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Legislative Council Panel on Welfare Services
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 health and social 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 health, social welfare and pre-primary services at the district level, the pilot CCDS model is made up of four components, viz, the identification and management of: -

(a) at-risk pregnant women;

(b) mothers with postnatal depression (PND);

(c) children and families with psychosocial needs; and

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

3. The CCDS model is underpinned by the multidisciplinary collaboration of nurses, medical practitioners, social workers and pre-primary educators to provide more comprehensive support to children and families in need. Needy children or at-risk pregnant women or families are identified at an early stage and referred to different health and social services units to receive early intervention services. To enhance cross-sectoral collaboration, we have developed a formal referral and feedback system to strengthen communication between the service providers involved in the pilot communities.

4. A total of $30 million recurrent resources have been allocated to implement, improve and partially extend the CCDS pilot. The bulk of the new provision is used to enhance staffing support in order to launch the CCDS in MCHCs. A review of the pilot implementation has recently been completed. The full report of the review has been uploaded to DH's website, at http://www.fhs.gov.hk/english/reports/files/ccds_full.pdf.

Review

Scope and methodology

5. The review covers the implementation experience in the four pilot communities from July 2005 to September 2006. In view of the time constraint, it is a concurrent formative and summative evaluation on the basis of a range of quantitative and qualitative data, including service statistics, client and staff feedback, the evaluation of training and case progress reports.

6. By **formative evaluation**, we seek to examine whether the structural and process changes to service delivery as introduced by the CCDS have been implemented as planned. For example, we have to consider whether the deployment of expertise across different organisations and measures in improving the communication between different service providers have been carried out according to the design of the CCDS model. The formative evaluation also seeks to assess how those changes have impacted on the quality of services and to identify the conditions necessary for their successful implementation. On the basis of service statistics and

client and staff feedback, we have improved the CCDS model on an ongoing basis.

7. By **summative evaluation**, we focus on whether there are changes in the quality of services.

Findings

8. The major evaluation findings of the four CCDS components are set out in the following paragraphs.

Identification and management of at-risk pregnant women

9. At-risk pregnant women, including illicit drug users, teenage mothers, pregnant women with mental illnesses etc., are identified as the target clients in the pilot communities. Target clients with bookings in the antenatal clinics of the Hospital Authority (HA) are screened and managed by relevant professionals, with midwives designated as the coordinators during the antenatal period, until visiting pediatricians from the HA in MCHCs follow up the cases. About 90 at-risk pregnant women have been identified during the trial period.

10. The review shows that under the pilot, the early identification of at-risk pregnant women has improved significantly their access to various health and social services. For example, as more pregnant women with drug abuse are identified during early pregnancy through the proactive effort of a non-governmental organization (NGO), they 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. Among the 47 at-risk mothers who gave birth during the trial period, seven (out of 15 mothers with drug abuse) underwent drug detoxification successfully or stopped drug use after delivery. While over half of those mothers had either no or improper contraception before pregnancy, all of them have adopted proper contraceptive practices after delivery. Their babies also have full vaccination coverage designed for their age.

11. Clients are highly appreciative of the integrated and multidisciplinary service and professional support they received under the CCDS. Many clients are able to make informed decisions on their pregnancy and lifestyle subsequent to their enrollment in the CCDS. For example, we have witnessed in Sham Shui Po some promising initial results in some clients. Among those 11 mothers with heroin addiction who had given birth, three underwent successful drug detoxification and eight became stable methadone users. Their babies have full vaccination coverage proper to their age.

Identification and management of mothers with postnatal depression

12. Under the pilot, Maternal and Child Health (MCH) nurses are trained to identify mothers with probable PND using the Edinburgh Postnatal Depression Scale (EPDS), and to provide those mothers with supportive counselling. 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 follow up, including consultation and medication.

13. About 1 200 mothers were identified as probable PND cases during the period. For management of mood problems, about 66% of them have subsequently received counselling service by MCH nurses, while about 28% were followed up by the visiting psychiatric nurses at MCHCs, with some mothers having received counselling by both MCH nurses and visiting psychiatric nurses. In addition to receiving mood management services, less than 10% of these mothers were referred to the Integrated Family Service Centres (IFSCs) to receive social services support.

14. Service statistics indicate that more postnatal mothers in need of mental health support have been identified to receive mental health and social services. Clients commended the support of MCH nurses and visiting psychiatric nurses, though there is still a degree of reluctance among some to accept referrals to psychiatrists due to a perceived stigma and reluctance to attend the specialist clinics. Initial findings show that mothers who underwent the EPDS screening report a better mental health outcome than those who received usual clinical assessment.

