Child and Adolescent Health in Rural NSW

Authors:
Valerie Tosswill, Dip.App.sc., D.O.B.A

Address for Communication:
RFWCHS
Orthoptic Department
PO Box 52, Manly NSW 1655
AUSTRALIA

ABSTRACT

When looking at child and adolescent health in New South Wales (NSW), a significant number of problems and limitations become evident. The expectations placed on children today are becoming greater, with social and peer group pressures ever increasing. The health status and expectations of a child are closely linked to such factors as socio-economic and employment status, geographical location and education levels. An orthoptist is trained to assess the eye and ocular problems, however embracing family dynamics and looking at the larger picture assists in orthoptic outcomes. This paper highlights these issues, how they are being addressed by one organisation and how the orthoptist must acknowledge them for optimal results.

INTRODUCTION

Royal Far West Children's Health Scheme (RFWCHS/RFW) is a health facility in Sydney for rural NSW children and adolescents. With approximately 14% of the Australian population living in rural and remote areas[1,2], the average health status of children and adolescents from these areas is worse than that of those living in metropolitan areas, and it is often impossible to consider health in isolation from other social and economic factors[3]. The orthoptist is just one member of the health service provision team concerned with the child's general health and well-being.

The National Rural Health Alliance (NRHA) [3] – the peak body for rural and remote services for Australia – believes that health services should be guided by the following principles:

- the best interest for the child shall be the primary consideration
- the overall aim of the health care should be to protect and promote, to the maximum extent possible, the survival and optimal development of the child
- investing in the health of children with effective health promotion and early intervention programs that have been demonstrated to be cost-effective; and
- the team providing health care for children should ensure continuity, timeliness and quality of care.

These NRHA principles exist at RFW, where it is also believed that no child should be deprived of his or her right of access to health care services (Article 24 of the 1989 United Nations Convention on the Rights of the Child).

CURRENT ISSUES FACING CHILDREN AND ADOLESCENTS

Mental Health/Behaviour/Mortality

One in 5 Australians will suffer from a mental illness in their lifetime, and 14-18% of children and young adults experience mental health problems of clinical significance. Depression among adolescents is high and, furthermore, at least 62% of people with a mental illness are not accessing any kind of mental healthcare [4]. Anxiety is a problem that can affect people at all ages and is the most common emotional disorder in children and adolescents, affecting about one in ten.

In Australia in 2001, 1,931 children aged 0-14yrs died, representing 2% of all deaths. Of these, 1,290 were infants. Among children aged 1-14 yrs, injury and poisoning were the most common causes of death in 2000, responsible for 285 deaths 3. In 1996, 71% of all deaths at age 15-24 years were caused by injury, including traffic accidents, sporting accidents, peer group violence and self-harming behaviours [5]; second to injury as a cause of death was suicide [6]. A significant cause or contributor to adolescent morbidity and mortality has been identified as a lack of accessibility for young people to health services [5].

It has been estimated that one out of five women less than 25 years has been a victim of sexual abuse and this often begins in adolescence and goes unreported [6]. International and Australian studies [7] demonstrate that children experiencing disadvantage are more likely to have poor life outcomes in terms of physical and mental health, school achievement, employment and general life satisfaction. They are more likely to experience injury and to be objects of, and the perpetrators of, violence and criminal activity.

Behaviour problems in children are becoming more apparent and widespread. The Australian National Health Strategy Report (2000) [8] stated that ADHD was the most common developmental variation, affecting 1.2% of Australian children[9]. Though a number of children will 'grow out of it', 60% will carry some degree of ADHD with them into adulthood [10]. Children with ADHD have also been found to commonly have learning difficulties (25-50% of children), Oppositional Defiant Disorder (40-67%), Conduct Disorder (20-56%), Anxiety Disorders (25%) and major depression (0-30%) [11]. Additionally, Convergence Insufficiency (CI) has been reported as being co-morbid with ADHD [12].

Obesity

Childhood obesity is an epidemic in Australia. In 1995, the Australian Institute of Health and Welfare reported the proportion of overweight children and adolescents aged 17 was 21% for boys and 23% for girls [3]. In 2003, the issue of childhood obesity is still of concern, with obesity affecting one in five Australian teenagers [13].

Economic/Financial/Environment

Health problems of children and adolescents are exacerbated by income inequality and relative poverty, unstable family structures and deteriorating social capitol and social networks[3]. An increasing number of families cannot provide for their

children. The number of families living in poverty is no longer confined to those without work. Of the 2.5 million Australians who live in poverty, there are nearly 1 million working families who are not earning enough to lift them above the poverty line of $415 a week [4].

