

Centre for Community Child Health





Improving children's health

Professor Frank Oberklaid September 5, 2012











Improving children's health through research, advocacy, training and service provision: Experience of the Royal Children's Hospital Centre for Community Child Health

Outline of presentation



- Major changes in child health three distinct but overlapping eras
- These changes are not yet reflected in training, organisation of services and paediatric practice
- Challenges and opportunities presented by these changes
- Examples of how CCCH attempts to address the consequent policy, service and practice issues

Evolving healthcare system

The First Era (Yesterday)

- Focused on acute and infectious disease
- Centred around hospital system
- Single cause and effect and treatment

The Second Era (Today)

- Increasing focus on chronic disease and disability
- Sub-specialization, increased technology leading to increased costs
- Multidisciplinary

The Third Era (Tomorrow)

- Increasing focus on achieving optimal health status for all
- Investing in population-based prevention
- Extends well beyond health care system

First era (1900 -1960's & ongoing) The Royal Children's Melbourne

- Health as absence of disease
- Model: infections single cause
- Mechanism: treatment of infection
- Mode of delivery: hospital, doctors' surgery
- Goal: reducing deaths

Second era (1960's - ongoing)

- Health as absence of disease, disability and dysfunction
- Model: multiple risk factors, behaviour, lifestyle
- Mechanism: chronic disease management and disease prevention
- Delivery mode: multidisciplinary, community agencies as well as hospital and doctors' surgery
- Goal: prolonging life and improving functioning

Second era



- Significant and ongoing changes to health care delivery - remains a work in progress
 - Hospital structures and philosophy
 - Changing morbidity patterns
 - Service delivery
 - Mode of clinical practice
 - Broadening of mission

Second era



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Service delivery



- Multidisciplinary clinics
- Programmatic (rather than departmental) approach to clinical problems
- New specialised multidisciplinary programs
 - Child development
 - Adolescent health
 - Rehabilitation
 - Pain management
 - International adoption/refugee health
- New academic centres
 - Centre for Adolescent Health
 - Centre for Community Child Health

Second era



- Significant and ongoing changes
 - Hospital structures and philosophy
 - Changing morbidity patterns
 - Service delivery
 - Mode of clinical practice
 - Broadening of mission



'A group of childhood difficulties that we have termed "the new morbidity" is now gaining attention. Many of these difficulties lie beyond the boundaries of traditional medical care... Handling such problems will be important to the future of pediatric practice, and a major shift in the orientation of training programs is required to prepare pediatricians for these tasks.'

- RJ Haggerty, 1975



'Health is affected by environmental and social processes as well as by sociological factors. The community in which a child lives is a major determinant of his health. Although such statements are widely accepted intellectually today, they are not yet reflected in our health care institutions.'

- RJ Haggerty, 1975

Second era



- Significant and ongoing changes
 - Hospital structures and philosophy
 - Changing morbidity patterns
 - Service delivery
 - Mode of clinical practice
 - Broadening of mission

Mode of practice



- Teams and partnerships
- Parent involvement
- Family centred practice
- Relationships with community providers

Second era

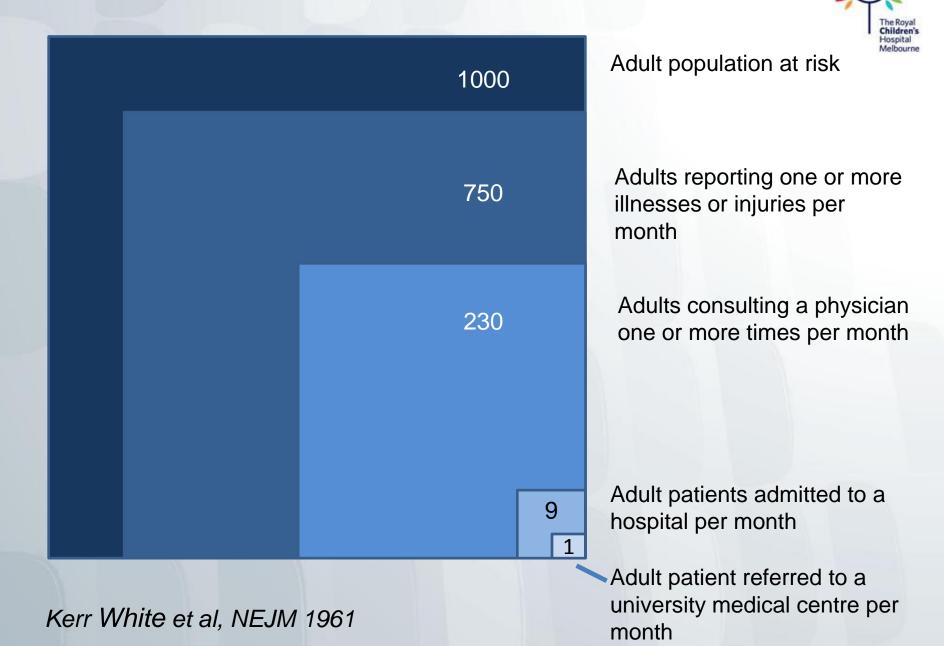


- Significant and ongoing changes
 - Hospital structures and philosophy
 - Changing morbidity patterns
 - Service delivery
 - Mode of clinical practice
 - Broadening of mission



'Most hospital paediatric admissions represent a failure of the health care system.'

- Dr Charles Janeway
Harvard Medical School



Broadening of mission



- System of health care, not just hospital
- Links and partnerships with community and with community based health services
- Beyond treatment of disease
 - Advocacy and public policy
 - Information, dissemination of knowledge, training and education of community providers
 - Prevention
 - Community based research

The second era



- Has catalysed and informed changes to hospitals and paediatric service delivery for a number of decades
- Will continue to pose many challenges for hospitals and policy makers in years to come





- Health as positive capacity to achieve life's goals
- Model: complex systems/social networks, geneenvironmental transactions across the life span
- Mechanism: health management and health promotion
- Delivery mode: multisectoral and including non-health agencies and professionals
- Goal: optimal health and well being for all

The third era



- Paradigm shift that builds on and expands on the significant accomplishments of the first 2 eras
- Drivers:
 - Broader definition of health
 - Changes in societal expectations
 - Emerging research about health and disease
 - Social gradients
 - Economics increasing cost of treatment and cost effectiveness of prevention/early intervention

Health - not just absence of disease

- Health is multidimensional
 - physical health and functional ability
 - psychological status and well-being
 - social interactions
 - education
 - economic and vocational status
 - religious and spiritual status

- Singer, Institute of Medicine -1998



Third era - underpinnings

- Ecological model of development (Bronfenbrenner)
- Changing morbidity patterns high prevalence rates of conditions such as mental health problems, obesity, child abuse, learning problems and ADHD...
- New knowledge about antecedents (including brain development) and early pathways (life course)
- Social gradient in health



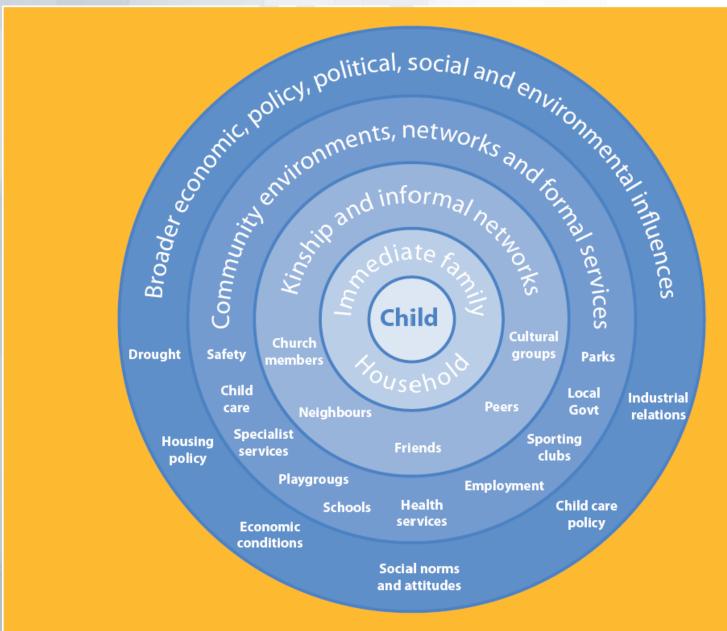
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The ecology of child development

The Royal Children's

Hospital



Reference: Bronfenbrenner (1979).



Third era - underpinnings

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Obesity in Victoria



1.1 million children age 2-18 years

- one in 5 overweight or obese

Very obese

Obese

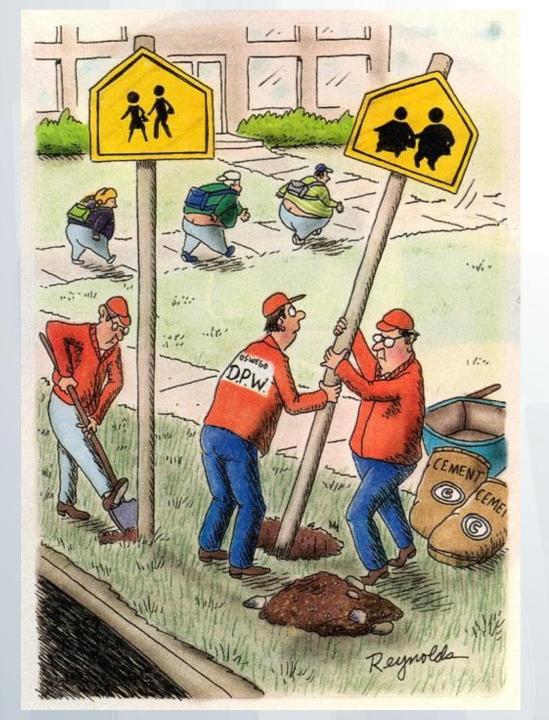
Overweight

Not overweight

22,000 seriously obese

33,000 obese

220,000 overweight





Mental health of children and young people in Australia



2000 - Sawyer MG et al. *Mental Health of Young People in Australia* (Child and Adolescent Component of the National Survey of Mental Health and Well-being - part of the National Mental Health Strategy

Canberra, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, 2000

Prevalence of mental health problems

	Total problems (Percentage)	Total problems (Pop.estimate)
All children	14.1%	521,886
Males 4-12	15.0%	181,749
Males 13-17	13.4%	90,678
Females 4-12	14.4%	166,817
Females 13-17	12.8%	82,221





Many conditions that make up the 'new morbidity' share a common characteristic: they are not principally health problems - they are social problems with health consequences

- after Schor, 1995





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What the research tells us



- The early years of a child's life are critical in impacting on a range of outcomes through the life course
- The environment experienced by a young child literally sculpts the brain and establishes the trajectory for long term cognitive and social-emotional outcomes
- If we want to improve outcomes in adult life we have to focus on the early years - this has profound implications for public policy
- Investing in early childhood is a sound economic investment ('the best investment society can make')



Children's development

- Development is the result of complex, ongoing, dynamic transactions between nature and nurture - a dance between biology and experience
- We cannot do much to change biology but we can change the environment in which young children grow and develop
- Optimal development dependent on good environment nutrition, good health, nourishing and stimulating parenting, etc

The neuroscience of brain development



- Brain architecture and skills are built in a hierarchical 'bottom-up' sequence
- Foundations important higher level circuits are built on lower level circuits
- Skills beget skills the development of higher order skills is much more difficult if the lower level circuits are not wired properly
- Plasticity of the brain decreases over time and brain circuits stabilise, so it is much harder to alter later
- It is biologically and economically more efficient to get things right the first time

