biopsychosocial well being of children, their families and carers and an evidence based approach to improving child health and well being at a population level. Staff provide home visiting, counselling, case management, child developmental surveillance, immunisations, early family education and support, prevention, health promotion and early intervention and therapy. This care is provided in a variety of settings such as the family home, school, preschool, playgroup, community health centre, etc.

Community child health fills a gap where generalist health services are not able to manage the special needs of children and families and are not always child focussed with the specialist expertise required. Many of the services provided to children and families are not available elsewhere in the community. There are perceived cultural, social and financial barriers to families accessing services in the private sector. Community Health based services are proactive and outreach to communities and provide equitable access to essential primary health care particularly for vulnerable children and their families. Aboriginal families would be particularly disadvantaged without community child health.

Importance of universal and targeted services

Studies have pointed to the potential benefits of universal, broad based programs which identify a high proportion of families at specific risk (Center on the Developing Child at Harvard University, 2007). Universal services/interventions aim to engage all families and provide support to them eg. universal home visiting of families with newborns, hearing and vision screening. It is based on universality of access, equity and fairness ensuring everyone gets similar services based on needs, assessment and intervention. It is non-stigmatising and engages those families who do not ordinarily access services and need extra support, thus ensuring connection to other services families may require. Universal programs such as the Child and Family Health Nursing and the Aboriginal Infant Maternal Health program are essential as they provide an early access point into the health service allowing for early assessment, intervention and treatment modalities. Universal interventions provide an opportunity for specialist staff to address common childhood

issues across communities. This is a cost effective mechanism which provides for health delivery across specific age groups/communities.

Targeted interventions are those which may target specific populations or groups, additional support for those at risk or vulnerable or have specific health conditions eg developmental delay, prematurity, low socioeconomic status or teenage parents. These interventions actively engage those families who need additional support and may not otherwise access services. Some studies demonstrate benefits from targeting populations that need, want and can benefit from services provided (Gutelius, et al, 1972; Koniak-Griffin et al, 2003; and Butz, et al, 2001). Targeted interventions ensure that individual child health issues are able to be addressed by health professionals who hold specific skills or qualifications. Targeted programmes are equally important to target those who are not able to access universal programmes or where there are barriers to this. This includes the provision of specific services for Aboriginal women and babies, teenage mothers, CALD communities and where mental health or drug and alcohol issues are present. Watson and Tully (2007) say that programs which have demonstrated the potential to improve parenting skills and decrease behaviour problems in children should be targeted at parents who need to learn specific behaviour management skills.

Potential impacts of community child health services include*:*

- Decreased presentations to the Emergency Departments and GPs.
- Decreased admission rates to acute facilities.
- Decrease rate of presentation of post natal depression in both men and women to acute facilities.
- Increased rate of immunisation, therefore decreasing the risk of communicable disease outbreak.
- Decrease in social cost and financial burden on the whole community.
- Decreased child protection rates and presentations, lower infant mortality.
- Decrease in children presenting to school ‘not school ready’- Fewer children experiencing learning and school issues leading to increased educational outcomes which are directly linked to good health outcomes in adulthood.
- Decreased rate of Juvenile Justice presentations.

- In the absence of community child health there would be lack of early recognition and early intervention in the life of health problems adding to the future health care burden/costs to the community.
- Children's needs are prioritised and do not have to 'compete' with adults for services/funding.

Complexity of work and skills required

Community child health requires clinicians from nursing, allied health and medical backgrounds who have specialised knowledge of infant, child and adolescent physical and emotional development, childhood illnesses and conditions and their effects of the social determinants of health on growth, wellbeing and development. Many conditions are unique to infancy, childhood and adolescence or have their origin in this period of life but have the potential to have long term impacts into adulthood. Child and Family Health staff have training and competencies to work in this field. It is known that practitioners in early intervention programs need to be well-trained and have excellent interpersonal skills (Watson and Tully, 2007). In the policy direction document, written by the NSW Commission for Children and Young People, the Commission for Children, Young People and Child Guardian and NIFTEY (2009), there is a call to raise the qualifications of staff working in children's services where staff have, as a minimum, child development and family centred practice training.

