



Education and Health Standing Committee

Child Health - Child Development: the first 3 years

Report No. 13
March 2012

Legislative Assembly
Parliament of Western Australia

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Education and Health Standing Committee

Inquiry into improving educational
outcomes for Western Australians
of all ages

Report No. 13

Presented by

Dr Janet Woollard, MLA

Laid on the Table of the Legislative Assembly on 1 March 2012

Chair's Foreword

I am pleased to present this interim report, which forms part of the Education and Health Standing Committee's *Inquiry into improving educational outcomes for Western Australians of all ages*.

Term of Reference two of this inquiry addresses the 'factors influencing positive or negative childhood development from birth to year 12.'

This report examines the early years (0 to 3 years) and the central role that child health nurses (CHNs) play in monitoring child development and in early intervention where this is required.

Much of the work undertaken by CHNs involves the development of supportive relationships. Through a series of contacts, CHNs are able to establish a relationship with parents and their children. This enables the development of trust which enhances their ability to work in partnership with the individual and family to address their concerns.

When present in the community in which people live, CHNs are publicly perceived as a safe and approachable source of accurate information and valuable support.¹ Child health nurses are critical facilitators of healthy child development in the period of 0 to 3 years, and as such are an extremely important part of the health service.

Research shows that what happens to a child in the first three years of its life can have an enormous impact on that child's brain development, social and emotional wellbeing, and later mental health.

Regular developmental assessments during the first three years allow for the early identification of problems and early intervention. This enables more cost effective intervention by reducing the severity of identified problems and in some cases, preventing them occurring in the first place. The savings to the child, the family and the community from such early intervention, in terms of both monetary and societal costs, are significant and quantifiable.

It is worth noting that in many cases, while it is not too late to intervene for a child arriving at kindergarten or school, the later the intervention, the more problematic it becomes. As an early childhood expert told the Committee, 'interventions need

¹ Abernathy et al, Community Health Nurses Western Australia (CHNWA) submission to Commissioner for Children and Young People, Western Australia, 2010

to occur before the start of kindergarten. It is not hopeless after this point, but it is much more expensive and difficult.²

Child health nurses are the mechanism by which infants, children and families in need can be identified. Without a child health nurse's ongoing engagement with families and the community, infants and children may have no contact with a health professional able to identify developmental problems until they reach the school system. As one Principal reported to me, metaphorically, most children run a 100 metre race to be ready to start school. For other children, they have to run 140 metres. They start at a disadvantage to other children. This leaves them poorly equipped to cope with the challenges of education and to less able to relate to other children.

A number of reports in recent years have found that funding for child health nurses is inadequate, and that infants, children and families are suffering as a result.

There is a growing population in Western Australia. This is placing pressure on child health nurses to see more and more infants and children. This results in an overstretched workforce struggling to provide a 'bare bones' service.

Factors within our community, such as: increasing numbers of Fly In Fly Out families; higher rates of post natal depression; teenage pregnancies; and more families needing extra support such as parenting advice, also place pressure on child health nurses.

As this report highlights, there has been a 28% increase in births between 2003 and 2010 (24,493 to 31,424). The increase in the annual number of births is cumulative in terms of its impact on the child health nurse work load as the CHN is supposed to carry out developmental assessments for the first three years of a child's life. Yet, despite the increased number of births, the ratio for full time equivalent (FTE) child health nurses to birth notifications over the past 3 years has worsened.

The Department of Health advises that this decline is due to a lack of growth in relevant primary care resources over the past decade. Because of this the Department has placed a priority on assessments in the first twelve months of a child's life. However, this approach means that other critical stages of children's development, most notably the 18 and 36 month assessment, do not receive the attention they deserve. The Federal Government is currently moving to place

² Professor Collette Tayler, Chair of Early Childhood Education and Care, Melbourne Graduate School of Education, Briefing, 17 October 2011.

emphasis on the three year assessment and other states are placing greater attention on the 18 month assessment.

As a representative of child health nurses told the Committee, child health nurses are 'very stretched to do anything too much over that first 12 months, we have cut down to the bone.'³

When the Auditor General reported on universal child health checks, he found that

Many children are missing out on key health checks between birth and school entry. As a result, some developmental problems are not being detected and intervention is being delayed. This can have a significant impact on children's development and school readiness.

In addition,

*Only 30 per cent of 18 month olds and nine per cent of 3 year olds received checks in 2009-10.*⁴

Child health nurses reported to the Committee that they identify problems and make referrals at each of the universal checks. This means that a child who misses even one universal check may miss an opportunity for a problem to be identified, a referral to be made, and treatment provided.

For Western Australia to have similar ratios of child health nurses to the number of births that exist in other states of Australia and in the UK, another 151 child health nurse positions would need to be created.

In his statement to Parliament at the opening of the 2012 year, the Premier acknowledged that 'There is no more important a job than ensuring every child, no matter what their circumstances, can achieve their potential...the critical years for learning are the early years.'

Research clearly shows that the critical years in early childhood are between birth and age three.

The Premier's statement recognised the input of this Committee's report 'Invest Now or Pay Later' into the government's investment of additional funds for 'child therapy' services. As the Premier reported, this additional funding has led to

³ Ms Angela Poole, Media Spokesperson, Community Health Nurses WA, *Transcript of Evidence*, 2 November 2011, p2,7.

⁴ Western Australian Auditor General's Report, *Universal Child Health Checks*, Report 11, November 2010, p6.

significant falls in the waiting times for children to access services such as speech and occupational therapy, and physiotherapy etc.

While this funding has been important in enabling children to access such services, there remains the problem of children who miss out on the universal assessments that may have resulted in a referral to those services.

More money is desperately required to open the door to all those who need it. This can only be achieved by increasing the numbers of child health nurses.

The Committee hopes that the Premier and the government will recognise the urgency of this need within the community, and act swiftly during the current budget process to provide essential additional funding.

I would like to particularly acknowledge the many passionate and dedicated individuals and organisations that have freely given of their time and expertise to this Inquiry.

I would like to thank the Committee's members, Mr Peter Abetz, Ms Lisa Baker, Dr Graham Jacobs and Mr Peter Watson for their ongoing support and dedication to the work of the Committee, and for their commitment to furthering the opportunities for improved education and health for all Western Australians.

In addition, I would like thank the secretariat of the Committee, Dr Brian Gordon, Principal Research Officer, and Ms Lucy Roberts, Research Officer. Brian and Lucy have provided professional, dedicated and enthusiastic support to the Committee. Their genuine interest and contribution has resulted in the creation of a valuable report.

Janet Woollard

Dr J.M. WOOLLARD MLA

CHAIR

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Executive Summary

This Report is premised on the established science that the first few years of a child's life are crucial in setting the foundation for lifelong learning, behaviour and health outcomes. There is a substantial and significant body of evidence that emphasises the importance of early childhood prevention and early intervention programs. In Western Australia, child health nurses are at the forefront of such strategies.

The current and significant inadequacy of numbers of child health nurses (CHNs) in Western Australia is therefore of grave concern. Insufficient CHNs can have a long term negative impact on the developmental health and well-being of infants and children.

The shortfall occurs, as the Report highlights, at a time when there has been a sharp increase in both birth rates and immigration rates into Western Australia with no concomitant increase in child health nurses. This is despite the fact that in the past three years alone there have been three Committee reports and a Western Australian Auditor General's report, all of which have found serious deficits in the delivery of primary health care and an inadequacy of child health nurse numbers.

The consequences of the lack of government response, as the Auditor General found, are that 'many children are missing out on key health checks between birth and school entry. As a result, some developmental problems are not being detected and intervention is being delayed. This can have a significant impact on children's development and school readiness.'⁵ Starting school behind other children can mean that disadvantaged children struggle to catch up to their peers, let alone succeed in the school environment.

Such reports have been further supported over this time, by calls for a government response to the child health nursing crisis from many parents, the Commissioner for Children and Young People as well as professional bodies such as Community Health Nurses WA. Yet despite this strong consensus as to the need and despite a steadily growing population, the ratio of child health nurses to birth notifications has worsened. The current deficit is calculated to be 151 FTE. . This is, as is outlined in the report, a simple consequence of a lack of allocated resources over the past decade. Such a lack of resources, it has anecdotally been suggested, is an unexpected consequence of merging the primary and tertiary health care sector budgets following the Report of the Special Consultant on Community and Child Health Nurses. The model which was

5 Western Australian Auditor General, *Universal Child Health Checks*, Report 11 – November 2011, p6.

introduced unfortunately led to resources being more easily diverted to the more visible, media sensitive areas of health.

The Committee takes the view that a continued reduction in assessments and services comes at a significant cost to the child, its family and, in the longer term, the community. Good quality support services at the right time can support families and may prevent child abuse and neglect, or at least reduce some of the harm to which children are exposed. Accordingly the Committee has made a number of consequential recommendations and urges their early implementation.

Ministerial Response

In accordance with Standing Order 277(1) of the Standing Orders of the Legislative Assembly, the Education and Health Standing Committee directs that the Minister for Health report to the Assembly as to the action, if any, proposed to be taken by the Government with respect to the recommendations of the Committee.

Findings and Recommendations

Finding 1

Page 4

Early childhood, particularly from birth to three years, is a time of rapid development in the brain and in physical, social and emotional development.

Finding 2

Page 9

Biological, environmental and relational factors, along with the family environment, the wider community and the socio-political circumstances, all influence a child's health and development. Of these, the family environment is generally considered to be the most important.

Finding 3

Page 19

There are clearly identified long term economic and societal benefits to antenatal, infancy and early childhood intervention. Such benefits include significant reductions in child maltreatment, substance abuse and criminal involvement, and improvements in educational performance, child and youth behaviour, employment, and income.

Finding 4

Page 22

Research indicates that up to 25% of children in Australia live in a household where one parent suffers a form of mental illness. In another study, 73% those young mothers surveyed diagnosed with mental illness, were offered no support or information on how to plan for the stresses of pregnancy and parenthood having regard to their mental health.

Finding 5

Page 24

There is a broad consensus that General Practitioners are already working with long waiting lists and would not want to take on the role, training, and responsibilities of child health nurses.

Finding 6

Page 26

Diagnosed findings in Western Australia show that more than one in six children in WA aged four to 17 years had a mental health problem. In 2005, 24 per cent of Aboriginal children aged four to 17 years were at high risk of clinically significant emotional or behavioural difficulties.

Finding 7

Page 30

Western Australia has seen a sharp increase in population in the past decade. Of the 0-17 year old cohort the strongest increase, at 21.5%, was among the early childhood, 0-4, age group.

Finding 8**Page 30**

The 2011 Productivity Commission report indicates that net overseas migration has contributed up to 60% of the population growth. However, the children who migrate to WA are not accounted for in the Department of Health records.

Finding 9**Page 31**

Fly in fly out families have a demonstrated need for support in the early years as many have moved away from existing networks of social support. This trend is forecast to continue to put further pressure on existing primary health services, most notably those provided by child health nurses.

Finding 10**Page 32**

It is the Department of Health's policy position that child health services offer universal child health and developmental assessments at the key developmental ages of 0-10 days, 6-8 weeks, 3-4 months, 8 months, 18 months and three years.

Finding 11**Page 35**

Between 2008 and 2010 there was an increase in the number of births in Western Australia. Funding for FTE child health nurse positions has not kept pace with the population growth over the past decade.

Finding 12**Page 36**

Based on the average ratio of child health nurses to birth notifications prevailing in the Eastern States and the UK, Western Australia is currently faced with a significant shortfall of 151 child health nurses.

Finding 13**Page 38**

Despite the Health Department of WA's policy position for 'child health services to offer child health and developmental assessments at the key developmental ages,' this is not occurring due to insufficient child health nurses being employed. This is because over the last decade resources have not been prioritised for early childhood development in the community sector. This means that significant numbers of infants and young children do not have access to assessments at critical points in their developmental journey, thereby reducing the effectiveness of early intervention.

Finding 14**Page 39**

The reduction in assessments and services by child health nurses comes at a cost to the child, its family and, in the longer term, the community. Good quality support services at the right time can support families and may prevent child abuse and neglect, or at least reduce the harm.

Recommendation 1**Page 43**

The Minister for Health ensures that funding is provided for the addition of 151 child health nurse full time equivalent positions in the 2012 state budget.

Recommendation 2**Page 44**

The Minister for Health should direct the Department of Health to secure and collate data from relevant Commonwealth Departments to help identify children in the 0-5 age group who migrate to Western Australia each year. This data should then be used to:

- Advise parents of the child health services available, in particular child health nurses; and
- Supplement birth notification data in staffing and workforce planning calculations for child health nurses.

Recommendation 3**Page 46**

The Minister of Health provide funding in the 2012 budget for the infrastructure required to support current and additional child health nurses to improve service delivery. This should include funding for:

- Improved information technology for all child health nurses;
- Administrative support;
- Significant improvements to the physical infrastructure of child health centres; and
- Better access to pool cars for metropolitan child health nurses.

Recommendation 4**Page 48**

The Department of Health be funded to enable more flexible service delivery by child health nurses, particularly through such mechanisms as:

- The provision of assertive outreach activities to locate and assess vulnerable children, and
- The development of more accessible services with flexible/extended opening hours for child health clinics and the provision of mobile services to childcare centres, shopping centres, etc.

Recommendation 5**Page 50**

That the Department of Health be funded to extend the current capacity of child health nurses to have ante-natal contact with a family.

Chapter 1

The importance of assessments in the early years

The early years are a period of vulnerability for a child's development. This chapter reviews the factors that influence a child's development during this vulnerable period, and their impact on a child's life.