The importance of relationships

- Nurturing and responsive relationships build healthy brain architecture that provides a strong foundation for learning, behaviour and health
- The relationships a young child has with their caregiver(s) literally sculpts the brain and influences the development of neural circuits
- When relationships are dysfunctional, levels of stress hormones increase - this interferes with formation of healthy neural circuits, and disrupts brain architecture

Toxic stress



- Strong and prolonged activation of body's stress response in absence of buffering protection of adult support
- Precipitants include extreme poverty, physical or emotional abuse, chronic neglect, severe maternal depression, substance abuse, family violence
- Disrupts developing brain architecture and leads to lower threshold of activation of stress management systems can lead to life long problems in learning, behaviour, and both physical and mental health

Adult problems with roots in early childhood



- Mental health problems
- Family violence and anti-social behaviour
- Crime
- Poor literacy
- Chronic unemployment and welfare dependency
- Substance abuse
- Obesity
- Cardiovascular disease
- Diabetes



Adversity

Any adversity that impacts on the parents or caregivers has the potential to have a negative impact on brain development in the young child and therefore act as a risk factor for the health and development of the child





- Leads to changes in DNA (methylation)
- 'Biological embedding of environmental events' (Hertzmann)
- Affects the development of biological systems
 - Immune
 - Cardiovascular
 - Metabolic regulatory
- What appears to be a social situation is likely to be a neurochemical situation - intergenerational nature of disadvantage and social exclusion





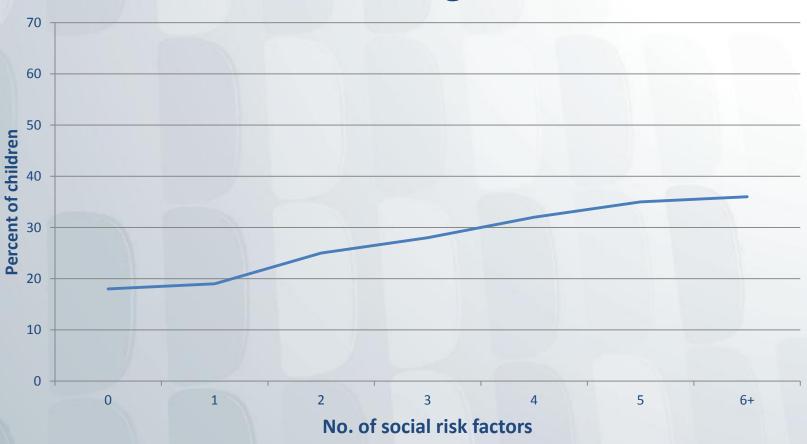
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- Less than high school education
- Low family income
- Single parent household
- Black/Hispanic
- Uninsured
- Family conflict
- Poor maternal mental health
- Unsafe neighbourhood
 - From Larson K et al. Pediatrics 2008