Community child health also requires specialised knowledge of the impact of family, school, culture and community on child development and well being (the bio-psychosocial model) at an individual and population level. Program evaluation research indicates several strategies can be effective for young children and families. These include home visiting by specialised nurses or highly trained practitioners. Using professionals is especially important in cases of maternal depression (Olds, Sadler and Kitzman, 2007: Ialongo et al, 2006).

Community child health specialists also require an understanding and applicability of a primary health care/social view of health model and philosophy; an understanding of local communities needs; an understanding and applicability of the context of the child in relation to their family/carers and an understanding and applicability of child development

models and practice. Knowledge of referral pathways and services for children and families and ability to work within a multidisciplinary and interagency framework is crucial.

Essential is a willingness and commitment to work with children and their families/carers in a multidisciplinary model. The specific disciplines that should have a place in all community child health services include Aboriginal Maternal and Infant Health, Child and Family Health Nursing, Specialist Community Child Health Paediatrics, Speech Pathology, Occupational Therapy, Physiotherapy, Audiometry, School Health, Counselling and Therapy Services, Mental Health, Sexual Assault Service, Genetic Counselling, Domestic Violence Programs and appropriate family support services.

Community child health specialists must also have an intimate knowledge of the child protection system, programs such as Keep Them Safe and reporting requirements. Clinicians are also increasingly expected to respond to S248 requests for information, case conferencing from Community Services to assist with risk assessment, participation in JIRT assessments and debriefing and assessments of children in out of home care. Adding to the workload is the increasing complexity of presentations requiring knowledge of domestic violence, drug and alcohol, mental health and child protection systems and interventions eg. referrals from Child Well Being Units, JIRT, Community Services, Out of Home Care.

Particulars for rural and remote

Providing a community child health service, like many other services in rural and remote areas is faced with particular difficulties such as adequate staffing levels and strategies for recruitment and retention of rural staff across all disciplines. Rural and remote communities have raised issues regarding limited access to: transport, coordinated (multi disciplinary) specialist services, after hours health-support and access to local health services (wait lists).

Needed are adequate training budgets to 1) ensure the appropriate clinical education and support of health professionals and 2) improve their professional networks and 3) adequate transport budgets to service clients in remote areas and to attend training. Acknowledgement of Casemix in rural and remote areas is required. Often lacking in these settings are health promotion staff such as those within the Rural Health Program to liaise

with communities, teachers, families and carers to support clinicians and promote positive outcomes.

Communities with high ATSI populations should have specific services targeted to the needs of this population group in effort to “close the gap”.

Funding models

Funding for child and family health service should be a planning and service priority of all levels of government. Various groups have called for an increase in public investment in early childhood expenditure. Funding should assist the integration of universal, targeted and sustained models at a local level and should reflect the health, social and economic needs of the community. Funding should be based on demographic population data and the prevalence of child development issues. Funding for child and family health services should be quarantined at the health service level, ensuring generational equity with other funding/clinical streams such as acute and aged care service/chronic care service provision. Funding should include health promotion staff to support clinical staff. There should be increased funding for sustained home visiting to enhance service provision, as well as provision within budgets for leave relief for all practitioners.

Funding should be based on a range of universal indicators applied to all health services, however communities deemed to have high at-risk factors (unemployment/low income rates, % of single parent families etc) should attract specialised or targeted funding. Funding should be identified by site/FTE with guaranteed maintenance of staff establishment and goods and services budget. Proper evaluations of community child health programs should be factored into the budget to ensure cost effectiveness and sustainability of such programs (Watson and Tully, 2007).

Conclusion

This discussion paper has described the important role of Community Child Health services and the need for specialised staff with expertise and skills specific to this field to deliver quality universal and targeted services. Community Child Health services have clearly established partnerships with both internal and external partners to provide a link for families between hospital and community services. Through the use of appropriate clinical pathways safe quality care can be provided for families. Community Child Health

services are positioned strategically as a key link for the implementation of whole of government approaches including Keep Them Safe and Families NSW.

Community Child Health services support the implementation of Public Health priorities such as health promotion, prevention and early intervention to enhance physical and mental wellbeing and socio-emotional development as well as strategic policies addressing issues such as the obesity epidemic, immunisation, breastfeeding and nutrition, readiness for school, early detection and intervention for developmental disability and autism, violence protection, decrease in SIDS, importance of the early years and infant mental health, environmental tobacco exposure, child safety and injury prevention

Community Child Health Services must be maintained and supported in order that families have equitable and timely access to these essential services.

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