Defining Community Social Pediatrics

1.1 Community social pediatrics is a comprehensive social medicine model[1] centred on the child's needs and concentrated on the resilience of the child, family and community. It merges expertise from medicine, law and social sciences in an effort to detect, reduce or eliminate sources of toxic stress or risk factors that affect the well-being or development of children from disadvantaged backgrounds.

1.2 It is based on scientific findings that social and environmental experiences during the early years of life (ecology) and genetic predispositions (biology) affect child development (American Academy of Pediatrics 2012). It ensures respect for family cultures and fundamental rights as stated in the *Convention on the Rights of the Child* (1989).

1.3 Developed by pediatrician Gilles Julien in the 1990s, this relationship-based medical model pays particular attention to at-risk children in urban neighbourhoods and from disadvantaged communities in rural areas. In order to connect with vulnerable people, the model uses the EEDA method (Establishing, Exchanging, Decoding and Action), which is a way to work with children and families with the aim of fostering effective access to coherent[2] services by implementing an action plan developed by everyone involved.[3]

1.4 The plan's success lies in the process, which is designed to secure commitment from all stakeholders. While seeking out toxic stressors and possible solutions, this process encourages active participation from children, their parents and other significant people as true partners alongside the professionals who are also involved in the situation (teachers, youth protection workers and social service staff). In this way, the process works as a

[1] Social medicine is defined as the study of relationships between society, health, illness and medicine, and it is a community-oriented practice (Social Medicine 2007).
Integrated medicine is defined as the best of conventional medicine combined with complementary therapies for which we have scientific evidence and guarantees as to their safety (Eisenberg 2002).
[2]Including access to primary care services characterized by: "an initial contact for each new need; long-term, person-focused care; comprehensive care for most health needs; and coordinated care" (Starfield 2005, p. 458), secondary and tertiary services.
[3]It is important to recognize that most families helped by CSP already receive several kinds of assistance.

catalyst, stimulating changes that benefit children and their families and ensure children's optimal development.

Research has highlighted recommendations for interventions involving children at risk (American Academy of Pediatrics 2012):

- Train all health care and social service professionals on the effects of toxic stress.
- Overcome institutional constraints to effectively address new morbidities.
- Deal with the lack of knowledge and limited availability to evidence-based intervention strategies.
- Seek funding to set up intervention strategies with the community that are also rooted in the community.

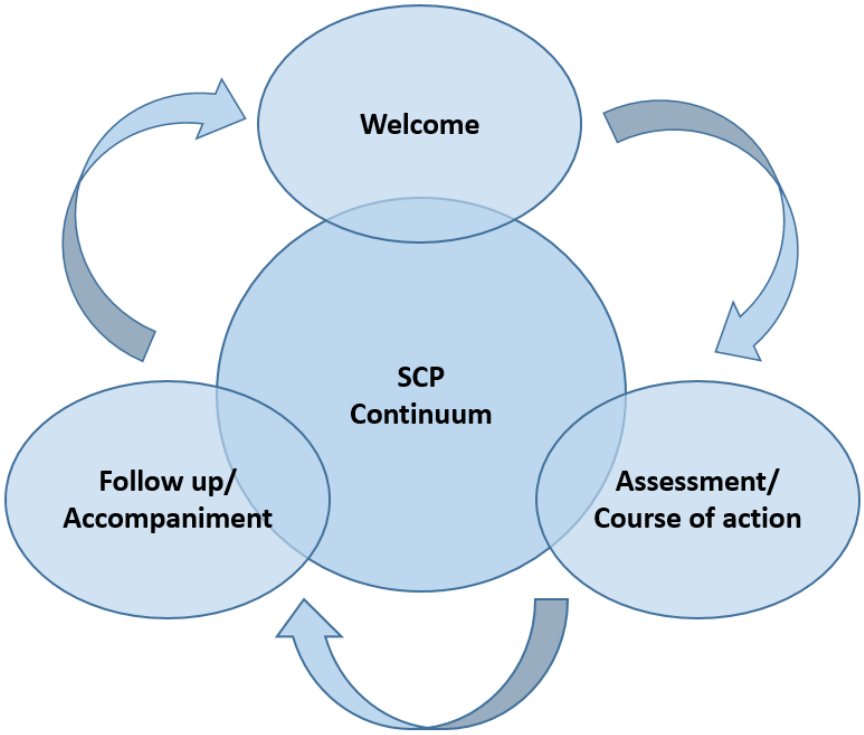
We would add the following recommendations for community social pediatrics:

- Incorporate law in practising medical and social interventions.
- Use universities to train future professionals to be able to respond to this millennium's morbidity issues. This means including new knowledge, skills and talents in university programs.
- Adapt services to each community's needs. Be wary of using "parachuted" programs that do not take a community's reality into account.
- Involve the community from day one to get them on board with CSP's activities.
- Train social entrepreneurs who are able to set up innovative services to better meet children's needs.