Literacy/education

In 1996, almost half of Australians aged 15-74 years had poor or very poor literacy skills[14]. There is an extricable link between health and education. Information sharing and the means of communication are also key determinants of health status. Good access to information and programs that promote early detection and intervention reduce the risk of poor health outcomes. Primary health care concepts can be very usefully integrated in the school curriculum and information dissemination can reduce the risk factors for adult chronic conditions such as hypertension, smoking, obesity and dental caries [3].

Australia spent over $66 billion on health in 2001-02, a rise of $11 billion since 1999-00 [15], yet the problems faced by children are still abundant. NSW Health recognises that allied health services are a critical part of the NSW Health Workforce [15]. However young people are generally low users of health services and consequently the ability of health professionals to positively influence health behaviour can be limited.

The NRHA [3] has stated that, for equivalent health and well-being, rural and remote communities need access to the same services as their city counterparts. To be effective, family services need to recognise the different types of family unity and to value their cultural differences. For effective family services in rural Australia as close to home as possible there needs to be

- an increase in the numbers of nurses, allied health professional and Aboriginal child health workers in rural and remote areas
- increased access to early intervention and health promotion programs for the early diagnosis of problems with hearing, vision, speech, ADHD, fine and gross motor development and dental care and hygiene, and
- more activities to strengthen family relationships, parenting skills and confidence.

Currently, there are a number of groups and organisations who are actively involved in rural and remote health care provision, including RFWCHS and Royal Far West School (RFWS).

ADDRESSING THE CURRENT ISSUES BY RFWCHS

Mental Health/Mortality/Behaviour/Family Relationships

It is important to identify children who are at risk of developing a mental disorder and /or attempting suicide eg those with a family history of mental illness, poor social skills, and/or those who are victims of bullying and abuse, neighbourhood violence, crime and peer rejection. RFW nursing staff conduct regular information sessions on depression to clients and offer counselling during the admission as well as follow-up post-discharge, especially for those children on medications. Referrals to local organisations are made if it is felt appropriate. RFW staff work in conjunction with DoCS/DADHC and various Disability Services.

The Social Work Department and the RFWS have developed the "Stop, Think, Do" Program so that the Scheme, School and the family are able to use the same social skills program throughout the child's admission and when the family returns home. Additionally, social workers offer ongoing counselling for all families whilst at RFW.

The RFW Recreation Team conduct activities that promote socialising skills and provide enjoyment for the children during their admission. The Occupational Therapy department addresses living skills including school skills, hand writing, dressing and the use of cutlery, thus creating a wholistic approach to the independence of the child.

To address the issues of mental health, behaviour and family relationships, a variety of programs have been developed - 'RAPteens' (for adolescents with adjustment difficulties which can lead to patterns of stress, anxiety and depression), 'Dolphin'(provides assessment and treatment for anxiety disorders in young people aged 7-16 years), 'ADDers' (for parents of children with ADD/ADHD with defiance or highly disruptive oppositional behaviour, aged 5-16 years) and 'Positive Parenting Program (PPP)' (aimed at families with children aged 2-8 years, who may be having parenting problems).

Obesity

Common causes of obesity are poor eating habits, lack of physical activity and family history. Nowadays, 'play' has been replaced by television, videos, computer games or the internet and children's diets have moved away from traditional eating habits. RFW addresses obesity in the following manor: the child's height and weight are monitored each admission; families with existing weight issues are regularly reviewed by the Dietician; exercise programs are tailored for individuals and the Catering Department maintains a healthy menu. A weight management and exercise group, 'WOW' (Weight Off Wisely), was developed a number of years ago. WOW is an interactive week-long program tailored to educate families about dietary modifications, the importance of exercise and behaviour changes in eating.

Literacy/Education

At the RFWS many of the students have significant learning difficulties, behavioural and emotional issues as well as a wide range of medical conditions and physical disabilities. The school provides a range of educational facilities, including literacy assessments, intensive reading support programs, parent education, referral to local educational services and a playgroup for preschoolers. There is an increasing emphasis on liaison with home schools and districts prior, during and after attendance at RFWS.

Cultural Awareness

RFWS has an Aboriginal liaison officer. There is also an Aboriginal policy and students to the school are invited to participate in all cultural activities.

