

Child health teams in community health

A survey of 11 community health services



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Published by the Victorian Government Department of Human Services
Melbourne, Victoria

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Authorised by the State Government of Victoria, 50 Lonsdale Street, Melbourne.

Printed by: Kwik Kopy Printing, Shop 4, Telstra Building, 242 Exhibition Street, Melbourne VIC 3000

Foreword

Growing Victoria Together is the government's vision for making Victoria a stronger, more caring and innovative state. Improving the health and wellbeing of young children is a priority for the government in achieving this vision.

'Giving children the best start in life' is a key strategy of *A Fairer Victoria*, the government's social policy action plan, which is pursued by giving a major boost to child and family support services. We understand that there is nothing more important to the people of Victoria than giving our children the opportunity to grow up healthy, happy and well educated.

Community Health Services - Creating a Healthier Victoria released by the government in September 2004, identified a greater focus for community health services on child and family health.

In April 2005, I was pleased to launch a research and development project to look more closely at the work of 11 community health services with child health teams to develop this strategic direction.

This report describes the findings of that project. These findings suggest that community health services are providing early intervention in areas that are essential to the current and future health and wellbeing of young children, such as language, literacy and behaviour. They also demonstrate that these services are targeted to children in the crucial period prior to and just after entering primary school.

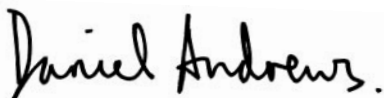
There is clear evidence nationally and internationally that effective intervention at this early stage will reduce the significant health and social problems that can emerge in later life associated with children falling behind key early development milestones.

Community health services are well placed to work with other children's services, families and local communities to better understand how we can prevent these problems and minimise their negative effects.

In recognition of the role these services can play in responding to high priority areas of children's health, wellbeing and development, through working with locally provided children's services, the government announced investment in 12 community health services, in May 2006, as part of the *Growing Communities Thriving Children* initiative. This initiative will strengthen the service response provided in Local Government Areas at the metro- rural interface and areas of disadvantage: communities with young populations who face rapid growth and limited availability of services.

I thank all the community health services that have contributed to this research, your efforts have improved knowledge about the role of community health services in responding to the needs of Victorian children and have identified the improvements required.

We look forward to working with community health services across Victoria to build their capacity to provide for the needs of children and their families.



Daniel Andrews MP
Parliamentary Secretary for Health

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Introduction

The importance of children's early years for promoting health, learning and school readiness is increasingly understood, as is the importance of identifying and mediating risk that can compromise later functioning. Parents and families have a critical role in providing children with nurturing relationships and supportive environments—the building blocks of healthy development. By working with parents, service providers, including community health, can influence children's health and development, including their readiness to learn at school.

Services can contribute by working with families to alleviate risk factors, address the broader determinants of health and provide more in-depth interventions where children have specific health or developmental issues.

In Victoria, community health services (CHSs), located in every local government area, are active contributors to their local communities. They seek to develop the health of individuals and communities by providing services and programs to meet local needs.

CHSs are generally well developed in responding to the needs of their aged population, but vary in their approach and capacity to provide services to children. Some CHSs have set child health as a priority and are responding to the needs of children through a multidisciplinary model of care that includes child health teams. These child health teams typically work within a primary health and early intervention approach—working with communities, engaging in family-centred practice, responding to the multiple determinants of health, and prioritising responses to those in most need.

In 2005, 11 CHSs that provide multidisciplinary services for children and their families participated in a survey to examine their role in addressing the health, wellbeing and developmental needs of children.

Given the potentially complex nature of developmental problems and the variety of children seen in CHSs, the survey focused on children with multiple needs, that is, those who require the services of two or more allied health practitioners. The overall aim of the survey was to improve the understanding of the nature of children's health services in a multidisciplinary team setting.

These agencies contributed to an initial questionnaire that collected information about their target group, objectives and staffing profiles.

The participating community health services

Casey–Cardinia Community Health Service focuses on younger children aged 0–6 years, giving a high priority to children aged 0–3 years. The service aims to provide comprehensive assessment and treatment to enable children to reach their potential. Services include speech pathology, counselling, occupational therapy, nursing, dietetics and podiatry. Service-specific assessments are carried out and information is shared through team leader, team and ad hoc meetings.

Central Bayside Community Health Service aims to provide high quality integrated assessment, interventions, education and support to children and their families. Services include psychology, social work, paediatric occupational therapy, paediatrics, speech therapy and physiotherapy. The intake process differs for each discipline in the team. Occupational therapy and psychology target 0–12 year olds, while speech pathology targets children 0–6 years. The team communicates through team meetings and case discussions.

Colac Area Health is an integrated health service that provides community health and acute services. Children are catered for through the allied health team, community programs and family services. The allied health team provides speech therapy, nutrition, physiotherapy, occupational therapy and preschool public dentistry. Counselling and support services are provided to children exposed to family violence. A family support program aims to respond to the needs of vulnerable families, and alcohol and drug services are also offered to families. Team members communicate through case conferences held when necessary.

Dianella Community Health's child health program focuses on children, young people and their families. The team offers social work, child psychiatry, preschool hearing, audiology and speech pathology. There are also family support workers and other supports offered to ethnic communities, as well as child psychology and paediatrician services.

Eastern Access Community Health offers early intervention services for children with a disability or developmental delay, occasional child care providing respite and developmental activities for children and families at risk of social isolation, as well as speech pathology and child psychology. A range of family and parenting support initiatives are also available, including a family support program, general and specialist counselling services, parent education, and support groups with links to other community services.

Frankston Community Health Service offers occupational therapy, psychology, speech pathology, physiotherapy and other services, such as audiology and dietetics, as needed. There is no target age group. While each worker contributes specialist knowledge and skills according to their discipline, overall goals are child and family centred. The child and family team meets regularly and case discussions between staff occur as needed.

Gippsland Lakes Community Health offers a number of programs, each with its own set of objectives and target groups. The early years team offers maternal and child health nursing and school nursing. Family support is offered through social work and play therapy, counselling and family therapy. Some outreach programs target children, including the Koori Outreach, Alcohol and Drug Youth Outreach, primary school counselling and the 0–2 years program. Regular meetings ensure services are coordinated.

ISIS Primary Care focuses on prevention and is family-centred. The service offers speech pathology and psychology to preschool children and occupational therapy and physiotherapy to children under the age of 12. There is a central paediatric intake worker who may refer children and families to other services if needed, following assessment. Within the service, the process for assessment differs for each discipline. Regular paediatric team meetings and ad hoc informal meetings enable internal communication.

