EDUCATION AND HEALTH STANDING COMMITTEE

AN INQUIRY INTO IMPROVING EDUCATIONAL OUTCOMES FOR WESTERN AUSTRALIANS OF ALL AGES

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 22 FEBRUARY 2012

Members

Dr J.M. Woollard (Chairman)
Mr P.B. Watson (Deputy Chairman)
Dr G.G. Jacobs
Ms L.L. Baker
Mr P. Abetz

Hearing commenced at 9.59 am

GRIFFITHS, MRS RUTH
Child Health Nurse, Child and Adolescent Community Health, examined:

SPRIGG, MRS LYNETTE
Community Clinical Nurse Manager, CACH, examined:

McLERNON, MISS ELISE
Child Health Nurse, CACH, examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee I would like to thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for an inquiry into improving educational outcomes for Western Australians. I would like to introduce myself, Janet Woollard, and the other members of the committee who are Graham Jacobs, Peter Abetz, Peter Watson and Lisa Baker. On my right is our secretariat, Lucy Roberts; and we also have Hansard. This committee is a committee of the Legislative Assembly of Parliament. This hearing is a formal procedure of Parliament and, therefore, commands the same respect given to proceedings in the house. As a public hearing, Hansard is making a transcript of the proceedings for the public record. If you refer to any documents during your evidence, it would assist Hansard if you could provide the full title for the record. Before we proceed to the questions we have for you today and to discussion with you, have you completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

The Witnesses: Yes.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The CHAIRMAN: Do have any questions in relation to being a witness at today's hearing?

The Witnesses: No.

The CHAIRMAN: Thank you. I know from walking in with you that you feel a bit nervous about coming in front of the committee today. The committee members are all great people! We have invited you here to help us because we do not have your knowledge and expertise in child health nursing. We have spent several months looking at early childhood development and we are aware that there is a shortage of staff, which influences your role. Could you tell us one at a time—we will start with Ruth because she went first with names—when you first became a child health nurse and how long you have worked in the area? Please describe your role when you first started as a child health nurse and what it encompassed. Can you tell us how many children you are seeing, whether you are seeing them for universal visits or whether you are going to childcare centres? Can you describe how many calls you take during the today, how many home visits you make and whether the home visits are first home visits or home visits after the first home visit because you thought that the children were in need? From you and other child health nurses we will invite to appear before the committee, each of us wants to have a very good picture of the role of a child nurse.

Mrs Griffiths: I completed my child health in 1991 when I was in the country. We sold our farm and came to Perth and I have been a child health nurse in Perth since 2003. I relieved in different clinics for two and a half years and then I got the permanent position at Lockridge. I have been there seven years this February. My role is mainly with children and parents. The commencement of that role is with the first home visit after a mother comes home from hospital. That is usually followed up in the clinic, unless there are twins or difficult families that we need to follow up. With the universal visits we see them at six weeks, three months, eight months, 18 months and three years. Those are the minimum number of visits. There are occasions when we see them between those visits if we are concerned about the child or the parent. One of my big roles is in postnatal depression and breastfeeding. Each year I refer from Lockridge between 35 and 40 women for postnatal depression. I am very fortunate to work in a child development centre where we have all the other disciplines so we are able to refer children for speech or other developmental problems. I also run mothers groups, which are very valuable, particularly for isolated mothers. I also run a breastfeeding clinic—I am a lactation consultant—which is very popular. I believe that when parents get support with breastfeeding they continue to breastfeed. The day is taken up with appointments and often up to 17 phone calls a day. Lockridge is an extremely busy clinic. It is a very rewarding clinic, which I enjoy very much. Sometimes that can be frustrating. Sometimes a simple appointment turns into a very complicated one. Child assessments are often quite normal but then you find that the family is dysfunctional, which takes up a lot of time. That is my average day.

The CHAIRMAN: You talked about the visits at zero, six months et cetera. When the Auditor General released his report about child health last year, the statistics he gave for those visits were that 90 per cent of children receive the first home visit, which is meant to be within zero to 10 days, but often it is up to four weeks depending on how busy a practice is.

Mrs Griffiths: Yes.

The CHAIRMAN: He said that while 90 per cent of children get that first home visit—which we now know is probably in the first month rather than in the first 10 days—only 30 per cent would be seen by a child health nurse at 18 months of age and only 10 per cent at three years of age. How do those statistics fit with you at Lockridge? Are you alone at Lockridge or does someone else work with you? Are those statistics similar to what is experienced at Lockridge?