The foundation years in a child's life

There is universal recognition of the significance of the early childhood period as it affects the future course of that individual's life. In particular, brain research shows us that the first three years of life are the most critical for health and development. A child's experience during this time influences their success in life in general, and in particular in the spheres of academic performance, employment opportunities, future socioeconomic status, social and emotional wellbeing, and in the development of meaningful relationships with others.^{6,7}

The dimensions of childhood development

Child development is multidimensional. These dimensions are interdependent and can be divided into five key, measurable areas:

- physical health and wellbeing;
- social competence;
- emotional maturity;
- language and cognitive skills; and
- communication skills and general knowledge.⁸

Each area is made up of specific developmental stages against which a child's development throughout the first years of life can be measured. In recognising the

6 Australian Institute of Health and Welfare, *A picture of Australia's children 2009*, 2009. Available at: <http://www.aihw.gov.au/publication-detail?id=6442468252>. Accessed on 2 November 2011.

7 Victoria Department of Education and Early Childhood Development, *A Research Paper to inform the development of An Early Years Learning Framework for Australia, 2008*, Available at http://www.deewr.gov.au/Earlychildhood/Policy_Agenda/EarlyChildhoodWorkforce/Documents/AResearchPapertoinformthedevelopmentofAnEarlyYears.pdf, Accessed on 8 December 2011.

8 Australian Early Development Index website: Available at <http://training.aedi.org.au/Secondary-Pages/Key-Questions.aspx>. Accessed 1 December 2011.

Chapter 1

importance of these developmental stages, not only are children in Australia provided with access to universal assessments but there is an Australia-wide population measure that places the focus on all individuals within a defined community. This is the Australian Early Development Index (AEDI). The AEDI captures the broader community factors that impact on a child's health and development, including the broader social environment.

Brain development

Early childhood is a time of rapid development in the brain and many of the body's biological systems that are critical to sound health. Perhaps no aspect of child development is as important at this time as the development of a child's brain. When the brain and other systems are being formed early in life, a child's experiences and environments have powerful influences on both their immediate development and subsequent functioning.⁹

During the first year of life the sensory regions of the brain, such as those responsible for sight, hearing and touch, undergo a rapid period of growth. By two years of age, a child's brain structure closely resembles that of an adult,¹⁰ and is approximately 80% of the size and weight of a fully matured, adult brain.¹¹

During the ante-natal period the brain develops at a rapid rate, creating virtually all the neurons a child's brain will ever have. At birth, these neurons are not connected as they are in an adult brain. A combination of biology, environment and experience facilitates the establishment of the required synaptic connections in the brain.¹² Figure 1.1 illustrates the rapid development of synapses in a child's brain between birth and 15 months of age.

Figure 1.1 Illustration of synapse development in a child's brain¹³

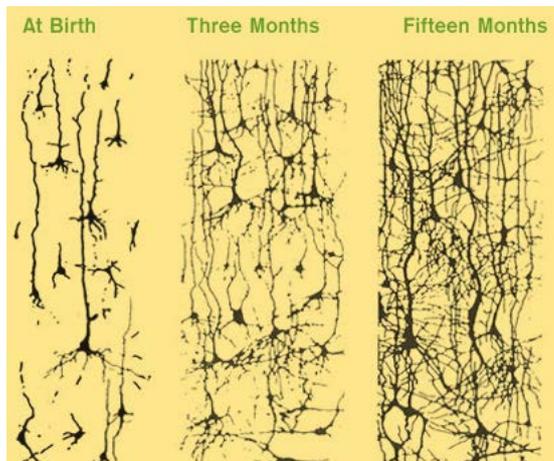
9 Harvard University, Centre of the Developing Child, 'The foundations of lifelong health are built in early childhood.' <http://www.developingchild.harvard.edu>

10 Johnson, M., 'Functional brain development in humans,' *Neuroscience*, vol 2, 2001.

11 Casey, B., Giedd, J., & Thomas, K, 'Structural and functional brain development and its relation to cognitive development.' *Biological Psychology*, vol 52, 2000, p242.

12 The Virtual Village, report prepared by the State of South Australia, Department of Education and Children's Services, DECS Publishing, Hindmarsh, 2007, p 28.

13 Image from Learning Steps Montessori Nursery website. Available at: <http://www.learning-steps.com/node/7>. Accessed 1 December 2011.



The newly formed synapses in a child's brain must be continually stimulated, otherwise 'pruning' occurs whereby those synapses which are not being used and stimulated, deteriorate. In short, the more synapses are used, the stronger and more resistant to pruning they become.¹⁴

While a stimulating and nurturing environment will result in the formation and maintenance of important neural connections within a child's brain, risk factors exist which can negatively impact on brain development. These in turn influence physical, social, emotional and cognitive development. 'Such risk factors include:

- ante-natal exposure to alcohol and illicit substances;...
- disease and injury;
- inadequate nutrition;
- a lack of stimulation;
- an absence of nurturance; and
- a lack of opportunity to explore the environment.¹⁵

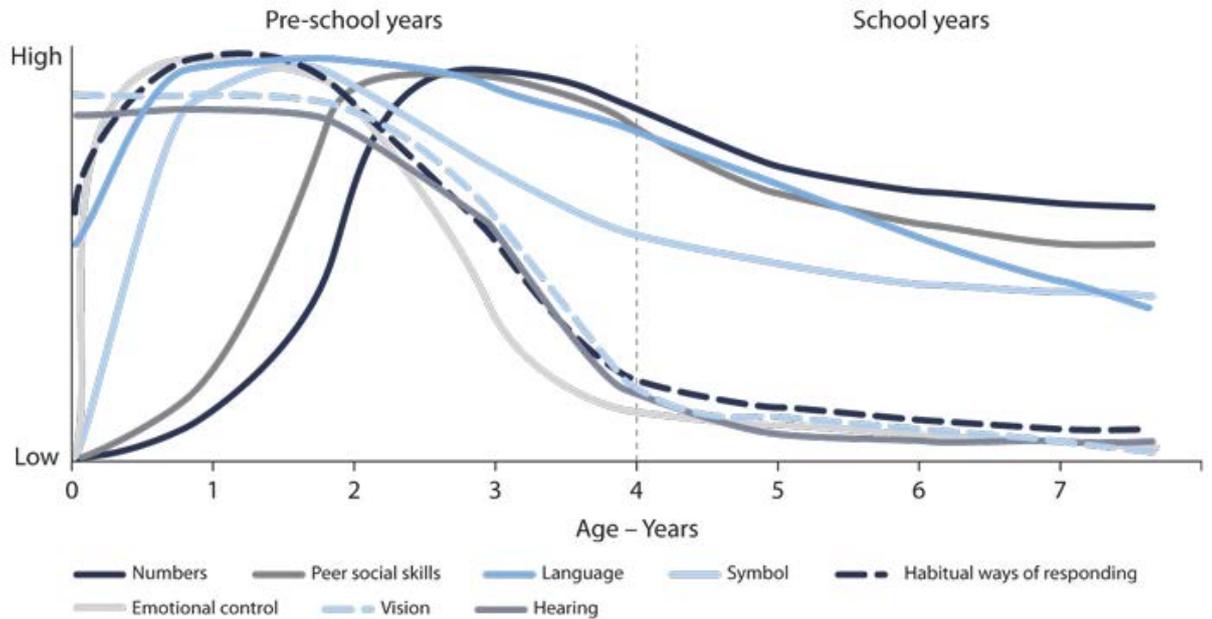
The following figure illustrates the sensitive periods in child brain development for key developmental areas. The optimal times for development and learning occur prior to four years of age.

Figure 1.2 Sensitive periods in early brain development¹⁶

¹⁴ Hawley, T., *Starting Smart: How early experiences affect brain development*, Ounce of Prevention Fund and Zero to Three, 2000, p2.

¹⁵ Hawley, T., *Starting Smart: How early experiences affect brain development*, Ounce of Prevention Fund and Zero to Three, 2000.

Chapter 1



The influence of risk factors should be minimised during critical developmental periods to ensure optimal brain development. Providing the opportunity for a child's brain to develop to its fullest potential produces long term social, emotional and educational benefits.

Finding 1

Early childhood, particularly from birth to three years, is a time of rapid development in the brain and in physical, social and emotional development.

Factors influencing childhood development

Both nature and nurture - both our genes and our environment - interact to determine how our early experiences shape our development as humans. Biological, relational factors and the environment, particularly the family environment, together with the wider community and the socio-political circumstances, all influence a child's health and development.¹⁷ Positive and negative experiences become 'embedded' in the

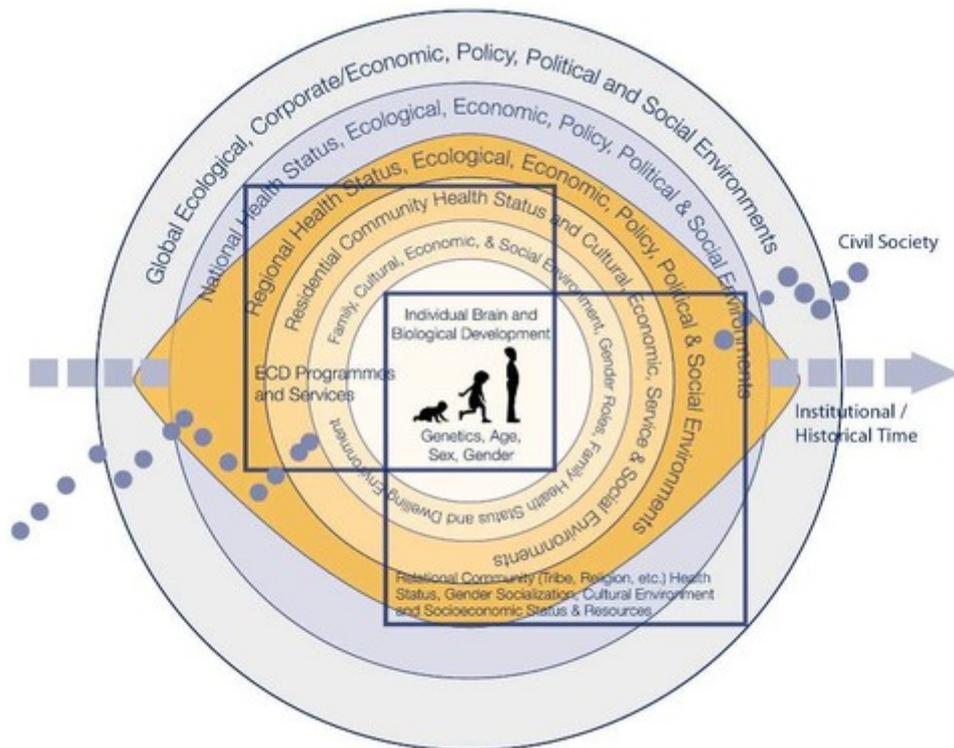
16 Early Childhood Education Task Force, An agenda for amazing children: Final report of the Early Childhood Education Taskforce, 2011, p45. Available at: http://www.taskforce.ece.govt.nz/wp-content/uploads/2011/06/Final_Report_ECE_Taskforce.pdf. Accessed on 23 November 2011. (Note : Graph developed by the Council for Early Childhood Development. 2010). Source: The Science of Early Child Development. www.council.ecd.ca.

17 Wachs, T., 'The nature and nurture of child development,' *Food and Nutrition Bulletin*, vol 20, no 1, p.4.

biology of our brains and bodies, persisting far into adult life and influencing our adult health and well-being.¹⁸

The many influences on a child's development are illustrated in Figure 1.3 below.

Figure 1.3 Diagram of the many spheres of influences on child development¹⁹



Of the many spheres of influence on child development, the family environment is generally considered to be the most important as families have a critical role in providing infants with nurturance, stimulation and care. Family characteristics, such as socioeconomic status, social support, and parental health and education, affect the ability of a family to provide for and nurture a child. A child's general health and

18 The University of British Columbia, 'The Human Early Learning Partnership,' Available <http://earlylearning.ubc.ca/about/> Accessed 7 December 2011.

19 The University of British Columbia, 'The Human Early Learning Partnership,' Available <http://earlylearning.ubc.ca/about/> Accessed 7 December 2011.

Chapter 1

wellbeing, along with socialisation skills, emotional competency, and academic achievement, are influenced both positively and negatively by its family environment.²⁰

The community and wider socio-political environment similarly exert influence over a child's development; access to health care and parental support services, an adequate education system, safe community and a stable economic environment are all important for ensuring health and wellbeing.

Each child faces individual and environmental risks to its healthy development. One witness appearing before the Committee detailed how a weak family environment, a child's repeated exposure to trauma, or to a primary caregiver's mental illness or substance abuse are significant negative risk factors impacting on child development.²¹

Other potential risk factors include:

- low birth weight;
- malnutrition;
- low socioeconomic status;
- experiencing neglect;
- experiencing poverty; and
- environmental health factors.

In short, the environment and individual factors to which a child is exposed, contribute to and shape brain development, social and emotional wellbeing, and early attachment experiences during the formative years of a child's life:

*...optimum development occurs when children and families are within a supportive environment that actively contributes to social and emotional wellbeing, physical health, sound nutrition, positive attachment.*²²

Importance of attachment

The first twelve months of a child's life are a critical time for brain development, and are important for establishing relationships with parents, caregivers and other family

20 Australia Institute for Health and Welfare, 'National outcome measure for early childhood development,' 2011. Available at: <http://www.aihw.gov.au/publication-detail/?id=10737419493>. Accessed 9 November 2011.

21 Dr Caroline Goossens, Child Psychiatrist, Faculty of Child Psychiatry, University of Western Australia, *Transcript of Evidence*, 28 September 2011, p12.

22 Mr Dawson Ruhl, Chief Executive Officer, Child Australia, *Transcript of Evidence*, 23 November 2011, p12.

members. Attachment is a biological instinct which drives infants to seek closeness with their primary caregiver. A child's relationship with their primary caregiver, and the attachment they have to that person, influences a child's long term future development.