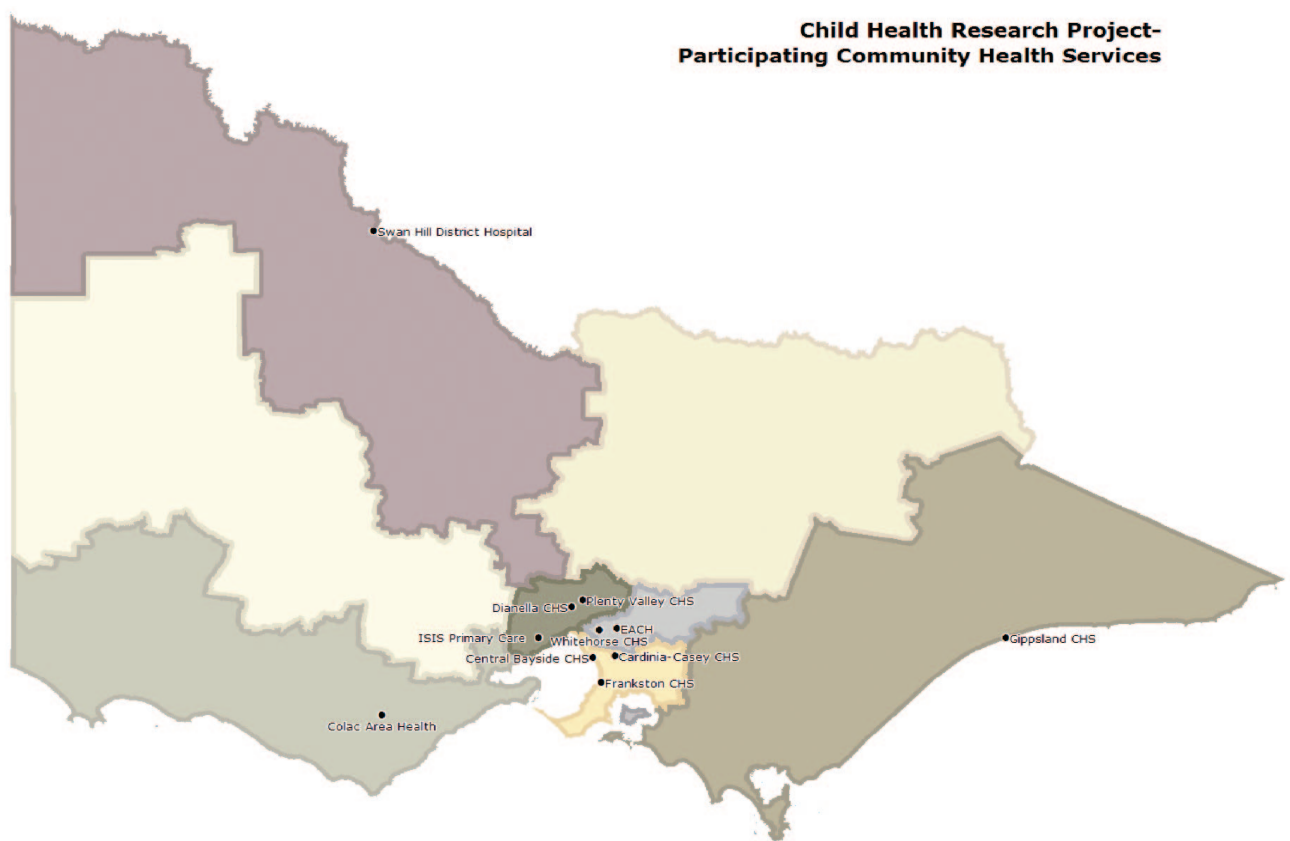
Plenty Valley Community Health aims to improve the development and wellbeing of children through the coordinated provision of an early intervention childhood service program. Services include speech pathology, occupational therapy, dietetics, neuropsychology and physiotherapy. Each discipline has a different target age group and offers services to children who would not be eligible for services elsewhere. The team is involved in regular team meetings and cross-disciplinary training is offered.

Swan Hill Community Health Service (District Hospital) targets children aged 0–18 years who require short-term rehabilitation. They may have a diagnosed disability such as cerebral palsy, autism, Down’s syndrome, developmental delay with substantial limitations, or have had a recent illness or injury that has resulted in the need for short-term rehabilitation. The team offers occupational therapy, physiotherapy, speech therapy, podiatry, dietetics counselling and case management. Information is shared through regular team meetings and ad hoc meetings.

Whitehorse Community Health Service targets children aged 0–6 years, giving priority to those in the lower socioeconomic bracket. The aim is to intervene early, taking a family-centred approach, to have a positive impact on children’s development by providing them and their parents with timely support and quality services. The services include speech pathology, psychology and occupational therapy. Communication within the team occurs through team meetings and case conferencing about common clients.

The location of the 11 participating CHSs is shown in Figure 1.

Figure 1: Location of participating community health services



Survey method

A survey instrument was designed to capture the following information:

- demography
- problems managed
- assessment and referral processes
- service impact.

The survey also explored the extent to which teamwork operated with the individual child and their family, and how information was shared between providers. The instrument contained both quantitative and qualitative aspects. CHSs were given the opportunity to review and comment on the survey instrument before it was finalised.

The survey consisted of two parts—part one tracked the impact of service on individual children and their families; part two examined the service more broadly.

The individual child and family analysis required each CHS to select a retrospective sample of 50 children aged 0–12 years who had received treatment/intervention from at least two allied health practitioners since June 2003. Data was sourced from case files and clinical/intervention histories were reviewed to obtain the survey responses.

CHSs were provided with an identical survey instrument, sample selection criteria and survey instructions. However, there were limitations to this methodology, for example, the recorded case information varied across services and each service had responsibility for their own data collection and coding of responses.

Primary caregivers' views were sought on their satisfaction with the service and its outcomes, through a mailed survey or telephone questionnaire.

Lastly, CHSs were surveyed about their partnership and health promotion activity.

Much of the survey data is quantitative and verifiable, however, the qualitative elements of the survey sought to assess the outcomes of service and the achievement of treatment goals. These findings should be regarded as observations only, given the limitations of the methodology and the nature of the presenting problems, including communication delays and behavior problems, where clear means of outcome measurement had not been instigated.



Survey findings

Demography

The sample for the survey was made up of approximately 50 children from each CHS, selected retrospectively (Table 1).