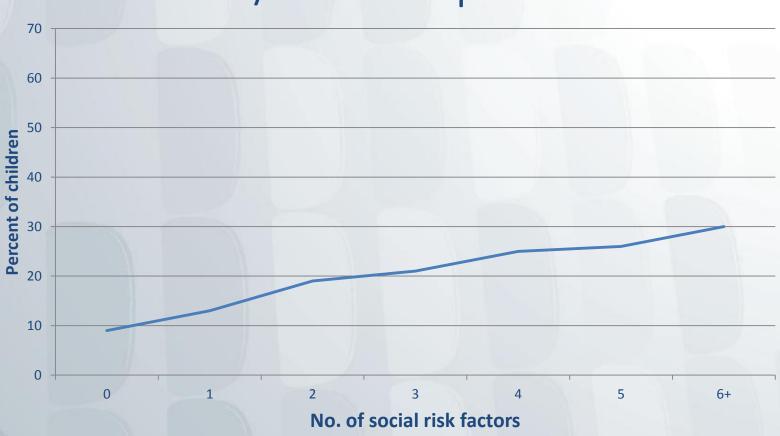


Overweight





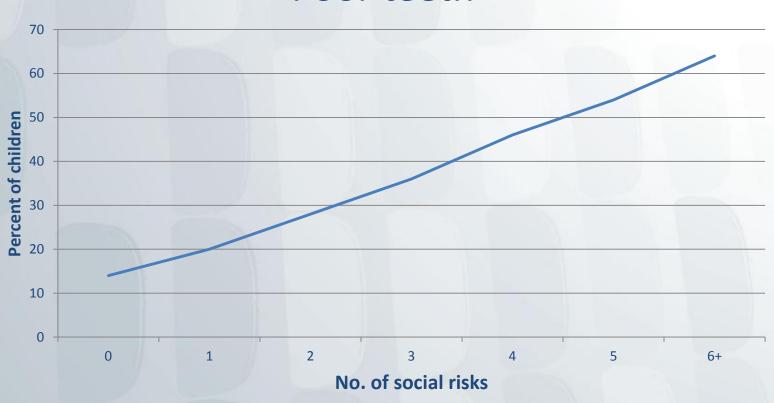
Social/emotional problems





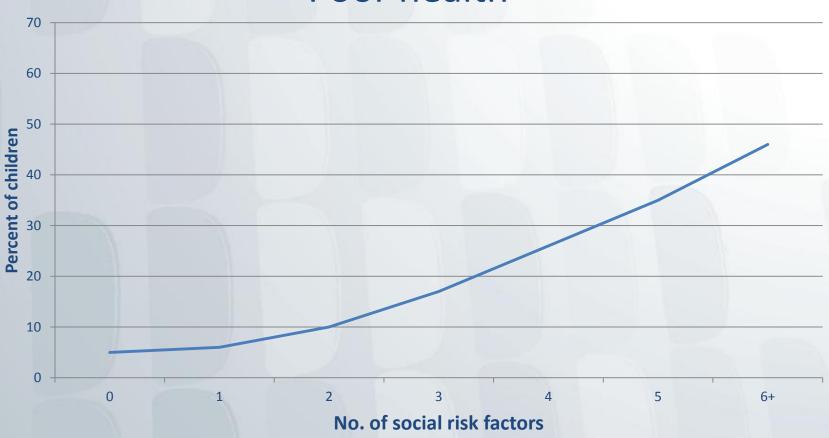


Poor teeth

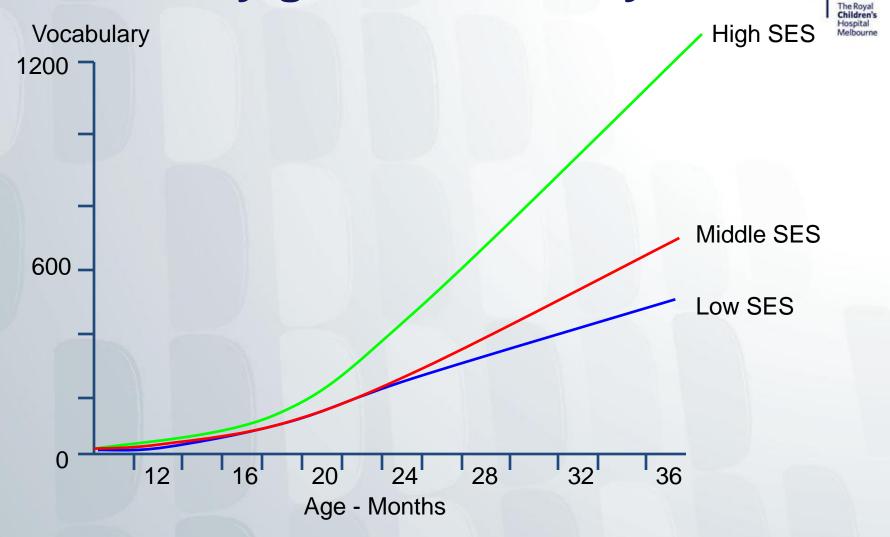




Poor health



Vocabulary growth - first 3 years



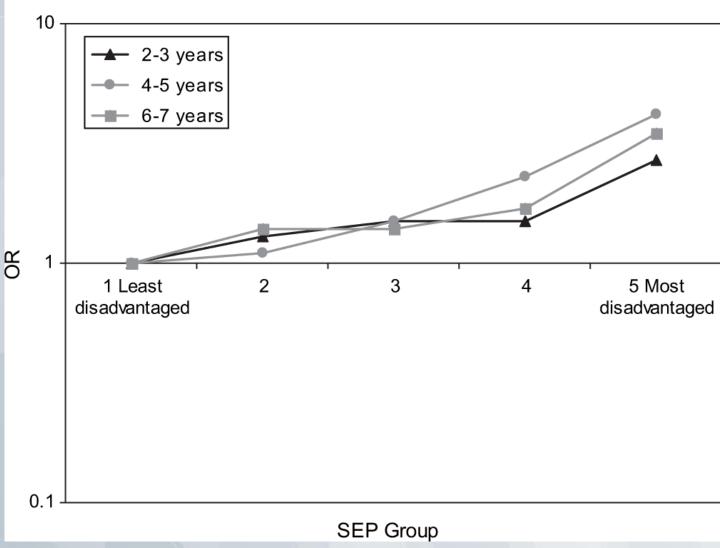


Health and developmental inequalities in Australia



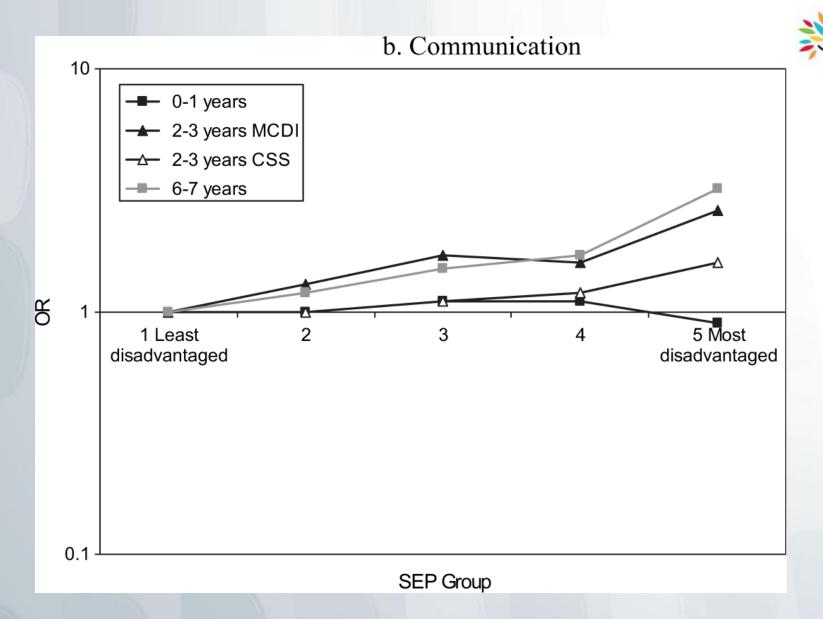
Preschool

a. Socio-emotional difficulties

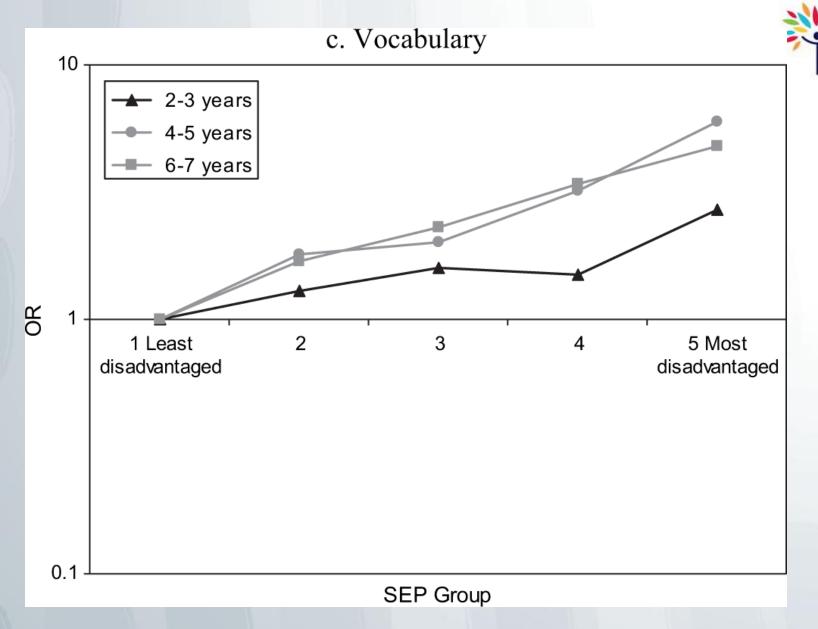


OR by socioeconomic position quintile for socio-emotional difficulties

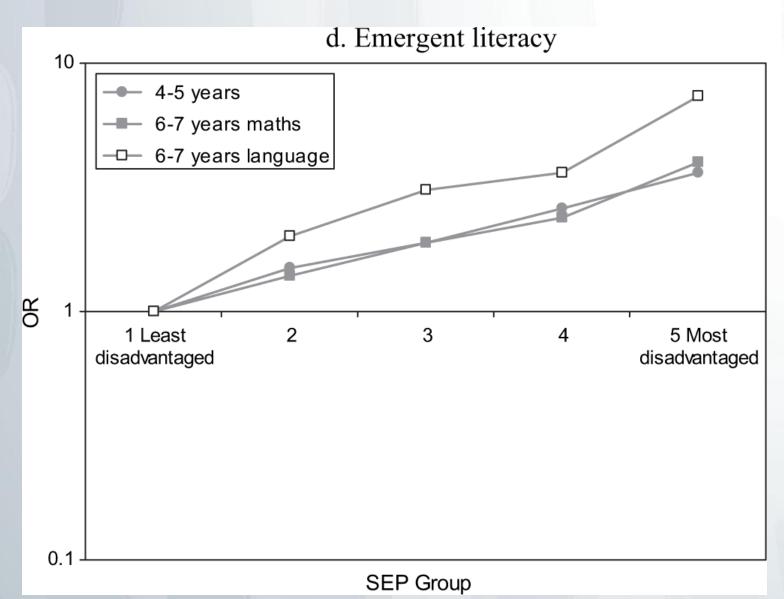
Nicholson JM, Lucas N, Berthelsen D, et al. J Epidemiol Community Health (2010), doc 10.1136/jech.2009.103291



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OR by socioeconomic position quintile for socio-emotional difficulties



School entry

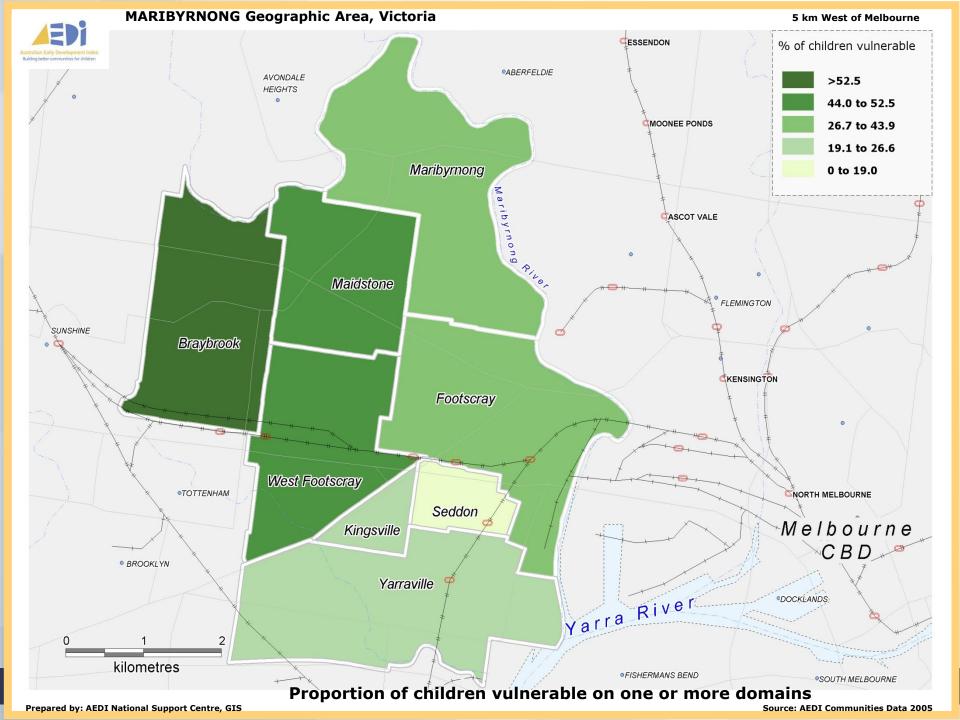
Australian Early Development Index (AEDI) The Royal Children's Hospital Melbourne

- A population based measure which provides information about children's health and wellbeing
- 100+ questions covering 5 development domains considered important for success at school
- Teachers complete the AEDI online for each child in their first year of full-time schooling
- Results are provided at the postcode, suburb or school level and not interpreted for individual analysis

Five AEDI 'subscales'



- The AEDI measures a child's development in 5 areas:
 - physical health and well-being
 - social competence
 - emotional maturity
 - language and cognitive development
 - communication skills and general knowledge





AEDI National Rollout 2009

•	Number	of	communities	660
	Nullibel	UI	Communica	UU

•	Number	of schools	7,423
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% of schools completed 95.6%

Number of teachers 15,528

Number of students 261,203

% of students completed 97.9%

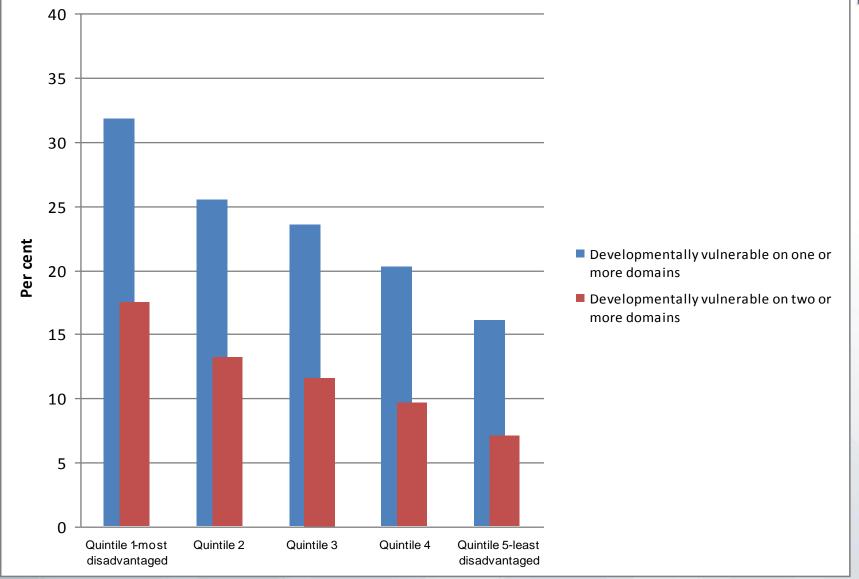
Key Findings

Percentage of children developmentally vulnerable (DV)

	DV ≥ 1 domains (%)	DV ≥ 2 domains (%)
Australia	23.3	11.7
New South Wales	21.2	10.2
Victoria	20.1	9.9
Queensland	29.2	15.6
Western Australia	24.3	12.0
South Australia	22.5	11.4
Tasmania	21.7	10.8
Northern Territory	36.3	22.1
Australian Capital Territory	21.9	10.8

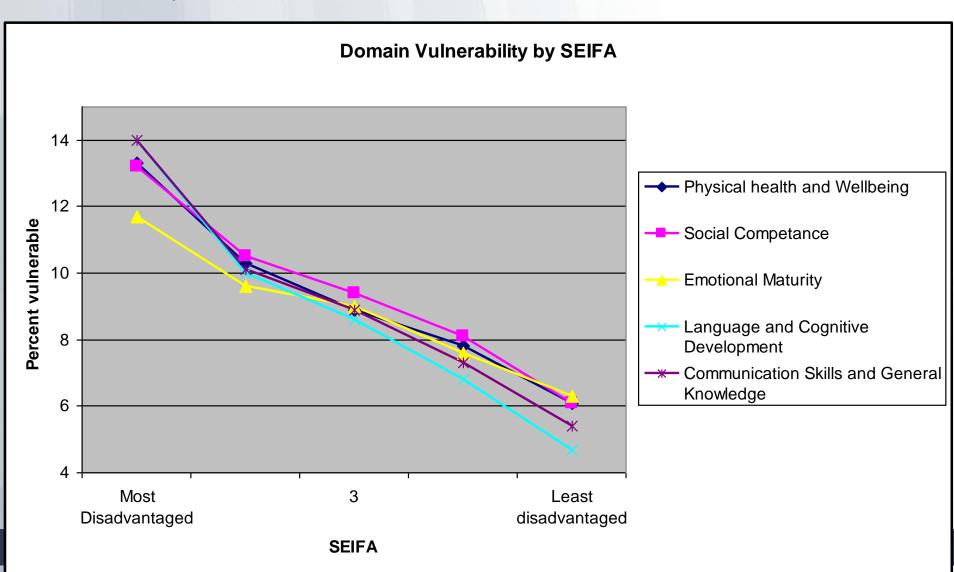
Results: Socio-economic status





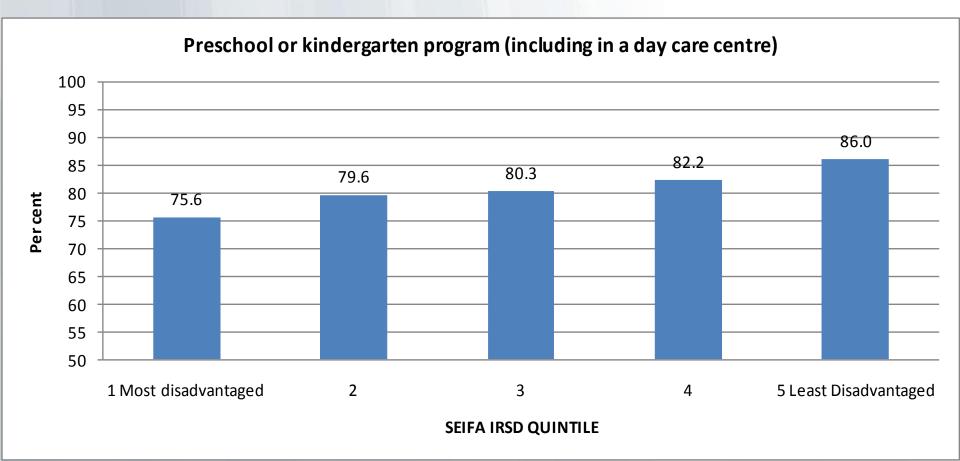
AEDI Domain comparison – vulnerability by SEIFA