The nature of the attachment relationship between a child and the primary caregiver can fall within one of four categories:

- secure;
- avoidant;
- ambivalent; and
- disorganised.²³

Secure attachment is characterised as a bond with a caregiver, which is affectionate, safe, responsive and predictable. Secure attachment positively influences child development and is associated with:

- development of healthy relationships with other people;
- ability to exhibit effective social and emotional regulations;
- better educational outcomes; and
- a greater degree of resiliency and optimism.²⁴

Dr Caroline Goossens, a Child Psychiatrist who appeared before the Committee in September 2011, described secure attachment as:

*... where you have a fairly robust relationship with your parent; where the parent usually is enjoying parenting; they have a capacity to tolerate both positive and negative emotions in their child; they are physically affectionate; and they can think about what they do as a parent.*²⁵

Disorganised attachment is regarded as having the greatest negative impact on cognitive, emotional and social development. Dr Goossens explained to the Committee the long term effects of disorganised attachment on the development of a child:

23 Dr Caroline Goossens, Child Psychiatrist, Faculty of Child Psychiatry, University of Western Australia, *Transcript of Evidence*, 28 September 2011, p8-9.

24 Perry, B., Childhood experience and the expression of genetic potential. *Brain and Mind*, vol 3, 2002, p95.

25 Dr Caroline Goossens, Child Psychiatrist, Faculty of Child Psychiatry, University of Western Australia, *Transcript of Evidence*, 28 September 2011, p8.

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We know that children who have a disorganised attachment, for example, really struggle in the classroom. They have a whole lot of problems; they struggle with, really, attention and concentration, and their capacity to settle themselves enough emotionally to be available for learning. They have struggles with their peers and they have far more conflictual relationships, often.²⁶

A number of biological and environmental factors influence the quality of child-caregiver attachment. These include nutrition, poverty, domestic violence and maternal depression.²⁷ Sleep and feeding difficulties in infants can be an indicator of attachment issues. These are all factors which a child health nurse discusses with parents to optimise a child's development.

While attachment is only one factor influencing an infant's overall development, starting life with attachment problems is a disadvantage and can result in lasting developmental problems, including social and emotional dysfunction.²⁸ Parents and caregivers need to be provided with the support and intervention required to ensure the development of strong, secure attachments.

Social and emotional wellbeing

A child's social and emotional wellbeing is considered a critical indicator of future development. As with brain development, social and emotional wellbeing is affected by biological, environmental and relational influences.²⁹

Social and emotional wellbeing is promoted by access to safe and stable care, opportunities for social interaction and secure parent-child relationships. Children who display high levels of social and emotional wellbeing are more likely to:

- be resilient in stressful circumstances;
- perform well at school;
- exhibit pro-social behaviour;³⁰ and

26 Dr Caroline Goossens, Child Psychiatrist, Faculty of Child Psychiatry, University of Western Australia, *Transcript of Evidence*, 28 September 2011, p4.

27 World Health Organisation, *Early child development: A powerful equalizer*, 2007, p22. Available at: http://www.who.int/child_adolescent_health/documents/ece_final_m30/en/. Accessed 4 November 2011.

28 Perry, B., Childhood experience and the expression of genetic potential. *Brain and Mind*, vol 3, 2002, p95.

29 Australian Institute for Health and Welfare, *Headline indicators for children's health, development and wellbeing 2011*, 2011, p51. Available at: <http://www.aihw.gov.au/publication-detail/?id=10737419587>. Accessed 9 November 2011.

30 Prosocial behaviour is often defined as actions carried out voluntarily which help or benefit another—for example, volunteering in an emergency situation.

- be able to regulate emotions effectively.³¹

In contrast, disability, exposure to domestic violence and parental substance abuse, social isolation, neglect and poor parent-child relationships negatively impacts on a child's social and emotional wellbeing.³² If social and emotional wellbeing is disrupted, a child's development can be impaired, resulting in:

- poor school performance;
- an increased likelihood of mental health problems;
- poor relationships with others; and
- engagement in antisocial behaviour.³³

Protective factors, such as secure relationships, are encouraged by child health nurses. In Australia, governments of all colours acknowledge that parents need to be supported in their parenting to ensure protective factors are promoted. Interventions which identify and eliminate or minimise the effect of risk factors, such as domestic violence and neglect, must be readily available to ensure healthy child development.

Finding 2

Biological, environmental and relational factors, along with the family environment, the wider community and the socio-political circumstances, all influence a child's health and development. Of these, the family environment is generally considered to be the most important.

31 Thompson, A., Development in the first years of life, *The Future of Children*, vol 11, no 1, 2001, p50.

32 Australian Institute for Health and Welfare, *Headline indicators for children's health, development and wellbeing 2011*, 2011, p51.

33 Australian Institute of Health and Welfare, *A picture of Australia's children 2009*, 2009, p60. Available at: <http://www.aihw.gov.au/publication-detail/?id=6442468252>. Accessed on 2 November 2011.

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The current role of a child health nurse and its limitations

This chapter reviews the current role of the child health nurse in the community, together with the critical qualities they bring to the role, in the context of the need for assessment and early intervention.

The United Nations Convention of the Rights of the Child, to which Australia is a signatory, obliges State Parties to:

recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services... [Including]... preventive health care, guidance for parents and family planning education and services.³⁴

Such principles have long guided both Federal and State government policy.

The role of child health nurses (CHNs)

As outlined in this report, it is socially, morally and economically important that a sound investment is made in the foundational early years of a child's life. Therefore the early identification of issues is critical, as are accessible intervention services. In Western Australia, CHNs are often the first or earliest points of contact with children. They are integral to the provision of information and support to families as well as referral. They work in their local communities to prevent illness and promote health through centre-based care or home visits.

Regular health and development checks—particularly visits with CHNs—allow for:

- identification of disease, disability or developmental problems;
- opportunities to minimise the effects of identified risk factors, including those related to poor parenting; and

34 Office of the United Nations High Commissioner for Human Rights, Convention on the Rights of the Child, Available from <http://www2.ohchr.org/english/law/crc.htm>, Accessed on 16 December 2011.

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- the application of interventions, or appropriate referrals, to ensure optimal child development, health and wellbeing.

CHNs, using the relational rapport and access provided by the more formal visits, 'are skilful at encouraging parents' early literacy initiatives [reading to the child], determining post natal depression, domestic violence and so on. They are able to build relationship around the best interest of the child.'³⁵

Current policy dictates that the Department of Health, through child and school health nurses, provides a range of services including:

- A programme of universal contact with parents and children during the early development years. CHNs are trained to assess the mental health of parents and infants using observation and formal screening instruments;
- A programme of targeted services for young children and their families when their needs exceed the services delivered by the universal schedule. Examples of these services include an enhanced home visiting service for families in need of additional support; a targeted Aboriginal child health schedule; and the 'Best Beginnings' programme delivered in collaboration with the Department for Child Protection;
- Visits to preschool centres to undertake routine hearing, vision and developmental screening; and
- A school nurse service for primary and high school students, in collaboration with the WA Department of Education and dependent on resourcing.
- Where present in a school a school health nurse is able to see young people who self-refer to the school 'drop-in' clinic for a variety of health reasons, which often concern mental health problems. Many young people respond well to support, education and counselling provided by these nurses and do not need referral. Others are referred to School Psychologists, General Practitioners or specialist treatment services.
- Child health nurses and school nurses are well placed to involve the family in the young person's care when appropriate. In addition to this screening, support and referral role, these nurses are increasingly active in promoting positive mental health and advocating for school policy and culture that promotes mental health.³⁶

35 Dr Trevor Parry, WA Chair the National Investment for the Early Years, *Briefing*, 15 December 2011.

36 Margaret Abernathy, Submission to Commissioner for Children and Young People, Inquiry into the Mental Health and Wellbeing of Children and Young People, 2010, p1.

In this way CHNs and school health nurses provide a comprehensive range of health promotion, early identification and intervention services to children, young people, adults and their families. The nurses work across all age groups.

Liaison between Child Health Nurses and General Practitioners

The role of child health nurses and how it articulates with that of a General Practitioner (GP) is outlined by a GP as follows:

GP's see their role in doing an appropriate 6 week check with stethoscope etc. from head to toe, looking for many things such as coarctation of the aorta, hip dysplasia, heart defects, sternomastoid tumours, neuroblastoma eyes, craniostenosis, foetal anomalies etc. alertness, smiling, appropriate developmental stages, being cognisant of the things that must be picked up before it is too late. Then they rely on the CHN doing the screening checks on hearing, weight, development at the specified times, encouraging baby books to be filled in etc. We rely on them sending us babies who are not meeting the expected milestones for growth development etc.

We then see them [the babies] and try to make a diagnosis, refer to specialists etc. whatever is required.

We also do vaccinations and I use that time to quickly ask parents re: all these issues. There is a formal 4 year old screening check the government gets GPs to provide - done by our surgery nurse then the GP - looking for those kids who don't meet appropriate levels for eyes ears growth ,vaccination status etc. We send out mail call ups for this.

So really we work as a team, because screening populations of children needs input from baseline tests done by say CHN to sort out who needs further intervention by the GP who then decides 'what is the diagnosis here?' and subsequently deciding if the child needs further intervention by specialists in whatever relevant field. Say ophthalmologist or assessment for learning difficulties/developmental paediatrician, or ENT surgeon, or speech pathologist.³⁷

The unique qualities of child health nurses

In the past the CHN 'was frequently positioned as the 'expert' providing advice and information to individual families on the health of their children and performing public health functions such as immunisation, child health and development screening, surveillance and assessment including hearing and vision screening of

³⁷ Email from Dr Beverley Crisp, 15 December 2011.

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children up to the age of five years.’³⁸ However, today ‘their health practice is informed by ecological and social models of health and is located within a population health and primary health-care framework to provide preventative health care.’³⁹

In contrast to the historical situation, the need to work within a framework of a social model of health means that CHNs should ideally work within communities fostering social networks by bringing families together, supporting the development of playgroups, participating in family fun days and mobile visiting playgroups and strengthening local community connections.⁴⁰ As one CHN put it, ‘I have done assessments in Hungry Jacks, outside grog shops on pay week, and under the trees, because that is where the children are.’⁴¹

Additionally,

*CHNs are constantly networking and collaborating with a wide range of health and social professionals and looking for opportunities for further collaborations that will facilitate the promotion of mental health. In WA, CHNs have been, and continue to be, involved in a number of innovative collaborative programmes designed to facilitate positive child mental health outcomes. CHNWA believes that CHNs presently play a vital role in promoting the mental health and wellbeing of children and young people in WA.*⁴²

A key role of child health nurses is to provide postpartum support to new parents. This is frequently undertaken through facilitating peer support groups for new parents.

Underwriting the role of a CHN is their ability to relate well with children, parents and professionals. Parents with greater needs or who are vulnerable have at times expressed hesitancy in using this universal service, or have even demonstrated overt avoidance, reportedly because mothers feel that the nurse is ‘watching over them’, particularly in home visiting, creating fear and a lack of trust. Unless the engagement is performed sensitively by the nurse and a good relationship is formed, mothers can often feel vulnerable and powerless. This has led to a call for nursing work

38 School of Nursing University of Western Sydney, *Collaboration for Research into Universal Health Services for Mothers and Children*, report prepared by Dr Virginia Schmied et al. ARACY, 2008, p16.

39 School of Nursing University of Western Sydney, *Collaboration for Research into Universal Health Services for Mothers and Children*, report prepared by Dr Virginia Schmied et al. ARACY, 2008, p17.

40 School of Nursing University of Western Sydney, *Collaboration for Research into Universal Health Services for Mothers and Children*, report prepared by Dr Virginia Schmied et al. ARACY, 2008, p19.

41 Ngala, Child Health Nursing Focus Group, *Briefing*, 11 December 2011.

42 Margaret Abernathy, Submission to Commissioner for Children and Young People, *Inquiry into the Mental Health and Wellbeing of Children and Young People*, 2010, p1.

to be informed by a framework of relational ethics in which child and family health nurses 'hold mutual respect towards everyone, no matter what the circumstances, engage in sensitive, responsive interactions with the family and child and embodiment (emotional engagement, attunement and a developing sense of moral agency)'.⁴³

To encourage trust in the CHN and reduce a parent's fear requires high level relational skills. The personal qualities that the child health nurse is required to bring to the relationship with the parent (family) include being empathetic, caring and understanding, and being dependable, honest and persistent.

In addition, a positive relationship between the nurse and client involves flexibility, by being able to shift focus when unexpected problems arise. To engage the parent in the initial visits, it has been suggested that the nurse may meet the mother antenatally to explain their role and to encourage the mother to accept the service.⁴⁴

In briefings and hearings the role of a child health nurse was further outlined to the Committee as follows:

- CHNs have a multifaceted relationship, working in partnership with families, services and communities to address roles and expectations right across the physical and psycho-social spectrum.
- The CHNs role in assessing infants and children takes an holistic approach to development and health, and is now significantly more than screening. Nurses have the training and skills to provide direct advice and modelling to families to address issues.
- The developmental approach requires proper assessment of family functioning, home environment and community resources. Such assessments are negatively impacted by lack of CHN time with families as a direct result of child health resource limitations. Assessment of issues such as maternal depression, speech and motor development require ongoing contact as issues become apparent at different times.^{45,46,47}

43 School of Nursing University of Western Sydney, Collaboration for Research into Universal Health Services for Mothers and Children, report prepared by Dr Virginia Schmied et al. ARACY, 2008, p22.

44 School of Nursing University of Western Sydney, Collaboration for Research into Universal Health Services for Mothers and Children, report prepared by Dr Virginia Schmied et al, ARACY, 2008, p22.

45 Ngala, Child Health Nursing Focus Group, *Briefing*, 11 December 2011.

46 Mr Dawson Ruhl, Chief Executive Officer, Child Australia, *Transcript of Evidence*, 23 November 2011.

47 Briefing Dr Trevor Parry, WA Chair the National Investment for the Early Years, 15 December 2011.

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The need for assessment and intervention

As our knowledge of developmental neuroscience grows and increasing evidence from longitudinal studies becomes available, the argument for additional expenditure for interventions in early childhood is both strengthened and shown to be economically responsible.⁴⁸ The research shows that early interventions can have a significant impact on outcomes for children, and can assist in ameliorating inequalities within society. This is particularly the case for children from low socio-economic (LSE) areas, who may experience impoverished circumstances, have delayed development and therefore start school at a substantial disadvantage.

