For discussion on
14 February 2008

Legislative Council Panel on Welfare Services
Progress report on the implementation of Comprehensive Child Development Service

Purpose

This paper updates Members on the Administration's progress in implementing the Comprehensive Child Development Service (CCDS).

Background

2. The CCDS aims to identify and meet, at an early stage, the varied health and social needs of children aged between 0 and 5 and those of their families. As Maternal and Child Health Centres (MCHCs) serve about 90% of newborn babies in Hong Kong, the CCDS uses them and other service units[1] as a platform to identify at-risk pregnant women, mothers with postnatal depression (PND), families with psychosocial needs, as well as pre-primary children with health, developmental and behavioural problems. Children and families in need are referred to appropriate service units for follow-up.

3. The Administration first piloted CCDS in Sham Shui Po, Tin Shui Wai, Tuen Mun and Tseung Kwan O in phases, starting from July 2005. Last year, we completed a review of the pilot service and reported the findings to this Panel in April 2007. As the review affirmed that the CCDS model was worth pursuing, we decided to regularise the pilot services and extended CCDS to two additional MCHCs in Tung Chung and Yuen Long in 2007. CCDS will be fully extended to the two MCHCs in Kwun Tong in the first quarter of 2008.

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[1] Other service units include hospitals under the Hospital Authority, Integrated Family Service Centres / Integrated Services Centres and pre-primary institutions.

4. We would like to report the progress of the CCDS, in terms of -

(a) the latest service statistics and implementation experience (paragraphs 5 to 19 below); and

(b) improvement measures implemented since the last review (paragraphs 20 to 34 below).

Service Statistics and Implementation Experience

Identification and management of at-risk pregnant women

5. At-risk pregnant women, including illicit drug users, teenage mothers, pregnant women with mental illness, are identified and provided with various health and social services.

6. The latest statistics of at-risk pregnant women identified in the Kowloon West, Kowloon East and New Territories West Clusters (covering the pilot communities, Tung Chung and Yuen Long) are set out below -

Major Problem of the At-Risk Pregnant Women	**Nov 2005 to Oct 2006 (Pilot)** (mothers identified at antenatal stage only)	**Nov 2005 to Sep 2007** (mothers identified at antenatal stage ***and*** mothers followed up at postnatal stage)
Mental illness	26[2]	191
Substance abuse	24	168
Teenage pregnancies	41	113
Others (single mothers, mothers with sexually transmitted diseases, etc.)	N.A.[2]	50
Total	91	522

[2] No breakdown for at-risk mothers with mental illness and other risk factors, such as single mothers and mothers with sexually transmitted diseases, is available.

7. During the pilot stage, more pregnant women who were drug abusers were identified in early pregnancy. They had more time to make important decision about their pregnancy and modify their high-risk behaviour. Almost half of the 15 drug-abusing mothers who gave birth during the pilot period underwent drug detoxification successfully or stopped using drug after delivery. Over 40 mothers with different risk factors, including the drug abusers, delivered their babies during the pilot stage. Their babies had full vaccination coverage designed for their age.

8. After the regularisation of CCDS, some at-risk mothers followed up by community paediatricians of the Hospital Authority (HA) at MCHCs have shown initial improvement, including successful detoxification, significant reduction in smoking and the adoption of safe contraceptive practices. At-risk mothers identified in Tung Chung and Yuen Long have similar characteristics as those in other pilot communities. They also show similar improvements after using CCDS.

Identification and management of mothers with postnatal depression

9. With the aid of the Edinburgh Postnatal Depression Scale (EPDS), Maternal and Child Health (MCH) nurses seek to identify mothers with probable PND. Where necessary, mothers with symptoms of PND are counselled by MCH nurses or visiting psychiatric nurses. The more serious cases are referred to psychiatrists in hospitals under the HA for consultation and medication.

10. To further reduce the psychological barrier for mothers in need of psychiatrist services, visiting psychiatrists from HA have started to provide consultation sessions in the MCHCs in Yuen Long, Tuen Mun and Tseung Kwan O since mid-2007 to establish rapport with the mothers before following up their cases in HA hospitals. Similar arrangements will be extended to other districts depending on their service needs, etc.

