

**COMMUNITY DEVELOPMENT AND JUSTICE
STANDING COMMITTEE**

**INQUIRY INTO THE ADEQUACY OF SERVICES TO MEET THE
DEVELOPMENTAL NEEDS OF WESTERN AUSTRALIA'S CHILDREN**

**TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 25 MARCH 2009**

SESSION ONE

Members

Ms A.J.G. MacTiernan (Chairman)

Mr A.P. Jacob (Deputy Chairman)

Mr I.M. Britza

Mr A.P. O'Gorman

Mr T.G. Stephens

Hearing commenced at 10.03 am

ABERNETHY, MRS MARGARET

**Senior Policy Officer, Child and Adolescent Community Health, Department of Health,
examined:**

ANSELL, MR DAVID

**Executive Director, Department of Education and Training,
examined:**

BARRERA, MS SUSAN

**Director General, Department for Communities,
examined:**

CRAKE, MR MARK

**Director, Child and Adolescent Community Health, Department of Health,
examined:**

CREED, MS HELEN MARGARET

**Acting Executive Director, Children and Family Services, Department for Communities,
examined:**

GATTI, MRS KATE

**Director, WA Country Health Service,
examined:**

GAUNTLETT, MS ERIN

**Senior Portfolio and Policy Officer, Department of Health,
examined:**

HORNBUCKLE, DR JANET

**Consultant Maternal Fetal Medicine and Co-Lead Women's and Newborns' Health Network,
King Edward Memorial Hospital,
examined:**

LANDER, MS FIONA JANE

**Executive Director, Department for Child Protection,
examined:**

MORRISSEY, MR MARK

**Executive Director, Child and Adolescent Community Health, Department of Health,
examined:**

The CHAIRMAN: Good morning, and thank you very much for coming. Would you like to introduce yourselves?

Mrs Gatti: I am Kate Gatti. I am the Area Director for Population Health in the WA Country Health Service. I am also co-lead for the Child and Youth Health Network.

Mr Crake: I am Mark Crake. I am the Director of the Child and Adolescent Health Service Policy Unit, which has a statewide responsibility within the Department of Health.

Mr Morrissey: My name is Mark Morrissey, Executive Director of Child and Adolescent Community Health. I am here representing the Director General of Health, Peter Flett.

Mr Ansell: David Ansell, Acting Executive Director, Office of Early Childhood Development and Learning. I am representing Sharyn O'Neill, the director general.

Ms Lander: Fiona Lander, Executive Director of Policy and Learning with the Department for Child Protection. That role takes in all the strategic and operational policy, as well as legislation and our training portfolio.

The CHAIRMAN: We have on our list that Terry Murphy would be here until 10.45 am.

Ms Lander: I am here on Terry's behalf.

The Principal Research Officer: He was a late apology. He rang this morning.

The CHAIRMAN: Okay. And from children and family services?

The Principal Research Officer: Susan Barrera is supposed to be here, but she may have gone over the road.

The CHAIRMAN: Thank you for attending. The purpose of this hearing is to assist the committee to gather evidence for its inquiry into the adequacy of services to meet the developmental needs of Western Australia's children. We are a committee of the Legislative Assembly. This is a formal procedure of Parliament; therefore, whilst we are not asking witnesses to provide evidence on oath or affirmation, you need to understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. This is a public hearing. A transcript of the proceedings will be made available. Can you just confirm that you have all completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIRMAN: Have you understood the form?

The Witnesses: Yes.

The CHAIRMAN: Do you have any questions about that?

The Witnesses: No.

The CHAIRMAN: Thank you. We have some further witnesses. Can you introduce yourselves so that we know who is here.

Ms Gauntlett: Erin Gauntlett. I am the Senior Portfolio and Policy Officer for Child Development within Child and Adolescent Community Health.

Mrs Abernethy: Margaret Abernethy, Senior Portfolio and Policy Officer for Child Health in the Department of Health.

Dr Hornbuckle: My name is Janet Hornbuckle. I am a maternal fetal medicine specialist working at the Women's and Newborns' Health Service. I am also the co-lead for the Women's and Newborns' Health Network.

The CHAIRMAN: We have just arriving Susan Barrera. Helen, if you can just take a seat there.

I will explain. We wanted to have all the agencies together because we have been concerned about gaps and about the way in which there seems to us to be a fragmentation of services that are dealing with this vital area, particularly of preschool needs. We wanted everyone to be present at the same time so that if there was a suggestion that that was someone else's responsibility, the person whose responsibility it was suggested it was would be able to respond to that.

With that, we will just start on some general questioning. First of all, David Ansell, do you come from the education department?

[10.10 am]

Mr Ansell: That is correct, yes.

The CHAIRMAN: You are in that role, so you are not just able to speak confidently on behalf of your office, but you are also representing the education department. We would like to understand something more about your role and what this new office of general development and early childhood is. How does this move DET particularly into the area of the zero to three-year-olds—does it move them into that area? What sort of role are you going to have; is it similar to the sort of thing we see in South Australia, or are you going to be taking an even stronger role like we see in Victoria?

Mr Ansell: There have been some high-level statements of role from government—when I say “government”, from ministers—and there is still some clarification of what I would call the scope and structure of the office. I have here some of the public statements that have been on record from the government, and some of the other questions you might want to refer back to the Minister for Education. Broadly, the office has been established to better coordinate development and learning programs, policies and services for children between zero and eight years old. In direct answer to your question, the education department would take some role in learning development in the zero to three, or three and a half years old age group at school entry. As yet, we are unsure as to the specifics of that, but my sense would be there would be coordination and working with and through other service providers or program providers. Western Australia has had input into the national early childhood reform agenda through COAG. I am unsure whether members are familiar with the COAG process in the early childhood area, but you would hear a term called “universal access”; moving kindergarten from what is currently 11 hours—this is the three-and-a-half to four-year-olds—to 15 hours. Notions of wraparound services are also in that COAG area. The third area has been providing local access for kindergarten students at their school. At the moment, you are probably aware from your own constituents, that if we have a full kindergarten centre—25—then we would move them to the next centre, which may not be in their local suburb, so local access.

The CHAIRMAN: Sorry, there were three aspects; I missed one. You are taking it from 11 hours to 15 hours?

Mr Ansell: Universal access, yes. The provision of what you will hear termed “wraparound services”; so full service schools, or “extended school” would be an education term for that concept. That is where other services, be they care or health broadly, are available with or through the school, located in the school or through referral from the school. Other ways might be some sort of joined up operational models with other agencies.

The CHAIRMAN: You have got responsibility now for looking at those wraparound services?

Mr Ansell: As it is defined in the COAG agenda, and that is around learning and development. That would not extend to issues to do with health and care specifically, but in terms of the coordination of learning and development, the announcements from government have been in that area.

The CHAIRMAN: This is where we do not really actually understand the difference. I would have thought things like speech therapy fall within health, but clearly that is a developmental issue.

Mr Ansell: Yes.

The CHAIRMAN: In your interpretation of COAG, is speech therapy included in this, or not?

Mr Ansell: I will just clarify my comments: I think some of these things are yet to be determined. If you read the COAG documentation, it kind of makes references, as I would see it, to some operational models that are yet to be developed and picks up some high-level concepts or notions.

Arguably, the technical details, such as you would have seen at a place like Challis, still need to be determined. In direct answer to your question—perhaps I would proffer this as a personal opinion, rather than from the documentation—the referral to that speech therapy service and the connection between what might be happening with that speech therapist and what may happen in the classroom or a care environment may be an area that we would be concerned about and seek to coordinate, rather than actually the provision of the speech therapy itself. Is that a good enough or clear enough answer?

The CHAIRMAN: I understand what you are saying.

Mr Ansell: Yes.

Mr T.G. STEPHENS: In the modelling in Victoria, the leadership is now through the portfolio of childhood development, having moved into the education portfolio. Is there, in the view of the education department, value in doing that in Western Australia?

Mr Ansell: It is probably a question that I should refer to the director general or the minister.

Mr T.G. STEPHENS: That is why she was invited.

The CHAIRMAN: That is right, and you are here as her representative.

Mr Ansell: I do not think we would have a view on that. We would say operationally that what works, works. It may be that in Western Australia structures different from Victoria will be more effective. There are some particular factors of their government over there that may make health or maternal health, as I understand it, sitting in children's services more effective in that environment. We would want to work with our minister and scope those options over the next coming weeks.

Mr T.G. STEPHENS: Can I try again around this issue?

Mr Ansell: Yes.

Mr T.G. STEPHENS: It would appear that there are an enormous variety of things happening across the apparatus of government, but there is not on display universal delivery of early childhood development strategies and programs that are succeeding to the satisfaction of the committee. The coordination of that by a central office, are there more pluses than minuses about that being in one department?

Mr Ansell: You are talking —

Mr T.G. STEPHENS: Coordination?

Mr Ansell: — about healthcare and education in one area?

Mr T.G. STEPHENS: The provision of the related services in the Victorian model.

Mr Ansell: The title of the office is the Office of Early Childhood Development and Learning, so it is taking that particular slant on zero to eight year olds, if we could say it that way. In terms of a published opinion or opinions stated by the education department, I do not think we have one, but I can take that question on notice.

Mr T.G. STEPHENS: Thanks. Do you mind if I just turn from David and turn to health and see —

The CHAIRMAN: Can we just finish with David on this, and then I think we will go on to Mark.