Mrs Griffiths: At this stage I have an extra 0.2 FTE because the clinic is very busy. The figures for the 18 months and three-year visits are not correct for the Lockridge clinic. I make ongoing appointments and I see a large proportion of children at 18 months and three years. Certainly, I would capture a large percentage of children aged 18 months. The children that do not attend after the first home visit and the six-week appointment are usually Aboriginal children, but they are referred to the Aboriginal health service, which makes contact with them and follows them up.

The CHAIRMAN: What records do you keep? We might want to ask you about statistics for the number of children seen and how many referrals you might make. It was interesting that you said that annually you would make 35 referrals because of postnatal depression. Where do you keep your statistics and how do you keep them in terms of child health visits and referrals to other people?

Mrs Griffiths: All those visits are kept on stats. We record all our visits and the codes for those stats. Each one of those has what we are seeing them for, what the service was and if we referred them. There is a referral code. For example, it might 31 for a general practitioner and 37 for a social worker. Those stats can be taken from the health department.

The CHAIRMAN: You send those stats into the health department?

Mrs Griffiths: Yes.

The CHAIRMAN: By way of supplementary information, would you be able to send us a copy of those statistics for the past two years?

Mrs Griffiths: I think that would have to go back to the department, because that would have to go where those records are sent and they can pull them off the computer.

The CHAIRMAN: You do not have a copy of those records.

Mrs Griffiths: Yes, I do have a copy; but it would be easier for the health department to pull them off than it would be for me to have to go back and do two years' work. I would probably need a good week!

The CHAIRMAN: It would take that long to get them out! It is not an easy thing to copy.

Mrs Griffiths: It is not on my computer.

The CHAIRMAN: So that we can follow up with the health department. Could you tell me—if you cannot tell me now you can tell me by way of supplementary information—what form or paperwork is involved? If we as a committee request this information from the health department, what exactly do we ask for? You said that they record how many visits you have had with each child and family and how many referrals for each child and family. What form or paperwork do you use to send that to the health department that can we request from the health department?

Mrs Griffiths: We have a stats book that we fill in after we have seen every child. At the end of the week—or whenever—those stats and forms are sent into the department. When I refer mothers to a social worker or the Midland Women's Health Care Place, which I use a lot, I write out a referral for them from a referral pad. One copy goes into the child's book, one copy goes into a file that I keep and one copy goes to the social worker or whoever I am referring to. There are three copies.

The CHAIRMAN: So only you have those referrals or does the health department have those referrals?

Mrs Griffiths: No. But at the end of the year we do an annual report. I am able to look at all those forms and I can say that I have referred 77 children to CDC for developmental problems.

The CHAIRMAN: So does each community health nurse prepare an annual report for the health department?

Mrs Griffiths: No, it is for our manager. I am not sure if that is what they do at every child health department, but that is what I do at Lockridge.

The CHAIRMAN: So at the end of the year you prepare a report that goes to your manager? So we would need to contact your manager if we want to get your report?

Mrs Griffiths: Yes.

Mrs Sprigg: Can I just add from a manager on that one? That might be slightly varied as a summary of a child health nurse's work and the stats that you would require from your perspective, which would all be reflected in H-Care stats if you are requesting that as supplementary information.

Mr P. ABETZ: Is it still done by paper recording or do you have a laptop that feeds into the database of the health department in terms of recordkeeping?

Mrs Griffiths: At the moment a lot of it is paperwork, but we are changing that system. I believe we are changing it in July. CDUS is coming in and then all that will be put onto the computer.

Mr P. ABETZ: I was thinking that it would save you a lot of time if you could do all that electronically. Obviously that is happening, which is good.

Mrs Griffiths: It might be if you are literate!

Mr P. ABETZ: I managed to learn, so I am sure you will!

Dr G.G. JACOBS: Ruth, welcome. It has been a long time since I last saw you; it is good to see you again. Can you tell me about waiting lists for child health nurses in your area? What is the

waiting list for a child nought to 12 months and from one to three? Do you have a handle on the waiting list profile?

Mrs Griffiths: Yes, I have. As I said, I am very fortunate that I have extra help. Most of my new mothers are seen within 10 days or two weeks at the most. I always make ongoing appointments to make sure that I get my clients in.

Dr G.G. JACOBS: So they are locked in.

Mrs Griffiths: Yes. Mind you, some do change through circumstances, but most times they are ongoing appointments because I feel that the parents have enough to think about without having to ring and make an appointment. It is written in their book. Because of the extra help I get at Lockridge, I am able to see the majority of children within a reasonable time. If I did not have that help, that might change dramatically.