Table 1: Sample size by agency

Agency	Children
Casey-Cardinia Community Health Service	50
Central Bayside Community Health Services	50
Colac Area Health	28*
Dianella Community Health	50
Eastern Access Community Health	50
Frankston Community Health Centre	47
Gippsland Lakes Community Health	50
ISIS Primary Care	51
Plenty Valley Community Health Services	50
Swan Hill District Hospital	50
Whitehorse Community Health Service	50
Total	526

*The CHS could only identify 28 children who fitted the criteria.

To put this total sample number in context, in 2004–05, CHSs in Victoria saw a total of 17,349 children aged 0–10 years.

Significantly more males fitted the selection criteria than females (Table 2).

Table 2: Gender distribution

	Number	%
Female	147	28
Male	379	72
Total	526	100

The finding that more boys than girls were receiving community health services is consistent with children's hospitalisation patterns, but more pronounced.

In the study sample, 521 children (99 per cent) were Australian-born. While the actual ethnic background of the children was not asked, 509 registered that English was the main language spoken at home. This is further reflected in the finding that an interpreter was used in only five cases, and suggests that culturally and linguistically diverse populations are not accessing the services. It may indicate limited awareness of CHSs or lack of recognition of the presenting problems' appropriateness to CHS intervention.

Seventeen out of 526 (3.3 per cent) were recorded as being of Aboriginal or Torres Strait Islander descent.

Concession cardholders comprised 41 per cent of the sample (of 493 responses to this question), which is a lower proportion than has been previously observed for users of CHSs in general. This is significantly lower than some participating CHSs believed and may be an underestimate, as there was some ambiguity to the question. Other CHSs, however, considered that it might reflect a lack of access to children's multidisciplinary services in the private sector. If referral is made into CHSs on the basis of health care need (rather than socioeconomic status alone), this may explain the higher than expected proportions of non-concession cardholders amongst the sample.

Children seen were predominantly preschool age or just starting school. The average age across all centres was 4.2 years for boys and 3.6 years for girls (Figures 2 and 3).

Figure 2: Age distribution of children

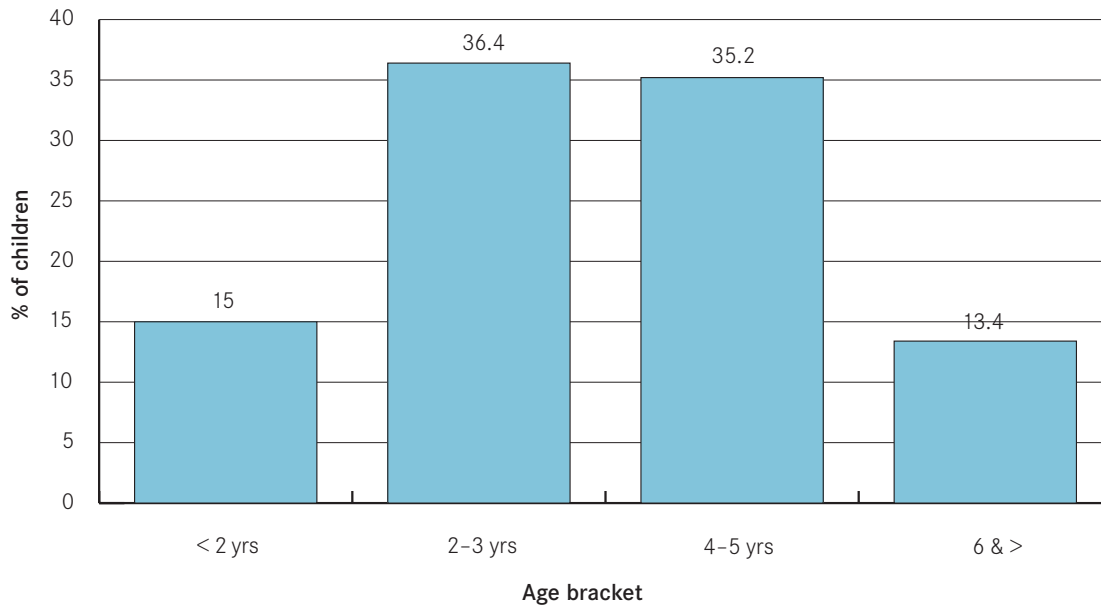
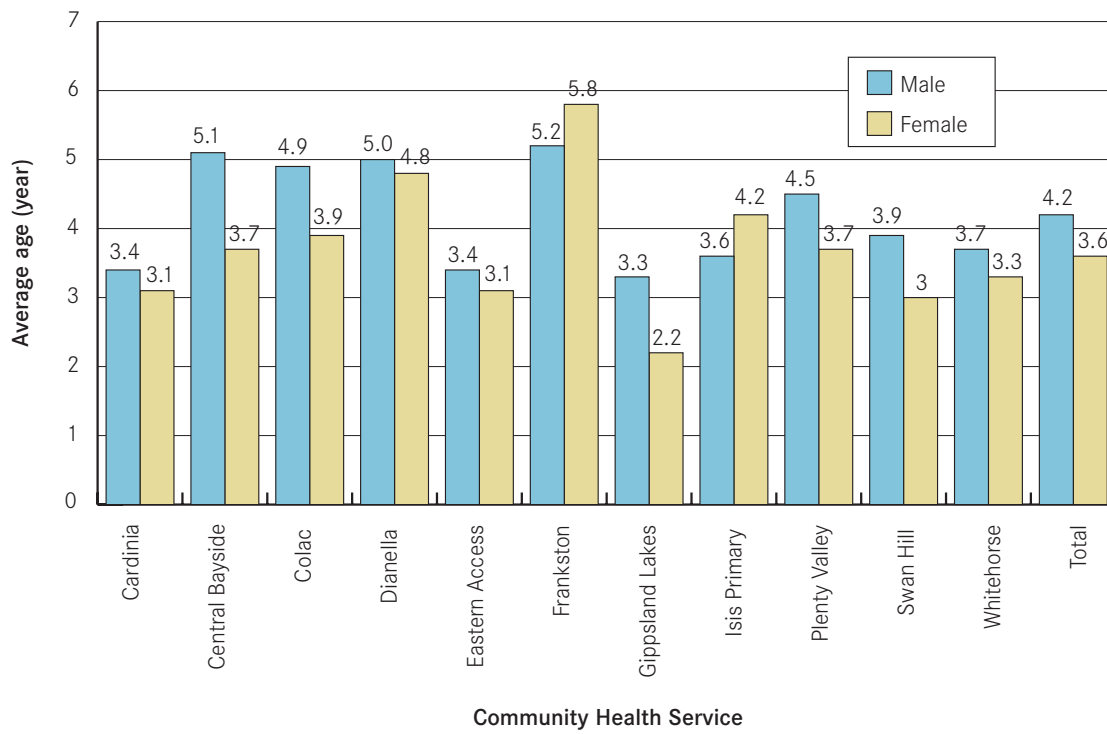


Figure 3: Average age by gender across the 11 community health services



Problems managed

Agencies were instructed to select children who had multiple needs requiring intervention from at least two allied health practitioners. A wide range of problems were managed, the most common being speech and language delay, motor skills delay, behaviour problems, communication difficulties and other developmental delay (Figure 4).