N=261,000 (



Disadvantage and preschool participation

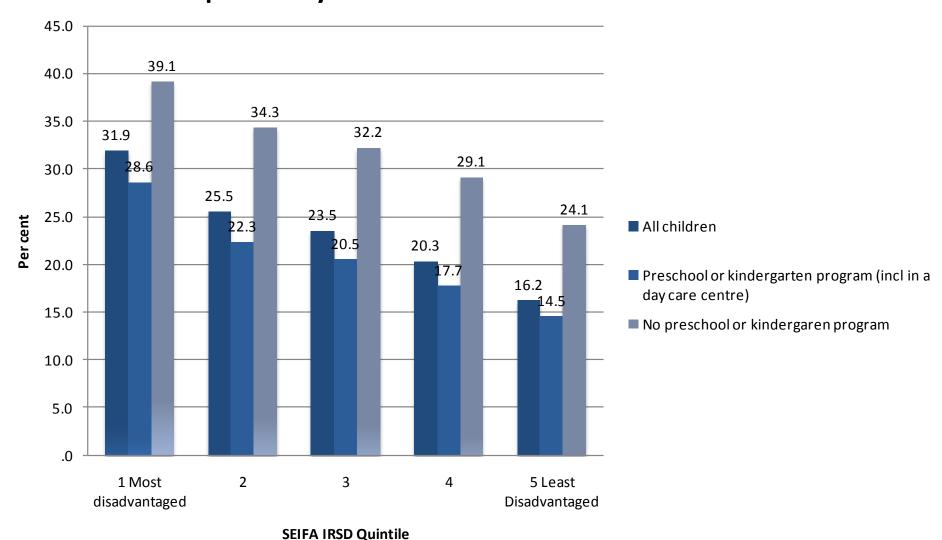




AEDI results and preschool participation



Developmentally vulnerable on one or more AEDI domain





Implications beyond paediatrics

Implications of the science of early childhood



- Education
- Parents and families
- Communities and the built environment
- Child care
- Child protection system
- Services
- Business
- Media
- An expanded view of building infrastructure

Parents and families



- Information about child's health, development and behaviour - what to expect and what to do -'responsive' parenting
- Support parents as individuals
 - Address personal issues relationships, financial stresses, ill-health, housing, depression
 - Family friendly workplaces leave provisions
 - Security of employment

Communities and the built environment



- Community can be effective buffer against stress
- Create child friendly communities
 - Access to services eg children's centres
 - Child oriented workplaces, organisations, community settings - child care, schools, libraries, parks, transport, pubs, pools, shopping facilities...
- Social connectedness
- Schools matter



Rethinking child care

Refocus child care based on three sets of relationships

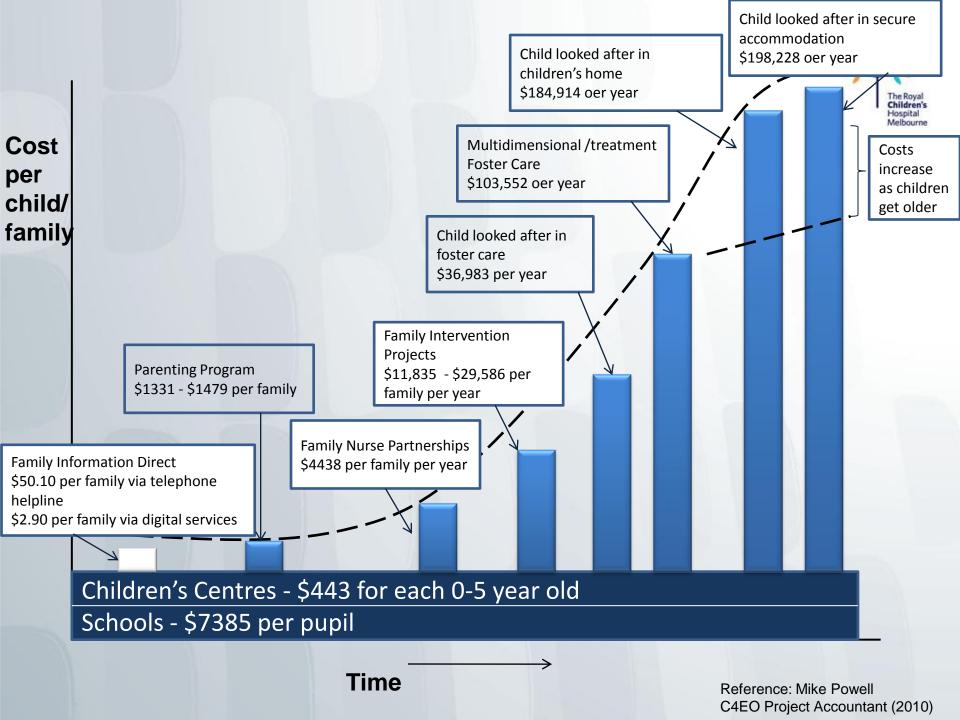
- With children training and quality of services
- With parents health promotion and early detection of problems
- With community child care as platform

Ability gaps open early in life



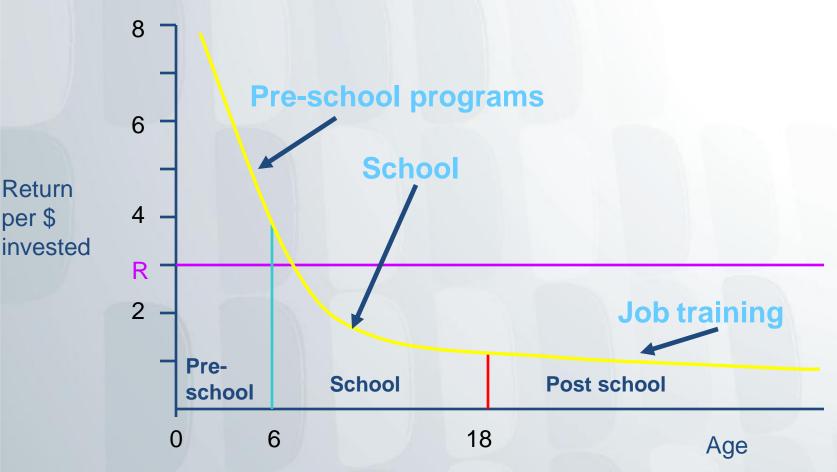
'Ability gaps between advantaged and other children open up early before schooling begins. Conventional school based policies start too late to completely remedy early deficits, although they can do some good. Children who start ahead keep accelerating past their peers, widening the gap... Early advantages accumulate, so do early disadvantages... The best way to improve the schools is to improve the early environments of the children sent to them.'

(Heckman J. & Masterov DV, 2005)



Rates of return to human development investment across all ages





Pedro Carneiro, James Heckman, Human Capital Policy, 2003

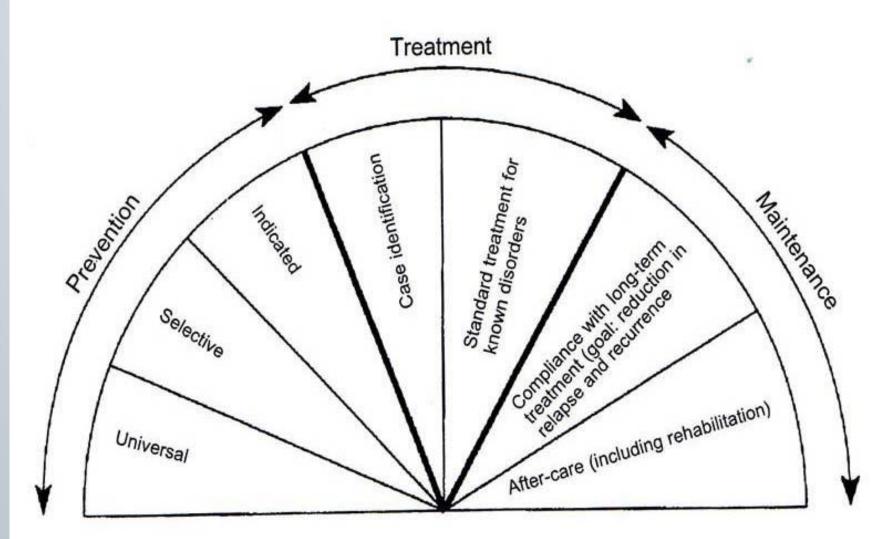


Response to the research?

- Need major shift in public policy, focusing not just on treatment but also on prevention and early intervention (fence on top of cliff rather than more ambulances at the bottom)
- There is accumulating evidence from successful demonstration programs that early intervention works - ie the research tells us how to build the fences

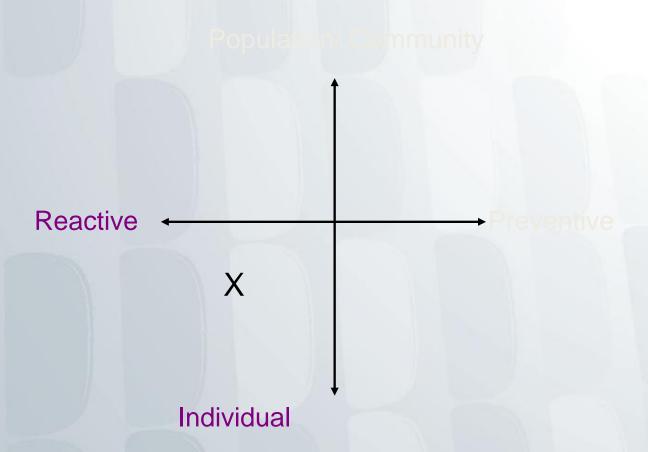
Mrazek & Haggerty: prevention / treatment spectrum





Where are our investments today?