For instance, analysis of the 1999 and 2000 editions of the US National Health Interview Survey, found that poor and low-income adolescents are more likely than their more affluent counterparts to be in fair or poor (versus good or excellent) health, to have limitations in their activities, and to have had behavioural or emotional problems. More recently, studies indicate that the association between low income and poor health has its origins in early childhood.⁴⁹

The United Kingdom's Department for Health's *National Service Framework for Children, Young People and Maternity Services* is unequivocal about the linkage between family poverty and children's poor attainment. It is recognised as a key link in a chain of poor health and social outcomes throughout childhood and the teenage years, resulting in social exclusion in adulthood.

Families living in poverty are less likely than other families to access health and other supportive services. Their children have higher than average rates of overweight and obesity, tooth decay, unintentional injury, and although death is a rare event in childhood it occurs more frequently in disadvantaged families. Similarly there are higher than average rates of substance misuse, smoking, teenage pregnancy, poor educational attainment, unemployment and social exclusion, but have lower breastfeeding rates.⁵⁰

If undetected and untreated, the extent of disadvantage and inequality can worsen. If unaddressed, that inequality can remain for the life of a child.

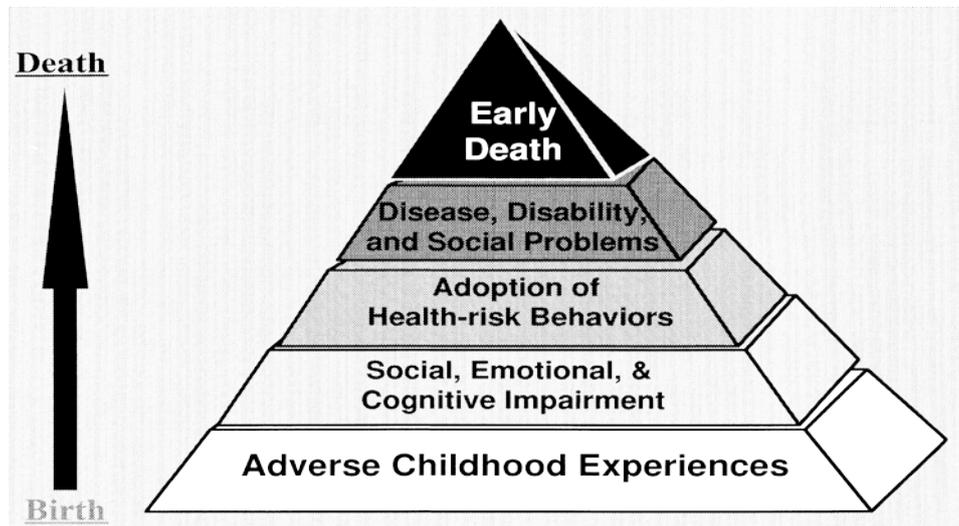
48 Australian Institute of Family Studies, *The efficacy of early childhood interventions*, report prepared by Sarah Wise, Lisa da Silva, Elizabeth Webster and Ann Sanson, Australian Institute of Family Studies, Melbourne, 2005, p1.

49 Health Services Research, *Socio economic status and the fate of adolescents*, Available from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360943/> Accessed on 12 January 2012

50 Department of Health, Standard 1: Promoting Health and Well-being; Identifying Needs and Intervening Early, Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4865614. Accessed 16 January 2012.

The social and economic consequences of inaction are detailed below.

Figure 2.1 Potential influences throughout the lifespan of adverse childhood experiences⁵¹



Economic benefit of early intervention

While there have been comparatively few longitudinal studies of the benefits of early intervention, those that have been undertaken provide a growing body of evidence that demonstrates that early intervention can be effective in achieving significant reductions in crime involvement, child maltreatment and substance abuse, and improvements in educational performance, employment, child and youth behaviour, and income. 'Importantly, these outcomes also produce significant financial savings, for both the individual participant and the wider community. There is mounting evidence that early intervention is a more cost effective strategy than more conventional approaches to reducing crime.'⁵²

One notable longitudinal study was that carried out by the Perry Pre-school Project. This evaluation was undertaken on participants 22 years after completion of that program. It found that the program had produced a saving to the community of \$13 for every dollar invested.⁵³ Nor was this an isolated finding. There is equally impressive

51 Felitti et al., *Relationship of childhood abuse and household dysfunction to many causes of death in adults*, American Journal of Preventive Medicine, 1998 Vol. 4 No.4 p256.

52 Australian Institute of Criminology, *The cost effectiveness of early intervention*, Available from <http://www.aic.gov.au/en/publications/current>. Accessed 14 December 2011.

53 Schweinhart, L. J. (2004). *The High/Scope Perry Preschool Study through age 40: Summary, conclusions, and frequently asked questions*. Ypsilanti, MI: High/Scope Educational Research Foundation.

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evidence of the long term financial return from other US projects before the 1980s, such as the Elmira Ante-natal/Early Infancy Project and the Seattle Social Development.

The demonstrated savings produced by such antenatal, infancy and early childhood programs are numerous and include:

- reductions in welfare assistance
- decreased need for special education
- increases in income tax revenue from the higher wages of participants (due to improved educational attainment)
- reduced operational costs to the criminal justice system
- reduced costs to victims.⁵⁴

This is not to argue that developmental (or preventative) interventions should be favoured over remedial interventions. Rather, that investing more in the front end (preventative) will help alleviate the pressure placed on the already overburdened remedial sector, resulting in long term cost-savings.

Societal benefit of early intervention

Early intervention is seen as foundational for life-long health and future learning outcomes. Such programs have been found to provide psychological and social benefits to children, families and communities. These include: higher rates of employment and skill levels in mothers; decreased welfare expenditure; increased school performance; a lower rate of criminality within families; a reduction of child abuse and neglect notifications and some decrease in health service (emergency room) attendance rates.⁵⁵

The aim of early intervention should be that all families have the opportunity and the resources to promote their children's development, regardless of their socio-economic status.⁵⁶

54 Australian Institute of Criminology, *The cost effectiveness of early intervention*, Available from <http://www.aic.gov.au/en/publications/current>. Accessed 14 December 2011.

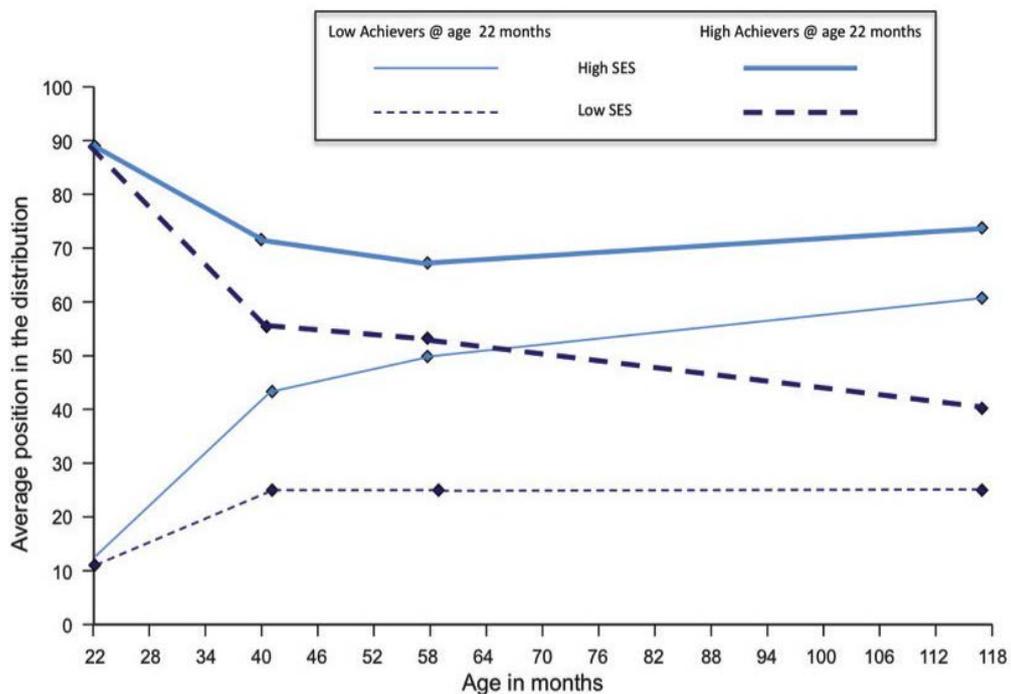
55 The Stronger Families Learning Exchange, 'The Benefits of early Intervention' Available at <http://www.aifs.gov.au/sf/pubs/bull2/ef.html>, accessed on 17 November 2011.

56 Cameron, Jill (Editor). *Integration of early childhood education and care: Meeting the needs of Western Australia's children, families and community in the 21st century*. National Investment for the Early Years, Perth, Western Australia (2009).

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There are clearly identified long term economic and societal benefits to antenatal, infancy and early childhood intervention. Such benefits include significant reductions in child maltreatment, substance abuse and criminal involvement, and improvements in educational performance, child and youth behaviour, employment, and income.

Figure 2.2: Impact of Socio-economic Status on Children’s Achievement



Source: Feinstein 2003

Inequalities can start in the womb

There needs to be intervention while a couple is planning a family, aimed at preventing anxiety, depression and stress during the pregnancy. Research has shown that high levels of anxiety and stress during a pregnancy can have a big impact on the child, both on its physical development, and its psychological development. Early intervention should include discussion and treatment for perinatal depression and/or anxiety.

There is a need for a seamless transfer of information from antenatal care to post-natal care. Antenatal care is a key to early intervention.

Chapter 2

Assessment is linked to referral

*The importance of any assessment, whether it is carried out at the designated times or during other consultations with professionals who work with children, is that it leads to planning in partnership with families, and the provision of appropriate and timely interventions.*⁵⁷

With recognition of the impact that a child's economic and environmental context has on its health, there has been a move away from a narrow focus on health screening and developmental reviews to a more broad-based program of support to children and their families. The purpose has been to address the wider determinants of health and to reduce health inequalities. In broadening the focus, child health nurses are well placed to continue with the assessment process, commenced during the antenatal period, through the use of a standardised assessment tool.⁵⁸

The difficulty for child health nurses is that once families are identified as vulnerable or 'at risk', funding gaps impact on the availability of appropriate referral pathways or readily accessible intervention programs. Organisational restrictions limit the time CHNs can spend with families needing additional support or management intervention. Resources should support access to referral pathways.⁵⁹

One significant risk factor for the child's future is the mental health of the primary adult carer. It is now well accepted that psychosocial adversity is often associated with adult mental illness. Adult mental illness subsequently has strong links with infant and child adverse outcomes. The number of children potentially affected is significant. 'The Young Carer Project Report identified approximately 1,082,402 children in Australia (25%) live in a household with at least one parent with a mental illness.'⁶⁰

A recent study found that of those young mothers surveyed with diagnosed mental illness, most (73%) were offered no support or information on how to plan for the stresses of pregnancy and parenthood on their mental health. In addition, the great majority (86%) received no extra support visits at home. These were vulnerable

57 Department of Health, Standard 1: Promoting Health and Well-being; Identifying Needs and Intervening Early, Available http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4865614 Accessed 16 January 2012.

58 Austin, M. P., Kildea, S., & Sullivan, E. (2007). Maternal Mortality and Psychiatric Morbidity in the Perinatal Period: Challenges and Opportunities for Prevention in the Australian Setting. *Medical Journal of Australia*, 186(7), 364-367.

59 School of Nursing University of Western Sydney, *Collaboration for Research into Universal Health Services for Mothers and Children*, report prepared by Dr Virginia Schmied et al. ARACY, 2008, p22.

60 Submission No 11 from South Metropolitan Area Health Service, December 2011, p1.

families, where half of the respondents (50%) feared losing custody and 22% actively considered relinquishing their baby.⁶¹

Given the importance of the early years in relation to the long term outcomes of a child's life, early identification of need, especially from the parents' perspective, is important. There is a clearly defined need for quality, accessible, available and appropriate services for children and their families.⁶²

Referral to child centred intervention services depends critically on their accessibility. The Committee was advised that there are insufficient services for families with very small children who have mental health problems. Early intervention is proven to restore 20% of affected children to the normal range of mental wellbeing.⁶³ Research has been conducted which shows that high quality early childcare can compensate for deficiencies in the home environment. It is in these foundational years that interventions provide the most effective and efficient way to help and support young families.

As one witness put it there is a need to: ... *'intervene early and often; ...doing so makes economic sense, but it is also just a moral imperative in terms of being able to give children the best opportunity for a successful outcome in their own lives.'*⁶⁴

In summary, the need for assessment and intervention for infants and children (0-4 years) is premised on:

- The first few years of life of a child's development are crucial in setting the foundation for lifelong learning, behaviour and health outcomes. This is partly because early childhood problems can establish developmental paths that become progressively more difficult to modify as children get older.
- 'Interventions need to occur before the start of kindergarten. It is not hopeless after this point, but it is much more expensive and more difficult.'⁶⁵

61 SANE Research Bulletin 13: Parenting and mental illness: the early years, (February 2011)

62 Mustard, J., *Early child development and experience-based brain development*, Paper presented at The 2005 World Bank International Symposium on Early Child Development, 2006, p52. Available from: [http://wwwFOUNDERS.net/fn/news.nsf/0/8ce0c5f5f9ab85758525710e00706362/\\$FILE/Brookings%20-%20Mustard.pdf](http://wwwFOUNDERS.net/fn/news.nsf/0/8ce0c5f5f9ab85758525710e00706362/$FILE/Brookings%20-%20Mustard.pdf). Accessed 7 November 2011.

63 Education and Health Standing Committee, *Inquiry into improving educational outcomes for Western Australians of all ages* Report No. 12 in the 38th Parliament, Parliament of Western Australia 2011, p3.

64 Mr Dawson Ruhl, Chief Executive Officer, Child Australia, *Transcript of Evidence*, 23 November 2011, p12.

65 Professor Collette Tayler, Chair of Early Childhood Education and Care, Melbourne Graduate School of Education, Briefing, 17 October 2011.