The CHAIRMAN: You mentioned the zero to 10 days. What are the waiting lists like for the six weeks, three months, eight months, 18 months and three years appointments? How many children come in for those? Do you phone for those? What is the waiting list for each of those appointments?

[10.15 am]

Mrs Griffiths: I do not really have a waiting list. For the 18 months, the assessment time is 18 months to 21 months; we see them within that period. I would certainly see those children within that time. For the three-year-olds, usually between three and three and a half is a really good time. Children aged three and a half are often more mature and can cope with the assessments.

The CHAIRMAN: Do you phone for the earlier visits—the six weeks, the three months and the eight months?

Mrs Griffiths: When we do the home visit we make the six-week appointment on that home visit. When they come in for the six-week appointment, I make an appointment for the three months, then the eight months and so on.

The CHAIRMAN: And if they do not come in for the six-week appointment?

Mrs Griffiths: We ring them.

Dr G.G. JACOBS: What is the magnitude of your cohort of children going into the system?

Mrs Griffiths: How many I see?

Dr G.G. JACOBS: Yes.

Mrs Griffiths: I am thinking about the annual report. I think there is something like 1 400 or 1 700 children that I have records for. That is from nought to four.

Dr G.G. JACOBS: I refer to allied health and referral pathways. Is speech therapy and other allied health services readily accessible to clients? Are you able to comment on which services are the most difficult or the longest to access?

Mrs Griffiths: Because it is a public health service there is always a waiting list. Children do have to wait. They are given a priority. If we think a case is urgent, we put that on a referral. But for most of the disciplines for Lockridge, you are looking at about a three to 12-month waiting list, which includes paediatricians.

Dr G.G. JACOBS: Which service is the hardest to access?

Mrs Griffiths: Probably the paediatrician. We have two who work part time. They get referrals from schools and child health services in a large area. A lot of children are being referred.

Mr P.B. WATSON: I would like to ask a question about your additional help. You said you could not survive without that additional help. Is that help from a volunteer or is it a paid position?

Mrs Griffiths: It is a child health nurse who comes from another clinic who is able to spare that day. Some of that too, I also get some backfill because I run a breastfeeding clinic once a week. Yes, it is paid. I would certainly survive without that help, but the parents would have to wait longer.

The CHAIRMAN: You said there are 1.2 FTEs at Lockridge for up to 1 700 children aged zero to four.

Mrs Griffiths: Without looking at the report, it is 1 400 to 1 700 —

The CHAIRMAN: Zero to four?

Mrs Griffiths: Yes.

Ms L.L. BAKER: I am interested in your comments about the Indigenous kids and mums you work with and I would like to be a bit more understanding of the situations you face when you see Aboriginal mums and their kids. What are the ages of the mums? What problems do they face? You mentioned postnatal depression, but I am interested to know whether you face other related conditions or problems. In that, can you comment on resourcing? Do you have Aboriginal child health nurses working with you?

Mrs Griffiths: No.

Ms L.L. BAKER: Okay. It would be great if you could talk a little bit about that.

Mrs Griffiths: With the Aboriginal children we have Aboriginal health services. If a mother does not want to come to clinic or we cannot contact her, they will go out and find her and follow her up. I find that a lot of Aboriginal families have good family support. Some of them do not, of course. I worked with Aboriginal people in the country for many years and there is still that stigma about going into a white man's clinic. When we overcome that, I do not know. They feel intimidated if they are waiting with white people. That is always an issue. There are lots of other issues at Lockridge. It is a high-need clinic. There are lots of drugs and alcohol. We have fly in, fly out parents, which can sometimes be quite difficult for the mother and her children —

Ms L.L. BAKER: Because she is on her own.

Mrs Griffiths: — which is a precursor for postnatal depression, especially if she does not have family. Sometimes I see four children who have four different fathers. There are lots of those issues where the parents or children need support.

Ms L.L. BAKER: You are able to deal with that service because you have had the experience.

Mrs Griffiths: Yes, but we have all those referral paths that we can refer those children and parents onto.

Mr P. ABETZ: Do child health nurses have to work extended hours? You said that you run lactation classes, which is fantastic, and mothers groups.

Mrs Griffiths: No, that is in our working day. I do not run any programs after working hours. If we do work a bit longer—I was talking about this yesterday—if your last client is at four o'clock and she is suicidal, you are not going to say that you are sorry and that you have to go home. We would adjust that time the next day or whenever we could.

The CHAIRMAN: What do you see as the most rewarding part of your role? If the government put a pot of money into child health, where would that money be best spent? And, yes, I will be asking Lynette and Elise that question as well!