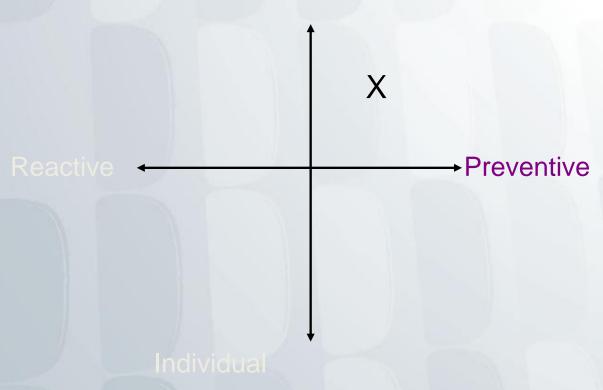


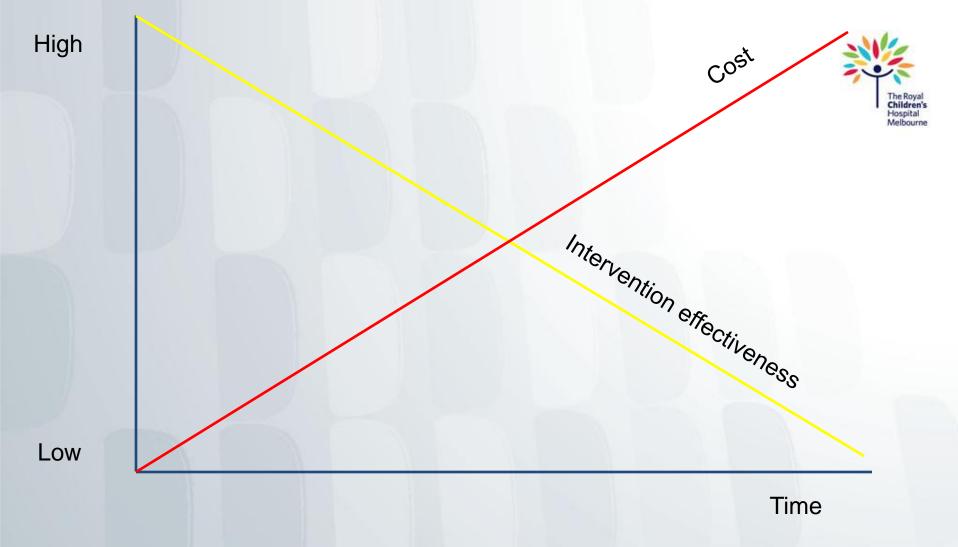


Where our investments should be



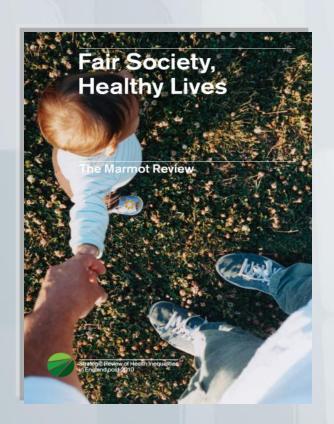
Population/ Community



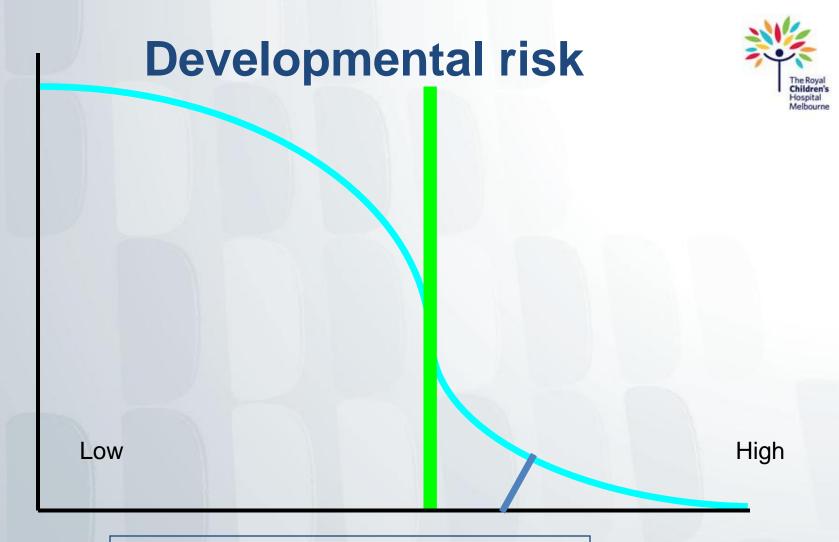


Intervention effects and costs of social-emotional mental health problems over time (Bricker)





Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.



Effort is devoted to identifying and managing the high risk group



risk amongst the entire population

Definition of community child health



'A comprehensive system of health care, responsible for promoting the health and development of *all* children within the context of their family and community.'

- Faculty of Community Child Health Australian College of Paediatrics

Principles of community child health



- Participation by the community and the providers in planning and service delivery
- Rational assessment of the health needs of the community and the health outcomes achieved
- Integration within the health services themselves, and between all other sectors affecting children's health and development.

Multi-sectoral and multidisciplinary The Royal The Royal Multi-sectoral and multidisciplinary The Royal The Royal Multi-sectoral and multidisciplinary The Royal The R

- Public policy and health care delivery for children must extend beyond health
- Different governments agencies health, welfare, education, housing, law, transport
- Different settings hospitals, doctors, community nurses, kindergartens, schools, child care centres, pharmacies (shopping centres, swimming pools etc).









Centre for Community Child Health Royal Children's Hospital Melbourne

Premises



- The early years have major impact on life course and a range of outcomes
- Prevention is more cost effective than treatment
- Intervening early is effective and cost effective
- There will never be sufficient resources
- Pediatricians are but one of the professional groups who come into contact with young children and their families
- Programs and interventions should be based on the research evidence of their efficacy and effectiveness
- Academic centres and paediatric teaching hospitals have a pivotal leadership role to play in the community research, training, and research translation (knowledge transfer)

An ecological approach



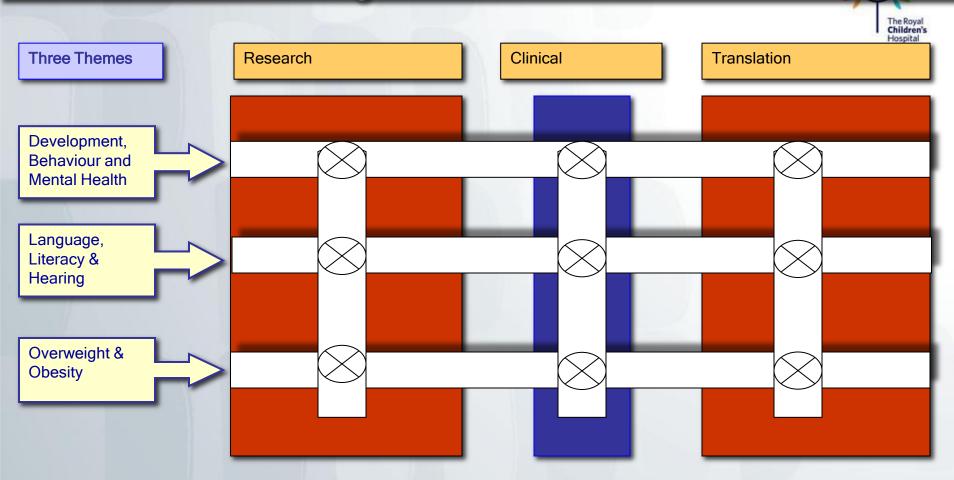


Making a difference

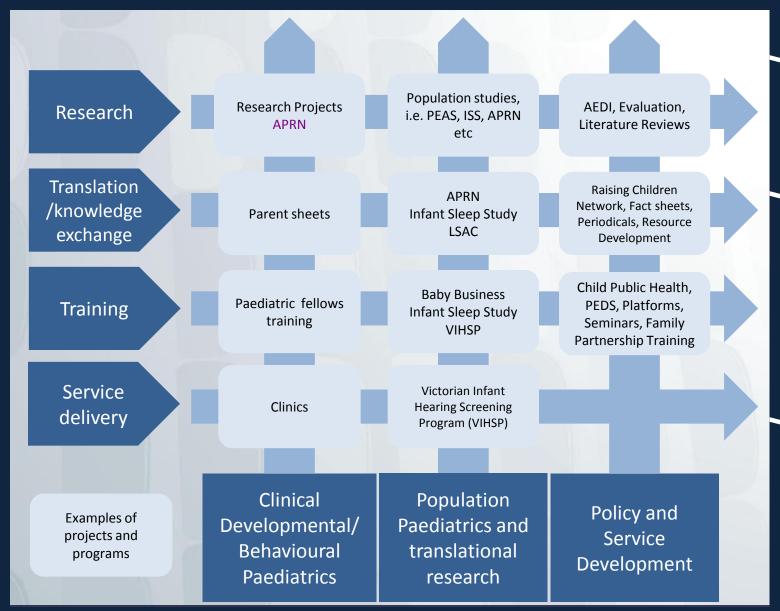


- Research clinical, population, intervention
- Research based public policy
- Research based service delivery
 - Data collection at community level
 - Organisation of community services
 - Universal developmental promotion strategies
- Professional practice
 - Training in DB paediatrics and CCH
 - Training of professionals and service managers
 - Early identification of problems and risk factors
 - Evidence based interventions
- Parent information and support

CCCH Functional Organisational Chart



Centre for Community Child Health (RCH) Community Child Health Group (MCRI)



Outcomes

Policy makers: using the best evidence to develop policy

Service providers: using the best evidence in their practice with families and children

Families:
optimal
environments
to support
healthy child
development

What we focus on

Research overview

Strengths/achievements



9	
Longitudinal population-based studies: Obesity, deafness, mental health, language	Content knowledge, new interventions, harmonisation, exploitation
Universal/targeted RCTs :	Streamline, strengthen, publicise

Community, primary & secondary care

Research platforms:

A ' ' ' D | D

Australian Paed Research Network (APRN)

Longitudinal Study of Australian Children

Census platforms:

Australian Early Development Index (AEDI)

Victorian Infant Hearing Screening Program

Web-based platforms:

Raising Children Network

Longitudinal databanks, eg hearing

Formalise as vehicle for RCTs & translation

Physical & biomarkers module

National child development census

Build research on rolling newborn census

- GIS and linkage opportunities

MCRI & international resources

Opportunities

Lead national secondary care research





















Australian Early Development Index

Victorian Infant Hearing Screening Program







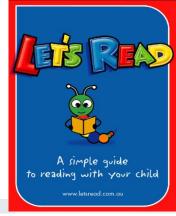
















Centre for Community Child Health





Translating the research to policy to practice



Potei	T1 ntial Applica	tion	T2 Efficacy		T3 Effectiveness	Pe	T4 Population-Based		
Basic Scientific Discovery	\iff	Potential Clinical Application	\iff	Evidence- Based Guidelines	\iff	Clinical Care or Intervention	\iff	Health of Community or Population	
Basic Knowledge		Theoretical Knowledge		Efficacy Knowledge		Applied Knowledge		Public Health Knowledge	

Translating the research to policy and practice

What outcome do we want?

What strategies do we use?

How do we do it?

Policy makers
are using the
best evidence
to develop
policy

Synthesise the evidence for
government and other
stakeholders

- Publications:
 - Policy briefs
 - Research snapshots
- Literature Reviews to inform policy and program development

Advocacy for the evidence by
representation on government
committees and advisory
groups

- Victorian Children's Council
- National Community Child Health Council
- National Framework for Protecting Australia's Children

Engage policy makers

- Policy roundtables e.g. Place-based approaches for children
- Seminar series

Policy related research

- Policy and program development/evaluation
 - Evaluation of Maternal and Child Health 3 year evaluation
 - Development of the model for Early Childhood
- Place-based initiatives development and evaluation

Translating the research to policy and practice

What outcome do we want?

What strategies do we use?

How do we do it?

Practitioners and service providers are utilising the evidence in their practice with families and children

Resource development
promoting the evidence
base

- Develop websites e.g. Lets Read, Linking Schools and Early Years
- Publications:
 - Grow and Thrive -targeting childcare/preschool and schools
 - Community Paediatric Review-targeting community nurses and MCH
- Platforms Service Redevelopment Framework: A place-based framework to improving children's outcomes

Training and development for practitioners

- Family Partnership Training
- · Platforms service development training
- Linking schools and early years training
- PEDS Training
- Sleep training
- Infant Sleep Training program
- LEAP and HopSCOTCH training
- Baby Business training
- APRN Allergy Study training

Demonstration research projects and pilots

- Northern Territory Integrated Service Development Action research
- Tasmanian Child and Family Centres Action research

Translating the research to policy and practice

What outcome do we want?	What strategies do we use?	How do we do it?
Families are able to provide optimal environments that support healthy child development	Parenting information	 National Parenting website Raising Children Network Monthly page views ~1,000,000, unique visitors per month ~440,000 Let's Read parent materials Parent fact sheets distributed through publications and clinics
	Proactive media and strategic communication strategies	 Media strategy timed with release of new content on Raising Children Network and publications topics Development of the "Frameworks" project which merge the science of early childhood with the science of communication
	Work with services	 Disseminate evidence and work with services to better meet the needs of children and families Seminar series





Aimed at

- Governments and policy makers
- Service managers local government, NGOs
- Professionals GPs, paediatricians, MCHNs, child care workers, teachers
- Parents
- Media

'Closing the gap between what we know and what we do'



POLICY BRIEF

Translating early childhood research evidence to inform policy and practice



Childhood Mental Health: Prevention & Promotion

Good mental health is essential for children's learning, social development, self-esteem, and resilience to stress throughout the life-course. Over half a million Australian children have significant mental health problems, a concern that has been recognised by the Coalition of Australian Governments (COAG, 2006). This Policy Brief addresses how to reduce the high prevalence of child mental health problems and how services can improve in supporting children and families to prevent further mental health problems from developing.