Mr Ansell: My understanding, from some of the meta studies and meta analysis would be that there are distinct advantages in health and care being associated. With health, the meta analysis that I read, it was not as clear that that was an advantage, but there is further research to be done in that area. I can provide the committee with a reference for that report, if it would like.

The CHAIRMAN: I think the issue comes back to just the complete interrelatedness of many of these health services actually dealing with the developmental issues. Obviously there are some health things that are not really related, but a lot of that mainstream monitoring of the child is to

monitor its reaching of those milestones. Perhaps we will ask Dr Hornbuckle to detail it little bit more later, but the sort of work that we understand is done in the maternal care area is very much looking at developmental issues. Certainly we see speech therapy as being probably in many cases a developmental issue that is not related to health in the sense of health ecology. But we will get you to comment on that, Mark, after I give the others an opportunity to speak with David on this issue of the formation of the office and the degree of coordination that goes on.

[10.20 am]

Mr A.P. O'GORMAN: Mark, can you tell us when the office was formally set up?

Mr Ansell: There was an announcement in January from government that responsibility for early development and learning—I might need to clarify the exact words—was moving from Minister McSweeney to Minister Constable. In February there was an announcement, again as I understand it, that the Office of Early Childhood and Development and Learning would be established within the Department of Education and Training. We are still working with the minister to clarify issues regarding structure—my word—governance and scope. Personally, I think it is important that we do consider those things carefully and if that takes some time, then so be it. Madam Chair, I read two or three key points that have been announced about the role. I might just run through the list on record. The proposed role is the coordination of early development and learning program zero to eight, COAG, which I spoke about, to look at operational capacity to develop a well-thought-through strategy for ensuring that interfaces between agencies involved in learning and development services zero to eight are aligned; to ensure that children have the best start in life to achieve optimal wellbeing, development and learning; and to examine and recommend and then action issues to do with coordination. Those are the sorts of things that have been intended by government. I cannot be more specific at the moment regarding that. We are still working, as I said, with the minister to get some more clarity.

The CHAIRMAN: What are you actually working on at the moment?

Mr Ansell: COAG would be my overriding agenda; the COAG national partnership and implementation processes with the commonwealth. So it was the responsibility for the early childhood national partnership. Do you need more clarification around COAG structures? There is a series of working areas in COAG called the federation of Australian governments. You may have heard of the productivity agenda working group. My understanding is that early childhood is a separate working group. Under that working group there are a number of areas of interest and a national partnership. One of the national partnerships is in an area that is now the responsibility of the Department of Education and Training, and in that national partnership are the three elements that I have said previously. What I am working on are the agreements with the commonwealth about the implementation of those three national partnerships. That involves extensive liaison with the Department for Communities, and we are working closely together and, from my point of view, working very well in that area. Those agreements will have funds attached to them around those three elements. That is COAG. The second part is to work with key stakeholders internal and the minister's office regarding the processes that we would put in place to establish the office and appropriate consultations procedures, if the minister wishes to do that.

Mr A.P. JACOB: You said “key stakeholder”. Who are you considering as key stakeholders?

Mr Ansell: There is a range of internal and external stakeholders. If I can just very briefly start with the internal stakeholders, obviously with the Department of Education and Training our agreement has been four to 17-year-olds, if I could describe it that way, and therefore, some of our own early childhood teachers and the support staff, both teacher aids and also the district and central office teams that have policy responsibility for them. There are numerous and many external stakeholders. Again, from my reading of the success of whole-of-government structures for coordination of early childhood development, the capacity to coordinate is critical and, therefore, other government departments are represented here, possibly the non-government sector. We would want to seek their

opinions, speaking on behalf of myself as the director, not on behalf of the minister, regarding key issues to do with the structure and operation of the office.

Mr A.P. JACOB: If I can ask and perhaps have a short answer. How are you communicating with those other departments and how successful is that?

Mr Ansell: That has yet to be determined. We have not had time as yet—I have been in this role for a week—to make those decisions. Having said that, again that would need to be done in consultation with the minister to make that determination as to if and who would be consulted.

The CHAIRMAN: Is there a cabinet decision that DET or this new office will be the agency that leads the COAG presentation?

Mr Ansell: The COAG business to do with that particular national partnership—perhaps I may be helped more regarding the specifics of that and announcement —

The CHAIRMAN: We know about the announcement. The other agencies will be required to funnel their COAG information through you?

Mr Ansell: We are working collaboratively with them regarding the Western Australian, what we would call bilateral agreement for that particular COAG national partnership.

Mr A.P. O'GORMAN: Exactly when did the COAG decision come down and when were the states advised?

Mr Ansell: The COAG process has been like a series of rolling processes, I guess from my point of view. There has been high level agreement, which in a national partnership sense is multilateral agreement. The early childhood working group has a national partnership to do with universal access and other things. These are what I would call templates, which all states and the commonwealth have agreed to, so you have federation. Under that each state then negotiates with the commonwealth using a bilateral agreement. That bilateral agreement is yet to be signed and is continuing to be negotiated. The Department of Education and Training has the lead in those negotiations and that has implications for other government departments, so we liaise extensively with them. That is where we are at this point in time.

Mr A.P. O'GORMAN: Have other states already signed these bilaterals?

Mr Ansell: My understanding is that no other state has signed the bilateral for this particular national partnership currently.

Mr I.M. BRITZA: Would that bring uniformity on a national basis?

Mr Ansell: That is the intent in a number of the areas. For example, it is intended that all children in Australia have access to 15 hours of what we would call a kindergarten program.

The CHAIRMAN: If I understand this rightly, whilst there will be some of those benchmarks, it will not dictate the particular structures that are put in place to manage early childhood.

Mr Ansell: I would agree with that. States, and indeed communities, may do it differently. That detail is not predetermined, as I have read it, in the bilateral, because the bilateral is not completed; it may be, but it is more about overarching targets, I guess you would call them, from the commonwealth, which the states have collectively said we will work with the commonwealth in achieving.

The CHAIRMAN: Would you be the person who would be able to explain what I think we have had some trouble working out, which is the different commonwealth programs that are being negotiated through COAG? We are talking about extending universal access to the three-and-a-half to four-and-a-half year program, but then there are also the early childhood centres that are being established. I do not know what those things are called that are basically focusing on Indigenous but not solely Indigenous centres, more family centres, that are coming out of education. Then there is also another batch of centres that are coming out of FAHCSIA. How does the last batch of things

that are coming out of FAHCSIA relate to what is coming out of the commonwealth education portfolio?

Mr Ansell: I may refer to some of my colleagues who have been longer in this process. I will start and maybe that will need to correct me. There is another national partnership for Indigenous early childhood issues. There are three elements to that.

The first element is that, in my understanding, the Department of Education and Training and the Department for Communities have carriage of that. We are still working with our ministers to clarify responsibilities in that area. Is that correct?

[10.30 am]

Ms Barrera: That is correct.

Mr Ansell: In that there is a number of initiatives, one of which is, in my understanding, the community and family centres—CFCs—and there have been discussions with government regarding the location of those. Because that national partnership has been signed, we would expect some funding in the 2008-09 financial year.

The CHAIRMAN: But is that coming? Because there is one coming out from FaHCSIA, and there is one that is coming out from—the one you are talking about is Indigenous —

Mr Ansell: Correct.

The CHAIRMAN: Right.

Mr T.G. STEPHENS: The community family centres are Indigenous.

Mr Ansell: Yes; Indigenous early childhood national partnerships —

Ms Barrera: Children and family centres.

Mr Ansell: Children and family centres, thank you.

Ms Barrera: Can I —

Mr T.G. STEPHENS: Please.

Ms Barrera: If I can assist, David is quite correct; there is the national partnership under the Indigenous early childhood COAG agreement, which has three components. One is the children and family centres of which WA is getting five; four regional and remote and one metropolitan. In addition, there are two health-related programs and that NP was signed by the Premier in the first COAG he attended, which I think was in October last year.

In addition, coming back to the productivity early childhood component again, you will remember the federal government had an election commitment to provide a dramatic increase in childcare places. To do that they proposed a large number—I will not say what the number is because I cannot remember exactly, but about 250-odd—of what they called “early learning and care centres”, ELCCs, of which they allocated about 25 or 26 to WA. However, these are only partially funded with respect to the capital, which is in contrast to the children and family centres that are fully funded; both capital and recurrent. Therefore, with the ELCCs, they will make a contribution to capital, and it is intended to be child care only. Although everyone would like them to be more inclusive and comprehensive centres, the commonwealth is only providing money for capital.

The CHAIRMAN: But, Susan, I understand that another thing has come out. There was a statement by Minister Macklin a few weeks ago—I think when we were in Canberra or just before we got to Canberra. The statement was about some other set of centres that will be established. Is anyone familiar with those?

Mr Crake: Can I make a comment? Susan, correct me if I am wrong, but I think the commonwealth was looking at turning some of the childcare early learning centres —

The CHAIRMAN: No, we are not talking about —

Ms Barrera: And that was never funded.

Mr Crane: To give additional moneys to expand them.

The CHAIRMAN: Yes, but I think this is a different—I do not know. Perhaps, Helen is able to help us here?