Children in the survey commonly required treatment of multiple problems (Figure 4). Boys showed higher rates of complexity, as indicated by the number of presenting problems managed.

Figure 4: Range of problems managed

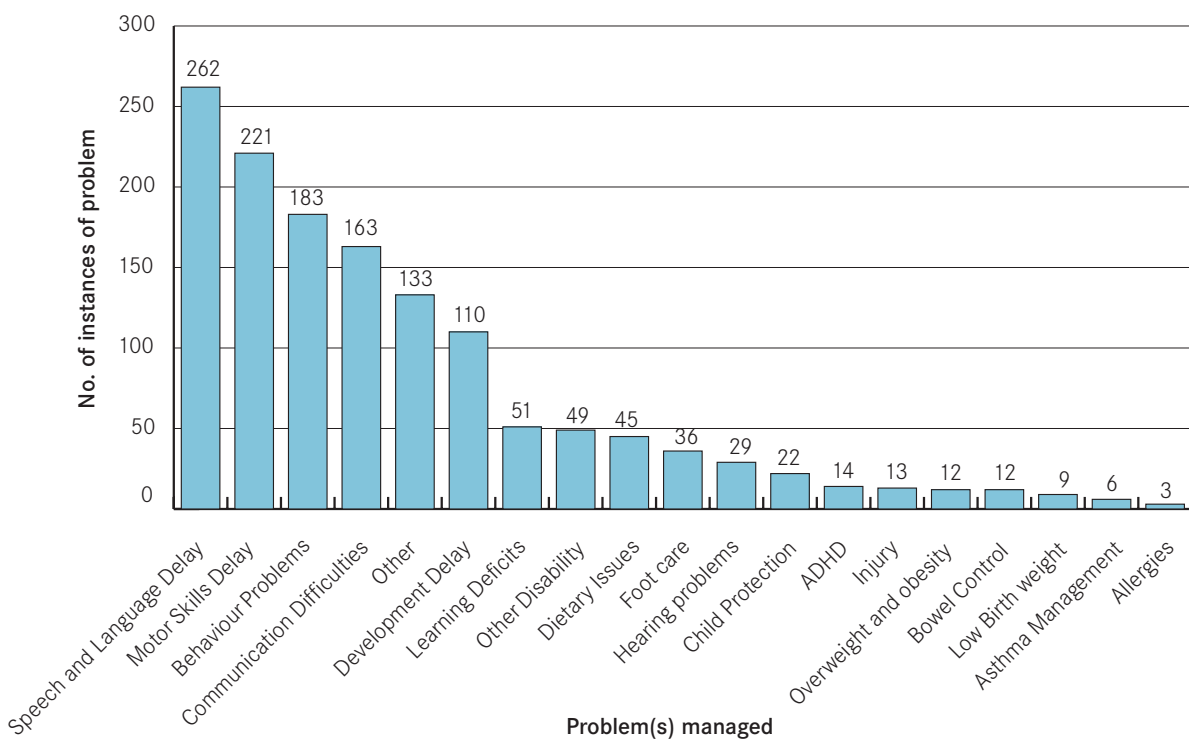
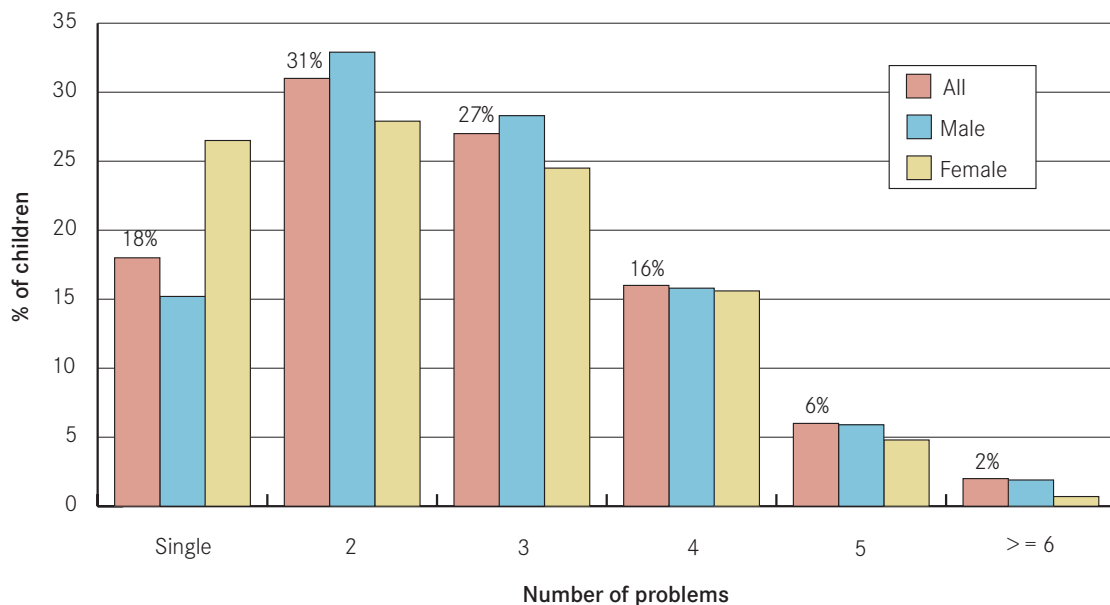


Figure 5: Number of presenting problems



Referral source

The survey demonstrated a breadth of referral sources into multidisciplinary child health teams (Table 3). CHSs in Victoria offer a *primary* health care service, that is a service that is available as a first point of contact. However, the parent or family directly initiated less than one third (28.5 per cent) of services. Maternal and child health was the main source of referrals in this service sector (27.5 per cent). General practitioners (GPs) were a source of referral in 12 per cent of cases, with paediatricians generating nearly 8 per cent of referrals. Kindergartens were the next leading source of referral.

In over 70 per cent of cases, the service was delivered following a referral. It could be argued that CHSs are seen in the community as a source of ‘specialist’ services for children.