Identification and management of children and families with psychosocial needs

15. With an emphasis on strengthening support for clients from socially disadvantaged background, MCH nurses are trained to use a systematic psychosocial need assessment tool, the Semi-Structured Interview Guide (SSIG)[1], in interviewing 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 to be in need are referred to IFSCs to receive individual counselling, supportive group activities etc. Social workers may also meet the clients in MCHCs by appointment if necessary.

16. During the period of trial, over 11 700 new born babies aged under one registered in the pilot MCHCs. Of which, about 31% or 3 680 families were assessed for their psychosocial needs. The majority of families assessed were extended families, low-income families, families with one parent on two-way permit, new arrival families or families with parents with low educational level.

17. Initial findings show that there was an increase in the number of referrals to IFSCs in comparison with the service statistics before the implementation of the pilot. Of those 3 680 families assessed for their psychosocial needs, about 16% or 600 cases were identified with psychosocial needs and recommended for referrals to IFSCs for follow-up support services. Among this group, about 70% or 420 cases accepted such referrals mainly to the 14 IFSCs in the pilot communities on account of, *inter alia*, emotional, marital, child care and financial problems. In cases where the clients still perceive the use of social services a stigma, a more detailed introduction to IFSC services along with follow-up interviews, have been useful to encourage service acceptance.

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

18. Clients generally appreciated the support of MCH nurses and social workers. The mental health outcome of the clients who completed the pre- and post-intervention questionnaire at six months after social services intervention or on case termination has improved. However, MCH nurses have expressed concern on the privacy issue when clients have to discuss their personal problems in open-plan facilities.

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

19. Pre-primary institutions in pilot communities may make use of the CCDS 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 with these problems.

20. During the trial period, 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 service.

21. 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.

Observations

22. The existing service statistics demonstrate the preliminary results of the 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 effectiveness of CCDS. That notwithstanding, the evaluation results thus far suggest that the CCDS model is worth pursuing. While the service 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 of young children and their families in need and early intervention in meeting those needs.

23. The CCDS has strengthened cross-sectoral collaboration. Service statistics and client feedback show that more children and families in need have accessed and accepted different health and social services. 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 them to health and social services. There is also initial data to suggest an improvement in the mental health outcome in some client groups.

24. On the basis of our implementation experience, we note that having visiting psychiatric nurses and social workers in MCHCs, where appropriate, reduces the stigmatization and inconvenience to receiving psychiatric and social services. The knowledge, skills and attitude of the front line professionals is also pivotal to the successful implementation of the service. The perception of clients on 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, both health and social workers are able to encourage the clients to share their personal difficulties and accept service referrals. As regards cross-sectoral 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.

25. On the other hand, the lack of privacy for clients when they were interviewed by MCH nurses may have hampered their desire to disclose their

personal difficulties. The additional workload, the lack of a sense of self-efficacy etc., may have also caused higher stress and lower morale for some MCH staff. Besides, despite the universal nature of MCHC services, the CCDS pilot has not reached potential clients who do not visit MCHCs personally. There is also room to encourage greater participation of pre-primary institutions.

Recommendations

26. As part of the formative evaluation, improvement measures to address the implementation issues, including the renovation of MCHCs, extra briefing sessions and more structured staff training programme, the development of a cross-sectoral computer interfacing system etc., have been completed or are under planning. While we are encouraged by the positive results of the CCDS pilot, we have also identified various areas for possible enhancement as follows: -

Manpower, training and team building

27. To ensure the smooth implementation of the service, there should be sufficient professional staff who are adequately briefed and trained to meet the increase in workload. Teamwork should be strengthened to enhance staff morale and to ensure smooth implementation.

Cross-sectoral collaboration

28. Although the pilot CCDS has enhanced cross-sectoral 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 mitigate workload.

Facilities

29. 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

30. We are looking into ways to improve service coverage, say by advancing the PND assessment to six week postnatal when most working 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.

Social services support

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 social services units to launch a Family Support Programme to reach out to vulnerable families which are unwilling to seek help, including those identified under the CCDS. We will closely monitor the impact of the CCDS on social services support and when necessary, follow up on the resource requirements.

Way Forward

32. In view of the encouraging outcome of the CCDS pilot, we plan to extend the CCDS to all districts in phases and strengthen social services support. We will extend the CCDS to Tung Chung, the whole district of Yuen Long and Kwun Tong in 2007-08 as our next step.

33. Subject to additional resources, it is our plan to complete the territory-wide extension of the CCDS by 2012. 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 and address gaps and pressure points in service delivery and fine-tune the CCDS model as appropriate.

Advice Sought

34. Members are invited to note the content of this paper.

Health, Welfare and Food Bureau
Education and Manpower Bureau
Department of Health
Hospital Authority
Social Welfare Department
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