Ms Creed: I think some of the confusion at the commonwealth level has been because a number of the programs have moved from FaHCSIA to DEEWR. There is a childcare part of DEEWR and the early childhood development —

The CHAIRMAN: Yes, we are clear on those ones.

Ms Creed: So, the Indigenous childcare programs have remained with FaHCSIA, but the Indigenous child and family centres are under the DEEWR banner. FaHCSIA announced a number of intensive supported playgroups, about two or three weeks ago, and some confusion, I suspect, may have arisen because a number of these intensive supported playgroups are likely to be in the same locations that the children and family centres are in. The idea is that they are, say, mobile playgroups, so that if you have a centre, you might have a playgroup that is operating out of the centre, but it has the capacity and the funding to go out to other areas. Therefore, if you look at, say, an area like Kununurra, if you have a playgroup that is based in a centre in Kununurra, it has the funding through the intensive supported playgroups funding to go out and run a mobile playgroup service in, say, Kalumburu or Oombulgurri or —

The CHAIRMAN: So that means the play leader and their sort of basic equipment; is that the idea?

Ms Creed: Yes, so those playgroups, and particularly intensive playgroups, have a parenting component to them as well —

The CHAIRMAN: That was a part of the playgroup —

Ms Creed: A specific resource worker as a parenting worker, and they were announced about two or three weeks ago, so that may be —

The CHAIRMAN: So what are they providing then? Is that a capital provision or is that a recurrent provision?

Ms Creed: Recurrent.

The CHAIRMAN: Right.

We might move on to Mr Morrissey. Is everyone okay if we do that just to get the health perspective? Are you happy with that?

Mr A.P. O'GORMAN: Yes.

The CHAIRMAN: We can go back to David, but I am just mindful of the time.

Mark, if you could, perhaps, address this issue of what exactly is being offered by the health department that relates to the developmental needs of children, particularly in the preschool years, but not exclusively preschool. If you can see the gaps that are being created and what your view is—trying to move out of territorial patch protection—of the Victorian model where the maternal health sector was actually moved into a new education and early childhood development department.

Mr Morrissey: I will start with a couple of examples of what is working on the ground. You have Enfield in South Australia, which is a great example—most people are familiar with it—of all the key agencies working together under a common governance model and I think the governance model is critical to its success. Therefore, health welcomes any attempts to bring together all the key agencies that will contribute to better outcomes; lack of, I guess, shared vision of what needs to

be achieved; overcoming duplication—all those things that we endeavour to deal with at grassroots but really needs pulling together at the top.

I brought various key members of our team just to briefly give an overview of the services that we provide in this critical period. Would you like me to just briefly ask them to —

The CHAIRMAN: We would like that and then we would like some sort of observations on how you determine whether these things are health, rather than developmental and whether it useful to make that sort of distinction. However, we are certainly very keen to hear about some of the key services. I guess it would be true to say that the committee has been concerned about what seems to be a much poorer level of service in terms of assistance to new parents than we gather is the case in South Australia and Victoria. Our model seems to have declined in its effectiveness or its coverage.

Mr Morrissey: So, if I may start at, obviously, logically, the beginning, Janet, could you give a brief —

The CHAIRMAN: Can we just do a bit of a swap of seats, so it is easier for everyone.

Mr Morrissey: I will just ask each person to spend a minute or so, just briefly, while you ask questions.

The CHAIRMAN: Thanks.

Dr Hornbuckle: As I mentioned, I am the co-leader of the Women's and Newborns' Health Network. One of the main aims of the network is to facilitate the implementation of the WA maternity policy framework that was launched in January 2008. The main thrust of that document is to ensure that services are moved to be more community focused, locally delivered, accessible and appropriate for those individuals in the community. Even though the Women's and Newborns' Health Network has only been going for a little over 12 months, we have already managed to get a multidisciplinary approach to what we are trying to do, an interagency approach, and a consumer focus, as well.

[10.40 am]

Clearly, we have a lot of work to do. There are some very good examples at King Edward where we are working with vulnerable groups, including adolescent girls who are pregnant, and also people with drug and alcohol problems in particular. Although those services exist, they really need to be more widely available and further enhanced within other areas in the metro area, and certainly in rural and remote areas. At the moment the services that already exist are working very well, but they need to be enhanced within the metropolitan area. At the moment they are focused basically at King Edward Hospital. Those services really need to be delivered in a community setting. One of the important aspects, for example, in adolescent pregnancy in particular is the postnatal visiting service that a proportion of these adolescent girls receive. That service ensures that their perinatal and mental health is addressed and that their early parenting skills are addressed, and also that they have access to and can engage with the other agencies to support their children's development. That is just one example.

The CHAIRMAN: Does that visitation program come within your remit?

Dr Hornbuckle: The current postnatal visiting service—or that aspect of that visiting service—begins in the antenatal period. It is delivered by a non-government agency, in fact.

The CHAIRMAN: The visiting service?

Dr Hornbuckle: Yes. There was a randomised control trial, which showed that the outcomes were improved if you delivered that sort of service.

The CHAIRMAN: Who delivers that service?

Dr Hornbuckle: I think it is mentioned here. I cannot remember off the top of my head.

Mr Crake: It is a Department of Health-funded program.

Dr Hornbuckle: Yes, it is. Sorry.

Mr Crake: It operates out of King Edward, and it does follow up with these young people. We can provide that information to you.

The CHAIRMAN: Yes, please. This is pretty crucial to some of our concerns. We are trying to find out exactly what happens with parents and what sort of interaction they have in the antenatal stage and then in the perinatal stage. I am a bit confused. Are the programs that you offer under your unit—the Women and Newborn Health Service—focused just on a small slice of time, or are they focused on at-risk parents? What is the scope of your particular agency; and if you are not the one who is in control of the visitation program, who is?

Dr Hornbuckle: During the antenatal period, specific screening is done to identify particular parents who may be at risk; for example, if they have children in care or have previously had children in care, if they currently using drugs or alcohol, or if they are homeless. We have a lot of homeless people coming to King Edward. If that is identified, they are then referred to the social work department within King Edward Hospital, and then interagency collaboration happens via that agency. Although that screening process happens, I still think improvements could be made in interagency collaboration. There is absolutely no doubt about that. We are also trying to engage community services in the antenatal period so that there is a seamless transition into that early parenting aspect. At the moment in WA it is a very medically-led model of maternity care services, with very little engagement in the community with midwifery support. Midwives can provide a lot of benefit and education to improve the health and wellbeing of women and their families. If they visit them at home, it means that they have a better understanding of that person's home environment and the services they may require. There is a program called Best Beginnings, which is again run by a referral agency and is operating in collaboration with the Department of Health and the Department of Child Protection. That is a home visiting support program above the existing child health nurse visits. It is a very good program. It is based on the Olds model of care, which is again an evidence-based system that shows improvements in subsequent child development. The issue about Best Beginnings is that although we identify people who may need to access that program, the resources to provide that program to all those who require it are indeed limited.

Mr A.P. O'GORMAN: You have mentioned only King Edward. You have not mentioned any of the other hospitals or even the remote and rural and regional areas. What services go into those areas?

Mrs Abernethy: If we may, we will come to that.

Mr A.P. O'GORMAN: Okay.

The CHAIRMAN: Your particular unit does not deliver Best Beginnings?

Dr Hornbuckle: We refer people who come through King Edward via the social work department, and they are then referred on to the Best Beginnings program. We interlink into that, and we do that by identifying the families who best require those services.

The CHAIRMAN: I presume there is a maternity unit at Joondalup hospital. However, if the child is born at Armadale hospital rather than at King Edward, do the parents get the same service?

Dr Hornbuckle: I believe that in this document somewhere we describe where the Best Beginnings programs currently exist, and clearly there needs to be an expansion of that. For example, I believe there is only one Best Beginnings provider in the Kwinana area, so it clearly needs to be expanded to serve that population.

Ms Lander: Madam Chair, if I may just add to that, there are 11 Best Beginnings services across the state. It is specifically for babies up to three months. That is the referral criterion. They may be referred either through our district offices—so if there is a child protection concern with that family

that has been identified separately to health, there may be a referral in that way—or it may come through a range of hospitals and the health department.

The CHAIRMAN: So at any one time, how many children and parents would be assisted by Best Beginnings?

Ms Lander: I cannot give you that information. I think you asked for that information to be provided as a supplementary last time, so it will be provided, but I cannot give it to you today.

Mr Crane: If I can just make a general comment, Best Beginnings is a joint Department of Health-Department of Child Protection initiative. The Department of Child Protection holds the program funds; the Department of Health provides in-kind staffing resources for child health nurses who work in partnership and in collaboration with the Department of Child Protection to provide Best Beginnings. It is an intensive home visiting program targeted towards —

The CHAIRMAN: We have had a number of presentations on that program, so I do not think we need a further explanation. When we met some weeks ago, we did, as you have pointed out, actually seek to understand how many children are being assisted by this program. I do not know who is going to be able to help us, but we are very keen to find out about the general visitation program, which we understand is health's responsibility, not just in the country, but the general visitation program.

Mrs Abernethy: I am the CEO of the Child and Adolescent Health Service in the Department of Health. The scope of the position is a statewide position. I am also a child health nurse by background. Our contact with families begins after birth. In the Department of Health we have a birth notification system, so for every live birth that is recorded, the child health nurse in each of the areas across the state will make contact with the new parents and offer a schedule of universal child health and developmental assessments. It starts with the offer of a home visit within 10 days. The next assessment is at six to eight weeks, and then at three to four months, eight months, 18 months and three years.