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- The process of resolving a developmental problem in the early years of a child's life is significantly less expensive than dealing with consequential issues in later life.
- Social ills such as crime, unemployment and illiteracy can be countered by early intervention therapies designed to root out problems before they become intractable.⁶⁶
- Left untreated, there are a range of collateral social and financial costs. These include high school dropout, family break-down, adolescent and adult depression, drugs and alcohol abuse and suboptimal workforce participation. Such issues result in a considerable cumulative drain on society while simultaneously undermining the productivity of the Western Australian workforce.

Finding 4

Research indicates that up to 25% of children in Australia live in a household where one parent suffers a form of mental illness. In another study, 73% those young mothers surveyed diagnosed with mental illness, were offered no support or information on how to plan for the stresses of pregnancy and parenthood having regard to their mental health.

The respective roles of General Practitioners and Child Health Nurses

It has been suggested that General Practitioners will fill the gap where there are insufficient child health nurses delivering child development interviews, assessments, counselling and referrals. This suggestion overlooks the fact that the child health nurse role is much broader than purely an assessment role.

*The reality in a child health nurse's day is that the checks - the universal screening - is only about a third, or even less, of their work. The majority of their work is that other stuff. Most mothers will tend to want to visit you more outside of those checks in the first year, for reassurance and for parenting issues. The child is doing well from a medical perspective and a developmental perspective. But it is important that support is given to that mother...The actual majority of our work is is in many respects more important than the checks, and that is the true value of the service, and it is linking them into the broader societal supports that are there, and identifying the psychosocial risks that are there early.*⁶⁷

66 Professor Frank Oberklaid 'How school for parents passed the test' Available at <http://www.theage.com.au/articles/2002/08/26/1030053033614.html> accessed on 17 November 2011.

67 Mrs Kate Gatti, Area Director, Population Health WA Country Health Service, *Transcript of Evidence*, 30 November 2011, p16-17.

Many General Practitioners are already working with long waiting lists and would not want to take on the role, training and responsibilities of child health nurses.

*They [parents] may do that [take child to GP for checks] but in fairness - and I do not want to be disrespectful to GPs - a lot of GPs do not do a lot in child development. I know we have had instances where a GP has said to mother, "I didn't talk until I was three; don't worry about it." There is not a lot of that, but it does happen.*⁶⁸

Some general practitioners may hand the role of assessment to their practice nurse, who may not have any training or expertise in early childhood development. An early childhood assessment by a child health nurse takes at least 45 minutes.

The Department of Health identified other problems with any move towards making this role the responsibility of general practitioners.

*From our perspective, the universal net needs to capture everybody. People might choose to go to another provider, which might be very adequate and quite appropriate in the circumstance, because we know that GP practices and services of that type, and even NGO providers, across the state do provide and are providing more and more comprehensive services and look at the family holistically... There might be similarities [between CHN services and GP services], but there are issues with GP practices around access as well. There are sometimes co-payments and the like that need to be made. That can be a factor and an inhibitor. Also, we have to look at the shortage of GPs that we have in Australia and their accessibility. Certainly I know my colleagues in the country can speak about that at length. But we know that there are pockets in the metropolitan area where access is quite problematical. An experienced, well-trained community child health nurse, I think, can address, and we need to create the time for them to address, and help new and existing parents or carers to navigate through the system and obviously undertake some of that checking work that needs to be done... It is case finding and they refer on, but they also often can provide another link to follow up with that family if they are not progressing their referral. So it is complementary; it is not replacement.*⁶⁹

68 Mrs Angela Poole, Media Spokesperson, Community Health Nurses WA, *Transcript of Evidence*, 2 November 2011, p4.

69 Mr Philip Aylward, Chief Executive Officer, Child and Adolescent Health Service, Department of Health, *Transcript of Evidence*, 30 November 2011, p9.

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Finally, it is broadly recognised that one of the important features of the child health nurse's role is the ability to build a relationship with the family that is seen as non-judgemental and as an assistance to the family. Several witnesses remarked to the Committee that 'the people who most need support are the ones who don't go to GPs'.⁷⁰ This perspective is heavily supported by research which demonstrates that families at highest risk for child maltreatment as well as other parenting difficulties are those least likely to take up primary health.⁷¹ Research shows that parents are often more comfortable discussing general developmental issues and sensitive queries with child health nurses.

Finding 5

There is a broad consensus that General Practitioners are already working with long waiting lists and would not want to take on the role, training, and responsibilities of child health nurses.

70 Professor Collette Tayler, Chair of Early Childhood Education and Care, Melbourne Graduate School of Education, *Briefing*, 17 October 2011.

71 Dr Johanna Watson, 'Active engagement: Strategies to increase service participation by vulnerable families' Available at http://www.community.nsw.gov.au/docswr/_assets/main/documents/research_active_engagement.pdf Accessed 12 December 2011.

Chapter 3

The demonstrated need for additional child health nurses

This chapter examines the factors in Western Australia relating to our population, the policies in place, and the practical constraints that show why additional child health nurses are needed.

*It is easier to build strong children than to repair broken men.*⁷²

The need for additional child health nurses is predicated on:

- the importance of the early years, as outlined in the previous chapter;
- Western Australia's growing population ;
- the need for assessment and intervention in the foundational years of a child's life (0-4 years); and
- the relational qualities that child health nurses bring to their role.

As in other parts of Australia, New Zealand, the United Kingdom and some Nordic countries, Western Australian government policy supports a system of free universal services for children in their early years. This is largely meant to be provided through community-based child health nurses.

In Western Australia, the overall health, development and well-being of children is high on many indicators. Childhood mortality rates have halved in recent decades, and the incidence of vaccine-preventable diseases has been reduced since the introduction of immunisation. 'However, concerns are emerging related to rapid social change and the associated new morbidities such as increasing levels of behavioural, developmental, mental health and social problems.'⁷³ This concern is supported by diagnosed findings in Western Australia, notably that in 1995, more than one in six children in WA aged four to 17 years had a mental health problem, and in 2005, 24 per cent of Aboriginal

72 Frederick Douglass, available from <http://www.quote garden.com/children.html>, accessed on 21 November 2011.

73 School of Nursing University of Western Sydney, *Collaboration for Research into Universal Health Services for Mothers and Children*, report prepared by Dr Virginia Schmied et al. ARACY, 2008, p4.

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children aged four to 17 years were at high risk of clinically significant emotional or behavioural difficulties.⁷⁴

Finding 6

Diagnosed findings in Western Australia show that more than one in six children in WA aged four to 17 years had a mental health problem. In 2005, 24 per cent of Aboriginal children aged four to 17 years were at high risk of clinically significant emotional or behavioural difficulties.

Western Australia's growing population

The rapid growth of Western Australia's population has placed an additional burden on existing primary care resources, most notably child health nurses whose numbers have not increased proportionately.

The Commissioner for Children and Young People advised the Committee⁷⁵ that in 2010, Western Australia had the fastest population growth rate, 2.2 per cent, of all States and Territories in Australia for the fourth consecutive year. The latest Australian Bureau of Statistics (ABS) data shows that this rate of growth has been sustained into 2011.⁷⁶ At 30 June 2010, there were 538,963 children and young people 0 to 17 years of age in WA, representing nearly one quarter (23.5%) of the State's population.

74 Submission No 5 from the Commissioner for Children and Young People, December 2011, p3.

75 Submission No 5 from the Commissioner for Children and Young People, December 2011, p3.

76 Australian Bureau of Statistics, available from <http://www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0>, Accessed on 12 December 2011.

Figure 3.1: Number and percentage of children aged 0 to 17 years, states and territories, 2010⁷⁷

	Number of children aged 0 to 17	Percentage of state population	Percentage of Australia's children
WA	538,963	23.5%	10.5%
NSW	1,637,073	22.6%	32.0%
Victoria	1,230,581	22.2%	24.1%
Queensland	1,088,135	24.1%	21.3%
South Australia	356,386	21.7%	7.0%
Tasmania	118,642	23.4%	2.3%
ACT	79,621	22.2%	1.6%
Northern Territory	63,049	27.4%	1.2%
Australia*	5,113,054	22.9%	100.0%

Source: Australian Bureau of Statistics 2010, *Population by Age and Sex, Australian States and Territories, Jun 2010*

* Figure includes other territories comprising Jervis Bay Territory, Christmas Island and the Cocos (Keeling) Islands.

This is the third highest percentage of children and young people 0 to 17 years of all States and Territories, and higher than the national percentage of 22.9 per cent.

In addition, the ABS projects that within the next 45 years the number of children and young people 0 to 17 years in WA will increase by 64 per cent, from 535,160 to 877,778.

In terms of population growth, from 2000 to 2010, the population of children and young people 0 to 17 years in WA grew by 11.4 per cent. The strongest increase, of 21.5 per cent, was among the early childhood age group of 0 to four years - the result of the high birth and the immigration rate in recent years.

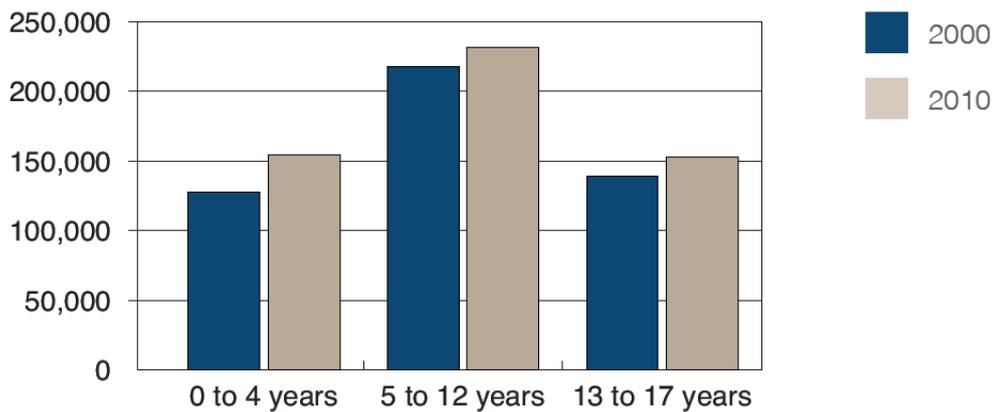
77 Australian Bureau of Statistics 2010, *Population by Age and Sex, Australian States and Territories, Jun 2010*, cited in Commissioner for Children and Young People in WA, *Profile for Children and Young People in Western Australia: Wellbeing Monitoring Framework, 2011 Report*, p5.

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Figure 3.2: The number of children in WA by age group⁷⁸

Age Group	2000	2010	Increase from 2000 to 2010	Percentage of population aged 0 to 17
0 to 4 years	127,215	154,511	21.5%	28.7
5 to 12 years	217,977	231,471	6.2%	42.9
13 to 17 years	138,617	152,981	10.4%	28.4
0 to 17	483,809	538,963	11.4%	100.00%

Figure 3.3: Population growth among children in WA, 2000-2010⁷⁹



The latest ABS 2010 data shows that the number of births in WA in 2010 was 31,424.

78 Australian Bureau of Statistics 2010, *Population by Age and Sex, Australian States and Territories, Jun 2010*, cited in Commissioner for Children and Young People in WA, *Profile for Children and Young People in Western Australia: Wellbeing Monitoring Framework, 2011 Report*, p6.

79 Australian Bureau of Statistics 2010, *Population by Age and Sex, Australian States and Territories, Jun 2010*, cited in Commissioner for Children and Young People in WA, *Profile for Children and Young People in Western Australia: Wellbeing Monitoring Framework, 2011 Report*, p6.

Figure 3.4: Births Registered, States and territories - 2009 and 2010⁸⁰

	2009	2010	Change	2009-2010
	no.	no.	no.	%
NSW	92 783	95 918	3 135	3.4
VIC	70 920	70 568	-352	-0.5
QLD	66 097	64 467	-1 630	-2.5
SA	19 734	20 076	342	1.7
WA	30 878	31 424	546	1.8
TAS	6 626	6 385	-241	-3.6
NT	3 819	3 899	80	2.1
ACT	4 858	5 149	291	6.0
Australia(a)	295 738	297 903	2 165	0.7

Since 2000, the number of babies born in WA has increased by 25.6 per cent and there has been an overall population increase of 22.2 per cent.

The December 2011 Productivity Commission Report No 50 draws attention to the remarkable increase in the contribution of 'Net Overseas Migration' (NOM) to Australia's population growth. In the period 1971-72 to 2005-6 NOM represented 40% of the population growth on average rising to more than 60% over the past four years. (Refer figure 3.5 below) NOM is projected to rise to 70% by 2050 with an aging population.

Given the demands of the resource sector there is no question in the Committee's mind that 'as for Australia so for Western Australia.' However, the children in this incoming population, including those born in the Eastern States, are not accounted for by the Department of Health in determining the adequacy of support by CHNs.