Childhood mental health problems are defined in this Brief as externalising problems - aggression, oppositional defiance, and attention deficit hyperactivity disorder, and internalising problems - anxiety and depression.

Why is this issue important?

Children's mental health problems have high human and financial costs for families and society in both the short and long term (Barlow & Stewart-Brown, 2000; Bor et al, 2004; Carr, 2000; Sanders et al, 2000). Costs include social problems and learning difficulties, along with costs of clinical treatment and remedial education services. Children's mental health problems often continue into adolescence and adulthood, adding further costs such as school dropout, substance abuse, poor vocational outcomes, family violence and suicide, along with sick leave, unemployment and criminal justice services. Adult mental health problems then affect the next generation of children. For example children whose parents have depression and anxiety are six times more likely to develop these problems themselves (Beardslee & Wheelock, 1994; Biedel & Turner, 1997).

"Good mental health is essential for children's learning, social development, self-esteem, and resilience to stress throughout the life-course..."

The NHMRC has identified mental health as a priority area, consistent with WHO (2006) reports that mental health problems represent 13% of the total disease burden. By 2020 depression is projected to reach second place in the ranking of disability adjusted life years for all ages (DALYs).

What does the research tell us?

How common are mental health problems for children?

Difficulties with child behaviour such as tantrums, aggression, and frequent night waking are common in the first few years of life. For some children these behaviours are transient and can be considered part of normal development. However 30% of Australian parents report problems with managing such behaviours in the preschool years (Armstrong & Goldfeld, 2004). If left untreated, up to 50% of preschool behaviour problems evolve into mental health problems (Campbell, 1995; Prior et al, 2001). In the 2000 National Mental Health and Wellbeing survey, 14.1% of children (half a million children) aged 4-17 years had significant mental health problems, including 12.9% with externalising problems and 12.8% with internalizing problems (Sawyer et al, 2000). The rate of mental health problems for Aboriginal children is higher at 24% (Zubrick et al, 2005).

What contributes to the development of children's mental health problems?

The younger the child, the more vulnerable the brain is to environmental influences affecting risk and resilience (Hertzman, 1999). Experiences in the early years shape the development of young children's brains in ways that have long lasting effects (NSCDC, 2004, 2005). Mental health problems can emerge at any time, from as early as infancy (Cytryn & McKnew, 1996; Luby et al. 2004).



POLICY BRIEF

Translating research evidence to inform policy and practice

Early childhood and the life course

What happens to children in the early years has consequences right through the course of their lives. There are many opportunities to intervene and make a difference to the lives of children and young people. The evidence shows the most effective time to intervene is early childhood, including the antenatal period. This Policy Brief explores the issues that impact the health, development and well-being of children and therefore their life course. These issues will be addressed from ecological and economic perspectives.

Why is this issue important?

Many children and young people are displaying worsening (or unacceptably poor) outcomes in many areas of health and development (Keating and Hertzman, 1999; Richardson and Prior, 2005; Stanley, Prior and Richardson, 2005). These outcomes can have consequences much later in the life course. Many of the health and wellbeing problems we see in adults - obesity and its associations such as diabetes and heart disease, mental health problems, criminality, family violence, poor literacy, unemployment and welfare dependency - have their origins in pathways that begin much earlier in life, often in early childhood (Halfon and Hochstein. 2002; National Crime Prevention, 1999). This does not mean that what happens in early childhood invariably determines later development; however early experiences set children on developmental trajectories that become progressively more difficult to modify as they get older (Hertzman and Power, 2003; Shonkoff and Phillips, 2000).

The problems noted above have associated social and financial costs that cumulatively represent a considerable drain on society and undermine Australia's productivity. (Richardson and Prior, 2005). Economic costs include reduced skill levels which make Australia less competitive internationally, suboptimal workforce participation and productivity, increased welfare payments, and increased costs of treatment services.

We do not fully understand all the causes of these problems, but they are clearly associated with the social and economic changes of the past few decades (Richardson and Prior, 2005). While a majority of families and children are doing well, parenting generally has become more stressful and complex, and there is an increasing number of families with multiple problems.

> "... health and wellbeing problems we see in adults ... have their origins much earlier in the life course, often in early childhood."

What does the research tell us?

The ecological perspective. The health, development and well-being of children, as well as the functioning of their families, is shaped by environmental factors.

For young children, the antenatal, family, and social environments are critical. The family environment is important because young children develop through their relationships with others; in the early years this means parents and caregivers (National Scientific Council on the Developing Child, 2004a). Genes predispose children to develop in certain ways, but it is their social environments that have an especially large impact. This is why Professor Clyde Hertzman













POLICY BRIEF

Translating early childhood research evidence to inform policy and practice

Work and family life balance

Balancing paid work and family responsibilities is a major issue for employers, governments and families across the western world (OECD, 2002). In light of rapid changes in the roles and responsibilities of men and women, and in the organisation and distribution of paid work, it is vital that the impact that the balance between work and family has on family life, child development and wellbeing is understood.

Why is this issue important?

Recent years has seen dramatic changes in the work patterns of parents. Just over two decades ago, a majority of Australian couples with young children fitted the male breadwinner pattern of father in the workforce. mother at home. Today, only 31% conform to this model. Twice as many families (62%) have both parents at work, and 57% of sole parents with children are employed (Pocock, 2003).

The working lives of parents have also become more diversified. There has been a large shift away from full-time and towards part-time work, a rise in the proportion of workers who are employed as casuals, and in those working long hours (Edgar, 2005; Richardson, 2005; Watson et al. 2003).

For parents who work (which means most parents), achieving a balance between work and family commitments is highly desirable for all family members. A good work/family balance can contribute to better health, educational and social outcomes for children, increase the opportunities available for women in the workforce, and help men to spend more time with their families (Gornick & Meyers, 2003). It is also linked to higher levels of satisfaction with parental relationships (Headey et al, 2006).

Juggling paid work and caring responsibilities is a major source of stress and tension for families (Tucci et al, 2004, 2005). The caring responsibilities of Australian workers have altered significantly: four in ten workers now have responsibility for the care of someone else - whether a child, aged relative, or sick dependent (Pocock, 2005). In a national survey (FaCS, 2002), 52% of parents said that work meant they missed out on some rewarding aspects of parenthood; 43% said they worried about their children while they were at work; and 40% said that work left them with insufficient energy to parent as they would like. One-third of fathers and a quarter of mothers report that the demands of their iob make family time less enjoyable and more pressured (de Vaus, 2004).

Declining fertility in most western societies is also influencing public debate about work/family balance. For many workers, the jobs that provide an adequate income deny parents enough time or predictability to provide necessary care for their children. As a result, 'many adults are avoiding the responsibilities of parenthood because the labour market will not give them the chance to have both sufficient income and sufficient time to be a good parent' (Richardson & Prior. 2005a). Research shows that countries that do not support working mothers are those that have increasingly low birth rates. In comparison, the highest birth-rate countries in Europe are those with generous conditions for parental leave, part-time work options, flexitime, regulated working hours and extensive systems of high quality, publicly funded child care (McDonald, 2000; Castles, 2003).

Initiative of:















Community Pædiatric Review

A NATIONAL PUBLICATION FOR COMMUNITY CHILD HEALTH NURSES AND OTHER PROFESSIONALS



www.copas.net.au/ccch

VOL 10 NO 2 APRIL 2001

An initiative of the Centre for Community Child Health, Royal Children's Hospital, Melbourne

EXECUTIVE INDEX

Irritable Babies - How research findings can help

Reflux and Irritability

REFERENCES
The references for these articles can be accessed through the "publications" section on the following website — www.copas.net.au/ccch

Irritable Babies - How research findings can help

Introduction

In Western societies, about 10-15% of parents seek professional help because their baby cries repeatedly, for prolonged amounts of time, without apparent reason. As well as distressing parents, this phenomenon is expensive for health services. Morris and colleagues, for instance, estimated that professional support for infant crying and sleeping problems in 1-12 week-old babies cost the UK National Health Service almost £66 million in 1997.

A recent review of the paediatric literature by Gormally & Barr's concluded that organic disturbances, including cow's milk protein intolerance, account for less than 10% of cases where persistent crying in 1-3 month old babies is the presenting condition². In contrast, there is extensive evidence that babies in general peak in their crying in the first three months of age. As a consequence, the crying is increasingly being viewed as normative, perhaps due to a neuro-developmental 'shift' which occurs at this age, while babies who cry a lot are considered to be at the far end of the normal distribution.

In keeping with this viewpoint, a number of recent studies have reported that above-average crying is due to a temperament-like predisposition to be irritable. The aim here is to summarise this evidence and to consider the implications of this view of early crying for healthcare practice.

The 'Irritability Hypothesis'

The terms 'crying' and 'fussing' (or 'fretting') refer to the behaviours heard, and seen, by

parents. In contrast, the word 'irritable' denotes a disposition underlying these behaviours. For a given stress or challenge, the idea is that some babies will respond by crying more intensely, or persistently, than most others. The words 'reactivity' and 'regulation' of response, used by temperament theorists, have similar connotations. By definition, a highly reactive individual responds rapidly and intensely to stimulation, while inability to inhibit, or regulate, a reaction will prolong a response (such as crying).

The first systematic evidence that persistent crying in young babies might be due to an irritable disposition came from observations of naturalistic behaviour at home. In 1995, Sue Conrov. Katie Wilsher and Ian St James-Roberts reported that 67 six week old babies who met a standard definition for prolonged crying (3 or more hours per day, on average), were difficult to soothe for trained researchers, using standard soothing manoeuvres, as well as for mothers3. The mothers of these babies were observed to be highly sensitive and responsive in their care behaviour, so that many of them received optimum scores on these measures+. The few differences there were between these and other mothers' behaviour were explainable in terms of the efforts made by the mothers to contain their babies' crying. Other findings, too, support the argument that variations in care-giving are probably not the explanation for most cases of prolonged crying in young babies. For instance, firstborns do not cry more at this age than laterborns, which would be expected if parental inexperience was a cause. Parental

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HEALTH AND NUTRITION TEL 1800 55 2229





Childcare and children's health

HEALTH CARE INFORMATION FOR CHILDCARE STAFF AND FAMILIES FROM THE ROYAL CHILDREN'S HOSPITAL, MELBOURNE

Dads want to 'be there' for their children – Childcare staff can help them 'get there'

There is a growing tendency in society for fathers to become more involved with their infants and small children. However, many men face difficulties when they try to put into practice their own notions of modern, nurturing fatherhood: to 'be there' for their children. Lack of role models, support systems, and paternity leave are examples of such obstacles. Early childhood professionals have a unique opportunity to encourage fathers' involvement with their children by actively encouraging and including men in all care-related issues.