[10.50 am]

The CHAIRMAN: Sorry?

Mrs Abernethy: A home visit at 10 days, then further visits at six to eight weeks, three to four months, eight months, eighteen months and three years. We then have a transition where we hand over to the school health service, which is run by the Department of Health, and we offer a school entry assessment, which is another child and developmental assessment. In total we offer seven universal child health assessments.

The CHAIRMAN: That does not seem very much compared to what seems to be on offer in Victoria and South Australia.

Mrs Abernethy: I guess the range across all of the states is from six to 10, and we offer seven. We offer seven based on the latest evidence of the NHMRC screening report written in 2002. When we looked at that report on what screening tests and visits children needed for their developmental assessments, we actually increased the number of visits from six to seven; we actually added in a three-to-four month assessment. That has been in place since 2006.

The CHAIRMAN: It previously was the case that parents could take their children to child health centres whenever they felt the need. When did that stop?

Mr Crane: It has not stopped.

The CHAIRMAN: Even if parents are offered these assessments, if they want to go more often, they can present?

Mrs Abernethy: Absolutely. The seven universal contacts for every family—in reality, we know that many families visit the child health service many more times, particularly during those first few

months after birth. We offer those services universally—seven contacts for every family. We know that, in reality, families have many more complex needs these days; they need help and support in terms of breastfeeding, settling and sleeping in those early days, and many more contacts are made in that initial period. Similarly with other states, we have seven universal visits.

Mr A.P. O’GORMAN: When you say you make the offer, if that is declined, is there a follow-up?

Mrs Abernethy: There is. It is a voluntary service; I think that is the first thing we need to mention. We try to engage, where possible, with families, and I guess that transition from maternity services, the notification and the information that is shared with maternity about early discharge programs, and that communication with the families, is so important. It is so important for us to actually form a relationship with the parents so they can actually see the service we offer.

The CHAIRMAN: What percentage of neonatal cases do you do home visits for?

Mrs Abernethy: Across the state there is a very high uptake of families. Within the first few weeks we would see approximately 95 per cent to 97 per cent of families.

The CHAIRMAN: Does that seem to be different from another figure we have?

Mrs Abernethy: In the country areas—my country colleagues will confirm that figure.

Mrs Gatti: In the country, in excess of 90 per cent of all mothers made contact within 10 days of leaving hospital. We say within 10 days of leaving hospital because —

The CHAIRMAN: They make contact?

Mrs Gatti: They are generally also home visited. If they say that they do not want a home visit, we cannot go. Most of them receive a home visit; they are offered a home visit within 10 days of leaving hospital. We say within 10 days of leaving hospital because they might have delayed hospitalisation in Perth before coming home, but they are contacted within 10 days and offered a home visit within those 10 days. Most of them take it up.

Mr T.G. STEPHENS: I am interested in the issue of people who decline the service. How does the response from the system then kick in?

Mrs Abernethy: We make a number of attempts to offer the service, whether centre-based or home visiting, but our preferred method in the early few weeks is home visiting. Some families do not want us to visit, so we then offer alternatives, whether in child care centres, community-based centres or other agencies. However, it is voluntary; if the family does not want us to visit, we also make suggestions about other services out there, whether through GPs or anything else.

Mr T.G. STEPHENS: If babies are at risk and their parents are declining services, is there any automatic guarantee of referral through to the Department for Child Protection?

Mrs Abernethy: If it is reported; if there is communication to us to inform us of that, but if we do not know, we do not know.

Mr T.G. STEPHENS: Has the number of child health nurses declined across the state, in terms of the numbers remaining static while the population increases?

Mrs Abernethy: Yes. The reality is that over the past five years there has been an increase in the number of births of between 20 per cent and 21 per cent. There has also been a high level of migration, and therefore a higher number of children than before. There are also many families with additional complex needs. There has not been a commensurate increase in child health nurses.

Mr T.G. STEPHENS: What was the increase over the past five years, and what is the current need for an increase?

Mr Crake: An increase in the number of nurses?

Mr T.G. STEPHENS: Yes.

Mr Crake: No.

Mr T.G. STEPHENS: There has been no increase? The number has remained static?

Mr Crake: It has been static for a few years.

Mr T.G. STEPHENS: What is the number of child health nurses needed to respond to population growth?

Mr Crake: We are looking at around 100 child health nurses and around 135 school health nurses to keep pace with current population trends.

Mr T.G. STEPHENS: That would then deliver to the apparatus of government the capacity for universal delivery of child health nurse services?

Mrs Abernethy: That will enable us to appropriately deliver the universal service. The uptake of families in the first year is very high; it drops off in the second and third years. Our priority has been for families in the first year. Therefore, the number of families coming to see us for the 18 month and three year assessments has dropped off. If we had additional staff, we could address that.

Mr A.P. O'GORMAN: How many staff do you actually have at the moment? How many child health centres do you have, and what is their distribution around the state?

Mrs Abernethy: We have 129 FTE child health nurses in the metropolitan area, and we have 67 FTE child health nurses in the country health services. We have approximately 300 child health centres. Some of them are open part-time, depending on need and depending on the population.

Mrs Gatti: In many of the country areas there are multipurpose centres, and they have child health staff that might be working shifts, but there may be child health specialists in a hospital or a multipurpose centre, so you have a more generalist model running in the country areas because you do not have the critical mass of specialisation.

Mr T.G. STEPHENS: A generalised service, so there will be a nurse who is multiskilled?

Mrs Gatti: That is right; the nurse will have child health training as well, as I did when working in the country.

The CHAIRMAN: There has been evidence, including oral and written anecdotal evidence from health professionals, presumably from community child health nurses, that in many communities within the metropolitan area, child health nurses are currently working on an acuity ratio of one to 420 new birth notifications each year, which is increasingly untenable and resulting in unavailability of services to families at critical times. The committee is a bit surprised that you are saying you are able to get a 97 per cent coverage within 10 days.

Mrs Gatti: That is because it has been our prioritisation. It has been our prioritisation to try to engage as early as we can with the new mums as they leave hospital. In the WA country health services—non-metropolitan—our core screening rates, which Margaret mentioned, are over 90 per cent in the nought to 10 days and four-year-old screens. It drops off relatively significantly in the middle, because it is a voluntary service, but we very proactively chase the ends.

The CHAIRMAN: To pick up on the question Tom asked earlier, are there other states that require the first visit to be compulsory? We got the impression from Victoria —

Mr T.G. STEPHENS: I think they described a program of aggressive intervention.

The CHAIRMAN: Yes.

Mr Crake: That may be for high-risk families.

Mr T.G. STEPHENS: Yes, it was for high-risk families.

The CHAIRMAN: How do you identify the high-risk families?

Mr T.G. STEPHENS: Have we got a program of aggressive intervention for families at high risk?

Mrs Gatti: The key that has just been mentioned is that we need to identify these families early, and preferably before birth, which Janet referred to. In some areas—the Kimberley is one—we have active ante-natal programs that identify high-risk babies or mothers through the ante-natal process, and they are linked through the continuum and the birthing process.

I do not believe, that is throughout the state. I believe that looking at and linking the antenatal socio-economic and lifestyle risk factors will significantly improve postnatal child development.

[11.00 am]

The CHAIRMAN: I do not want to labour this point, but we are a bit concerned because the committee is getting conflicting information. We have a submission from Ngala in which it is stated —

Many Child Health Centres are now not responding to new parents following birth until about 2 months, in quite a number of cases. Ngala surveyed 31 Child Health Nurses (metropolitan) recently to ascertain the level for unmet need. The immediate weeks following birth were highlighted as urgent ...

You are saying you are getting to 97 per cent of parents within the first couple of weeks, but we seem to be getting some information saying that is not the case.

Mrs Gatti: We have the figures that give us the information about the contact we have made with families. Ideally, the process is such that we will see all families within the zero to 10 days —

The CHAIRMAN: We know about “ideally”, but we are actually trying to work out what is happening.

Mrs Abernethy: In reality—if for example nurses have an unexpected influx of births in that particular centre—it is about prioritising the workload in most cases when we have looked at these figures. As I have said, our particular priority is the first year of life and we do try to make contact with the family within that first 10 days to offer either a visit in the centre or at home or wherever the family —

Mr Morrissey: If I may comment, I am interested in that information. I have not heard of it or seen it and Ngala have not approached me with it. But our data supports what Margaret is saying. However, I would be very happy to look into it.

The CHAIRMAN: But we need to get clarity here Mark because, on one hand, it is being said that contact is made and that is not actually saying the same as making a visit. The committee would appreciate—and I think it is important that you know we want—accurate information. We would appreciate a report about exactly how many or what percentage of parents, over the past 12 or 18 months, have actually been seen within that first two weeks. I think it is important for us to get some clarity on that because, quite clearly, the evidence presented to us is that level of visitation is not being achieved.