Table 3: Sources of referral

Source of referral	%
Parents/family	28.5
Maternal and child health	27.5
GP	12.0
Paediatrician	7.6
Kindergarten	7.2
Preschool	3.7
Early Childhood Intervention Service	3.3
School	3.1
Family services	2.8
Child care	2.6
Children's Services Resource and Development Officer (CSRDO)	1.7

Respondents were given the opportunity to nominate ‘other’ sources of referral. Here ‘hospital’ was the most common category, generating eight referrals. ‘Preschool field officer’ and ‘child protection’ were the source of two referrals each. In 63 per cent of cases, the referral identified the specialist discipline required. There was, however, no correlation between the source of referral and the nature of the problems referred. Parents and family, maternal and child health, paediatricians, GPs and kindergartens were all referring for the same core group of problems.

Letters and phone calls were the most common source of referral (Table 4). The fact that only 9 per cent used the Service Coordination Template Tool for referral was a reflection of the utility of that tool for child health issues¹.

Table 4: Modes of referral

Mode of referral	Number	%
Letter	194	37
Family (self)	133	25
Phone call	128	24
Service Coordination Template Tool (SCTT)	45	9
Fax	24	5
Email	2	0
Total	526	100%

A total of 467 responses listed the ‘reasons for referral’. The correlation between ‘reasons for referral’ and the ‘problems managed’ could be taken as an indication of accuracy and appropriateness of recognition. Speech and language delay was the most common issue referred. Behaviour problems were also often reported and included bullying, frustration tolerance, anxiety, social/play skills and emotional/self-esteem issues.

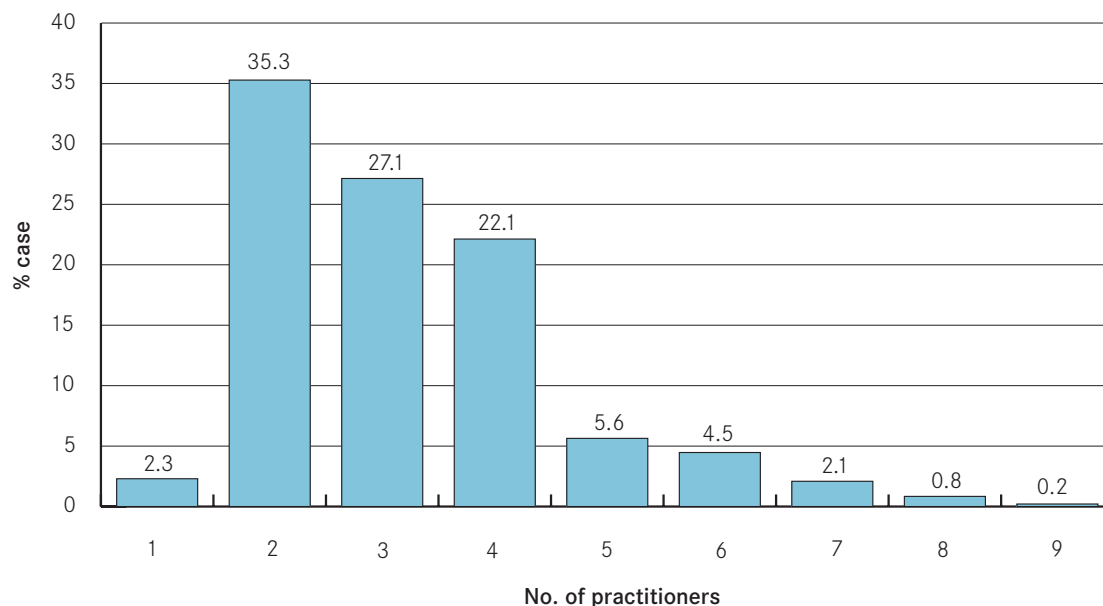
¹ The revised Service Coordination Template Tool (SCTT), for release in 2006, has an increased capacity to collect carer/parent information. Further work is anticipated over the next revision cycle to improve the SCTT's utility for referral of children and their families.

Developmental delay was a common reason for referral. This category included school readiness and transition, Asperger’s, autism, dyspraxia, global delay and poor hand skills. Motor skills delays were also commonly referred as were family and parental concerns, including domestic/family violence, parental health issues, family break-up, parenting skills, substance and alcohol abuse, postnatal depression, mental health issues and maternal anxiety. Responses do correlate with the ‘problems managed’ and reflect well on the accuracy and appropriateness of recognition.

Service provision

The children in the sample were selected on the basis of needing at least two allied health practitioners. In 169 cases, the intervention involved two practitioners, in 130 cases it involved three, and in 106 cases, four practitioners were involved (Figure 6).

Figure 6: Number of practitioners per case



The most common disciplines involved in providing treatment were speech therapists (involved in nearly 60 per cent of cases in the study sample), occupational therapists and child psychologists (Table 5).

Table 5: Range of disciplines involved

Discipline	Cases	%
Speech therapist	299	56.8
Occupational therapist	225	42.8
Child psychologist	187	35.6
Physiotherapist	116	22.1
Maternal and child health nurse	85	16.3
Case manager	54	10.3
Family support workers	50	9.5
Counsellor	45	8.6
Dietician	41	7.8
Podiatrist	37	7.0
Preschool field officers	31	5.9
Audiologist	20	3.8
CSRDOs	11	2.1

In over half (54.4 per cent) of cases, the child was receiving services concurrently from health and community support services external to the CHS.

Just over half of survey returns (52.5 per cent) indicated that the family was involved in treatment and was also receiving services. This involvement included assessment, parent education and support, and home programs. In only 9.6 per cent of cases, the intervention offered by the service involved the child alone.

Service outcome

In the majority of cases (88.7 per cent), there was a documented intervention plan and even more (92.2 per cent) indicated that treatment goals were identified. The survey sought to assess how treatment goals were articulated. There were 488 responses to this question. These included:

- 'To work on phonetic sounds, problem solving, play and to attend a social skills group weekly.'
- 'To complete the PEER (paediatric examination of educational readiness), school visit for observation, to provide parenting support. To focus on social skills development and anger management strategies to address rages and tantrums.'
- 'To attend motor therapy group, to improve visual memory and handwriting skills.'
- 'To encourage play skills, listening and cooperative behaviour. To encourage articulation.'
- 'Support mother to accept help for depression; support mother and partner to establish stable relationship; support mother to increase her self esteem; baby to settle and sleep through the night.'
- 'To assess motor skills and monitor weight. To build on social skills and to educate parents with ideas and strategies in this area.'

However, treatment goals were not written in measurable terms such as percentage improvement against a base line score. As such, goals achieved are a subjective measure.