In most western societies there is a trend for fathers to be more involved in childrearing even if women usually remain the primary caregivers, i.e. spend most time with the children and related chores. Interviews with 'expectant' fathers in several countries have revealed that men want to 'be there' for their children more than their own fathers, who were perceived as often absent and uninvolved. However, many men are faced with the lack of role models and support from their environment – they have to construct the notion and practice of good fatherhood for themselves without obvious examples to follow.

Historically, the father-ideal has gone through different phases – from moral teacher and disciplinarian, through breadwinner, gender-role model and 'buddy', to the 'newage', nurturing, co-parenting father. An increasing number of couples opt for a more equitable position with regard to parenting and demands are being made for better parental leave policies, including paid leave for fathers. Because of these social changes, many of the assumptions and expectations about fatherhood might have to be reconsidered: we must be open to new interpretations of fathers' roles and places in their children's lives.

Researchers today talk about factors that are of importance



in determining paternal involvement: motivation (or interest), spousal and other social support, self-confidence, the acquisition of practical skills, and institutional practices, such as paternity leave. The more these circumstances are satisfied the better are fathers' chances to be involved and stay involved with their children: to truly 'be there' for them. Early childhood professionals have a unique opportunity to help fathers to 'get there' by actively supporting men in these areas.

Naturally, fathers have to feel the need to be involved in their children's lives themselves. However, **motivation** needs to be fuelled. A father who is not encouraged to participate in everyday tasks or to take part in health care routines may eventually lose some of his motivation.

Actively encouraging fathers to visit the Maternal and Child Health Nurse and directing questions to them as well as to

VOL.5 NO.3 SEPTEMBER 2002

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Dads want to 'be there' for their children	1-3
Self-regulation in early childhood	3-4
Website update	4











Childcare and children's health

AN INFORMATION SHEET FOR PARENTS



Separation anxiety and child care

Separation anxiety in young children is a normal part of infant development. It usually occurs around the age of nine months and again at 18 months, although it can happen at any age and can re-occur. At about nine months, the development of memory means the child becomes much more wary of strangers and is sensitive to separation from their parent. Infants adjust more readily to separation anxiety if there is a small and consistent number of familiar adults with whom they associate.

Separation anxiety can be extremely distressing for parents and their children. Parents often have strong feelings of guilt and anxiety when leaving their child in care. This can quickly turn a positive child care experience to a tense and teary one. In comparison, separation anxiety for some children can be shortlived, even when it happens on a daily basis. Children really do settle, happily playing with others, while you are still feeling worried and anxious hours later. If they don't settle, be assured that staff will talk with you about what is happening to your child and how to support the day-to-day situation.

KEY POINTS TO REMEMBER

- Plan ahead for separation time with infants particularly if it is in a new environment, or with a new caregiver
- Choose a small circle of caregivers with whom your child has contact
- Give your child time to become familiar with new situations and new caregivers
- Develop a consistent routine when you leave your child
- Let your child know that you are leaving and make sure they are clear on who is looking after them.

It may be helpful if parents arrange a build-up of visits or orientation time where the child spends longer periods at the centre before being left for the whole day.

How to deal with separation anxiety

Children experiencing separation anxieties need a predictable routine and lots of reassurance. Parents also need emotional support from co-operative caregivers, friends and family. It can take anywhere from two to 10 weeks to resolve; there is no "quick-fix" solution. Plan ahead your approach:

• Develop a predictable routine with caregivers. You will need their support and involvement as they are used to dealing with separation issues. The routine starts from the time your child wakes in the morning to the time you say goodbye at child care. Use the same words every day, something simple like: "We are going to see the kids at the centre today," Do not deviate from the routine. If you have a late start or a day off from work, although it would be tempting to have a more relaxed morning, it may only serve to worsen your child's separation anxieties. Do the drop-off as usual.







THE WORLD'S GREATEST

explorers and scientists wear nappies!



grown-ups home

newborns

babies toddlers preschoolers

school age

services & support!

wa-z power search

my neighbourhood

forums

tools & activities

make a book

subscribe

site help











GROWN-UPS

Looking after yourself Family management

Returning to work Stress

all ages

NEWBORNS

0-3 months

Breast or bottle? Colic Baby equipment Sleep patterns

BABIES

3-12 months

Night feeds Ready for solids? Crying

Talking

TODDLERS

1-3 years

Discipline Toilet training Fussy eating Play ideas

PRESCHOOLERS

3-5 years

Praise Healthy food Nightmares Television

SCHOOL AGE

5-8 years

Bedtime routines Breakfast Lunch boxes Activities for school kids



Parenting in pictures

Visual guides on essential information such as how to put baby to bed safely.

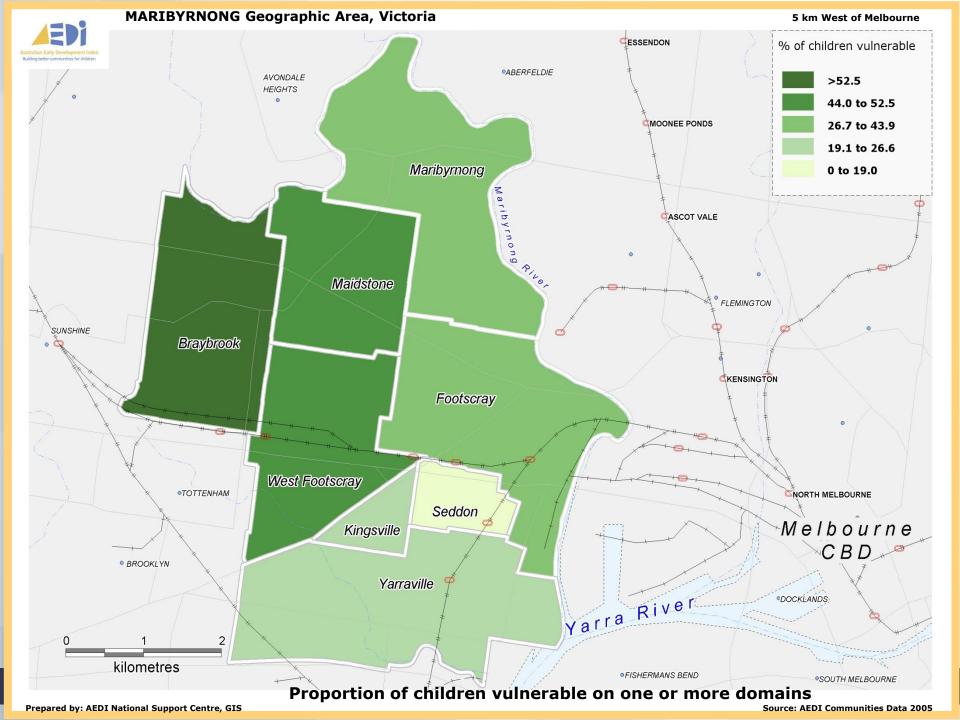
Parents like me

- ▶ Indigenous parents
- ▶ Dads

Proudly supported by









AEDI Community Profile Summary MARIBYRNONG Geographic Area, Victoria



Proportion of children developmentally Vulnerable (%)

Average Scores (0-10)

Suburb	No	Phys	Soc	Emo	Lang	Com	Vul 1	Vul 2	Phys	Soc	Emo	Lang	Com
Braybrook	103	21.1	18.9	18.9	23.2	41.1	52.6	34.7	8.00	7.08	7.12	8.46	5.63
Footscray	93	10.5	3.5	12.8	4.8	15.1	26.7	14.0	8.86	9.17	8.46	9.23	8.75
Footscray West	97	15.4	13.2	9.9	14.6	20.9	44.0	18.7	9.00	8.33	8.08	9.62	8.13
Kingsville	21	5.0	10.0	5.0	5.0	15.0	20.0	10.0	9.32	9.38	8.56	9.42	8.44
Maidstone	56	9.8	21.6	9.8	24.0	31.4	47.1	29.4	8.64	7.50	7.31	8.65	6.25
Maribyrnong	32	3.4	13.8	6.9	0.0	27.6	34.5	10.3	9.09	9.58	9.23	8.85	8.75
Seddon	39	2.6	5.1	2.6	10.3	5.1	15.4	5.1	10.00	9.79	9.42	10.00	10.00
Yarraville	139	2.9	8.1	3.7	4.5	11.8	19.1	5.9	9.55	9.17	8.82	10.00	9.38
									Co	stra for C		v Child L	la alth

Centre for Community Child Health

AEDI Checklists completed for all children in the community

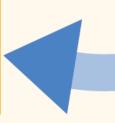


Communities obtain a comprehensive picture of early childhood development

AEDI results and other community and socioeconomic information



Communities implement strategies to improve early childhood development



Communities plan actions to improve outcomes for children based on evidence

Community Dissemination

Phase

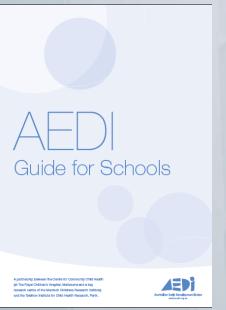


Engagement strategies and resources



- Forums/Presentations
- E-Newsletters/Articles in publications
- Posters
- Guide for Schools
- Video about the AEDI
- AEDI Results Planning Guide

- Webinars
- Fact Sheets (teachers, principals, parents)
- Community Preparation and Implementation Guide
- Guide for Teachers (including teacher training CD)











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Infrastructure of existing services



- Child care
- Family day care
- GPs
- MCH nurses
- Preschool
- School
- Specialist services
- Parenting programs

- Neighbourhood houses
- Family support
- Telephone counselling
- Family violence
- Problem gambling
- Child protection
- Adoption/foster care
- Mental health services

The existing service system



- Fragmented service delivery
 - Different sectors, (health, education, welfare) funding streams, cultures
 - Lack of co-ordination operate in silos
- Difficulty accessing services
 - Demand greater than services available
 - Narrow programmatic criteria for eligibility
 - Socio-economic factors limit access social gradient in treatment and outcomes



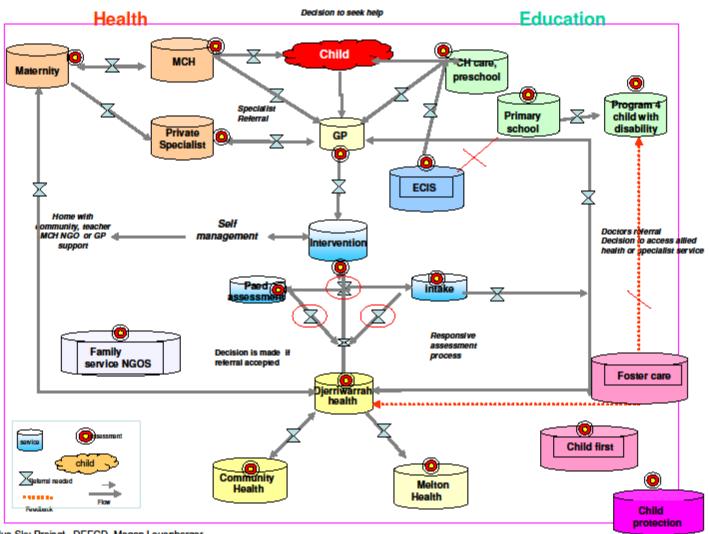
The existing service system

- Uneven quality
 - Families have complex needs, often beyond capability of any single service
 - Variable understanding of early years issues
- Model of care is outmoded
 - focus on treatment rather than prevention/early intervention
 - episodic contact
- Local community limited accountability or responsibility