Mrs Gatti: If I may, I will give two examples from contrasting demographics within WA Country Health Service. In many respects, we are somewhat luckier than our colleagues in the metropolitan area because we have generalist services and a smaller demographic and so know our players; that is, we know who is and who is not pregnant and there is no doubt that that is a distinct advantage. In the Kimberley, for instance, a higher percentage of first mums are seen during a home visit in the first 10 days than are seen in the south west. The south west is generally a high socioeconomic group and if they are on their second or third baby will say—as I did—“No, I don’t want to see you.” That is why our figures are often lower in a demographic like the south west when compared with the Kimberley. So a proactive—what is the terminology you used? —

Mr T.G. STEPHENS: Aggressive intervention —

Mrs Gatti: —aggressive intervention approach is used within WACS, but in the south west that intervention is often a phone call to say, “How are you going? I know this is your second or third

baby”, or whatever, “Do you want a home visit? Let us know.” And the response is, regularly, or more often, a no. In the Kimberley, the intervention is not a phone contact; that is not the way we engage for more obvious reasons —

Mr T.G. STEPHENS: Sorry, someone better help the chair before she jumps and that is to say: is there an aggressive intervention program in Armadale?

The CHAIRMAN: No; I just think it is important that we were told first up, at the start of the inquiry, that the figure was 97 per cent and the implication was for visits—it might be 97 per cent contacted. The committee wants some certainty around that figure and although we understand that there may well be reasons why second and third parents do not require a visit, we do not want to just be given a bland assurance that 97 per cent of people are being seen within the first 10 days if that is not the case. We are a committee of Parliament and we need to know the reality of the situation. I have one further question because, quite clearly, the evidence seems to be that many more childcare nurses are needed in order for home visits to be done properly. Is this particular aspect of your service being affected by a three per cent cut; that is, is there a three per cent budget reduction in this area?

Mr Morrissey: There have been no cuts to service delivery provided by the nurses who see these families; we have maintained the status quo.

The CHAIRMAN: And in terms of all of the on-costs they might have incurred —

Mr Morrissey: Absolutely; that has been quarantined.

Mr A.P. O’GORMAN: I wish to ask about child development and early childhood learning. Child health nurses go out and make visits and certainly pick up some developmental issues, but clearly we are getting information that some young children get to school age and go into school without having the basics—that is, the very very basics—that enable them to learn. Where is the coordination between health and education that will pick up that earlier so that parents are advised about or taught how they should be treating and educating their children, so they are ready for education when they hit the formal years? Is there any coordination at all?

Mr Morrissey: There is quite good coordination. Health has a range of programs that intervene during that critical period and I will ask Erin to comment about education child development. The big issue that we acknowledge that we face is that of significant population growth and that we really, at times, struggle to meet the needs that we know are out there. That is part of the response, but there is some excellent work happening in an attempt to use our resources more effectively. I will ask Erin to elaborate.

Ms Gauntlett: The child development service forms part of child and adolescent community health, so we have a seamless transition from the universal services in the child and maternal health area. When we identify children who might have some possible developmental delays, they can be referred to the child development service and we can provide further assessment, treatment, therapy and/or intervention as appropriate. Those services are provided by a range of disciplines. We have paediatricians and a range of allied health staff working in the service and we provide a range of assessment, early intervention and treatment services for children—everything from a single issue, perhaps speech delay, through to children who have a multiple or global delay across a number of different developmental domains.

Mr A.P. O’GORMAN: Can I ask: there are most certainly waiting lists for speech pathology —

Ms Gauntlett: Yes.

Mr A.P. O’GORMAN: — when we get to that stage, what is the waiting list? And how harmful or damaging is that wait to the children who are not receiving treatment as early as they should be?

Ms Gauntlett: Can I just say, first of all, with the child development service, we have a prioritisation framework for the service. We do prioritise our services to younger children and

children with very complex and severe needs. We do have waiting lists. In terms of how long those waiting lists are, we do have some estimates at the moment, but up until now we have not had an information or database for the service. We have just completed the development of a database for the service which will be rolled out as of next week. We are certainly expecting that database will be rolled out across all 20 of the metropolitan centres that we have. We will be in a position to have much better data in the future. The waiting lists vary by discipline and they also vary across the metropolitan area. Currently the other way we prioritise our service is by recognising that there are key moments in a child's life when critical learning needs to take place. We are very careful to try to ensure that we prioritise our services and interventions to those key transition and developmental stages.

[11.10 am]

Mr T.G. STEPHENS: To me there appears to be a fragmentation in the delivery of government programs across a range of agencies and there is the prospect of hanging on to speech development and learning development issues support through a professional like a speech pathologist. If the playgroup activities and day-care facilities that are supported by the Department for Communities had programs that focused on speech development and language acquisition in a focused education environment, would there not be a better prospect that we would not then have this reliance upon the professionals on their arrival in schools?

Ms Gauntlett: My first comment is that speech and language is one of five developmental domains that we provide services in. It is a very critical one and is certainly associated with better educational outcomes later. The reality is that if we could get in way before, in terms of what Janet was talking about, newborns would have a better start in life and better prospects. If we get to the point where, despite all the best universal preventive services, children have a developmental concern or delay, if we can get in early and provide effective services, those children would have better educational outcomes. There is no doubt about that.

The CHAIRMAN: On a related point, we would like to see the information on the number of speech therapists who have been engaged either directly or indirectly by the state government for the zero to six age group. Have you increased the number of speech therapists? Is the demand for speech therapy increasing? Is there more developmental delay in language occurring now than there was 10 to 20 years ago? Has any research been done through state government agencies on the reason for this increased demand for speech therapy?

Ms Gauntlett: I think there has been an increase in demand across all areas and there has been increased prevalence of developmental delay across all areas. That is partly to do with the fact that we are seeing families with increasingly complex needs present to government services across the board in all areas of health and government services.

In answer to your question about increased FTEs, the child development service is in the same position as other areas within community health. We have had a pretty static FTE despite the increase in births and the increase in the number of families with complex needs.

The CHAIRMAN: You do not engage all the speech therapists, do you? You contract out to groups like Therapy Focus.

Ms Gauntlett: I could not tell you the number of FTE speech pathologists we have in child development services, but we can easily provide you with the information. Within the metropolitan area we provide direct services in speech pathology, occupational therapy, physiotherapy, paediatricians, social workers and clinical psychologists as well as a few other allied health professions. Children can also access private therapists, and Medicare and primary health care screen those sorts of things. We do not contract out our services. For children who have a disability or are vulnerable to a disability, the Disability Services Commission contracts a number of providers, including Therapy Focus, that provide services to those children.

The CHAIRMAN: Are there others? I am looking at Challis, for example, and language therapy is provided there through Therapy Focus, a not-for-profit group. Presumably someone is funding them to do that.

Ms Gauntlett: I would think that the Disability Services Commission funds Therapy Focus; we do not.

Mrs Gatti: Health is the sole provider in the country.

Mr A.P. O'GORMAN: You mentioned that families are presenting with more complex issues. What sorts of issues are making these things more complex? What is happening to families in general that is making them demand more services? Can something else be done before they reach the services to try to prevent that, rather than put more and more pressure on very scarce services?

Mr Morrissey: Margaret's area—early maternal child health home visiting—will have a profound influence. Janet's area is working with mothers, even prior to conception. There is a lot of investment that will get a really good outcome the earlier we get in. That evidence is becoming increasingly profound.

The CHAIRMAN: Why is it not working? The fundamental question is: why is it the case that from what the teachers are reporting and from what the WALNA results show among the largely lower socioeconomic demographic the results are worse? We have all these programs but kids of three and a half or four are turning up more developmentally challenged than children their age have done before.

Mrs Abernethy: As I mentioned earlier, the fall-off in the developmental assessments, particularly in that second year, is notable. I guess that because of our resource constraints and static numbers our focus has been on the importance of the first year in supporting families and early learning. Ideally we should be seeing every family at 18 months and three years in preparation for the children's transition to school. We know that our figures in the second and third year reflect mainly that families are more mobile or parents have returned to work and the children are in day care or playgroups. In terms of our resources and delivering those services in that second third year —

Mr A.P. O'GORMAN: Do services by visiting child health nurses stop at five in the afternoon or do they visit families after hours? What are the hours of operation? Are there enough resources to allow you to extend those hours?

Mrs Abernethy: At the moment the service is traditionally a nine-to-five service. There are limited after hour services that are mostly in terms of a group format.

Mr A.P. O'GORMAN: Does it struggle to service working families?

Mrs Abernethy: Yes, and that is an identified recognition. If both parents are back at work it is a struggle for them to actually attend some of our services.

Mr A.P. O'GORMAN: As a state, we should be in a position to offer those services. If both parents in families are working, they may be still from lower socioeconomic families that struggle to understand the development of their child and what they need to do to help that child. The state is clearly falling down in that area.

Mr I.M. BRITZA: What are the issues that have sprung up that all of a sudden have put pressure on and stretched the department a bit more? Can you give a couple of examples?

The CHAIRMAN: Clearly we have evidence that the number of staff that you have has not kept pace with the growth in demand. Ian's and Tony's questions are directed at what are the social precursors that have led to this great complexity. It cannot all be just because you are not visiting in the second year or whatever.

Mr Morrissey: The pressures are not just on health. They are generated by unemployment, poverty and foetal alcohol syndrome. A range of things are happening and all the agencies are facing similar

pressures. Without being too brief, a lot of that stuff could be addressed early on if we could work with families with the different agencies' skills, and, ideally, before conception in regard to health. There are other areas responsible for what you are talking about—housing and unemployment. I guess that those areas that have been described as the social determinants of health are the key contributing factors.