Mrs Griffiths: For me I feel that parents need a lot more education about the antenatal period, because their expectations are really not very great. Sometimes they have no idea about the normal development of children. Their expectation is that their baby will sleep and feed and not cry. They often get a shock. Perhaps in the schools there should be more about prenatal care and the growth

and development of children. I am not a school health nurse. I am not really sure how much is put into that. Lynette can answer that. Also, it would be great to have more access to postnatal depression services. Meerilinga is just setting up a postnatal depression playgroup for mothers, which I think will be great. That is what I would be looking at. In particular there should be more support for fly in, fly out mums.

The CHAIRMAN: Lynette, can you tell us when you started in child health nursing and how long you have been in child health nursing? What was it like when you first started in the role and what is it like now? Can you tell us the number of child health nurses, the hours you work, your work conditions, your job satisfaction and what problems there might be. The government knows—everyone knows—that three years ago we were short 110 child health nurses. What have those shortages led to in terms of extra work and extra strains for you and other nurses in the role?

Mrs Sprigg: I started in 1984 as a school health nurse. I did school health nursing purely for the first number of years in between having my own children and having child health input from the other side. I then progressed through. Whilst I was doing all that, I did a postgrad diploma in midwifery. I worked as a midwife alongside also doing child health nursing. I finished child health nursing in 1993. I have spent my career working in a mix of roles across schools and child health. I have worked in high schools, district schools, education support schools and in child health. I have run the gamut of most of it. I also immunise. I have done school-based immunisation and I still immunise children aged nought to four. Over the past six years I have progressed into a nurse manager's role and I manage one of the clinical health regions within CACH. The area I manage has a team of child health nurses and school health nurses across all those disciplines, and I specifically manage four education support schools within that region and the staffing for that. That is my longevity, for want of another word. What has changed over that time is obviously as governments have come and gone regions have changed numerous times. You asked about FTEs and resourcing. Some of that has changed just by the movement of areas over that time. Our boundaries change, therefore the people we work with change. I know the spectrum of your terms of reference also goes from birth to year 12. Whilst I have worked in child health, I have a fair predominance of school health in there as well. I do believe the education that we can provide over that time goes across that spectrum. The evidence provides for early brain development and early input, but I guess the balance of that is educating adolescents at the other end of it, pre having the children which is what Ruth intimated with antenatal education.

The CHAIRMAN: Which region do you manage?

Mrs Sprigg: I manage Canning.

The CHAIRMAN: You would get annual reports from your child health nurses. Can you tell us a bit about those annual reports?

Mrs Sprigg: There is not a prescriptive method for doing that. The standard method of presenting stats is through the H-Care system and all the nurses put those in. All the information is collected within the H-Care stat form. Within each region managers have various ways of setting up an annual gathering of information. Ruth has intimated that they do an annual summary. Within our area for the last few years we have tried to improve as far as using IT skills and assisting staff to develop those skills. We have electronic monthly reporting which id then collated. The birth numbers come through from the Department of Health, but we record them as well. Some move across different regions. It is a matter of checking those.

The CHAIRMAN: You said that birth numbers come through from the Department of Health. Western Australia has had a massive intake of people from other states and countries because of the mining boom. How do you find out who is where in the different areas?

Mrs Sprigg: Just to clarify, do you mean new births?

The CHAIRMAN: No, because it is not necessarily new births. A family that comes here from another country might have a two-week-old, a 10-month-old and a two-year-old. How do you find out about new children moving into your area?

[10.30 am]

Mrs Sprigg: Various means; most of it would be parent-generated. If they transfer from one local area to another local area, the child health nurse may well know and say, "You've got this parent coming in" and they will touch base with the neighbouring child health nurse and say, "They are coming in and they probably need just to touch base." The records will then transfer over. Obviously, if they are coming in from overseas or interstate, that then requires the parents to actually make contact with the child health nurse because there is no current system to find that. Having said that, migrant and refugee health clients will obviously come through the public health system and often those clients will be notified about the child health nurse or a school health nurse, or they may already be in programs that link them through and support them to make contact.

The CHAIRMAN: For refugee children, who would notify you?

Mrs Sprigg: It may be the public health nurses who are actually supporting those families integrating into society—wherever their local society may be. They would then flag a child health nurse within an area and say, "This is where you need to make your contact", and support them to do that.

Mr P.B. WATSON: A question: are nine to five office hours an issue?

Mrs Sprigg: Standard rostering hours are either eight to four or 8.30 to 4.30 or nine to five. But there is some variation.

Mr P.B. WATSON: Do you think that you should be open at different times—weekends?