CHSs used a wide range of indicators to assess goal attainment. These included:

- PEER = Pediatric examination of educational readiness
- CELF = Clinical evaluation of language fundamentals
- BEERY = Visual Motor Integration test (VMI)
- PEABODY = Picture Vocabulary Test
- TOLD = Test of language development
- ASSQ = Autism Spectrum Screening Questionnaire
- Victorian Risk Assessment Framework (used by Child Protection)
- North Carolina Family Action Plan
- Maternal and Child Health Development Assessment
- other formal assessment tools/tests
- psychometric tests
- improvement
- parental/teacher feedback reporting positive change
- clinical observation
- formal/informal assessment results
- Interviews/consultation.

The survey sought to determine the extent to which treatment goals were attained. Treatment goals were either wholly or partially attained in most cases (Table 6).

Table 6: Attainment of treatment goals

Treatment goals attained	Number	%
Yes	130	24.7
No	48	9.1
Partially	325	61.8
Not answered	23	4.4

The majority of treatment goals were assessed as partially obtained, which may result from the fact that treatment was still ongoing for 43.2 per cent of cases or that the articulation of the treatment goals tended to have limitations, written in terms not conducive to measurement and definitive achievement.

Non-attainment of treatment was explained through ‘family withdrawing or ceasing contact’ in 29 per cent of cases. In 22 per cent of cases, the child was referred to another agency, and 11 per cent recorded ‘poor engagement in intervention’ as the explanation.

Treatment had ended for 299 (56.8 per cent) cases within the sample. Over two thirds (64.2 per cent) of children whose treatment had ended had a follow-up plan in place (Table 7).

Table 7: Treatment outcomes

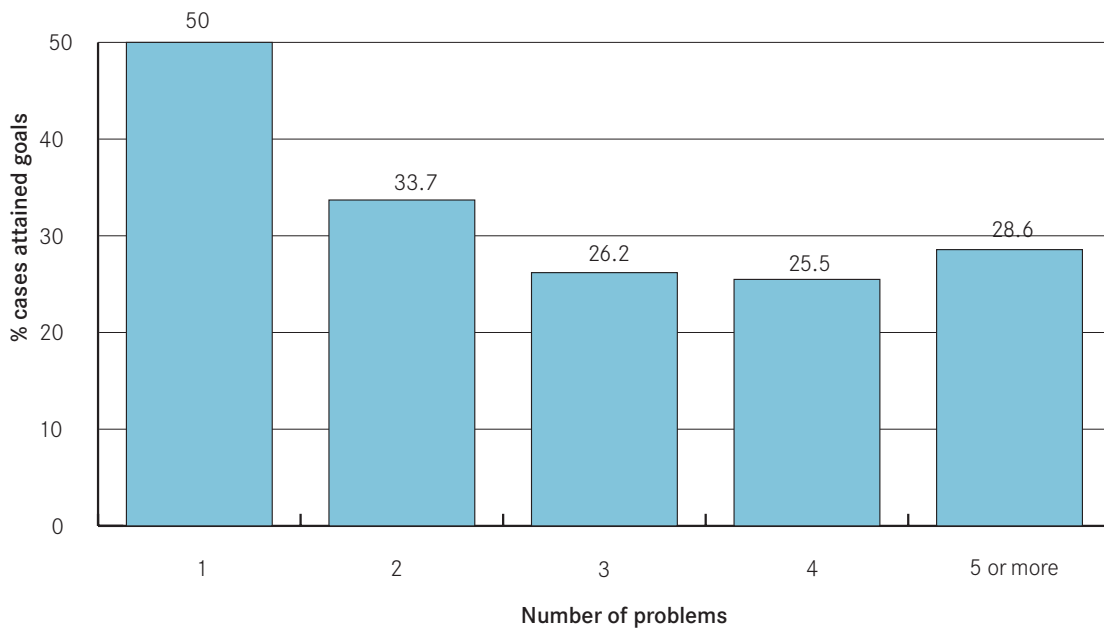
Treatment ended n=299

Goals attained n=96 (32.1%)		Goals partially attained n=168 (56.2%)		Goals not attained n=28 (9.4%)	
Follow-up n=59	No follow-up n=37	Follow-up n=116	No follow-up n=52	Follow-up n=15	No follow-up n=13



The number of problems managed was examined in the 299 cases where treatment had ended. It was evident that the more problems managed, the less likely treatment goals were achieved (Figure 7).

Figure 7: Goal attainment by number of problems



The goal attainment rates are likely to reflect the nature and complexities of the problems managed and are influenced by a range of factors, including their initial documentation.

The under two years age group had the highest rates of assessed goal attainment, with similar results for the over sixes. The preschool age group had lower levels of treatment goals obtained (Table 8). There were no gender differences for goal attainment in the group that had ended treatment.

Further work will need to be undertaken to ensure treatment goals can be measured. This also requires setting specific objectives with parents\carers and children that are realistic, attainable and measurable, providing a clear picture of the extent of goal achievement over time. This would provide a better understanding of outcomes sought and the impact of interventions.

Table 8: Goals attained for age groups

Age group	Goals attained %
Under 2 years	50.0
2-3 years	30.9
4-5 years	23.7
Over 6 years	45.7

Teamwork

Teamwork, which brings together the skills and perspectives of a range of disciplines, has been advocated in the management of children with complex problems. The survey instrument sought to assess the extent to which multidisciplinary care was provided in the CHSs. The main aspect of teamwork probed by the survey was the nature of information sharing. Respondents were able to select more than one method of information sharing between health care professionals. The most common means of information sharing were team meetings, mailed written reports and informal means (Table 9).

Table 9: Methods of information sharing

Information sharing	No. cases	%
Team meetings	121	23.9
Written reports mailed	114	22.5
Informal/other	94	18.5
Case planning meetings	59	11.6
Case conferences	48	9.5
Electronic communication	36	7.1
Phone calls	20	3.9
Others	14	2.8

Joint assessment across disciplines occurred infrequently, in less than a quarter of cases (24.6 per cent). One hundred and ninety-four children had two separate assessments, 88 had three separate assessments and 37 had four separate assessments. Assessment was undertaken separately in most cases.

Joint intervention was carried out in 36 per cent of cases. The most common types included a group-based approach, a combination of approaches and individual sessions (Table 10).