Mr A.P. O'GORMAN: What work is health doing with child protection, the Department for Communities and Department of Education and Training to try to address that? I know that resources are tight, but is there any opportunity for you to meet with those agencies to address those issues?

[11.20 am]

The CHAIRMAN: Just before you answer, Mark, I need to go out for five minutes, but I am sure Mr Jacob will take the chair.

Mr Morrissey: I will respond, and the others may wish to. I think Best Beginnings has come up as an example of agencies working together. It has twice been evaluated thoroughly by the Institute for Child Health Research. It is one of the best programs around, and that involved both agencies working closely together.

There is a whole range of activities on the ground. We mentioned Challis earlier, which is a great example of all the big departments working closely together. At every opportunity—often generated by the staff on the ground—some great work happens. I think we sometimes struggle if there are different, I guess, priorities at the top of the agencies, which can often divert the focus and the ability for that whole-of-agency response. However, we are trying to address that as much as we can within our various domains.

Ms Lander: And also keeping in mind that our specific cohort is children, either in care or at risk of coming into care. There are a range of opportunities for the Departments of Health and Child Protection to work together. An example would be the interagency pre-birth protocol at King Edward—the pre-birth planning that we do. If the baby is at risk of coming into care, we have four meetings with the mother and King Edward and other agencies where we work through what the best intervention for that child will be at birth.

We have also got the pilot program that I think my director general talked about last time. We are piloting health assessments and checks for all children in care in the school system. Immediately on coming into care—I think we are working towards five working days—those children will have a health and education check and assessment. That is a top-to-toe assessment of how they are faring developmentally, and then the appropriate supports will be put in place. We continue to look for opportunities in working with that specific cohort around child protection issues.

Mr A.P. O'GORMAN: That is talking about children who are at risk all the time. What about those who are at a little bit higher or lower level and who are not at such a high level of risk? If we concentrate everything on the higher risk ones, what is the danger that those at slightly lower risk will move into the higher risk category?

Ms Lander: Well, we do not. The two population groups that we target are at the tertiary end—the pointy end—where we have a statutory intervention; and then at the secondary end is those who are at risk. Where there is an identified risk, we work with those families and children through things like Best Beginnings or responsible parenting and parent support. So, again, parent support is a referral-initiated intervention in which the Departments of Corrective Services, Education and Health can actually refer, and we have parent support workers who help in developing parenting skills. The Department for Communities also have a range of parenting programs that Ms Creed might want to touch on.

Ms Creed: We have talked about that.

Mrs Abernethy: If I can comment: the question is what the Department of Health is doing in terms of working with agencies, and I have another couple of quick examples. Within Child Development services, as part of the reform process we have been through, we have developed formal agreements with other key agencies, such as the Disability Services Commission and Child and Adolescent Mental Health Services so that we can make sure there is a seamless transition for families between the relevant agencies they are involved with, rather than its being disparate. They are just some more examples.

Mr T.G. STEPHENS: To that point then, is there a document the committee can have that actually positions the overarching framework of the early childhood work that is guiding interagency collaboration? You talked about an agreement. Is there a policy or overarching framework that has been put in place that guides this?

Mr Crake: I am Mark Crake from Child and Adolescent Community Health policy. It is fair to say that there are a range of memorandums of understanding and service level agreements that exist between agencies at a range of levels; but at a whole-of-government level, I do not believe there to be any overarching government framework that draws all the threads together.

Mr T.G. STEPHENS: In the absence of that framework could someone like me think, legitimately, that we have failed—I fear that is self-evident in the communities in which I operate, where kids at risk have not been picked up in a universal program of support—while simultaneously efforts of government are going into things that, to me, look utterly frivolous and trivial in this area of early childhood? Should I be pushing for a framework? What do I have to do? It is incredibly frustrating at this end of a parliamentary career to be looking at communities in absolute failure. With all respect, you talked with confidence about seamless programs, but it is not seamless, it is a mess, an utter mess.

Mr Morrissey: I believe there is a need for an overarching framework, and I think it has been identified in conversations between the various departments. I understand the last endeavour was the Premier's Statement in 2003, the Early Years framework, which may need to be revisited. That is a personal view. I think we would all benefit from a more robust approach to that.

Mr T.G. STEPHENS: On that issue, inside that framework—if the framework was so robust—we are talking about moving resources into another agency like the Victorian model. Is that movement of resources what is needed?

Mr Morrissey: That would be a decision of the minister, to be candid—or ministers.

Mr T.G. STEPHENS: What would be the pluses of such a decision?

Mr Morrissey: To answer your question, the other states—Victoria, South Australia, and Queensland more recently that I am aware—have moved in this direction and there are some very good documents available that point out all the positives.

Mr T.G. STEPHENS: Are there negatives?

Mr Morrissey: Personally, I think there are more positives than negatives. I think it needs to be done well, thought through carefully, but it is possibly the way to go.

Mr T.G. STEPHENS: I will quickly add that your own early childhood program—at Selby Street is it? You have world-class practice going on in some of your agencies. Is the risk of disrupting all that by picking up some of that stuff and putting it in another portfolio too big a risk to run?

Mr Crake: May I make two comments in that regard? The first is that the model of service delivery or the types of services provided in jurisdictions vary a lot. New South Wales does not have a publicly provided school health service; WA does. Victoria does not have a publicly provided child development service; WA does. In WA they all hang together within the Department of Health: maternal and child health, school health and child development services, so it is an integrated

service in that regard. In my view, certainly there would be some risks to split those apart, because at the moment there are clinical pathways for children with identified needs.

Within Victoria, the providers of services—we are talking about child health services—are located in local government and non-government services; so the government becomes a funder and a policy setter not a provider. I think that WA would need to look at what works best here. Needless to say, I think there would be no danger in having overarching outcome objectives, government frameworks, targets et cetera set by government in its own right. How that would look, I am not one to know.

Mrs Gatti: We also need to be mindful of the different demographics of the other states. From a WA community health perspective, we have small, scattered, remote and shifting populations. We will use speech therapy as an example because it has been mentioned around the table today. The speech therapists on the ground in WA country areas are generalists because we do not have the critical mass to support specialists. While, say, 50 per cent of their work is with children, there are also the swallowing difficulties in adults et cetera. If you look at recruitment and retention in remote areas, you need to be mindful of what is needed to get that resource there at all, and to make it viable in terms of the demographic.

[11.30 am]

Mr A.P. JACOB: When you are talking about universal services—I think you may have alluded to that earlier—in some ways regional facilities are a little bit better because they start at that universal end, and there is the general services, and maybe then identifying areas of need and funnelling them into specialised areas that may be in centres that can provide for all of them.

Mrs Gatti: Yes, and there is some advantage in being able to do that. I just want to mention Fitzroy Crossing, looking at social determinants and lifestyle issues that affect child development. Fitzroy, as you know, has been a very proactive community. The community itself owned the change there and it brought together the agencies to help start to try to effect change. Some preliminary measures are now showing that we do have some change in lifestyle factors in Fitzroy and, hopefully, down the track we will see children being born without foetal alcohol, and we will actually start seeing a change. Child development is an socioeconomic lifestyle created factor. One of the reasons we are seeing an increased number is because we have issues like alcohol. It is not just the agencies sitting around the table that will be able to influence and effect change. We have talked primarily today around intervention. The horse has bolted. In my opinion we need to look at the pre-conception, the lifestyle and socioeconomic conditions.

Mr A.P. JACOB: Picking up on pre-conception, I am not sure whether pre-conception is, but prenatal is definitely within the scope of this inquiry. Pre-conception is not an area we have gone into. Would you be able to expand on that?

Mr I.M. BRITZA: I have not heard that terminology used in this frame, I guess.

Mrs Gatti: What was the word?

Mr T.G. STEPHENS: The use of the word pre-conception and the social environment into which people are born.

Dr Hornbuckle: Clearly, there is increasing recognition that the health of women and their families has a profound influence on the development of the foetus. Clearly, if women are in good health before they get pregnant, it sets them and their offspring in good stead for their further years. Unfortunately, a significant proportion of the families in which there is disadvantage do not in fact plan their pregnancies; therefore, trying to get to that pre-conception stage is very difficult. However, we try to target those groups in the first pregnancy and ensure during the antenatal period that we are addressing those lifestyle changes across that period in which parents in general are concerned about the health of their growing foetus. That is when they are then more likely to change towards a healthy lifestyle, provided they are given appropriate advice and support—for

example, smoking cessation advice, which we know reduces low birth weight, and low birth weight is a very important factor in child development—and we identify drug and alcohol use. And then not only ensure women, but also their families and their partners—because there is no point in just the woman reducing her access to that—realise the importance of stopping it, and give them the support to be able to do that and access to those services. They are the main priorities. Also, by continuing in that interpregnancy interval to ensure that families continue to develop their healthy lifestyle behaviours, hopefully we will see a generational change and an increase in the health of people in Western Australia.

Mr A.P. JACOB: Whereabouts is that being provided from? It maybe coming out of King Edward, but where else in the state is it being provided from?