1.5 The model is set within a service continuum: welcome, assessment/course of action[4] and follow-up/accompaniment, with a view to providing children with the tools they need and supporting the important people around them throughout the children's lives.

[4] Assessment/course of action also works in three phases: the welcoming children phase, the first assessment/course of action meeting, and assessment/course of action during follow-up and

accompaniment. Some social pediatrics centres refer to the assessment/course of action follow-up meetings as lifecourse trajectory follow-up.



1.6 As a general rule, welcoming or providing access to community social pediatrics services features a relationship-based approach, an efficient referral system to target children at risk, and screening activities. These three features allow access to coherent services tailored for each child.

1.7 Assessment/course of action is at the heart of the community social pediatrics model. It features three elements: its own method called EEDA (Establishing, Exchanging, Decoding and Action), a clinical approach and an organizational model within the clinic called collaborative intervention.

1.8 The collective know-how within assessment/course of action is the feature that distinguishes community social pediatrics from other medical approaches designed to serve this clientele. It provides more accurate diagnosis of the child over time through knowledge shared by the child, his or her family network and the various professionals involved in the family's life. This know-how means that all participants in the meeting work together to

develop a common understanding and are involved in coordination[5], and that the child and family are full partners who actively participate in decision-making.

1.9 Assessment/course of action promotes shared responsibility for the child's well-being among family, social and institutional networks. It also facilitates an interdisciplinary[6] (health sciences, social sciences and law), multi-sectoral[7] (school, police, health and social services, legal services, etc.) approach, offering services which are adapted to each child in keeping with the milieu in which he or she lives. This vision for building social participation includes mechanisms to redistribute power, thus promoting the individual's empowerment (Solar 2009).

1.10 This approach to working collectively, which is known in community social pediatrics as collaborative intervention, implies the same level of collaboration from all the actors involved in the meeting. These include the child and the family, with guidance from the CSP team. The child's needs are the focus of the meeting. The child and family play an active role in this; they are not the subject of discussion, rather they are true partners in seeking solutions to their problems.

[5] Coordination as viewed by Solar et al. (2009): Shared responsibilities must not only be planned for or defined by the professionals from various sectors; it is also essential that this understanding be set out clearly in action plans.

[6] Interaction between two or more disciplines that involves a desire to work together and discussions to link them (OECD 1972; Darbellay 2005). It is based on "a combination of three interdependent fields: expansion of sciences or other knowledge, intellectual development, and the problems that come with modern life" (Bertrand et al. 2002).

[7] "Approaches by actors from more than one intervention area who organize and commit to complementary actions that will capitalize on each other's skills in a mutual agreement to meet specific, clearly-recognized community needs" (Lebeau et al. 1997, p. 12).