Table 10: Types of joint intervention

Type of joint intervention	No. cases
Group	78
Secondary consultation	18
Individual sessions	25
Combination	69

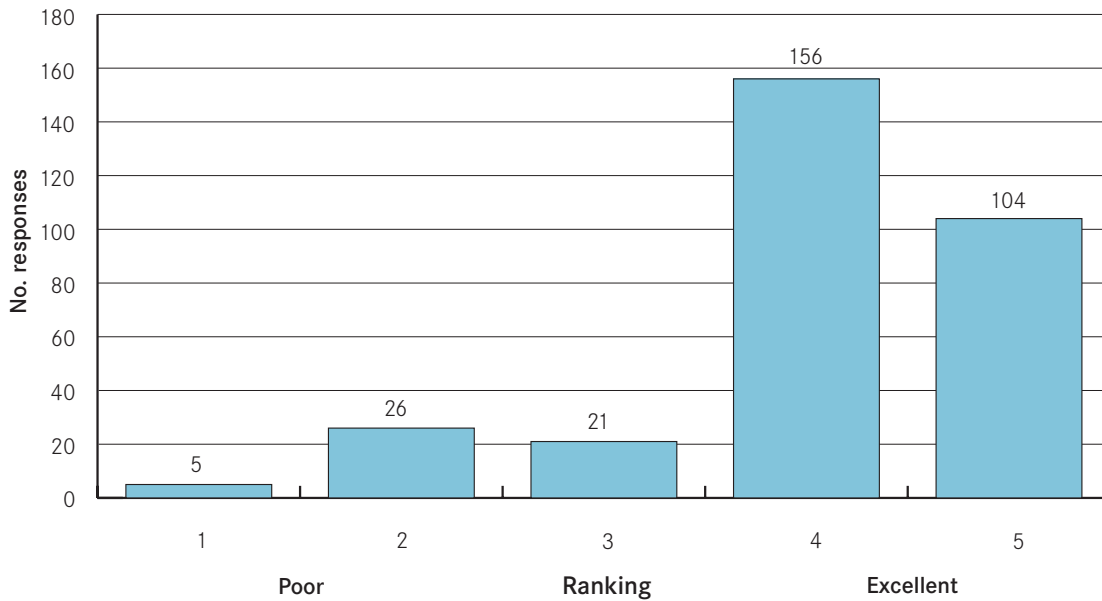
The disciplines most commonly engaged in joint interventions were speech and occupational therapists, and psychologists (Table 11).

Table 11: Disciplines engaged in joint intervention

Discipline	Number	Proportion % (n=190)
Speech therapy	161	84.7
Occupational therapy	119	62.6
Psychology	81	42.6
Special education	15	7.9
Physiotherapy	15	7.9
Counselling	12	6.3
Paediatrics	11	5.8
Audiology	6	3.2
Dietetics	5	2.6
Nursing	4	2.1
Family support/social work	4	2.1
Child care	4	2.1
Other support worker	4	2.1
Maternal and child health	2	1.0
General practitioner	2	1.0
Podiatry	2	1.0

The CHSs were asked to rate their level of information sharing with external services. On a scale of 1 (poor) to 5 (excellent), information sharing with external services was clustered at the ‘excellent’ end (Figure 8). However external stakeholders views were not canvassed.

Figure 8: Satisfaction levels for client information sharing with external providers



Primary caregivers’ views

The survey assessed the satisfaction of primary caregivers across three aspects of service outcomes. Most agencies undertook this survey by telephone; others mailed the survey to home addresses. Nine agencies submitted data on 274 responses.

Primary caregivers reported high levels of satisfaction with the service, with over half the respondents (50–57 per cent) reporting that they were ‘very satisfied’ and an average of 89.3 per cent of respondents either ‘satisfied’ or ‘very satisfied’ with the effect of interventions on the child, their own understanding of the child’s problem or their ability to manage the child problem (Table 12).

Table 12: Satisfaction levels of primary caregivers

	Very satisfied	Satisfied	No opinion	Dissatisfied	Very dissatisfied
Effect of treatment	%	%	%	%	%
Helped the child’s problem	57	38	4	2	0
Helped your understanding of the child’s problem	52	38	7	3	1
Helped you manage your child’s problem	50	38	8	4	1

Health promotion

The survey sought information on the health promotion interventions in operation by the child health team and across the community health service.

Only the health promotion activities that specifically targeted children or their parents are included in this report. Within any particular health promotion intervention, a number of health outcomes can be achieved, however, the data presented below categorises programs according to the priority issue targeted.

Range of health promotion programs

Across the CHSs, three common types of health promotion priorities were evident: social connectedness, nutrition/obesity and physical activity/wellbeing (Table 13). This result is unsurprising, with the latter two categories reflecting national priority areas.

Table 13: Types of health promotion interventions

Health promotion priority	Target	Number of health promotion interventions
Social connectedness/support/mental wellbeing	Parents	16
Nutrition/obesity	Children and early childhood settings	10
Physical activity/wellbeing	Children, parents and early childhood settings	8
Parenting/self-confidence	Parents	5
Capacity building/practical skills development	Parents	3
Asthma	Early childhood settings, children	3
Behaviour/self-esteem	Children	3
Drugs/alcohol/tobacco	Children and parents	2
Speech/reading	Children and parents	2
Community building	Children, parents and community	2
Sexual and reproductive health	Children	1
Child safety	Parents	1
Total		56

The significant proportion of health promotion strategies encompassed within the priority area of social connectedness targeted parents and used a broad range of interventions, including those addressing mental wellbeing and parental support. Interventions included facilitated social support groups with parents and their children, groups to develop parental mental health self-efficacy, and contributions to community events.

Nutrition/obesity interventions tended to directly target children and early childhood settings and schools. These commonly focused on providing age appropriate health education and skill development in preschools and primary schools. Strategies also included supporting childhood settings to integrate health promotion and providing health information to local business and community.

Physical activity/wellbeing strategies targeted children, parents and childhood settings. Interventions included implementing exercise programs, including the Walking School Bus program and after school physical activities for children. Exercise programs also targeted parents. Childhood settings were also supported to embed physical health practices into daily activities.

A range of other health promotion interventions were delivered and cover a breadth of areas including parenting skills, substance and asthma education.

Health promotion activities related by this sample of CHSs tended toward health education and skill development at the individual/group spectrum of health promotion, with some population-focused strategies, including supporting childhood settings.