Dr Hornbuckle: Clearly, all health professionals engaged in providing care to pregnant women do concentrate on health promotion. They are aware that it is an important point of time. Clearly, the time available during a single consultation and being aware of the various programs and agencies that people link into depend on a very effective communication strategy about those services. Certainly, an area we need to focus on is how we communicate and further develop the existing programs and make sure they can be effectively delivered in local communities. There are very good examples in the Kimberley area, which we have alluded to before, where local communities are developing those strong community-based programs. There is a Strong Spirit, Strong Mind program, which targets alcohol and drug use within specific communities, using a whole-of-community approach, which clearly targets pregnant women too. The expansion of programs like that and communication of “this works there, can we see if we can integrate that into your local community” will help to close that gap.

The CHAIRMAN: It seems to us fairly obvious from what we have seen that a lot of trials are run, whether they be by communities, health or education, which receive glowing results, and then someone else comes up with another program. So we have seemingly this proliferation of trials and pilots and everyone can quote nice little examples, but they are not being really spread. Getting a successful trial into some form of more mainstream, targeted, systemic application seems very problematic. I guess we would like to know how we get beyond having all these trials and nice little programs that provide photo opportunities, of doing good in a sense, to actually getting some of them implemented in a more systematic way. This goes back to the number of agencies and the number of NGOs that are involved and how we can get some sort of branding or central entry point that gives some legitimacy to the system. It was pretty illegible to us when we started, so if you are a mother from a low socioeconomic group, how would you have a clue?

Dr Hornbuckle: Indeed. Getting research into practice is always a big challenge. You find that when you try to roll out a lot of studies, the success of the programs are never quite as good as the original research suggests, but that does not mean to say you should not expand it. Part of the problem is that the pilot studies usually have a little seed funding, the program continues for two to three years and suddenly it is expected to continue within the resources rather than under a commitment to ongoing funding of that program. That is one of the main problems with that.

Mr Crake: We are always looking at how to improve our services and at the evidence base. Translating that into action is often a workforce capacity issue. It means something else must be let go to do the new piece of work. Often our core business is things like maternal child health contact schedule for new mothers or some core business activity that has a universal platform. In my experience, many times it comes down to a workforce capacity issue.

Mr A.P. O’GORMAN: Is it not the case that all these pilots and trial programs go great and then they have to be converted into actual services for delivery; they are services on top of what is already proved. It should not be a case of saying that we can do this and not this one any more. It should be an addition, and that is where extra funds and resources come from government. It should not be a case of, “This one is good and this one is good but it is either or.” We are now at a stage at

which we must say that a lot of these pilots and trial programs must be converted to services, and to convert them to services, government must step up to the plate and provide those resources.

[11.40 am]

Mr Crake: I would agree.

Dr Hornbuckle: With regard to your second question about where people go to get information, the maternity policy identified a need for improved consumer access to consistent, reliable information, potentially in a branded way. The Women's and Newborn's Health Network has been working towards providing this sort of resource and we, in consultation with a consumer information working group, have developed a website that will go through the prenatal and antenatal parenting aspects and will basically be a link to enable people to identify what services are available where and how to best to access those services.

Mr A.P. O'GORMAN: How do lower socioeconomic people access the website if they do not have access to a computer? We are delivering everything on the web now and we are assuming that everybody has access to it, but they do not.

Dr Hornbuckle: We have evaluated this website with consumers and we recognise that we still need to evaluate it with the culturally linguistic diverse groups, Indigenous groups and the lower socioeconomic classes. When we asked consumers from the lower socioeconomic groups about it, they told us that they actually saw it as a useful portal to start with. Clearly not all people have access to the internet and we will have to think about how to provide a resource for that group of people. More importantly, the website will work as a services directory to identify what is where, which programs are running where and how they can best be accessed.

Mr A.P. O'GORMAN: We will still need the basics on the ground with the child health nurses. They are an initial face-to-face contact for the people who need the services. They can then be directed to the other services. If we do not have the basics on the ground, the web pages, newsletters and anything else we do is just blowing in the wind. It will not go anywhere unless we have the basic resources on the ground.

Dr Hornbuckle: I agree and I add to that that we need to think about not only the child health nurses on the ground, but also increasing the community's access to the services during the antenatal period rather than expecting women to travel to specialist services in the centre of the city when they cannot afford transport et cetera. We need to increase the home visiting capacity of antenatal services, particularly in the metropolitan area.

The CHAIRMAN: Following up on Tony's question, I agree with him that the families with the most dysfunctional and developmental challenges may not have access to a computer. Probably of more importance is that they do not know what they do not know. Part of the whole problem is that they will not wonder whether their child is developmentally at risk because they are not thinking about that. I would have thought that a web page was probably the least significant way of dealing with the families that are most at risk. I am not saying that there is not a role for a website for the general population but when looking at the children who are developmentally vulnerable, I would have thought that a web page was the last way to try to reach them.

Mr Morrissey: The most powerful way to reach that group is by a nurse driving to their home and knocking on their door. The nurse will always get in the door and be well received and do some good work.

Mr A.P. O'GORMAN: Exactly how many of those nurses are you short of? You told us 129 and 69 and that you are short by about 20 per cent. Is that right?

Mr Morrissey: Around 100 are needed to do what we think needs to be done.

Mr I.M. BRITZA: I feel like I am asking this question for the second time, most probably because I want clarity. The social precursors that we were talking about that are putting pressure on the

front-line services are unemployment, poverty and alcohol. They are the same things that were happening 30 years ago. Have these numbers increased simply because of our increased population while the number of people to address them has not, or do we have new specific cases that are coming up?

Mr Morrissey: That requires a two-part response. We have a population that is growing in the context of a static workforce. We also have the ability to identify problems and diagnoses that we did not have before. I am not an expert on autism, so I will comment as a layperson. We are much better at picking up autism than we were a generation ago. If you go looking for something, you will find it.

Mr I.M. BRITZA: I appreciate that.

Mr Ansell: At the University of Canberra is a centre called the National Centre for Social and Economic Modelling. I understand that it has research that would answer your question about the underlying societal factors that are leading to the greater presentation of health care. You may wish to look at that information.

Mr I.M. BRITZA: I appreciate that.

The CHAIRMAN: That is a very interesting issue for us.

Mr T.G. STEPHENS: I have a question about the King Edward Memorial Hospital. King Edward sees large numbers of people from the remote regional areas of Western Australia, including mothers and babies who are at risk. You have described the seamlessness of the program for the metropolitan area. Does that same seamlessness work in the country with regard to the referral of your programs from King Edward?

Dr Hornbuckle: I might have to ask Kate to answer that.

Mr T.G. STEPHENS: Do you refer to country health services?

Mrs Gatti: WA Country Health Service, for your interest, delivers about the same number of babies per annum as King Edward Memorial Hospital. Those who are identified as at risk at pre-delivery are referred to King Edward Memorial Hospital. The birth notification process, which Margaret mentioned earlier when giving evidence, is a backup referral process. For every baby who is born, the midwife's notification form is sent to the local child health nurse, and it usually gets there within a week of the birth. That is the referral process. If there is a context needs with the baby—correct me if I am wrong, Janet—King Edward Memorial Hospital makes contact with the child health nurse or other specialist nurses if they are trying to relocate the mother and baby home on a post-discharge program.

Dr Hornbuckle: If the child, for example, is born preterm or has a low birth weight or some other complication, the neonatologist will liaise with the paediatric hospital services within the regional country areas to ensure that there is an appropriate follow-up program for the preterm infant.

Mrs Gatti: The aim is to get them home as early as possible because generally the mother and baby do better in their own home.

The CHAIRMAN: Members, I was going to ask each of our witnesses today to add anything that they feel we perhaps have not asked that is an important insight.

Mr A.P. O'GORMAN: Can I turn it around and ask all the witnesses if there is something that they think they should be doing that, for some reason or another, their organisations are not funded for by the government? Perhaps something that you should be doing has not come up on our radar in Parliament? Is there one thing that you could do that would help prevent this situation of children being sent to school who are not yet ready to learn?

Dr Hornbuckle: I have two comments to make. There is a reliance on the specialist services provided at King Edward Memorial Hospital. I am not necessarily talking about the medical

services to assist women with existing cardiac or specific medical needs but about the adolescent pregnancy services and the drug and alcohol services. They do not need to be focused at King Edward and should be distributed throughout the other hospitals in the metropolitan area, and support should be provided to deliver those services in the regional areas. Secondly, if at-risk women can engage the services that are traditionally delivered in the postnatal period during the antenatal period, then we will certainly see an improvement in childhood development. That is where I think the best investment in any further resources should be made.

[11.50 am]

The CHAIRMAN: Susan or Helen?

Mr A.P. O'GORMAN: This is your opportunity for your wish list!

Ms Barrera: I do not think I would air my wish list in public! An issue that I think we would like to focus more of our attention on is the quality of child care in the state. We have seen a catastrophic shift because of the collapse of ABC and the need to re-look at the market model of child care. The mix of privately owned and funded and community-based child care is a really important issue. The report on government that came out a couple of months ago did indicate that there is a problem with quality in child care in WA and that the quality of care that kids get—this relates to the working parents you mentioned, and they are in child care for quite a long time while their parents are working—very much could influence their ability to participate in school and in life.