Mrs Sprigg: We have actually been able to provide occasional services, with planning, when things are to be done in a targeted fashion. So there might be, for example, a PPP group—a positive parenting program—run as an evening class and a nurse will then work an evening shift to cater for those sorts of supports. There is a little bit of flexibility, where we are able to provide that; it just requires a bit of planning.

Mr P.B. WATSON: It is a big issue now because a lot of parents both work or are in the fly in, fly out world.

Mrs Sprigg: Hence my comment about rostering hours. Often we will have nurses who start at eight o'clock, which provides for an earlier appointment, because some mums will be quite happy to come to an early appointment and then go off to work or take the child to child care. Sometimes it fits with the social demographics of the area and the nurses work those hours. As a manager I would support them making slight changes in that. I would support that they work nine to five because they demonstrate that that is better, because they have parents who come to a late appointment. More often than not it is those who, as you say, are going back to work, who would prefer an earlier appointment. The nurses will work an eight to four to support an early appointment for those mums.

Mr P.B. WATSON: Thank you.

The CHAIRMAN: Could you tell us a little bit more about the H care standard form.

Mrs Sprigg: The H care standard form —

The CHAIRMAN: Is that what it is called?

Mrs Sprigg: There is the standard, written, hardcopy template of a H care form, which enters the age of the child and/or the client; and as Ruth has noted, there are standard codes for whatever the issue—for universal checks and/or other things. There is a code to say that the child has been

assessed and was fine and no further action is required, or the child requires a follow-up and/or referral. The codes will marry up and the data can be pulled out.

The CHAIRMAN: And is that data submitted on a weekly basis?

Mrs Sprigg: Yes.

The CHAIRMAN: To the health department?

Mrs Sprigg: It is submitted through to the admin —

The CHAIRMAN: From the manager or from each child health —

Mrs Sprigg: No; each child health and school health nurse will actually submit their H care data weekly to the administration team to enter. And then it is obviously collated and can be pulled out.

The CHAIRMAN: Oh, so it goes to—who are the administration team?

Mrs Sprigg: In various areas there are various persons allocated for data entry.

The CHAIRMAN: Right. So the information—whilst the child health nurse may not have a computer—goes to the admin team and is put on to —

Mrs Sprigg: We are working towards supporting getting better systems—slowly—as we go along. Many still do a hardcopy form, but in some areas we have developed what is basically an Excel format of the same spread sheet so that they can enter the data on the computer as they are going through the day and then email it in, which is actually saving a little bit of time and is getting the data there more promptly. And/or we now have a universal drive which, if they can access it, we can have the information there and the data entry people can directly access the sheets weekly. So that is some improvement in time.

The CHAIRMAN: Can you tell us about travel for child health nurses? I believe that child health nurses are not supplied with cars and that it is difficult, sometimes, to get pool cars. In the absence of—I mean do more pool cars need to be made available for child health nurses or are there other ways—taxi vouchers—or something else that can be done to assist those child health nurses who need support in the way of transport?

Mrs Sprigg: Accessing cars is variable—you are right. There are pool government cars out there; it is just the numbers. And in the areas that I work we try to optimise the use of those to nurses to roster through having specific days for home visiting so that they can share and maximise the use of those vehicles for those sorts of roles, as opposed to not needing a car when they have appointments at the centre. Having said that, if the government decides to give us a pool of money and give us more cars, we are probably not going to argue. But the reality is that we optimise the resources that we have for those.

Your question around taxi vouchers and things like that: given the actual policy recommendations that we practice under, taxi vouchers would not fit with the guidelines and you would obviously need to get hold of those if you want to clarify that. But they would not fit with policy guidelines for security of staff.

The CHAIRMAN: If you had to say, would each full-time equivalent child health nurse really need to be able to use a car one day a week, two days a week? Has anything been done in terms of trying to develop a formula? It is very hard to say that you need more pool cars, but if we can say that for each child health nurse there should be a car for X-number of hours or days of the week, it —

Mrs Sprigg: Obviously the need will change from area to area; it depends on both numbers for the year and that changes around and, as Ruth has intimated, that changes the numbers. For example, Lockridge is currently where the birth numbers are. Within each region, each manager will be managing the total FTE for child health and/or school health—whatever it is that you are referring to—within that region. If your birth numbers are slightly shifting, there will be slightly extra FTE at this centre or at that centre. So, again, to clarify black and white for cars, I could not actually do that

at the moment. It would require further input. For example, these are the birth numbers and these are the number of visits you can fit in a day. As a guide, the standard is usually for about four home visits in a day for a universal newborn. But to extrapolate that over the whole of the birth numbers would obviously require someone with a better maths brain than me sitting at this table.