11. While CCDS is extended to more districts, the service usage pattern is rather consistent with that at the pilot stage. Details are tabulated below -

	July 2005 to Sep 2006 (Pilot)	**July 2005 to Oct 2007**
Total no. of newly registered children (under one year old) at MCHCs implementing CCDS	11 702	29 301
Total no. of mothers with probable PND (% of all newly registered children (under one year old))	1 257 (10.7%)	3 463 (11.8%)
Follow-up services provided (a mother may receive more than one type of follow-up services)(% of mothers with probable PND)		
Management of mood problems • *Counselling by nurses of MCHCs* • *Counselling by visiting psychiatric nurses*	 831 (66.1%) 350 (27.8%)	 1 891 (54.6%) 974 (28.1%)
Referral to HA's visiting psychiatrists / Psychiatric Department / Accident and Emergency Department (more serious/urgent mental health problems)	44 (3.5%)	109 (3.1%)
Referral to Integrated Family Service Centres / Integrated Services Centres	120 (9.5%)	301 (8.7%)
Other MCHC services (including parenting programme, breastfeeding counseling, etc.)	421 (33.5%)	1 715 (49.5%)

12. Similar to the pilot experience, the two MCHCs in Tung Chung and Yuen Long identified significantly more mothers with probable PND after implementing CCDS. The monthly average percentage of mothers identified with probable PND increased from 2.8% (in 2006) to 14.9% (March to October 2007) for Tung Chung and from 3.7% to 8.8% for Yuen Long during the same period.

Identification and management of children and families with psychosocial needs

13. MCH nurses apply a systematic psychosocial need assessment

tool [3] 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 Integrated Family Service Centres (IFSCs) / Integrated Services Centres (ISCs) for follow up.

14. Upon receiving referrals from MCHCs, social workers at IFSCs / ISCs will thoroughly assess the needs and problems of the families and provide appropriate services. In addition to individual counselling, groups and programmes on stress management, marital and interpersonal relationship, parenting skills, etc., are offered to service users to enhance their capacity in problem-solving and facing life's challenges. Tangible services such as financial and housing assistance may also be provided. To reach out to mothers and children in need, social workers of IFSCs / ISCs stand ready to meet them and their families in MCHCs by appointment.

15. Families assessed by MCH nurses up to October 2007 have similar types of psychosocial needs as those identified in the pilot stage. Details are set out below -

	July 2005 to Sep 2006 (Pilot)	**July 2005 to Oct 2007**
Total no. of newly registered children (under one year old) at MCHCs implementing CCDS	11 702	29 301
Total no. of families assessed for psychosocial needs (% of all children newly registered (under one year old))	3 682 (31.5%)	10 042 (34.3%)
Total no. of families recommended for referrals to IFSCs / ISCs (% of families assessed)	601 (16.3%)	1 353 (13.5%)
Total no. of families accepting referrals to IFSCs /	421 (70.0%)	883 (65.3%)

[3] The tool is known as the Semi Structured Interview Guide. It is developed by a team of psychologists and doctors in the Department of Health for MCH nurses. It aims to increase their awareness of the clients' background and enables them to use more systematic and structured interview techniques to identify and assess the clients' social services needs.

	July 2005 to Sep 2006 (Pilot)	**July 2005 to Oct 2007**
ISCs (% of families with social service referral recommended)		
Top 5 reasons for referrals to IFSCs / ISCs (A family may be referred for more than one reasons)(% of total no. of families recommended for social service referral)		
Emotional problem	237 (39.4%)	525 (38.8%)
Marital problem	199 (33.1%)	518 (38.3%)
Financial assistance	190 (31.6%)	425 (31.4%)
Child care	198 (32.9%)	417 (30.8%)
Family relationship	142 (23.6%)	373 (27.6%)

16. As in the pilot stage, there was a marked increase in the number of families identified to be in need of social services support after the two MCHCs in Tung Chung and Yuen Long introduced systematic screening. From March to October 2007, the percentage of referrals to IFSCs / ISCs in Tung Chung and Yuen Long rose by two to three times when compared with the figures in 2006. The monthly average proportion of families referred to receive social services also increased from 0.6% to 1.6% in Tung Chung and from 1.9% to 3.9% in Yuen Long.