Doveton current service matrix **

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Housing	Ø								Ø		Ø	11/12	45.5	Ø									
Financial Counselling			Ø					-	V	☑		-			1110	7							

Blue Sky Project-Melton South



Blue Sky Project - DEECD Megan Leuenberger

Fragmentation of services

Child health information

Family support

Childcare



School

Parenting programs

Preschool

Early intervention programs

Pediatrician

Disability services

Child protection agency

Kindergarten

Children's library services

Linking services Child health Childcare Family support information Child protection agency School Early intervention programs **Parenting** Kindergarten programs Pediatrician **Preschool** Children's library Disability services

Integrating services Child health Childcare Family support information Child protection School agency Early lidtervention Peramy Hub **Parenting** Kindergarten programs Pediatrician Preschool Children's library Disability services

Obstacles to progress



- Territorialism
- Tribalism
- Traditionalism
- Tunnel vision
- Timidity
- Terror
- Toolopoenia & atoolia
- Targetitis
- Tiredness, exhaustion and cynicism

- Aynsley-Green

WHAT TO CHANGE

AIMS



More supportive communities

To build rich and supportive social environments for families with young children

Better interface between services and communities To develop ways in which the service system is able to respond promptly and effectively to the emerging needs of young children and their families



Improved health and developmental outcomes for young people

Better integrated service system

To build a well-coordinated and easily accessible system of services for young children and their families



The Platforms concept



- Builds on the notion that in the early years young children and their families make contact on numerous occasions with a range of community providers - child care, MCH nurses, GPs, preschools, schools
- Reframe these visits into a 'platform' where parents are supported, and concerns elicited and responded to
- This provides the best opportunity both to support parents and detect emerging problems and risk factors at an early stage

Aims of Platforms



- Strengthen capacity of the existing service system
- Improve coordination and access to services
- Re-orient services to prevention and early intervention.
- Develop earlier identification and responses to child and family issues
- Improve professional practice through systematic training of professionals and community organisations.
- Encourage greater flexibility of services, evidencebased and family-centred practice, and outcomes focus

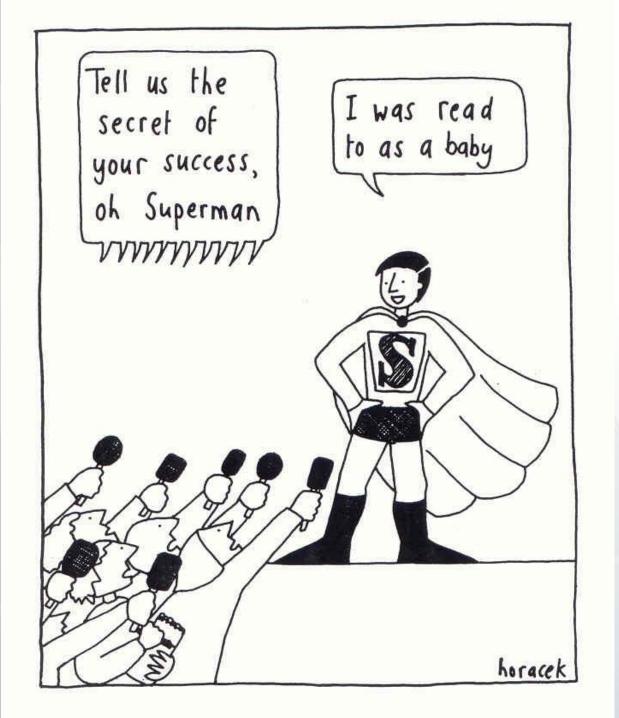
Platforms Service Redevelopment | Framework

PHASE 1	Raising awareness of ECD
PHASE 2	Community engagement and documentation
PHASE 3	Planning
PHASE 4	Implementation
PHASE 5	Monitoring and evaluation

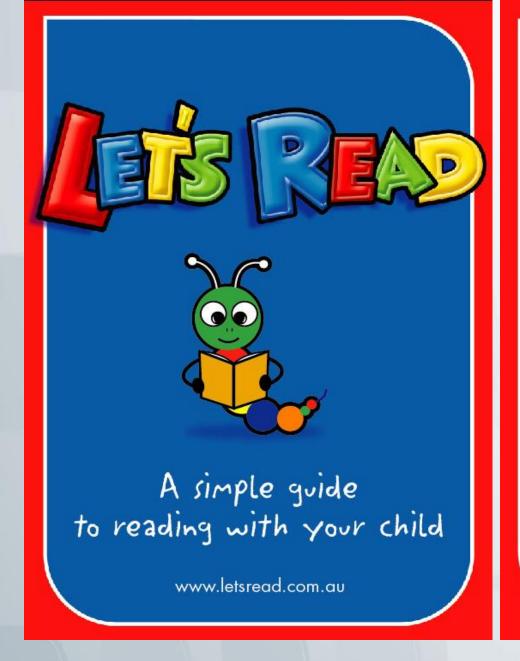
Impact of poor literacy



- Poor school performance, low self esteem and reduced adult life chances
- Generally lower employment and social outcomes
- Higher rates of welfare dependence, high risk behaviours and teenage parenting
- Poor health literacy and increased risk of poor health outcomes







Let's Read has been designed to encourage and support you to read with your young child.



It is important to read with your child because it gives you special time together and helps to prepare your child for success at school. Reading can be a fun daily activity to share with your child, and it can start when your child is just a baby.

You will find many simple and practical tips on how to read with your child from four months the age until the start of school.

Watch and learn from other parents reading with their child. See a range of books being read aloud in different and funs ways that your child will love so Let's Read

An initiative of:









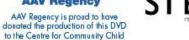
Hosted by Monica Trapaga and Andrew Daddo.

Supported by:





Health and The Smith Family.





More information about Let's Read can be accessed from www.letsread.com.au



Let's pick a book



Look for rhyme, rhythm and repetition in books.



Children like the same book read over and over.



- Babies like pictures of babies.
- Toddlers like bright colours and pictures of everyday things.
- Older toddlers like alphabet and counting books and a story.



Let your child choose the books.



Things to do when you are reading



Let your child turn the pages.



Point to words as you read.



Point to pictures and say what you see.



Ask questions and talk about things you see.



Try funny voices and sounds; play and have fun!





All babies are different. They move through the same stages of development but not always the same pace.

What babies like:

- The sound of your voice.
- Being close to you.
- Books with textures and bright colours.
- Pictures of babies.
- The same book over and over and over.
- Being moved to the rhythm of a story, song or rhyme.







These materials have been developed by the Centre for Community Child Health in partnership with The Smith Family for the Let's Read project and are for research purposes only. @2004





- Turn off the TV or radio so that your baby can hear your voice.
- Hold your baby on your knee while you read.
- Start at the front and talk about things that your baby knows, such as a ball and a tree.
- Reading the same story over and over helps your baby remember what comes next.
- Try our funny noises and sounds; play and have fun!
 The exact words don't matter.
- Make a routine and try to share at least one book every day.







An initiative of the Murdoch Childrens Research Institute's Centre for Community Child Health in partnership with The Smith Family © 2005 www.leteread.com.au.

Traditional to New Paradigms

Traditional Paradigm	New Paradigm The Roy Childre Hospita Melbou
Treatment Models Focus on remediation of a disorder, problem or disease, or its consequences	Promotion Models Focus on enhancement and optimisation of competence and positive functioning
Expertise Models Depend on professional expertise to solve problems for people	Empowerment Models Create opportunities for people to exercise existing capabilities as well as develop new competencies
Deficit-Based Models Focus on correcting peoples' weaknesses or problems	Strengths-Based Models Recognise the assets and talents of people, and help people use these competencies to strengthen functioning
Service-Based Models Define practices primarily in terms of professional services	Resource-Based Models Define practices in terms of a broad range of community opportunities and experiences
Professionally-Centred Models View professionals as experts who determine the needs of people from their own as opposed to other people's	Family-Centred Models View professionals as agents of families and responsive to family desires and concerns

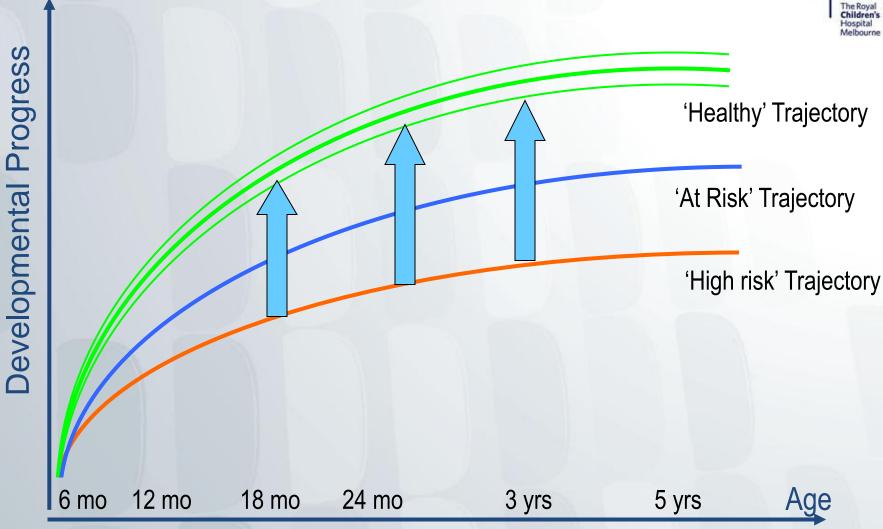
perspectives

Current and Future Healthcare Systems

Current	Future The Royal Children's Hospital Melbourne
Geared to acute conditions	Geared to long-term conditions
Hospital centred	Embedded in communities
Doctor dependent	Team based
Episodic care	Continuous care
Disjointed care	Integrated care
Reactive care	Preventative care
Patient as recipient	Patient as partner
Self-care infrequent	Self-care encouraged and facilitated
Carers undervalued	Carers supported as partners
Low Tech	High Tech

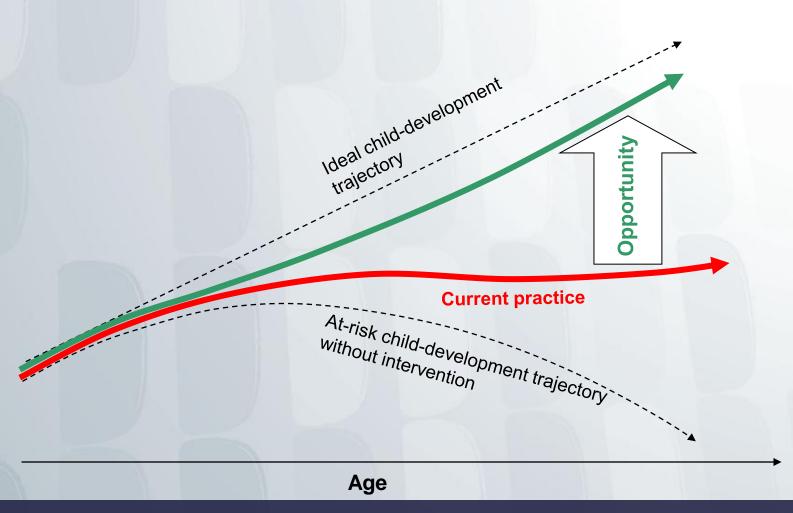
Early childhood life trajectories





Developmental health - Aims





Sustainable solutions

(Dr. Julius Richmond)



- 1. Knowledge base
- 2. Political will
- 3. Social strategy



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