The CHAIRMAN: And how long would this home visit usually take?

Mrs Sprigg: Usually it is 45 minutes but often—that is a fairly standard home visit; it would not allow for interpreter use or for any issues going on—a more realistic figure is to allow closer to an hour. But 45 minutes to an hour, especially down at —

Mrs Griffiths: Especially down at primary —

Mrs Sprigg: Yes.

Mrs Griffiths: You need an hour.

Mrs Sprigg: And that is not allowing for travel time.

The CHAIRMAN: So four home visits would really be one day a week. As the committee, we were told, I think, that in some areas, for example Rockingham, there were—was it 40 birth notifications for a—

Mrs Sprigg: For a month?

Mrs Griffiths: For a month.

The CHAIRMAN: A monthly basis—or something.

Mrs Sprigg: That is what I am saying. Your need would have to be determined on the birth numbers for the area and obviously there would always be slight changes on an annual/biannual–type basis.

Mrs Griffiths: To add to that: we have just had a policy come out to say that we are to do only four home visits a day unless there is a quick follow-up; that is, you are following up someone. And we are to allow an hour for each client visit. Also, the clinic visits are to be allowed 45 minutes each. I always take 45 minutes.

The CHAIRMAN: My background is in nurse counselling, and I would think, when someone comes in depressed and stressed and having problems, that 45 minutes is a joke. You would not be able to support that person. Are there allowances for those patients? Is that 45 minute set for all patients?

Mrs Griffiths: Within reason. I mean, you know, particularly if you know your client. If you know your client has an issue, you are going to make sure that you have enough time to spend with them. And if you have not, you would bring them back in, quickly.

Mr P.B. WATSON: The commonsense rule.

Mr P. ABETZ: Some would be a lot quicker in the sense that everything is humming along.

Mrs Griffiths: If you went out to see a mum who has had her third baby and you know she is coping really well, as Lyn said, it is probably going to take only 45 or 50 minutes.

Dr G.G. JACOBS: Working in the area and particularly in the management area, are you aware of an acute shortage in child health nurses? An add-on question to that is: do you think that child health nursing is attractive to nursing undergraduates? And the add-on to that is: what do you think you could do to attract more nurses into child health? It's a long question because there are lots of parts to it.

Mrs Sprigg: There were lots of parts to it—yes.

Do I believe that there is understaffing? I cannot give you—it is well publicised for the numbers —

Dr G.G. JACOBS: Put it this way —

Mrs Sprigg: —of FTE that it is believed to be short.

The CHAIRMAN: And the health department read these transcripts!

Dr G.G. JACOBS: Right. So you are the clinical nurse manager. If in fact one of your nurses came to you and said, "Sorry Lyn, I have to move on; my husband has a job in the Pilbara" or whatever, do you find yourself thinking, "Oh my god—struggle; I have to get another nurse to replace her and that is going to be hard." Is that the sort of situation that you are faced with?

Mrs Sprigg: Our organisation actually runs a recruitment pool continually for level 2 nurses. It is a strategy developed a few years ago to try to support staffing and having access to staffing. Obviously in some areas you are not guaranteed of getting someone the next day if something changes, but we do run a pool, which has improved that situation over the past, probably, couple of years. It supports having a few more staff available who have child-health qualifications. Again, I cannot guarantee that I will get someone tomorrow if I needed to find someone, but there is an improved situation to do that.

Part of the question was: are we attractive to nursing? My belief is that people do nursing because they have that ethos and sort of practice. Part of someone maintaining themself by way of continuing study means that it is the area of work that they like to be in. Community health nursing does have its differences to the acute sector; therefore that is another area that we have gone into in recent years in supporting grad nurses. I will let Elise answer more about that when it gets to her turn. I believe that over the past few years we have also increased our opportunities to encourage grad nursing within the area. We have been lucky enough with the workforce development area getting support to have grad nurses come through. I know that, particularly in our area, we have always been very happy to have grad nurses come through. We usually have a second year grad nurse running through now pretty much all the time.

The CHAIRMAN: Grad nurses?

Mrs Sprigg: Graduate nurse programs.

The CHAIRMAN: So that would be with whom?

Mrs Sprigg: With CACH.

The CHAIRMAN: With who?

Mrs Sprigg: With child and adolescent community health—a grad nurse.

Dr G.G. JACOBS: Can you clarify for the committee: in order to become a child health nurse, firstly, you have be a nurse?

Mrs Sprigg: A registered nurse.

