Refashioning child and family health services in response to family, social and political change

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One hundred years ago maternal and child health services emerged as a community response in Australia, and most other industrialised countries, to concerns about the high rates of infant and early childhood mortality from infectious disease and poor nutrition. Major family and social changes over the past 30 years have impacted in new ways on children's health and wellbeing leading to a profound rethink about the kinds of services that are needed. At the same time, second thoughts have emerged about the role of government in service provision, driven by neoliberal and rational economic philosophies as outlined in the paper in this issue by Keleher and Reiger (2004). Together, these issues have challenged the very foundations on which the services were traditionally based.

US social policy academic Francis Fukuyama asserts that the social and family changes witnessed in the last half century have been unparalleled since the industrial revolution (Fukuyama, 1999). Knowledge has replaced mass production as the basis of wealth, power and social intercourse. Despite all the benefits of the information age, the period has been characterised by increasing levels of crime and social disorder, the decline of families and kinship as a source of social cohesion, and decreasing levels of trust, leading one might add, to an intense fear of 'the other'. 'The essence of the shift in values that is at the centre of the Great Disruption is, then, the rise of moral individualism and the consequent miniaturisation of community' (p91).

Many factors contribute to rising crime rates, but considerable emphasis is placed on early life antecedents (Olson *et al.* 2002; Tremblay, 2000), academic difficulties and non-engagement in schooling (Zubrick *et al.*, 1997) and the quality of neighbourhood supervision and supports for young people (Weatherburn & Lind, 2001). Tremblay has emphasised that the majority of juvenile crime is committed by "early starters", children who manifested behaviour disorders in early childhood. These are frequently the same children who as infants had experienced poor attachment relationships with their parents and related difficulties in acquiring self-regulatory capacities – an essential prerequisite for establishing mutually supportive peer relationships and academic success (Sroufe, 1996).

The promotion of effective parenting has now moved to centre stage in the mission of child and family health services, replacing earlier concerns about malnutrition, infectious disease and to some extent the routine screening for biologically-based developmental delays and disorders that characterised much of the work of these services until the last decade (NHMRC, 1993, 2002). Hoghuhi (1998) convincingly asserted recently that parenting should be the primary public health concern in contemporary society – a message reflected in the Acheson review of health inequalities in Britain (Acheson,1998) and recent service developments in Australia and elsewhere (DFaCS, 2004; SureStart, 2004).

The miniaturisation of community to which Fukuyama refers has manifested in family life through smaller family size and a breakdown in the extended family, as well as isolation of family units from each other by their less frequent engagement in community group activities – one result of the phenomenon of the "famine of parental time" arising from many parents' struggle to balance work and family commitments. Enhanced parenting is thus not only about encouraging parents to be more adaptive and attuned to their children's changing needs but also about supporting parents through social policies and community services that respond

effectively to the new realities of family life – increasing female participation in the paid workforce; greater fluidity within families as a result of single parenthood, parental separation and repartnering; long-term unemployment in some families, and the widening gaps between the aspirations of the socioeconomically advantaged and disadvantaged, and the likelihood of satisfaction of those aspirations.

Keleher and Reiger outline some of the other challenges that Victorian maternal and child health services have had to face as a result of compulsory competitive tendering introduced as part of the Kennett government's neoliberal reforms. Victoria is unique amongst Australian states and territories in that its maternal and child health workforce has traditionally been employed through local government (rather than employed by state health authorities as occurs elsewhere). In some ways this made the Kennett reforms easier to introduce than would have been the case where there was no experience of their provision beyond state government agencies.

Despite the opportunities, the Victorian reforms provided for innovation and a move away from screening and surveillance as the primary activity to a greater focus on socio-ecologically based interventions, these opportunities were not grasped. The authors assert this was at least in part because of medical bias towards the former activities. Whilst this was probably true at the beginning and middle of the decade, it is no longer the case, as consensus grows that the early years are a major social policy issue requiring a socio-ecological response from governments and the community more broadly. Earlier signposts towards this new direction had already emerged in the Health Goals and Targets for Australian Children and Youth Project (Commonwealth Department of Health, Housing and Community Services, 1992), where the fifth goal flagged the importance of improved social and family functioning and led to a subsequent search for appropriate indicators (Zubrick et al, 2000). This changed emphasis amongst community paediatricians developed in response to the rapidly expanding body of evidence demonstrating the impact of early experience and environments on brain development and its long term implications for health and wellbeing (Shonkoff & Phillips, 2000), as well as the publication of several US studies demonstrating that socio-ecologically based interventions in early life could alter children's developmental trajectories (Karoly et al.1998; Olds et al.1997; Schweinhart et al.1993).

