For information on
13 February 2007

CoP TFCY Paper 1/2007

Commission on Poverty
Task Force on Children and Youth

Comprehensive Child Development Service (0-5 Years): Review of Pilot Implementation

Purpose

This paper informs Members of the review findings of the pilot implementation of the Comprehensive Child Development Service (0-5 Years) (CCDS) in four selected communities.

Background

2. The pilot CCDS aims to identify and meet the varied needs of children of 0 to 5 years and their families at an early stage. On the basis of district needs and demographic characteristics, we launched the pilot in the Maternal and Child Health Centres (MCHCs) of the Department of Health (DH) in phases in Sham Shui Po, Tin Shui Wai, Tuen Mun and Tseung Kwan O starting from July 2005. Built on the existing services provided in MCHCs, hospitals of the Hospital Authority (HA), the Integrated Family Service Centres (IFSCs) of the Social Welfare Department (SWD) and Non-Governmental Organizations (NGOs), and pre-primary institutions, the pilot CCDS model is made up of the following components: -

(a) identification and holistic management of at-risk pregnant women;

(b) identification and management of mothers with postnatal depression (PND);

(c) identification and management of children and families with psychosocial needs; and

(d) identification and management of pre-primary children with physical, developmental and behavioural problems.

3. The CCDS model is underpinned by the collaboration of Maternal and Child Health (MCH) nurses / doctors of DH; paediatricians, psychiatrists and midwives under HA; social workers in IFSCs and pre-primary educators at the community level. To enhance intersectoral collaboration, we have developed a formal referral and reply system to strengthen the communication between the participating organisations in the pilot communities.

4. A total of $30 million recurrent resources have been allocated to implement and improve the CCDS pilot, and for extending the CCDS to a few more communities. A review of the pilot implementation has recently been completed. The Executive Summary of the report is at Annex.

Review

Scope and timeframe

5. The review covers the implementation experience in the four pilot communities from July 2005 to September 2006. It attempts to answer the questions: "Did the CCDS work?", "What worked?" and "Why and how did it work?"

Methodology

6. The evaluation includes both formative and summative evaluation. Quantitative and qualitative data are collected, including training evaluation, service statistics, client and staff feedback, and client outcomes. The formative evaluation examines the structural and process changes to reflect whether the implementation has been proceeding according to plan, how this has impacted on the intermediate outcome (quality of services) and the conditions necessary for the successful implementation. The data collected has also been used to inform service improvement. The summative evaluation focuses on whether there are changes in the quality of services.

Findings

Identification and holistic management of at-risk pregnant women

7. Based on district needs, at-risk pregnant women, including illicit drug users, teenage mothers, pregnant women with mental illnesses, suspected victims of domestic violence, single mothers and other pregnant women with important clinical

conditions (e.g. mother with sexually transmitted disease, physical disability, etc.) are identified as the target clients in the four pilot communities.

8. About 90 at-risk pregnant women have been identified. There is a great enhancement in the collaboration and communications between the obstetrics, peadiatrics and psychiatry departments in HA hospitals, as well as the collaboration between HA hospitals and other relevant service providers (including MCHCs and social service agencies) in supporting target clients. High-risk mothers with bookings in HA's antenatal clinics will be screened and managed by designated midwives during the antenatal period until the clients are followed up in MCHCs.

9. Under the pilot, service access is enhanced by outreaching to the targeted at-risk pregnant women and enabling early identification of at-risk pregnant mothers that need special attention and intervention. For example, as more pregnant women with drug-abuse are identified during early pregnancy, clients could have more time to make important decision about their pregnancy. The provision of such services has been made possible through business re-engineering and re-deployment of existing resources of the NGO concerned.

10. Clients are highly appreciative of the integrated service and the professional support provided by doctors, nurses and social workers. Many clients are able to make informed decisions on their pregnancy and lifestyle subsequent to their enrollment in the CCDS. The experience in Sham Shui Po has in particular showcased how the collaboration between specialist NGOs, HA hospitals and IFSCs could help "hard-to-reach" mothers and their children. In Sham Shui Po, the CCDS has strengthened the linkage between medical professionals and social workers specializing in serving high-risk clients. It has also rallied more intensive professional support from other social and health care workers for those cases. We have witnessed some promising initial results in some clients, including an increased rate of successful detoxification and proportion of stable methadone users among heroin-abused mothers, as well as improved vaccination coverage rate of their children.