Dr G.G. JACOBS: A registered nurse—an SRN as my wife keeps reminding me. And then, obviously, you have to do your midwifery. Is that right? Do you have to do midwifery, or can you go to child health nursing without doing midwifery?

Mrs Griffiths: Yes.

Mrs Sprigg: You can actually do a bridging course to do child health now and do the graduate certificate.

Dr G.G. JACOBS: So the answer is you do not have to do midwifery to be a child health nurse.

Mrs Sprigg: Not any longer.

The CHAIRMAN: So the one Curtin runs is a one-year course for child health nurses?

Mrs Sprigg: The graduate certificate.

The CHAIRMAN: That is the graduate certificate, and so you do not need midwifery to do that certificate?

Mrs Sprigg: No.

[10.45 am]

Dr G.G. JACOBS: My question is that obviously that potentially increases your pool, because if the child health nurse has to be a midwife first, then obviously your pool to get child health nurses is quite limited, or much more limited.

Mrs Sprigg: Having said that, supporting the training and supporting the skills in a grad program allows the growth of someone from just being a registered nurse to actually having the skills and working more in the developmental field with children and parents.

The CHAIRMAN: I have not had an opportunity to update the other committee members yet, but I did meet with the person who runs a program at Curtin who said that last year they graduated 60 child health nurses, but because there were no positions in child health, they have all had to go elsewhere. So, I believe they are running a good course and you are helping those students then with their graduate course, but they are not able to finish and work as child health nurses. So, one has to think that there is a lot of money and time being wasted on those nurses.

Mrs Sprigg: My comment would be that I actually have a graduate nurse who finished the program at the beginning of February this year who is actually on a fixed-term contract and is working. So, perhaps the qualification may be for some that they actually do not have permanent work but they are on contracts until permanent positions become available.

The CHAIRMAN: How many child health nurses are not full-time and how many are contract casual, just within your area?

Mrs Sprigg: There is a conflict in that statement. Full-time, as opposed to part-time, or permanent?

The CHAIRMAN: Permanent is what I am after.

Ms L.L. BAKER: Yes, FTEs; full-time equivalents. What FTEs have you got?

Mrs Sprigg: In purely child health, personally I manage 6.55 FTEs in child health, but I manage about 28 staff in total but that is not child health. I would manage about nine in child health.

The CHAIRMAN: We heard from Ruth that she may have seen between 1 400 and 1 700 children between the ages of zero and four. For the 6.55 FTEs for your area—and I think you said Cannington?

Mrs Sprigg: Canning.

The CHAIRMAN: How many children between zero and four—do not worry if it is not the exact number—approximately would you have in your area?

Mrs Sprigg: I cannot give you an answer to that today, sorry.

The CHAIRMAN: Can you let us know that by way of supplementary information?

The CHAIRMAN: For those 6.55 nurses, how many children are they caring for?

Mrs Sprigg: Yes.

The CHAIRMAN: That would be useful. That might be something we ask all child health nurses to try to put the numbers together, because in the UK the numbers are something like one child health nurse to—was it 70 we were told at the last hearing?

The Research Officer: No, 87, but that was births.

The CHAIRMAN: Births, all right.

Mrs Sprigg: And most FTEs are worked out on birth numbers as a guide, because to go from nought to four, obviously the workload varies over that period of time.

The CHAIRMAN: So, FTEs are worked out on birth numbers then, are they, usually?

Mrs Sprigg: Yes.

Mr P. ABETZ: I am just curious as we have been told that there is this massive gap and that we are hundreds of child health nurses short. But it would seem to me that actually the system is working, that kids are being seen. Ruth has told us what is happening in her area in Canning, so is this 100 and something child nurses that we are supposedly short some sort of theoretical figure that somebody has come up with, or actually on the ground it is all happening and it is just somebody who has done some calculations and some theoretical number has been arrived at? Or is it actually at the grassroots, where nurses are tearing their hair out because they just cannot get around to everybody, and people are not being followed up because there is a shortage of staff? I am still puzzled at this. I mean, 100 child care—was it 100 and something?

The CHAIRMAN: It was 108, I think, in 2008, and there has been a massive increase in population since then. So, it is probably 150 now.

Mr P. ABETZ: It might be 140 or whatever it is, but we hear this number given to us. I guess, sort of being a grandfather now, and you may even have seen my grandson in Cloverdale —

Mrs Sprigg: Probably.

Mr P. ABETZ: — they all seem to be seeing their child health nurse and everything seems to be fine. So, can you enlighten us on that?