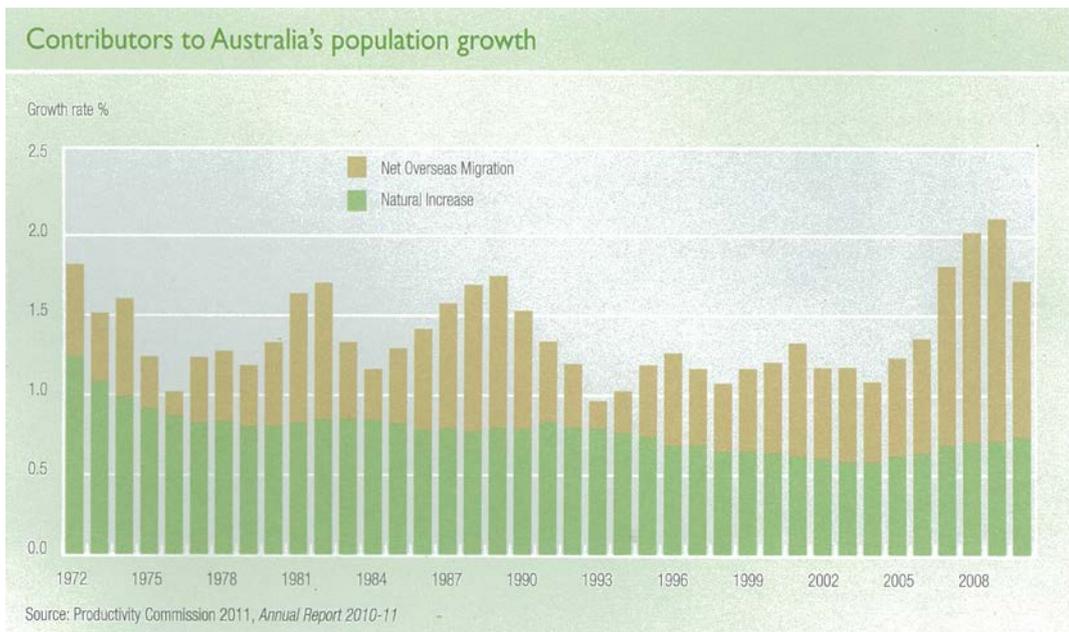
The Department of Health advised the Committee that it has no data on the number of children under the age of 5 who arrive in Western Australia as migrants. The

80 Australian Bureau of Statistics, 3301.0 - Births, Australia, 2010 Available from <http://www.abs.gov.au/ausstats/abs@.nsf> Accessed 17 January 2012.

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Committee was surprised by this, as migration has long been a key driver of population growth in Western Australia, and these children should form part of the Department's target client group.

Figure 3.5: Contributors to Australia's population growth.⁸¹



As well as the growing population contributing to the marked increase in births, so too is the higher fertility rate. After reaching an historic low in 2002, the total fertility rate for all women in Western Australia increased from 1.7 per woman to 2.0 per woman in 2010. Specifically for Aboriginal women, the total fertility rate in WA increased from 2.6 per woman in 2000, to 2.8 per woman in 2010.⁸²

Finding 7

Western Australia has seen a sharp increase in population in the past decade. Of the 0-17 year old cohort the strongest increase, at 21.5%, was among the early childhood, 0-4, age group.

Finding 8

The 2011 Productivity Commission report indicates that net overseas migration has contributed up to 60% of the population growth. However, the children who migrate to WA are not accounted for in the Department of Health records.

81 Productivity Commission, 'PC Update No 50', December 2011, p15.

82 Australian Bureau of Statistics 2010, Births, Australia, 2010, ABS cat.no.3301.0.

Fly in fly out families

A recent estimate by the Chamber of Minerals and Energy suggests that there are approximately 50,000 fly-in fly-out (FIFO) workers in Western Australia, with that number expected to increase in coming years.⁸³

While not all of these will have families with small children, and others will have established social networks, it was made clear to the Committee that there is a significant pool of FIFO people who will require additional support and assistance. This need will grow in the next few years with the expansion of the resource sector.

As one witness from the Faculty of Child Psychiatry put it

*I think the other issue is that we have had substantial social change in WA as well; things like we have had a huge influx of families who have young children and who have moved away from their social supports, and we have a large shift to FIFO workers. **It was interesting that when I was doing a clinical intervention with young children that 80 per cent of the group that I ended up treating were FIFO families.** I think that has a huge impact. That is just anecdotal; that has not been done in a study, but it does make sense, doesn't it, that **that has a huge impact on the capacity of families to cope in that first year of life, especially if they are away from their other social supports and extended family and then they have a husband who is flying away.**⁸⁴*

Her testimony was supported by evidence from child health nurses at Ngala who noted the extra support needs of FIFO families. They advised that Ngala's parent telephone helpline receives many calls from FIFO parents in the gap between the regular universal child health checks, particularly between the 6 week check and the 8 month check.⁸⁵

Finding 9

Fly in fly out families have a demonstrated need for support in the early years as many have moved away from existing networks of social support. This trend is forecast to continue to put further pressure on existing primary health services, most notably those provided by child health nurses.

83 Balding, Andrew, 'FIFO Family Support', *Western Australian Country Hour, ABC*, 9 January 2012, www.abc.net.au/rural/wa/content/2012/s3404582.htm?site=perth, accessed 11 January 2012.

84 Dr Caroline Goossens, Child Psychiatrist, Faculty of Child Psychiatry, *Transcript of Evidence*, 28 September 2011, p7.

85 Ngala, Child Health Nursing Focus Group, *Briefing*, 11 December 2011.

Chapter 3

Child Health Nurses in WA

The policy position

The first chapter of this Report sought to present a rationale for a health policy that is about building a strong foundation in the early years for lifelong physical, emotional and mental health. The Western Australian Department of Health's position on the need for regular assessment in the early years is unequivocal:

The universal child health schedule is based on a population health surveillance model whereby contact with the target group occurs at key points over a period of time. This ensures that patterns in health and development are monitored, understood and followed up as appropriate. Once off, point in time assessments are less effective in identifying health issues and the need for follow up action, particularly in early childhood when growth and development is very rapid.

The checks offered through the universal schedule are a point of engagement and a pathway to additional services provided by the community child health staff as well as providing a point of referral to other services as required. Checks are important but the provision of follow-up is equally important.

In WA, it is recommended that child health services offer child health and developmental assessments at the key developmental ages of 0-10 days, 6-8 weeks, 3-4 months, 8 months, 18 months and three years. In practice there is a committed and persistent effort by community child health nurses to see new parents/carers in their home within 10 days of the birth of a child to engage with the carers, to monitor maternal health, to ensure the new born is healthy and developing normally and to promote parenting practices that support the wellbeing of child and carer.⁸⁶

Finding 10

It is the Department of Health's policy position that child health services offer universal child health and developmental assessments at the key developmental ages of 0-10 days, 6-8 weeks, 3-4 months, 8 months, 18 months and three years.

⁸⁶ Submission 12, Department of Health, December 2011, p6.

The practical constraints on policy implementation

Resource constraints

In recent years resourcing has consistently been identified as an issue. In its 2009 report *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs*, the Education and Health Standing Committee detailed the challenges faced by child health workers in Western Australia. The report found that:

*While WA's child health system aspires to emulate principles accepted in other jurisdictions...this Inquiry has found that it is currently inadequately funded to systematically collect and analyse data on child health conditions, and to offer treatment in a timely fashion to all Western Australian Children. However, this isn't a reflection of the dedication and quality of staff, nurses and teachers within the child health system. WA's child health screening process suffers because an under-resourced labour force works in a disjointed system that has responded too slowly to recent demographic changes and emerging conditions that impact on a child's learning.*⁸⁷

The Committee recommended that the government fund a significant increase in child health staff in order to meet the growing demand for their services, and that the Department of Health look at innovative service delivery approaches to improve service delivery, given resourcing pressures.

The most common measure used to determine the adequacy of numbers of CHNs is the ratio between full time equivalents (FTE) and new birth notifications, known as the acuity ratio. This measure is an imperfect one, as it does not take account of individual circumstances that may impact on a child health nurse's workload, nor of children who migrate to the area. In addition, the Committee was told that birth rates vary significantly between geographic and socio-economic areas with some CHNs receiving 40 birth notifications a month (480 a year). Additionally, we were told that the needs and thus the time spent working with mothers varies between clients and clinics. Factors such as postnatal depression, and the number of refugees, teen mothers and FIFO clients will impact on the time needed for each client.

Despite these shortcomings, the FTE to birth notification ratio is the commonly used measure, and can give at least a partial picture of the workload.

87 Education and Health Standing Committee, *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs*, Report No. 2 in the 38th Parliament, Parliament of Western Australia, 21 May 2009, p93.

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In Western Australia current constraints are evidenced by the upward trending number of births versus static CHN numbers. There has been a 28% increase in births between 2003 and 2010 (24,493 to 31,424) but no significant increase in CHN numbers.^{88,89}

The increase in the annual number of births is cumulative in terms of its impact on the child health nurse work load as the CHN is supposed to carry out the universal developmental assessments for the first three years of a child's life.

The ratio for full time equivalent (FTE) child health nurses to birth notifications over the past 3 years has worsened. The Department of Health advises that this decline in CHN capacity is due to a lack of growth in relevant primary care resources over the past decade.⁹⁰ This lack of growth in primary care resources has resulted from funding being allocated to the hospital sector at the expense of the community sector.

Figure 3.6: Ratio of CHNs: Birth notifications^{91,92}

Year	No. of CHN FTE	Birth Notifications	Ratio FTE to Birth notifications
2008	196.0	30,368	1:155
2009	194.5	30,878	1:159
2010	191.2	31,424	1:164

The ratio of child health nurse full time equivalents to birth notifications does not take account of migrants from the Eastern States or overseas who have children aged under 5 since the Department of Health does not maintain data on these children.⁹³ As outlined above an estimated 60% of the State's population growth between 2007 and 2010 is attributable to net overseas migration alone.^{94,95,96}

88 Answer to Questions on Notice asked in preparation for hearing on 30 November 2011, by the Education and Health Standing Committee and answered by the Department of Health, p1.

89 Australian Bureau of Statistics, 3301.0 - Births, Australia, 2010 Available from <http://www.abs.gov.au/ausstats/abs@.nsf> Accessed 17 January 2012.

90 Email Department of Health 5 December 2011.

91 Answer to Questions on Notice asked in preparation for hearing on 30 November 2011, by the Education and Health Standing Committee and answered by the Department of Health, p1.

92 Australian Bureau of Statistics, 3301.0 - Births, Australia, 2010 Available from <http://www.abs.gov.au/ausstats/abs@.nsf> Accessed 17 January 2012.

93 Email Department of Health 16 December 2011.

94 Department of Training and Workforce Development 'Western Australian skilled migration strategy,' 2011.

95 Productivity Commission, 'PC Update No 50', December 11 p15.

When this omission is taken into account, the shortfall in CHNs is significant. Commenting on the resultant deficit in CHNs, Professor Fiona Stanley stated:

I get very frustrated, I feel like sometimes banging my head against a brick wall. We've been singing this song for 20 years now. Often when I go to the other states people say to me 'what is going on with child health in the boom state?' and I have to hang my head in shame. In WA, there is approximately one child health nurse for every 1,000 children under the age of six.⁹⁷

Finding 11

Between 2008 and 2010 there was an increase in the number of births in Western Australia. Funding for FTE child health nurse positions has not kept pace with the population growth over the past decade.

The association of Community Health Nurses Western Australia (CHNWA) advised the Committee that in the Eastern States, the standard acuity ratios are between 1FTE: 70-100 new birth notifications.⁹⁸ Overseas, the United Kingdom has an acuity ratio of 1:87.⁹⁹

In 2011, there were 198 child health nurse full time equivalents in WA.¹⁰⁰ If a standard acuity ratio of 1:90 is used as a benchmark in WA, being above the median in eastern states but comparative with the United Kingdom, then WA would require an additional 151 FTE positions. This would bring the total number of child health nurse FTE to 349.

The benefit of an improved ratio is evidenced by the state of Victoria. Victoria is generally considered to be the state in Australia with the most proactive approach to early childhood, and has the highest number of children receiving health checks. They have achieved a 'record of 99.8 per cent of children receiving a check after birth. 80-90 per cent received checks during the first year of life and 63 per cent receiving a three-year check.' By comparison, only 9% of Western Australian children receive the three-year old check.

96 Department of Training and Workforce Development 'Western Australian skilled migration strategy,' 2011 and ABS, Cat 3101.0, *Australian Demographic Statistics*.

97 ABC News 'The front line facing child health nurses' Available from <http://www.abc.net.au/news/2011-04-04/the-front-line-facing-child-health-nurses/2630924> Accessed 13 January 2012.

98 CHNWA Submission to Education and Health Standing Committee September 2009.

99 UK 1:87 <http://ukpolicymatters.thelancet.com/?p=703#ref>

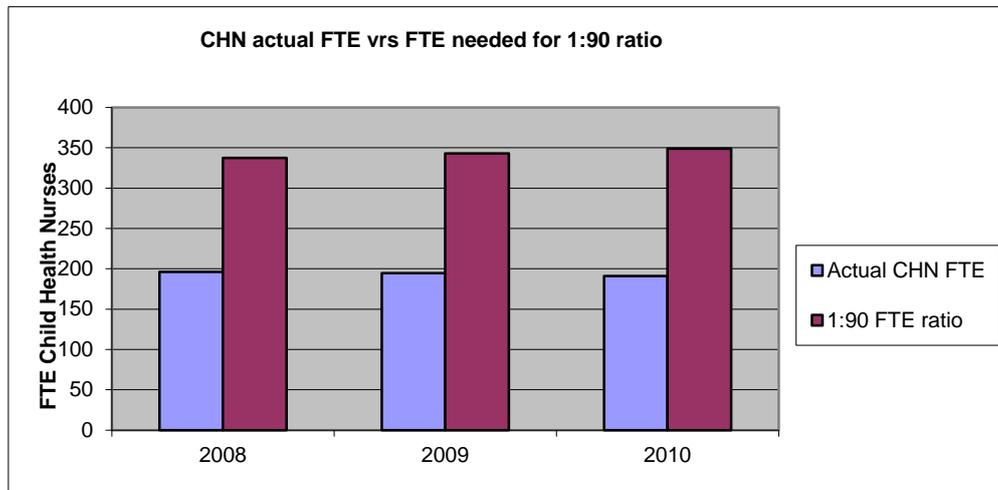
100 Answer to Questions on Notice asked in preparation for hearing on 30 November 2011, by the Education and Health Standing Committee and answered by the Department of Health, p1.

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Figure 3.7 CHN: actual FTE 'v' the number required based on a 1:90 acuity ratio

Calendar year	Number of births	Number of CHN FTE	Ratio FTE to births	No. CHN required for 1:90 ratio	Difference between CHN FTE and CHN FTE required for 1:90 ratio
2008	30,368	196	1:155	337.4	141.4
2009	30,871	194.5	1:159	343.01	148.51
2010	31,424	191.2	1:164	349.15	157.95

Figure 3.8 Graphic representation of CHN: actual FTE 'v' the number required based on a 1:90 acuity rate.