Identification and management of mothers with postnatal depression

11. Under the CCDS pilot, MCH nurses are trained to identify mothers with probable PND using the Edinburgh Postnatal Depression Scale (EPDS) and to provide them with supportive counselling. In addition, visiting psychiatric nurses from HA

hospitals provide on site counselling and specialized support to mothers with special need. Where necessary, mothers are referred to psychiatry departments in HA hospitals for further management, including consultation and medication.

12. About 1 200 mothers were identified to be probable PND cases during the period. Over 60% of them have subsequently received counselling service by MCH nurses. About 30% of those mothers were followed up by visiting psychiatric nurses at MCHCs. Those with more serious or urgent conditions are referred to psychiatric departments or the accident and emergency departments in HA's hospitals. About 10% of these mothers were also followed up in IFSCs.

13. Service statistics indicate an increase in service access for postnatal mothers in need of mental health support. More clients have been identified and supported by appropriate services, such as counselling by MCH and visiting psychiatric nurses, as well as social service support. Clients have commended the support of MCH nurses and visiting psychiatric nurses, though there is still a degree of reluctance among some to accept referral to psychiatrists due to the perceived stigma and inconvenience in attending consultation in specialist clinics of the regional hospital. Compared with the usual practice of clinical assessment, preliminary results also indicate better client mental health outcome under EPDS screening. Nonetheless, clients who do not personally attend MCHCs are not able to access PND assessment.

Identification and management of children and families with psychosocial needs

14. With an emphasis on strengthening support for clients from socially disadvantaged background, MCH nurses are trained to enhance their interviewing skills and to use a systematic assessment tool, the Semi-Structured Interview Guide (SSIG)[1], to facilitate the early identification of the psychosocial needs of children and families with preset demographic attributes, including extended and single parent families, low income families, new arrival families and families with one parent who is a two-way permit holder. Subject to their consent, families identified are followed up in IFSCs to receive appropriate services, including individual counselling or supportive group activities. Social workers may also meet the clients in MCHCs by

[1] The SSIG is developed by a team of psychologists and doctors of DH for MCHC nurses. It aims to increase their awareness and facilitate them to use a more systematic and structured interview techniques, through the use of probing questions, to identify and assess the social service needs for groups of families with certain preset demographic attributes.

appointment if necessary.

15. Over 3 600 families were assessed for their psychosocial needs. Probably due in part to the demographic characteristics of the pilot communities, the majority of families assessed are extended families, low-income families, families with one parent on two-way permit, new arrival families or families with parents with low educational level. About 10% were referred to IFSCs for follow-up for reasons including emotional, marital, child care and financial problems. There was an increase in the number of referrals to IFSCs in comparison with the service statistics before the implementation of the CCDS pilot. We have also observed increased acceptance of referrals to IFSCs by those clients, with the majority of them (about 70%) accepting referrals. In case where the clients still perceive the use of social service a stigma, a more detailed introduction to IFSC services along with follow-up interviews, have been useful to encourage service acceptance. Overall, there has been an improvement in service access.

16. Clients generally appreciate the support of MCH nurses and social workers. MCH nurses have expressed concern on the privacy issue when clients need to discuss their personal problems in open-plan facilities. In addition, clients who cannot personally turn up at MCHCs may not be able to access the service.

17. There is an improvement in the mental health outcome among those who returned the pre- and post-intervention mental health questionnaire at six months after social service intervention or on case termination by IFSCs.

Identification and management of pre-primary children with physical, developmental and behavioural problems

18. Pre-primary institutions in pilot communities may make use of CCDS's referral and feedback mechanism to refer children displaying physical, developmental or behavioural problems to MCHCs for assessment. Training has been provided to pre-primary educators to identify and support children in need.

19. Nearly 100 pre-primary children were referred by pri-primary institutions to MCHCs for assessment. Though direct invitation letters were sent to the pre-primary institutions in the pilot communities, about 40% of them replied in a survey that they were not aware of the CCDS. The reasons for those who did not participate in any CCDS training activities were either because they were not aware of

the training or the lack of time and manpower. Some pre-primary educators also reflected that they were receiving or had received similar training in their teacher education courses. That said, pre-primary educators who have used the referral system are satisfied with the CCDS.

20. According to pre-primary educators, most parents are receptive to referring their children to MCHCs for assessment. The default rate of MCHC appointments and the decline rate of subsequent recommended services, such as multidisciplinary developmental assessments at the Child Assessment Service, parenting programmes at MCHCs or speech therapy at HA, is low.