Assessing problems vs Assessing needs

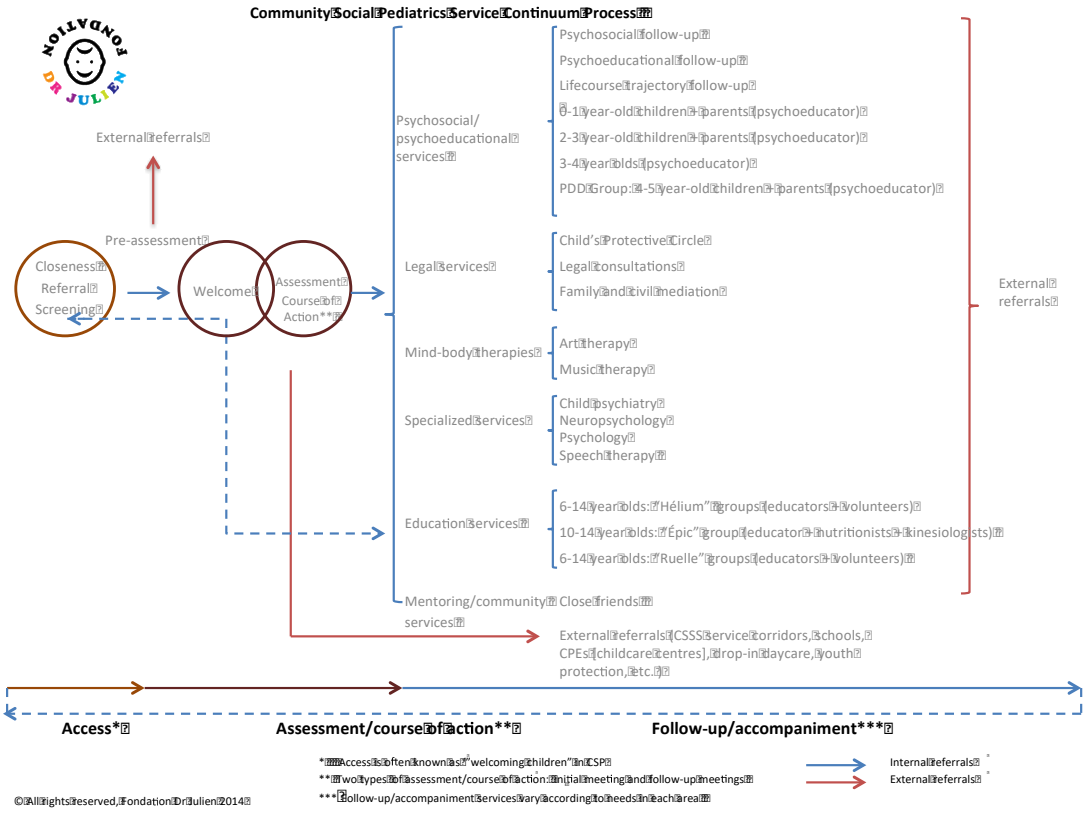
Community social pediatrics

1.11 As a final point, follow-up services help ensure long-term support for the child, which strengthens the bond between the professional team and the family. The model is designed to meet the diverse needs of children through both in-house services, which complement ongoing services in the same area, and external services delivered through introducing service corridors. The rationale is to provide prompt and effective in-house access to services adapted for children at risk, complementing existing services supplied by other agencies in the network. If an external referral is needed, community social pediatrics sets up service corridors, thereby ensuring swift and effective access to needed services.

1.12 In-house services are classified according to the sort of professionals involved; there are legal, psychosocial and psychoeducational services, mind-body therapies (music and art therapies) and mentoring/community services. From the outset, these services demonstrate the interdisciplinary nature of the approach (medicine, law and social sciences), followed by community involvement (volunteers, via mentoring/community services) and finally,

incorporating innovative services such as mind-body therapies (music and art therapies). Once again, it is the collective know-how that differentiates this kind of service from other existing services. Professionals from different disciplines and across sectors team up in the collaborative intervention process. They work and develop strategies together with the families, keeping empowerment a central priority.

1.13 Here is an example of a community social pediatrics service continuum:



1.14 Follow-up/accompaniment services vary intentionally from one area to another in order to suit each community's needs. This flexibility is a guarantee of social innovation in community-based services, because it is a way of paying regular attention to people's needs and seeking solutions at the same time. All of this helps to reduce the risk of duplicating services and improves service delivery alignment within a given area.

Several keys to success have been identified, including:

A local structure to ensure more effective intervention and to foster resilience (roots in the community)

Being rooted in the neighbourhood helps community social pediatrics centres identify children at risk, give children and families the tools they need, and accompany them throughout their lifecourse trajectories. A strong sense of belonging to the community creates a presence and the centre soon becomes an accepted part of the landscape due to the mix of activities it offers. All of these elements are important to helping children and families find a safe and comforting place conducive to developing their resilience.

A concerted action plan for coherent services (collective intelligence and harmonization with other systems)

In order to better meet the child's needs, the model encourages follow-through with a range of coherent services through an action plan agreed upon by all actors, including the child and members of the family network. These services are harmonized with those offered through other networks and the community.

Using law to defend children's rights

Incorporated into the social pediatrics model in 2007 by lawyer and accredited mediator Hélène (Sioui) Trudel, the Integrated Rights component facilitates access to justice and respect of fundamental rights in the spirit of the *Convention on the Rights of the Child* and the *Charter of Human Rights and Freedoms*. These services are designed to resolve disputes involving respect for the child's fundamental rights swiftly and effectively through mediation, legal counsel or referrals to legal aid or *pro bono* legal services. They cover areas of law affected by negative repercussions from toxic stresses in the child's environment. More specifically, they may involve the right to housing, the right to information, the right to education, the right to appropriate health and social services, the right to employment and work, and human, civil or other rights.

Qualified, trained professionals who are aware of the complexities involved in intervention (decompartmentalizing disciplines and institutions or service sectors)

The CSP approach is interdisciplinary (health sciences, social sciences and law) and cuts across sectors (school, health and social services, police, etc.). Decompartmentalizing disciplines and working together with the child and family have proven effective and essential to grasp a given situation's complexities and to respond effectively, in a way that respects the child's fundamental rights.

Informality as a lever in a relationship-building approach

Informal group behaviour is a radical form of social innovation (Lesemann 2011). In community social pediatrics, professionals adopt a relationship-based approach, which makes it easier to create a connection with the child and the family. Experiential knowledge results, which can bring out two key features in the relationship (Laville cited in Clément et al. 2009): daily life experiences and reciprocity. In order to set up this kind of approach, the process needs to remain informal. It is a sine qua non for establishing a special relationship with a child.

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