Finding 12

Based on the average ratio of child health nurses to birth notifications prevailing in the Eastern States and the UK, Western Australia is currently faced with a significant shortfall of 151 child health nurses.

Accessibility constraints

Too many mothers find that they cannot access CHNs because there are too few of them.... This situation is exacerbated by the closure of

*many centres and the individual work load being too large. It is not uncommon to have wait lists of three weeks and in some areas it can be six weeks.*¹⁰¹

As is implicit in the foregoing quote, subsequent to the ten day check, not all parents have access to, or are taking advantage of, available, child health and development services and interventions. The implications have been noted by the Western Australian Auditor General, who reported in November 2010 that:

*Many children are missing out on key health checks between birth and school entry. As a result, some developmental problems are not being detected and intervention is being delayed. This can have a significant impact on children's development and school readiness.*¹⁰²

In an acknowledgement of the problem, the Department of Health has since commissioned the Telethon Institute of Child Health Research to:

- Assess whether current child health services meet the needs of parents; and
- Identify why parents are not accessing the 18 month and three year assessment service.¹⁰³

However, in respect to the latter issue, the Department of Health suggested to the Committee that their priority has been, and is, the first check after birth followed by the school entry check. This prioritisation of some checks over others is stated to be an issue of scarce resources.¹⁰⁴ CHNs have told the Committee that they have been told by the Health Department of WA to prioritise appointments for the first year. This factor will need to be taken into consideration when parents state their reasons for not accessing the 18 month and the three year appointment. The prioritisation of services has resulted in a lack of ongoing public promotion of screening for ages and stages beyond twelve months.

This situation is compounded by the fact that 'Health's model of service delivery is not well suited to the lifestyles of many modern families. The limited opening hours and the historical location of some centres impacts on many working parents and reduces the potential number of children that could be checked.'¹⁰⁵

101 Ngala, Child Health Nursing Focus Group, *Briefing*, 11 December 2011.

102 Western Australia Auditor General, *Report 11: Universal child health checks*, 2010, p6.

103 Submission No 5 from the Commissioner for Children and Young People, December 2011 p3.

104 Mr Philip Aylward, Chief Executive Officer, Child and Adolescent Health Service, and Mr Mark Morrissey, Executive Director, Child and Adolescent Health Service, *Transcript of Evidence*, 30 November 2011, p7.

105 Western Australia Auditor General. *Report 11: Universal child health checks*, 2010, p6.

Chapter 3

The universal scheduled visits were established as a bare minimum, however, current resourcing is not even allowing bare minimum to be reached as documented in the Auditor General's Report.¹⁰⁶ As one witness put it, because CHNs are **'very stretched to do anything too much over that first 12 months we have cut down to the bone.'**¹⁰⁷ In the view of this witness and others,¹⁰⁸ when the need for further support home visits is added to the first visit, the CHNs struggle to meet their prioritised work.

Current limited involvement with children after the first year means **many issues are not being picked up or addressed in the 1-3 year period when many developmental milestones occur (e.g. speech, walking, toileting, sleep)**. Behaviour management issues are very different for this age group and many problematic parenting styles will only become evident when children are toddlers. The Committee was told that referrals to child development services are spread across each of the universal visits. This means that children missing out on any of the CHN assessments miss an opportunity for early referral and intervention.

The Department of Health is currently unable to provide details of waiting lists for CHNs.¹⁰⁹

In further confirmation of evidence received by the Committee, the Auditor General found that Health is giving priority to the first four checks, and is reaching 99 per cent of newborns within the first month in the metropolitan area. He also found that this is at the expense of other checks with only 30 per cent of 18 month olds and nine per cent of 3 years olds received checks in 2009-10.¹¹⁰ This prioritisation of the first four checks at the expense of other checks means that developmental delays are being detected late.¹¹¹

Finding 13

Despite the Health Department of WA's policy position for 'child health services to offer child health and developmental assessments at the key developmental ages,' this is not occurring due to insufficient child health nurses being employed. This is because over the last decade resources have not been prioritised for early childhood development in the community sector. This means that significant numbers of infants and young children do not have access to assessments at critical points in their developmental journey, thereby reducing the effectiveness of early intervention.

106 Western Australia Auditor General. *Report 11: Universal child health checks*, 2010, p6.

107 Ms Angela Poole, Media Spokesperson, Community Health Nurses WA, *Transcript of Evidence*, 2 November 2011, p2,7.

108 Ngala, Child Health Nursing Focus Group, *Briefing*, 11 December 2011.

109 Email, Department of Health, 5 December 2011.

110 Western Australian Auditor General, *Universal Child Health Checks*, Report 11 - November 2010, p6.

111 Western Australian Auditor General, *Universal Child Health Checks*, Report 11 - November 2010, p7.

Finding 14

The reduction in assessments and services by child health nurses comes at a cost to the child, its family and, in the longer term, the community. Good quality support services at the right time can support families and may prevent child abuse and neglect, or at least reduce the harm.

Chapter 4

The way forward

This chapter makes recommendations on the changes that need to be made to enable Child Health Nurses to fulfil their role more effectively in Western Australia.

Children are the World's most valuable resource and its best hope for the future.

John F. Kennedy

Prevention and education are better policy than bandage solutions after the fact.

WA parent, surveyed by Playgroup WA.

The need for 151 new FTE child health nurses

As outlined, there has been a consensus over a number of years that the government must provide significant new funding to increase the number of child health nurses.

The shortfall, along with the far reaching consequences of that shortfall, has been highlighted throughout this report. As one parent put it:

Child Health nurses need to follow up children for check ups. My youngest child is 2.5 years and I have not heard from my Child Health nurse since he was 8 months old. It is only that I worked in childcare for 10 years that I know his development is on pace but this proves how easy it is for children to slip through the net for developmental tests at such a key age so that it does not become more of a problem for the child later in life.¹¹²

In the Committee's estimation, for the reasons outlined in chapter three, there is a demonstrated need for an additional 151 full time equivalents. These include:

- Advances in research and neuroscience have shown that the earliest years of a child's development are of crucial importance, particularly for brain development. The experiences the child has in these early years are vital to the child's long term development and success.

¹¹² Playgroup WA 2010 community survey

Chapter 4

- Broad, population-based preventative initiatives that facilitate optimal conditions for brain development in children have significant societal and economic long term benefits. Such initiatives improve educational and employment outcomes and reduce crime.
- Research demonstrates that early identification of problems and early intervention can reduce the impact of the problem over the course of an individual's life. In addition, early intervention makes addressing a problem easier before it has become entrenched.
- Western Australia's population is growing significantly, but the number of child health nurses has remained static for at least a decade. The population growth is being driven both by increased migration to the state, and by an increase in the birth rate.
- Current services are struggling to provide a minimum service of the 'bare bones' of child health assessments with a focus on the 0-12 month checks. The evidence presented to the Committee suggests that a very large proportion of the state's population could be missing out on the full suite of child health assessments.
- There are significant cost savings to government and to society in intervening early. Addressing a problem early and preventing it becoming a major issue is significantly easier and less expensive than intervening at a later point.

In recent years, there have been several Parliamentary inquiries into the adequacy of child health services in Western Australia:

- The Education and Health Standing Committee *Invest Now or Pay Later: Securing the Future of Western Australia's Children*, 2010;
- The Education and Health Standing Committee *Health Child-Healthy State: Improving Western Australia's Child Health Screening Programs*, 2009;
- The Community Development and Justice Standing Committee *Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children*, 2009;

Each of these reports found that funding for child health nurses has been inadequate for many years and that service delivery has been negatively impacted by lack of resources.

In addition, the Western Australian Auditor General's November 2010 report into *Universal Child Health Checks* found that 'many children are missing out on key health checks between birth and school entry. **As a result, some developmental problems are**

not being detected and intervention is being delayed. This can have a significant impact on children's development and school readiness.'¹¹³

Finally, the Commissioner for Children and Young People's *Inquiry into the Mental Health and Wellbeing of Children and Young People in Western Australia* of April 2011 recommended that 'The number of community child health nurses be increased to provide a comprehensive universal health service to parents and children across Western Australia.'¹¹⁴

The government has partially responded by addressing the waitlists for child development services. The 2010/11 budget committed \$49.68 million over 4 years to improve timely access to community child development services. While this money was very welcome and has resulted in significant reductions in the waiting lists for crucial child development services such as speech pathology and physiotherapy, it has not solved the problem of children missing out altogether on assessments.¹¹⁵

Children who have had a universal development assessment with a child health nurse, and who require referral, are now able to access therapeutic services with a shorter wait time. But there are still large numbers of children who miss out on the universal assessments.

More money must be invested at the start of the process, i.e. into funding child health nurses, to open the door to all those who need it.

Recommendation 1

The Minister for Health ensures that funding is provided for the addition of 151 child health nurse full time equivalent positions in the 2012 state budget.

Better data on children migrating to WA

As discussed in chapter 3, population growth in Western Australia is being driven by both a rising birth rate and by significant levels of interstate and international migrants. The Department of Health has advised the Committee that it does not keep statistics on children within the 0-5 age group who migrate to Western Australia. Given these children form a significant proportion of the priority client group, the Committee considers that it is imperative that the Department of Health develop a mechanism to take account of these children in its planning for child and community health nurse

113 Western Australian Auditor General, *Universal Child Health Checks*, Report 11 – November 2011, p6.

114 Commissioner for Children and Young People, Michelle Scott, *Report of the Inquiry into the Mental Health and Wellbeing of Children and Young People in Western Australia*, April 2011, Recommendation 29, pg 103.

115 Department of Health, Submission No. 12, 16 December 2011, pg9.

Chapter 4

staffing. This may involve developing information sharing agreements with federal government agencies.

Recommendation 2

The Minister for Health should direct the Department of Health to secure and collate data from relevant Commonwealth Departments to help identify children in the 0-5 age group who migrate to Western Australia each year. This data should then be used to:

- Advise parents of the child health services available, in particular child health nurses; and
- Supplement birth notification data in staffing and workforce planning calculations for child health nurses.

The need for increased funding for infrastructure and support

While the provision of additional CHN FTE would represent a significant improvement on the current situation, there is a parallel requirement to remedy the deficits in infrastructure and support, as follows:

Information technology: Given the mobile nature of the child health nurse job, with its significant home-visiting component, all nurses should have access to mobile technology such as laptops, tablets and/or smart phones. The Auditor General's report found that currently, 'Many child health nurses do not have access to adequate IT.'¹¹⁶ Better access would make data recording and scheduling more efficient, and would facilitate better recordkeeping. The Committee understands that the Department of Health's new data system, the 'Child Development Information System' (CDIS) (to be implemented by mid 2012) will assist with streamlining of the data entry requirements for CHNs.

Administrative support: The Committee was told by several witnesses that much of the nurses' time is taken up with tasks such as answering phone messages, scheduling appointments, data entry and other administrative tasks.¹¹⁷ The Auditor General's findings agreed with these witnesses, finding that 'Nurses are spending considerable time doing clerical tasks instead of checking children'.¹¹⁸ The Auditor General reported on the trial of a centralised booking service in the Greater Bunbury area, which has been shown to have significant benefits for the child health nurse workload in that

116 Western Australian Auditor General, *Universal Child Health Checks*, Report 11 – November 2011, p27.

117 Ms Angela Poole, Media Spokesperson, Community Health Nurses WA, *Transcript of Evidence*, 2 November 2011. Ngala, Child Health Nursing Focus Group, *Briefing*, 11 December 2011.

118 Western Australian Auditor General, *Universal Child Health Checks*, Report 11 – November 2011, p27.

area. Such initiatives should be extended throughout the metropolitan area, and in regional and remote areas where the workload suggests they are required.

Child Health Facilities Management: an area identified by the Auditor General as being in need of significant investment of resources is the management of the community child health facilities. 'Many centres are in a state of disrepair...Health relies on local government to provide premises for child health centres, but it is unclear who is responsible for maintenance...significant underspending on repairs and maintenance means some centres are not safe.'¹¹⁹ The Department of Health has advised the Committee that progress is being made in this area; that a facilities manager position has been created; and that the Department is working with the Western Australian Local Government Association to address the issue.¹²⁰ While the needs in each area will be different depending on the local government area, existing buildings and other facilities, the Committee supports the allocation of significant additional funding for the updating of this infrastructure to support current and additional staff.

Cars: The association of Community Health Nurses (WA) raised with the Committee the issue of access to pool cars for child health nurses. They advised that pool cars are not always easy to access from the point of view of location, and in addition 'we do not have enough pool cars for child health nurses', meaning many must use their own cars for work purposes.¹²¹ Feedback from members of the association has been that access to cars is problematic throughout the metropolitan area, and that 'the Department of Health relies on community health nurses to use their own car, otherwise parents would not receive a home-visit.'¹²²

Further feedback suggests that the 'limited travel allowance provided to staff who use their vehicles...barely covers the petrol costs never mind the ongoing maintenance costs.'¹²³ It is the Committee's belief that the delivery of a service as vital as home visiting to new parents should not be dependent on the use of a nurse's private car. However, should the nurse prefer to use their own car and receive reimbursement from the government, the ability to do so should be retained if it saves the government money.

119 Western Australian Auditor General, *Universal Child Health Checks*, Report 11 – November 2011, p27.

120 Answer to Questions on Notice asked in preparation for hearing on 30 November 2011, by the Education and Health Standing Committee and answered by the Department of Health, p12.

121 Ms Angela Poole, Media Spokesperson, Community Health Nurses WA, *Transcript of Evidence*, 2 November 2011, p5.

122 Community Health Nurses WA, *Submission to the Review of WA's Current and Future Hospital and Community Health Care Services*, September 2009, p4.

123 Community Health Nurses WA, *Submission to the Review of WA's Current and Future Hospital and Community Health Care Services*, September 2009, p4.

Chapter 4

Any calculation of the need for pool cars should be based on the number of home visits a nurse can carry out a day (policy suggests 4), and the number of birth notifications a nurse receives each month.