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

17. Pre-primary institutions may make use of the CCDS referral and feedback mechanism to refer children displaying physical, developmental or behavioural problems to MCHCs for assessment. Training is provided to pre-primary educators to help them identify and support these children.

18. More pre-primary children have been referred to MCHCs for assessment since the regularisation of CCDS. Details are as follows -

	July 2005 to Sep 2006 (Pilot)	**July 2005 to Oct 2007**
Total no. of children referred by pre-primary institutions to MCHCs for assessment	99	251
Top 5 reasons for referrals to MCHCs (A child may be referred for more than one reason)(% of total no. of children referred)		
Learning problem	45 (45.5%)	125 (49.8%)
Emotional / behavioural problem	46 (46.5%)	96 (38.2%)
Articulation / Language problem	28 (28.3%)	47 (18.7%)
Parenting problem	11 (11.1%)	25 (10.0%)
Physical health problem	7 (7.1%)	13 (5.2%)
Top 5 provisional diagnosis by MCHCs (A child may be diagnosed to have more than one problem)(% of the total no. of children with assessment completed[4])		
Articulation problem	24 (24.5%)	47 (21.8%)
Developmental delay	12 (12.2%)	39 (18.1%)
Normal	14 (14.3%)	36 (16.7%)
Emotional / behavioural problem	14 (14.3%)	35 (16.2%)
Language delay	9 (9.2%)	29 (13.4%)
Parenting problem	18 (18.4%)	29 (13.4%)
Top 5 services recommended after MCHC assessment (A child may be referred to receive more than one service)(% of total no. of children with assessment completed)		
Detailed assessment at Child Assessment Service	41 (41.8%)	108 (50.0%)
Parenting progamme at MCHCs	22 (22.4%)	32 (14.8%)
Speech therapy at HA	16 (16.3%)	29 (13.4%)
Other MCHC services	13 (13.3%)	28 (13.0%)
No service recommended as child was already receiving service	6 (6.1%)	9 (4.2%)

[4] MCHCs have completed the assessment of 98 and 216 children during the pilot and in the period from July 2005 to October 2007 respectively.

19. To encourage pre-primary institutions to make use of CCDS, regional offices of the Education Bureau (EDB) have stepped up promotion at the district level. The number of parents who declined service appointments upon referral or who did not turn up for scheduled appointments remained low. Out of some 250 referrals from July 2005 to October 2007, only three families declined / failed to turn up for assessment by MCH doctors. Two families declined referral to Child Assessment Service or speech therapy at HA after the preliminary assessment in MCHCs.

Service Improvement since the Last Review

20. The review of the pilot experience has recommended a number of improvement measures to enhance the CCDS. Our progress in implementing these measures are summarised in the following paragraphs.

Manpower, team building and staff training

21. It was concluded in the review that there should be sufficient professional staff who were adequately briefed and trained to meet the increase in workload arising from implementing CCDS. Teamwork should also be strengthened to enhance staff morale and ensure smooth implementation.

22. Nurses at MCHCs have become more competent and confident in handling mothers with mood and psychosocial problems, as they accumulated more experience, and benefited from training, professional support from HA's visiting psychiatry teams and exchanges with social workers.

23. The concerns and needs of frontline staff have been closely monitored. Since the review, the Department of Health (DH) has developed a structured programme to consolidate the skills of nurses and doctors of MCHC in identifying and managing mothers with PND, which complements the professional support of the visiting psychiatry teams from HA. A peer support and quality management system is also being developed.