Since the late 1990s there have been many significant changes across the country in the style and content of these services and more changes are advocated (NHMRC, 2002; Vimpani, 2003) or foreshadowed, Oberklaid et al. (2003) for example, urging the greater use of children's services facilities as platforms for offering health care.

Whilst screening still forms an important part of child and family health service practice, it now focuses more on validated screening for which there is a strong evidence-base. Routine developmental screening has been replaced in some jurisdictions with parent checklists (PEDS) that provide opportunities for parents to raise concerns with their nurse (Glascoe, 1997). Newborn hearing screening using oto-acoustic emissions or auditory evoked brain stem responses is gradually replacing the relatively insensitive distraction testing traditionally administered towards the end of the first year (NHMRC, 2002; National Council for Community Child Health, 2004).

Universal home visiting to mothers of all newborns has been reintroduced in several states in an attempt to provide mothers with a more responsive and relaxed environment in which to discuss their concerns as well as offering a non-threatening entry point for those who might benefit from longer term in-home support, by either volunteers or nurses, because of underlying social or health needs (Families First, 2004). There has been an increased emphasis on mental health promotion and parenting skills (Commonwealth Department of Health and Aged Care, 2000) with evidence-based behavioural family interventions such as Triple P being offered widely by nurses and other professional groups (Sanders & Markie-Dadds, 1996). There is growing recognition of the importance of flexibility in what is offered and a clear understanding that one size does not fit all. There is increasing awareness that variations in parental self-efficacy - critical determinants of program impact - need to be taken into account and addressed (Coleman & Karraker, 1997). Child health centre opening times and locations are being reviewed in many places to take account of changing parental work patterns. There is increasing recognition that services have failed to cater adequately for the growing numbers of fathers who care for their children – whether this be the sense of alienation induced by the name of the service, the way client groups are managed, staffing profiles or the display of posters in waiting rooms that support traditional notions of early childhood being 'women's business' (Fletcher, 2003).

There are also increasing demands from parents for more integrated services, many arguing for "one-stop shops" where they can access services such as child care, play groups, or experiences in music, craft and drama for their young children along with health services and opportunities to meet with staff from Centrelink to organise family benefits, as is happening in many of the 'Early Excellence Centres' springing up in the UK under the Sure Start banner (often modelled on the Coram Family Centre's prototype in Central London) (Pugh, 2002). In some states (e.g. NSW) early childhood health, education and other community services are being planned at a regional level using whole of government frameworks (Families First 2004), a model that will hopefully be further extended with the Australian Government's 'Communities for Children' initiative that forms part of the current 'Stronger Families and Communities Strategy' (DFaCS, 2004).

The new ways of working also create challenges for workforce preparation and ongoing professional development. A recent review by the Centre for Community Child Health (2003) for the Department of Family and Community Services and the Australian Council for Children and Parenting found that many professionals working with young children lacked a good understanding of the emerging trends in developmental and prevention science that underpin their work. Moreover, skills in family-centred practice that uses a strengths-based approach and incorporates adult learning principles were found to be wanting for many. Some states – NSW, WA, SA - have been utilising Hilton Davis's Parent Advisor Model (Davis, Day & Bidmeade 2002), known in Australia as Family Partnership training, to facilitate good communication between professionals and parents in order to engage with clients in an effective therapeutic alliance.

These developments in early childhood services demonstrate the translation of research evidence into policy and practice, even if the implementation may be flawed, belated or under-resourced. As the proportion of children in the community shrinks at the same time as the numbers of aged persons increases, children's successful transition from birth to productive young adulthood has never been more crucial for the future of our country. Whilst children are important in themselves, they are also our most crucial resource for the future and we cannot afford large numbers of welfare dependent young adults if we want to provide a decent standard of living for our aged persons. Helping children on to developmental trajectories that will lead to productive and creative adult lives is a challenge that begins at conception and continues through the early years and adolescence. It calls for strong partnerships between parents, health, education and other paid and volunteer community service workers, and children and young people themselves, supported by good government policy and realistic funding levels.

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