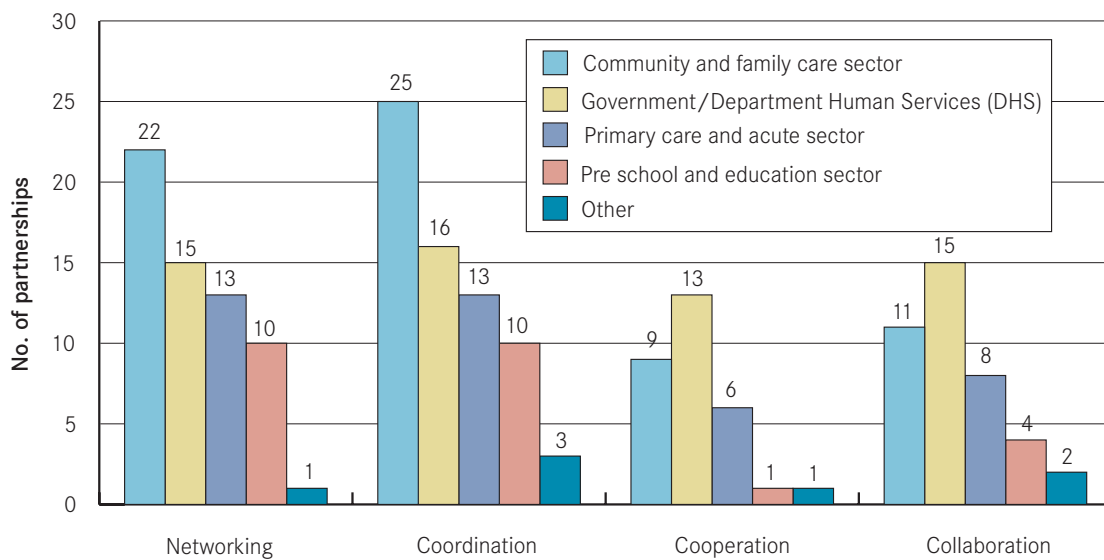
As services re-orient their health promotion priorities toward children, the mix of health promotion interventions should encompass a greater balance of individual and population-wide activities.

Partnerships

The survey also sought information about partnerships maintained by the CHS and the level of integration of the child health team within their local community and service system. Agencies were required to identify partners, map their relationship with the identified services and present the level of integration with the child health team.

The findings demonstrate that CHSs have developed a wide range of partnerships across the service system. Most partnerships stem from the community and family care sector and government services, with a smaller percentage from the primary care, acute and education sectors.

Figure 9: Range of community health service partnerships with external services



Examples of services within each of these sectors include:

- **Community and family care sector:** Anglicare, Uniting Care, Aboriginal Community Controlled Organisations
- **Preschool and education sector:** kindergartens/preschools, primary, secondary and special schools
- **Primary care and acute sector:** local hospitals, Royal Children’s Hospital, local health services, allied health professionals, GPs
- **Government sector:** Children’s Services Resource Development Officers, Centrelink, Disability Services, Early Childhood Intervention Services, local councils
- **Others:** childcare centres, parents/carers and professional groups.

As shown in Table 14, the level of integration with partners was rated on a continuum from networking, coordination, cooperation and collaboration.

Table 14: Partnership definitions

Integration	Process	Purpose
<p style="text-align: center;">Low</p> <p style="text-align: center;">↑</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">High</p>	Networking	<ul style="list-style-type: none"> • The exchange of information for mutual benefit. • This requires little time and trust between partners. • Clearinghouse for information.
	Coordination	<ul style="list-style-type: none"> • Exchanging information and altering activities for a common purpose. • Match and coordinate needs and activities. • Limit duplication of services.
	Cooperation	<ul style="list-style-type: none"> • As above, plus sharing resources. • It requires a significant amount of time and high level of trust between partners.
	Collaboration	<ul style="list-style-type: none"> • In addition to the other activities described, collaboration includes enhancing the capacity of the other partners for mutual benefit and a common purpose. • Building interdependent systems to address issues and opportunities. • Sharing resources and making equal commitment.

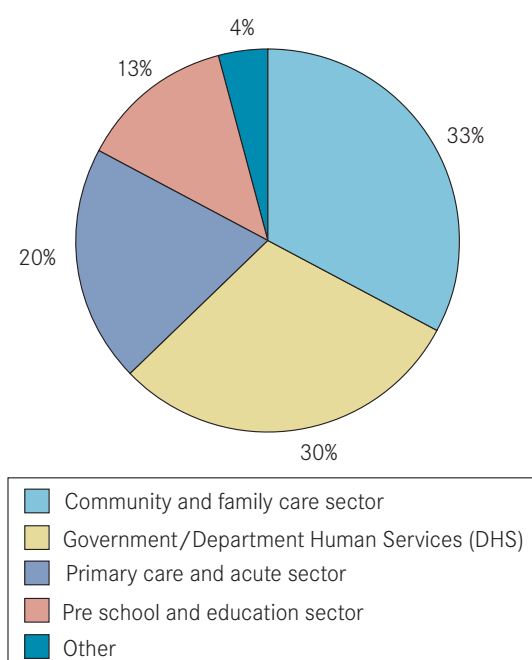
Department of Human Services, Primary Health Branch (2003) *Integrated health promotion: a practice guide for service providers.*

The majority of partnerships were reported as operating at the lower levels of integration, through the processes of networking and coordination.

Given the complexity of the service system and the time and commitment required to achieve collaboration, progression along this continuum is an ongoing priority for CHSs and their child health teams as they continue to develop their capacity.

The greatest number of partnerships operated at the ‘coordination’ level of integration within the community and family sector. Figure 10 presents the level of integration in each of the service sectors CHSs had partnerships. Where collaborative relationships existed, these were mainly with the Department of Human Services, child protection, maternal and child health and specialist children’s services.

Figure 10: Level of partnership integration



Conclusion

The first few years of a child's life are vitally important. By intervening early, providers and parents can influence children's health and development.

The findings of the survey demonstrate that CHS child health team services are targeted at children in the crucial period prior to and just after entering primary school. There is clear evidence that effective treatment at this early stage will reduce the significant health and social problems that emerge in later life associated with children falling behind key early development milestones. The rewards of early intervention will be a healthier, more economically productive and more socially cohesive population.

The survey of 11 child health teams across CHSs was the first of its kind carried out in Victoria. As such, it is exploratory in nature and its purpose is to discover more about the provision of children's health services in CHSs. The survey was retrospective and relied on what was documented in case notes. This may have varied between CHSs and between cases within CHSs. There is likely to have been further variation in how case notes are interpreted by those providing the data. Nonetheless, survey participants consider that the findings represent the programs and services well.

Early childhood programs and services, such as child health teams, provide essential foundations to build for the future. The funding of 12 CHSs in 2006, to extend their services for children, presents an ideal opportunity to demonstrate that by building on existing practice, Community Health can effectively respond to the needs of children and families in their communities.

This research provides CHSs with a better understanding of child health teams upon which to build. The development of their child health teams will contribute to the capacity of Community Health Services across Victoria to effectively support children and families.