HOW THE RFW ORTHOPTIST FITS INTO THIS MODEL

To make appropriate orthoptic management suggestions, all information regarding the child needs to be considered. If a family is struggling financially, consideration is given to the cost of glasses; if behaviour problems are a primary concern, glasses may be broken instantly or occlusion therapy patches removed and if the parents are unmotivated and the child has behaviour problems, home treatment for reduced convergence is unlikely to be carried out. When the family dynamics are such that the child is living in an unstable environment, expectations of any treatment being carried out will be lower. In cases where eye surgery is needed and hygiene is very poor, the child may be asked to stay on at RFW for longer post-operative care rather than returning home. If a child with very poor self-esteem, no ocular symptoms and good orthoptic standards wants glasses, they may be given plano glasses for a limited time to assist in improving self esteem and overall confidence. When confronted by an angry, depressed teenager with conduct disorder, who will not do their convergence exercises or wear their glasses, chastising will be of no help - a different approach is needed for the benefit of treatment to be understood.

Low literacy levels may make the assessment difficult if the child is unable to read a linear line or near text. Cultural awareness will ensure the most appropriate test and techniques are utilised. The orthoptist needs to be mindful that attention deficit (hyperactivity) disorder has a link to convergence insufficiency [12,16] and should therefore assess this binocular function more closely. Giving more praise than is necessary to a person with low self-esteem, or a teenager with poor family dynamics, may assist the orthoptist to gain maximal results. Extra encouragement to make a session more personalised gives consolidated quality time that the child might not gain from other areas of their life. Knowledge of a particular child who feels they cannot do anything well, may prompt the orthoptist to do a small yet significant act such as displaying the child's drawing on the clinic wall.

CONCLUSION

Feedback must be given to, and received from, all health disciplines, care-givers and teachers to ensure a positive outcome for a child or adolescent. Without this rounded input and knowledge, there will be an incomplete picture. There are many issues facing children and adolescents of today, especially those living in rural and remote areas – as a health care provider, the orthoptist needs to be aware of the child as a whole, not just as an orthoptic patient.

ACKNOWLEDGEMENTS

I would like to thank all of the RFW families and staff who assisted me in collating this information.

REFERENCES

1. Australian Bureau of Statistics: *Measuring Australia's Progress 2002 Population* Retrieved 05.10.03 from the World Wide Web: http://www.abs.gov.au/ausstats/abs@nsf/0/1ADA0CC3233F510DCA256BDC001223F3.
2. Australian Bureau of Statistics: *Australia Now Year Book Australia 2002, 2002, Population, Population Distribution* Retrieved 05.10.03 from the World Wide Web: http://www.abs.gov.au/ausstats/abs@nsf/0/FE3FA39A5BFAA5ACA256B350010B3FD.
3. National Rural Health Alliance Inc: *Draft Position paper, Child and Adolescent Health*, August 2003
4. *"PARTYline"* May 2003, Newsletter of the National Rural Health Alliance
5. Stevens L, Appleyard M, Urlwin S, Naccarella L (2002): *A Co-ordinated approach to improving adolescent heath in rural South Australia* 6th National Rural Health Conference, 2002, p1
6. Bartik W, Massey P (2003): *Health Services for Young People, How do you Rate?* 7th National Rural Health Conference, Hobart March 2003, p1-7
7. *NIFTeY* National Newsletter July 2003. Retrieved 26.08.03 from World Wide Web: http://www.niftey.cyh.com/webpages/newsletter/newsletterframe.htm
8. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition. Washington, DC. American Psychiatric Association, 1994.
9. Moran, S. (2001): *Exceptional Peformances from Chaotic Lives.* Conference Proceedings 'ADHD in the Third Millenium Perspectives for Australia', The Children's Hospital at Westmead, 16-18 March 2001, p76-77.
10. Green, C., Chee, K. (1994): *Management of Attention Deficit Disorder: a Personal Perspective.* Modern Medicine of Australia, February 1994, p38-53.
11. The National Mental Health Strategy Report: *The Mental Health of Young People in Australia,* Oct 2000. Commonwealth of Australia.
12. Tosswill, V (2001): *ADD/ADHD and Ocular Conditions* Australian Orthoptic Journal 2001/2002, Vol 36, p17
13. ABC Online: *The World Today – Friday 26 September 2003, "The World Today – Fast food ads target children"* Retrieved October 2003 from World Wide Web: http://www.abc.net.au/worldtoday/content/2003/s954539.htm
14. Australian Bureau of Statistics: *Australia Now, Australian Social Trends 1998, Education-Educational Attainment: Literacy skills* Retrieved 05.10.03 from World Wide Web: http://www.abs.gov.au/ausstats/abs@nsf/0/7551EA164D95600CCA2569AD000402B4?...
15. Retrieved 26.09.03 from NRHA email: *Subject 1st NSW Rural Allied Health Professionals Conference 'Sharing Innovations in Rural Health'*
16. Granet, D.B., et al (2000): *Relationship Between Eye Condition and ADHD.* Retrieved January 2001 from the World Wide Web: http://www.newswise.com/articles/2000/4/SHILEY.UCD.html