Critical success factors

21. In analysing the critical success factors of the CCDS, we note that having visiting psychiatric nurses and social workers in MCHCs, as appropriate, reduces the stigmatization and inconvenience to receiving psychiatric and social services. The arrangement is pivotal to increasing the access of clients to those services. As demonstrated by the component targeting at-risk pregnant women, the service accessibility of the socially disadvantaged groups is further enhanced by the outreaching and one-stop service. Clients' perception of the competence and professionalism of frontline service providers contributes significantly to their confidence in the latter. With empathy, a caring attitude, perseverance, and good knowledge of services available, health and social workers are able to encourage clients to share their personal difficulties and accept service referrals. As regards intersectoral collaboration, mutual respect, open communication, responsiveness and flexibility in service delivery and experience sharing are instrumental in ensuring that clients receive the most appropriate services.

22. On the other hand, the lack of privacy for clients when they were interviewed by MCH nurse may have hampered the desire of clients to disclose their personal difficulties. The increased workload, manpower deficiency, the lack of a sense of self-efficacy may have also caused higher stress and lower morale for some MCH staff. It may in turn affect the quality of service delivered.

23. In summary, statistics and client feedback show that the CCDS pilot has resulted in **increased service access** and **improved service acceptability** through structural improvements and process changes. There is still room to encourage greater participation of pre-primary institutions. The two components aiming at

identifying and managing at-risk pregnant women and families with psychosocial needs have particularly **strengthened the support to the socially disadvantaged groups** by proactively connecting health and social services to them. There is initial data to suggest an **improvement in the mental health outcome** of postnatal mothers with probable PND identified through EPDS screening, as well as those who have received social services. The existing service statistics only demonstrate the preliminary results of the CCDS pilot for one-and-a-half years, and they are not conclusive of the model's long-term effectiveness. More time is required to monitor the long-term efficiency of CCDS.

24. Notwithstanding the above, the evaluation results suggest that the CCDS model is worth pursuing. While the CCDS will not address all the problems of young children and their families due to a host of reasons outside the scope of the CCDS, there is early evidence indicating that the CCDS can achieve its primary objective, i.e. the early identification and the support of the needs of young children and their families.

Recommendations

25. While we are encouraged by the positive results of the CCDS pilot, we have identified the following areas of possible enhancement:-

Manpower, training and team building

26. To ensure the smooth implementation of the service, there should be adequate professional staff to meet the increase in workload. Staff should be adequately briefed and trained beforehand. Teamwork should be strengthened to enhance staff morale and to ensure smooth implementation of the service.

Intersectoral collaboration

27. Although the pilot CCDS has enhanced intersectoral collaboration, we should encourage more information sharing, mutual visits, case discussion and flexibility in managing service boundary issues to better meet clients' needs. Referral procedures and record keeping should be streamlined to reduce workload.

Facilities

28. There should be sufficient interview rooms in MCHCs to ensure privacy for interviewing clients. A computerised data management system should also be made available to enhance the efficiency in processing statistics.

Service coverage

29. Despite its universal nature, the CCDS pilot has not reached potential clients who do not visit MCHCs personally. We are looking into ways to improve service coverage, say by advancing the PND assessment to six week postnatal when most mothers are still on maternity leave. The possibility of having visiting psychiatrists at MCHCs would be explored to further reduce the barrier for women with PND requiring further management by psychiatrists. The utilization of the CCDS by pre-primary institutions could be enhanced through more intensive service promotion at the district level. We are also considering providing briefing and training materials through more user-friendly means, such as producing audio-visual aid instead of providing direct training to pre-primary educators.

30. Improvement measures to address the implementation issues identified during the pilot, including the renovation of MCHCs, extra briefing sessions and more structured training programme to enhance the clinical skills of MCH nurses, setting up of computer interfacing system between HA, DH and IFSCs, etc., have been completed or under planning.

Follow-up Services

31. We are conscious of the need to enhance the follow-up services to deal with the varied needs of children and families identified under the CCDS. To this end, additional resources have been allocated to IFSCs and other relevant social service units to launch a Family Support Programme to reach out to vulnerable families which are unwilling to seek help. Some IFSCs in pilot communities have also organized programmes tailored to families' needs, such as emotional support and home help, according to community circumstances. We will also closely monitor the impact of the CCDS on follow-up services and strengthen downstream support as and when appropriate.

Way Forward

32. In view of the encouraging results of the CCDS pilot, we plan to extend the CCDS to other communities in phases. We will extend the CCDS to Tung Chung, the whole district of Yuen Long and Kwun Tong in 2007 as a start.

33. Subject to additional resources, it is our plan to implement the CCDS territory-wide in the long term. The pace of the extension is contingent on district needs and operational readiness of the various implementing agencies. In the interim, we will continue to monitor the progress of implementation, collate service statistics, identify gaps and pressure points in service delivery and fine-tune the CCDS model as appropriate.

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February 2007