Ms Lander: My comment is: we need money just to manage our demand—I do not have a wish list—of what is walking in the door for Child Protection; we need more money. My comment links back to the Chair's comment about the plethora of pilot programs. I think that if there was money on the table, what I would be saying is that instead of having one-off pilots, let us make them systemic if they work. The other thing is that instead of targeting specific locations for programs that work, let us have them statewide. An example for us is parent support—Responsible Parenting. We have Responsible Parenting in a number of locations but not others. We need that statewide to actually work.

The CHAIRMAN: Responsible Parenting being a program that you offer?

Ms Lander: Yes. It is a referral and an intervention around parenting skills, working at the coalface with the family to teach them how to parent better.

Mr A.P. O'GORMAN: Would that then reduce the number of kids who come into care in the long-term?

Ms Lander: It is all linked, yes.

The CHAIRMAN: How does that work with the health department program?

Ms Lander: We have Best Beginnings, which we have spoken about. That is for referrals up to three months. Responsible Parenting parent support is for kids up to 15. They can be referred at any point from zero to 15. Other agencies can refer and we link them up with services. It is not all about our parent support worker providing those parenting skills; that is part of it. But it is also linking them up with community supports and other government supports. If we had that statewide, that would be a benefit.

Mr Ansell: My personal sense is that there is a bipartisan political will to do interagency coordination better. I see that from both sides of politics. That is a personal comment. As agencies, I think, collectively we would share that; we would want to do it better. Ultimately, we just cannot have a bottomless pit of resources; we need to use the resources that we have better. In our circumstances, the establishment of the office of early childhood development and learning is another initiative in that coordination area. We would hopefully work better than we have in the past with our partners sitting at the table here. It may be worth the committee looking at successful whole-of-government strategies that have operated in Western Australia. What have they been—

you may know more about them than we do—and what have been the political and bureaucratic drivers that have made them successful? There is literature on that in the public sector literature on whole-of-government, and there would be academics who could provide some insight into the principal success factors around that. Having said that, from the education department's point of view, we would want to work better within and through others, so I reflect Mark's comments. We continue to strive to do that, albeit those efforts are often inadequate.

The CHAIRMAN: I have one question on the education role. When those AEDI results that show the developmental vulnerability come in, there is no work that is then done on researching what is happening in those particular families, is there? That seems to me to be a bit of a gap. We have all been talking about what is causing this. We are getting the AEDI results for four-year-olds, but is anyone going to those families in which children are not performing well and seeking to research the precursors?

Mr Ansell: That is probably a question that I would personally refer to others. For example, the Institute for Child Health Research through the Western Australian child health research and Aboriginal child health research—Mark would know better than I would—would have a worthwhile opinion on those matters and what research has been done. Just to clarify this, the AEDI is, in my understanding, a population measure and came from health. Therefore, we do not collate data at the level of individuals and use that data for a particular intervention per se.

The CHAIRMAN: No, but as a research tool because we are all speculating why this is happening. We have a tool that identifies individuals, so it could be just a research mechanism rather than a personal intervention mechanism.

Mr Ansell: I probably should let the people who are expert in the AEDI respond to that.

The CHAIRMAN: It is teachers—the education department—who collect the data.

Mr Ansell: That is correct. The origin of the AEDI—again, I will get my colleagues to assist me—was that the information that preprimary teachers or their equivalent knew about families was harvested and used as a measure of population health around some of these social determinants of health.

Mr Morrissey: In essence, it is measuring the health of communities, as opposed to what is going on in the families. There has been some excellent work done by TICHHR in regard to what is going on in families, in particular Aboriginal families. There is some great work. I am happy to source some of that information and send it to this committee. There has been a lot of work done.

The CHAIRMAN: Do you have any general comments that you would like to make, Mark, about what you would like, besides the extra 100 child health nurses?

Mr Morrissey: One thing that I would like to be able to do better as a department is to continue to focus on Aboriginal child health. It is one of our priority areas. All our particular programs focus on what they can do with Aboriginal child health. I think it is something that we need to be moving towards doing better. That is my vision for that. I concur with David in regard to some processes to ensure higher-level coordination across departments that actually gets better outcomes than we may have been able to achieve in our current environment.

The CHAIRMAN: Mark, do you have anything to add?

Mr Crake: I just have a comment about the AEDI. At a service development level, we use the AEDI data to identify where services should be located; for instance, Best Beginnings. We use a range of other socioeconomic indicators to try to identify which places might have higher needs for particular targeted services. This is used at a policy and a program development level. The current AEDI is being rolled out now and the data will be available in the future. That will be available nationwide as well, so we will be able to get some better senses about where needs are nationally as well as locally. My comment, looking within the health department first, is that the health

department has been undergoing a reform process for the past few years now. Out of that reform process, which has been about better coordination and collaboration within health, we have improved capacities; for instance, maternal and child health services came together in to one service within metropolitan Perth and child development services came in to one integrated service within metropolitan Perth, which has enabled us to do better coordination and collaboration with our partners—education, health and child protection—to improve. Within the agency of health, we had to reform ourselves to be able to work better outside. I think that process has been very advantageous for collaborative working in the early years.

The second thing I would say is that I think this general conversation has been about a higher-level social and family policy issue, which sits at high levels in government, and what is the social and family policy that government needs to have in place to be able to address or achieve certain identified outcomes. I agree with the comments that Mark just made that some higher-level outcome objectives, performance measures and government frameworks would assist in that regard.

[12.00 pm]

The CHAIRMAN: Erin?

Ms Gauntlett: No, I do not have anything to add.

The CHAIRMAN: Kate, do you have anything to add?

Mrs Gatti: I would really like to support Janet's comments on investment in the antenatal period, and ideally preconception, and Mark's comments on Aboriginal being a focus in that. One of the key stakeholders in all this that I think we have not talked about—particularly when we are talking about Aboriginal—is the community. I think there is benefit in having a high level framework, but some flexibility in how it is delivered, and there being very strong engagement with the community if we are to make a difference. Often, we fly in with our wonderful programs and we have not engaged with the community. The reality is, it may not be a priority for that particular individual in the community because they are dealing with child safety. Law and order is absolutely essential if we are to have an impact on child development. It is a multi-agency, multidisciplinary response that we have to do.

The CHAIRMAN: Margaret?

Mrs Abernethy: I guess I reiterate what my health colleagues have said. I guess as a child health nurse myself, I recognise the important role of child health nurses, and they are ably supported as well by Aboriginal health workers and ethnic health workers, so there is actually a team of staff out there. Ideally we would like to be visiting in the antenatal period. That is where you start your relationship with families—we cannot do that at the moment. As you mentioned before, we have pilots that you have probably seen in our submission, but with the current resources we cannot universally offer every family —

The CHAIRMAN: You are talking antenatal, not —

Mrs Abernethy: Antenatal, yes; starting actually the relationship before the baby is born.

The CHAIRMAN: What is the pilot project you have got on that?

Mrs Abernethy: We have got a pilot project where we are visiting four sites in WA, and the child health nurse is offering home visiting to parents who are pregnant and starting up contact in the antenatal period.

The CHAIRMAN: Where are those four projects?

Mrs Abernethy: They are in the goldfields, in Narrogin, and in two areas of metropolitan Armadale, and Cannington.

The CHAIRMAN: What is that project called?

Mrs Abernethy: It is just called the antenatal visiting program, peri-natal project.

The CHAIRMAN: How long has that been going for?

Mrs Abernethy: It is only going for a six-month period.

The CHAIRMAN: Who is assessing it?

Mrs Abernethy: We are, as part of the child and adolescent community health policy. It is more about what resources we need, do the parents see the usefulness of the visit, what are the outcomes that we are actually looking to achieve, and starting to identify families earlier, particularly the vulnerable families, and starting that network of support for them in the antenatal period.

The CHAIRMAN: I think it was you—it may have been Janet—who made a comment about midwives. Do you think that our particular way of delivering midwifery services adds to this, that if we had a more nurse-based system that we might have —

Mrs Abernethy: Maybe Janet would like to comment. I think we have got a really good relationship between midwives and child health nurses in terms of the communication with families. I think it was Janet who talked about increasing home visiting with midwives, or having more midwives out in the community.

Dr Hornbuckle: Yes, at the moment there are virtually no midwives working within the community setting. There is a very small visiting midwifery service offered from most hospitals, but the majority of antenatal care is delivered within a hospital setting or in isolation with GPs. Really, if we can get midwives working in the antenatal and early postnatal period in people's homes or local communities, then the community sees that—it devolves from the medical model, "Oh, you go to the hospital for all your care."

The CHAIRMAN: Would the obstetricians allow it?

Dr Hornbuckle: The fact of the matter is that there are significant proportions of people—certainly in the outer metropolitan area—who have no access to community-based services; that is, delivered by their GPs. The obstetricians who work in the public hospitals are extremely keen engage in this sort of model because we are fed up with having 100-plus women turn up in a morning to an antenatal service. There is no need for the majority of antenatal care to be delivered within a busy antenatal clinic; it is best delivered in the community.

The CHAIRMAN: Could we get a submission from you about how that sort of structural change would work to the benefit of the developmental—are you able to provide us with some detail on that?

Dr Hornbuckle: Yes.

The CHAIRMAN: Any final questions?

Thank you very much, and thank you very much for your patience. We thought we would trial out this room—perhaps it was a bit ambitious with the number of people that we had brought along. Thank you very much for your presentations, and we need to apologise for the not-very-good space.

Hearing concluded at 12.05 pm