24. To better manage families with psychosocial needs, training has been provided to MCHC staff to improve their skills in assessing the clients' readiness for service referral and in motivating them to accept referral offers. The systematic tool for screening psychosocial needs has also been enhanced to incorporate these skills.

Cross-sectoral collaboration

25. In the review, we found that more information-sharing, mutual visits, case discussion and flexibility in delineating service boundary should be encouraged. Referral procedures and record keeping should also be streamlined to alleviate workload.

26. It has become a standing practice that prior to the extension of CCDS to a new MCHC, details of implementation will be discussed at the respective District Coordinating Committee led by DH. Moreover, briefings on the implementation are also provided to staff of IFSCs / ISCs and other social service Non-Governmental Organisations in the community. The staff of IFSCs / ISCs and MCHCs will also arrange mutual visits and share information to pave way for smooth and effective coordination.

27. To strengthen the support to families in need, regular / ad hoc case conferences involving representatives from MCHCs, IFSCs / ISCs and HA are held to discuss the management plan for certain at-risk clients.

28. To enhance the communication on service referrals among different service providers, DH, in collaboration with HA and the Social Welfare Department, is developing an e-bulletin board (i.e. a computer system) by which MCHCs, IFSCs / ISCs and HA can make referrals through the internet, share basic client information, their specific service needs and keep track of their attendance at different services. It will also facilitate the tracking of clients who do not turn up for scheduled service appointments. The e-bulletin board will be piloted in the Tseung Kwan O district by 2009-10.

Facilities

29. In the review, MCH nurses had expressed concern about privacy when clients had to discuss their personal problems in open-plan facilities.

To improve the situation, renovation work in MCHCs to install partitions and construct individual interview rooms has been completed or is in progress.

30. To increase the efficiency of ongoing service evaluation, a new computer system is being developed in MCHCs to capture client and service data and to minimise the workload of nurses in handling paper work. The system will be ready by the end of 2008-09.

31. Parent Resource Corners or Parent Resource Kiosks have been or will be set up in each MCHC to provide comprehensive information on child / family issues and related services and resources in the community.

Service coverage

32. In the review of pilot service, we noted that some mothers were unable to attend MCHCs to undergo EPDS screening because of work commitment. To address this problem, DH has exercised flexibility in conducting PND assessment either at the six-week postnatal visit (when most working mothers are still on maternity leave) or when the mother returns to MCHCs with her child for the routine child health visit for the two-month-olds. For mothers who do not turn up, EPDS questionnaires are sent to their homes for completion and return to MCHCs for follow-up. MCH nurses also monitor the mother's mood indirectly by asking about this when other family members accompany the child to MCHCs.

33. For the management of PND, a team comprising MCH nurses, psychiatric nurses and psychiatrists is now in place to provide a continuum of primary and secondary health care services in MCHCs. For this purpose, DH and HA have increased the number of visiting sessions by psychiatric nurses. Some MCHCs have also introduced consultation sessions by visiting psychiatrists. The aim is to reduce the psychological barrier of some mothers in accepting psychiatric treatment, as mentioned at paragraph 10 above.

34. To help pre-primary institutions participate in CCDS, EDB has uploaded information on CCDS and related referral forms to the EDB homepage, and is assisting DH in developing a special training kit for pre-primary educators. The kit aims to facilitate early detection, referral

and management of pre-primary children with developmental and behavioral problems. It will cover -

(a) an introduction of CCDS, MCHC and IFSC / ISC services and the service referral mechanism;

(b) knowledge in the normal development of pre-primary children and their common developmental problems;

(c) principles and skills in handling children with behavioral, emotional and learning problems in the classroom setting; and

(d) skills in motivating parents to accept service referral.

The kit is expected to be ready by the end of 2008.

Way Forward

35. In 2008-09, we will further extend the CCDS to Tsuen Wan and Kwai Tsing to serve more young children and families in need. We will continue to monitor its implementation and fine-tune the CCDS model as appropriate.

Advice Sought

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

Labour and Welfare Bureau
Education Bureau
Department of Health
Hospital Authority
Social Welfare Department
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