Recommendation 3

The Minister of Health provide funding in the 2012 budget for the infrastructure required to support current and additional child health nurses to improve service delivery. This should include funding for:

- Improved information technology for all child health nurses;
- Administrative support;
- Significant improvements to the physical infrastructure of child health centres; and
- Better access to pool cars for metropolitan child health nurses.

Recognising and funding CHNs to support infants, children and families, particularly vulnerable families

The role of CHNs as set by policy and outlined in previous chapters includes:

- a universal visit to all families with new births within the first few weeks;
- universal child health and development assessments from birth to age 3;
- intensive targeted visiting for families at risk; and
- fostering group activities for mothers and babies, such as playgroups.

In addition, the Committee believes that the current role of the CHN should encompass:

- outreach into childcare centres and other places children frequent in order to access children whose families are not accessing the child health assessment program;
- capacity to take on an antenatal role, particularly for families at risk.

Outreach to families who are not accessing the universal child health assessment program

The universal child health assessment service in Western Australia is a voluntary program. In WA there is a significant drop-off in the percentages of children who receive assessments after their first birthday. This means that many children may not be seen by the child health nurse between the first year and the point of entry to

school. By this stage, the opportunity for prevention and early intervention in problems is sharply reduced.

As Mrs Poole told the Committee:

*By us getting there really early and doing those assessments, doing the developmental assessments, ... we can actually identify areas that might need some assistance, to be able to refer them off, whether it is to a GP for a medical thing or whether it is to our child development service, which obviously we work very closely with. **The importance of that is that really we need to get in early to have children assessed and some therapy or what needs to be put in early.** ...The issue is that if we do not get those children into a referral pattern and have some intervention early, by the time they are picked up at five and six, the waiting lists at the child development centres are much longer and they are not seen as a priority.¹²⁴*

There is therefore a need for a more assertive approach to ensure that as many children receive the assessments as possible. The association of Community Health Nurses (WA) reported that this form of outreach had occurred in the past, but is no longer possible due to resourcing.

***We used to have nurses who went into day care centres; that is an area that we just do not go in anymore, but it is an area that needs some attention, because children in day care centres do not access child health services because they are in day care most of the day. We used to go in there and we used to do the same universal screening to children in day care, but we do not do that anymore.**¹²⁵*

Anecdotally, the children who are the most likely to have missed out on an assessment are often those who are the most likely to need one, and the most likely to benefit from any intervention that may be required. The situation is compounded by the existing model of service delivery not being well suited to the lifestyles of many modern families, making it difficult for working parents to access the service even if they wanted to.

¹²⁴ Mrs Angela Poole, Media Spokesperson, Community Health Nurses WA, *Transcript of Evidence*, 2 November 2011, p2,4.

¹²⁵ Mrs Angela Poole, Media Spokesperson, Community Health Nurses WA, *Transcript of Evidence*, 2 November 2011, p7-8.

Chapter 4

As the Auditor General commented, 'In the main, the service delivery model has not changed in the metropolitan area since the 1960s.'¹²⁶

The Auditor General went on to encourage the Department of Health to consider more flexible methods of service delivery such as:

- Centres could open in the evenings or on weekends for working parents;
- Regular mobile services to childcare centres, shopping centres and at community events;
- Making the service more 'father' friendly through the introduction of fathers' groups, using father centric language and emphasising the importance of the father's role.¹²⁷

Recommendation 4

The Department of Health be funded to enable more flexible service delivery by child health nurses, particularly through such mechanisms as:

- The provision of assertive outreach activities to locate and assess vulnerable children, and
- The development of more accessible services with flexible/extended opening hours for child health clinics and the provision of mobile services to childcare centres, shopping centres, etc.

Capacity to take on an antenatal role, particularly for families at risk

A collateral outcome of the reduction of child health nurse capacity has been the reduction in the role played by CHNs in antenatal care. **The Committee was advised that the CHN's role at one time included a significant role in ante natal care.** This was one of the first things to go due to resource limitations. Ante natal care has since become the province of the hospital system with less emphasis on parenting and more on the birth process.¹²⁸

Several witnesses suggested to the Committee that it would be advantageous if the pre-existing antenatal role of the CHN was restored, with its focus on building relationships through engagement with the service. Child Australia emphasised to the

¹²⁶ Western Australian Auditor General, *Universal Child Health Checks*, Report 11 – November 2011, p23.

¹²⁷ Western Australian Auditor General, *Universal Child Health Checks*, Report 11 – November 2011, p23.

¹²⁸ Briefing , Dr Trevor Parry (NIFTEY), Stephen Breen (Primary Principal's Association), Kim Wedge (Ngala), Ailsa Munns (Curtin School of Nursing), David Zarb (Playgroup WA), 23 December 2011.

Committee, 'I would, for the record, mention positive early childhood development begins in utero; it is inextricably linked with peri-natal, mental and physical health.'¹²⁹

The association of Community Health Nurses (WA) representative stated that there is currently no capacity for a broad reaching program of antenatal engagement:

*Unfortunately, as child health nurses, there is no ability at this point in time – although obviously it would be ideal – to get involved antenatally, although in some certain areas there are projects going on where there is involvement, but on the whole we do not.*¹³⁰

The Department of Health, in its submission to the Committee, stated that in some areas this already occurs:

*In some areas, child health services provide antenatal contacts. The purpose of these contacts is not to replace or duplicate services provided by maternity providers but to increase early engagement by developing a rapport with families, providing health information and early identification of families who will require priority services in child health or other support services. Antenatal contact improves the transition of care for families and has shown to improve participation rates in child health services.*¹³¹

The Department of Health has not identified which areas of the state benefit from this program, or what proportion of the population is covered by the program.

There are many benefits to initiating contact between child health nurses and mothers-to-be in the antenatal period. Building a relationship between the child health nurse and the mother prior to the birth of the child can help to encourage engagement with child health services once the child is born. Ante-natal contact can be an opportunity to provide advice and information on child health services available, factors influencing the baby in-utero, and early child health concerns in advance of any issues.

Ante-natal contact with a family will enable the child health nurse to identify vulnerable families that are likely to need support and intervention at the earliest stage. This will enable better workload planning where nurses are aware of such high need families well in advance of the birth of the child.

Finally, ante-natal contact with the family would enable the child health nurse to work on a preventative basis on some of the ante-natal factors that have been shown to

129 Mr Dawson Ruhl, CEO, Child Australia, *Transcript of Evidence*, 23 November 2011, p12.

130 Mrs Angela Poole, Media Spokesperson, Community Health Nurses WA, *Transcript of Evidence*, 2 November 2011, p2.

131 Department of Health, Submission No. 12, 16 December 2011, pg6.

Chapter 4

have a negative impact on a child's development. For example and as outlined in other parts of this report, high levels of stress, anxiety and depression for the mother during the pregnancy and post-natal period can have significant negative consequences for the child. Alcohol, tobacco and drug use during pregnancy have serious negative consequences for the child. So any advice and assistance that the child health nurse is able to provide to the mother in the early stages of the pregnancy can have large positive impacts on a child's development. In addition, any records that the child health nurse is able to keep regarding ante-natal risk factors such as drug and alcohol use during pregnancy may become vital information for later diagnostic efforts, particularly of Foetal Alcohol Spectrum Disorders (FASD).

The Committee understands that the Victorian Government is considering whether to extend its universal visiting/assessments program to include an antenatal component.¹³²

Recommendation 5

That the Department of Health be funded to extend the current capacity of child health nurses to have ante-natal contact with a family.

¹³² Dr Jenny Proimos, Principal Medical Advisor, Department of Education and Early Childhood Development, Victoria, *Briefing*, 16 October 2011.

Appendix One

Abbreviations

ABS	Australian Bureau of Statistics
AEDI	Australian Early Development Index
CHN	Child Health Nurses
CHNWA	Community Health Nurses, Western Australia
FIFO	Fly in fly out
FTE	Full time equivalent
GP	General Practitioner
LSE	Low socio-economic
NGO	Non-governmental organisation
NOM	Net Overseas Migration
SES	Socio-economic status
SEWB	Social and emotional wellbeing

Appendix Two

Inquiry Terms of Reference

Inquiry Terms of Reference

1. Current and future resourcing of new methods and activities to improve educational outcomes such as e-learning and school partnerships;
2. Factors influencing positive or negative childhood development from birth to year 12;
3. Facilitating greater opportunities to engage all students in year 11 and 12;
4. Improving access and opportunities for adult learning in regional and remote WA; and
5. Foetal Alcohol Syndrome: prevalence, prevention, identification, funding and treatment to improve education, social and economic outcomes.

The Committee will report by 30 November 2012.

Appendix Three

Committee's functions and powers

The functions of the Committee are to review and report to the Assembly on:

- (a) the outcomes and administration of the departments within the Committee's portfolio responsibilities;
- (b) annual reports of government departments laid on the Table of the House;
- (c) the adequacy of legislation and regulations within its jurisdiction; and
- (d) any matters referred to it by the Assembly including a bill, motion, petition, vote or expenditure, other financial matter, report or paper.

At the commencement of each Parliament and as often thereafter as the Speaker considers necessary, the Speaker will determine and table a schedule showing the portfolio responsibilities for each committee. Annual reports of government departments and authorities tabled in the Assembly will stand referred to the relevant committee for any inquiry the committee may make.

Whenever a committee receives or determines for itself fresh or amended terms of reference, the committee will forward them to each standing and select committee of the Assembly and Joint Committee of the Assembly and Council. The Speaker will announce them to the Assembly at the next opportunity and arrange for them to be placed on the notice boards of the Assembly.

Appendix Four

Submissions received relevant to this report

Name	Position	Organisation
Ms Amanda Gillett	Community Services Manager	Association of Services to Torture and Trauma Survivors
Dr Ron Chalmers	Director General	Disability Services Commission
Ms Michelle Scott	Commissioner	Commissioner for Children and Young People
Mr Ron Dullard	Director	Catholic Education, Office of Western Australia
Mr Matt Burrows	CEO	Therapy Focus
Mr Ron Gorman	Deputy Director	Association of Independent Schools of Western Australia
Mr Warwick Smith	Operations Manager	Peel and Rockingham Kwinana Mental Health Service
Mr Kim Snowball	Director General	Department of Health
Mr Terry Murphy	Director General	Department for Child Protection
Ms Sharyn O'Neill	Director General	Department of Education
Dr Elizabeth Stamopoulos	Senior Lecturer	

Appendix Five

Hearings relevant to this report

Date	Name	Position	Organisation
21 September 2011	Ms Elaine Bennett	Director Services	Ngala
	Mrs Raelene Walter	CEO	Ngala
	Ms Susan Kiely	A/Senior Coordinator Service Development	Child and Adolescent Health Service
	Ms Gail Clark	AEDI Coordinator	Department of Education
	Mrs Robyn Kinkade	Manager Special Projects	Department of Education
28 September 2011	Dr Caroline Goossens	Child Psychiatrist	Faculty of Child Psychiatry
19 October 2011	Ms Anne Russell-Brown	Group Director Social Outreach and Advocacy	St John of God Healthcare
	Ms Anna Roberts	Group Manager Early Years	St John of God Healthcare
	Mrs Cecilia Cox		St John of God Healthcare
2 November 2011	Mrs Angela Poole	Media Spokesperson	Community Health Nurses WA
9 November 2011	Mrs Amanda Gillett	Community Services Manager	Association of Services to Torture and Trauma Survivors
	Mr Joel Richards	Youth Programs Coordinator	Association of Services to Torture and Trauma Survivors
23 November 2011	Mr Terry Murphy	Director General	Department for Child Protection
	Mr Dawson Ruhl	CEO	Child Australia
30 November 2011	Mrs Kate Gatti	Area Director Population Health	WA Country Health Services
	Mr Ian Smith	CEO	WA Country Health Service
	Mr Philip Aylward	Chief Executive, Child and Adolescent Health Services	Department of Health

	Mr Mark Morrissey	Executive Director Community Child Health	Department of Health
22 February 2012	Mrs Ruth Griffiths	Child Health Nurse	Child and Adolescent Community Health
	Miss Elise McLernon	Child Health Nurse	Child and Adolescent Community Health
	Mrs Lynette Sprigg	Community Clinical Nurse Manager	Child and Adolescent Community Health

Appendix Six

Briefings relevant to this report

Date	Name	Position	Organisation
10 October 2011 Adelaide	Mr Graham Jaeschke	General Manager South Australia	The Smith Family
	Mr Brenton Wright	Previous advisor to the Government of Western Australia	
11 October 2011 Adelaide	Mr Daniel Cox	Director Service Modernisation	South Australian Health
	Mr Adam Kilvert	Manager, Service Modernisation	South Australian Health
12 October 2011 Canberra	Dr Evan Arthur et al	Canberra Office	Department of Education, Employment and Workplace Relations (DEEWR)
	Ms Lisa Carroll et al	Deputy Secretary	Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA)
13 October 2011 Melbourne	Ms Sarah Cavanagh	Kidsmatter	The Australian Psychological Society
	Ms Jo Lawrence	Kidsmatter	The Australian Psychological Society
	Ms Lynette O'Grady	Kidsmatter	The Australian Psychological Society
	Dr Sharon Goldfeld	Senior Fellow Child Health Advisor	Centre for Community Child Health Victorian Office for Children
	Dr Daryl Higgins	Deputy Director (Research)	Australian Institute of Family Studies
	Dr Ben Edwards	Senior Research Fellow	Australian Institute of Family Studies

	Dr Jenny Proimos	Paediatrician and Adolescent Health Consultant Principal Medical Advisor	Centre for Adolescent Health Department of Education and Early Childhood Development
	Professor Collette Tayler	Chair of Early Childhood Education and Care	Melbourne Graduate School of Education

Appendix Seven

Glossary

Definition of early childhood interventions	For the purpose of the EECI project, early childhood interventions were defined as programs that attempt to improve child health and development during the period from conception to six years of age with the expectation that these improvements will have long-term consequences for child development and wellbeing.
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