Mrs Sprigg: The nature of the business alludes to what Janet asked before, or I think Graham asked, about whether we are an attractive organisation. My belief is that the nurses do the role because they believe in the role and undertake it because it is part of their ethos and practice. So, therefore, we actually present that. Having said that, the workload changes over the time that I have worked in community health mean we have streamlined things. So, my example about the fact that we have tried to streamline even things like H care to make it a slightly shorter process, it is not perfect, but its processes to make things more time efficient to enable achieving seeing those children nought to four as best we can. The priorities will always be within the first 12 months because that is the evidence and, you know, we are being directed by policy and evidence at this point in time. So, therefore, over that they will be offered appointments; it might just take a little bit longer to see them. So, where there were extra services, perhaps of groups at different ages, perhaps some of those over time have been trimmed to fit the resourcing. So, yes, I understand your question, but I guess it is the changes over time that have been adapted to and worked around to support reduced FTEs per birth number.

Mr P. ABETZ: So it is not a system in crisis, would you say, but more a system that could benefit from more staffing?

Mrs Sprigg: I do not think I am appropriate to comment on whether it is in crisis. That is not my call.

Mr P. ABETZ: You do not feel that you are in crisis in your particular area?

The CHAIRMAN: Peter, I think Lynette made it very clear that is not her call.

Mr P. ABETZ: Yes, but are you satisfied with the number of staff you have to work, for your staff to be able to do the job that they are supposed to do?

Mr P.B. WATSON: She says she has to streamline stuff.

Mr P. ABETZ: Yes.

Mrs Sprigg: I manage the staff and I support the staff as best I can to do the work we can, and we look at the strategies we can to optimise that workload.

Mr P.B. WATSON: You should be a politician! Very good! Are we going to get anything out of Elise? She is sitting there patiently and we have not asked her a question yet.

Miss McLernon: That is fine.

The CHAIRMAN: We might actually move to Elise. As you said, you do the work as best you can, and we were made aware that the health department informed child health nurses that they had to focus on the zero to 12 months, and we appreciate that that is why the 18-month visits and the three-year visits are not being undertaken, and that is why we are trying to get additional funding for those visits.

Mrs Sprigg: Yes. Can I clarify that I do not think it is that they are not being undertaken. They are being offered; they may just have to wait a bit longer.

The CHAIRMAN: The Auditor General said 30 per cent and 10 per cent were his figures from the data. We might then move on to Elise.

Elise, could we go back then again to when you started in child health nursing, what your role was when you first started in child health nursing, what your role is now and, I guess, the good parts about your role and where you would like additional support? Not necessarily yourself; it might be better if you talk in the third person in your discussions with child health nurses, what they see as their greatest satisfaction and where child health nurses have maybe suggested there could be improvements and more support given to them.

Miss McLernon: My background is I completed a graduate program at Princess Margaret Hospital and then from there I was offered a community graduate program for a year. So, I did that from the middle of 2010 to the middle of 2011. In that graduate program I rotated around everywhere in community health. So I did school health, child health, and immunisations, working with an Aboriginal health team. I got a good understanding of how the community actually works, so I was very lucky. From there then I got my job in the Riverlands region, so I am on contract and I have been working with them since the middle of last year. So, I am relatively new out in the profession as a child health nurse, probably going on to seven to eight months now that I have been at my clinic. My role is, as per what Ruth said, we do so many home visits and appointments per week. We also run the new parent group in the drop-in clinic. Probably a lot of the work that we do is very time-consuming, administration-wise. Like Ruth said, we can have 10 to 20 phone calls a day, and that may be organising appointments, it may be follow-up support for a mum who has presented two weeks earlier with mental health problems, or it may be just support in terms of breastfeeding. So a lot of phone calls, which are added on to your appointments and home visits, are what takes a lot of time out of your day job. And then of course with documentation, we know that everything has to be documented now; so things like drop-in clinics, which are perfect for the community, are great for the mums to have but if you have 20 or 30 mums that come through that clinic, that needs to be documented in all of their files. So that is where the time-consuming part comes into it. I find in talking to other nurses about the positives and the negatives, obviously we are in child health because we believe in it, we have a passion for it. I think it comes down to the time, of being able to follow up all the mums that we would like to follow up in due time.

The CHAIRMAN: Could I follow up on the phone calls? We were told by one community health nurse that there was a health department directive not to take phone calls. When Ruth was talking before, she mentioned that at four o'clock a mother may come in who is suicidal or depressive. You could understand then that you would not want to take a phone call when you are dealing with a mother and a child like that. But is that, again, a flexible policy, that you could take phone calls provided that you have not got someone with you who is in dire straits?

Miss McLernon: Yes, we have got an answering machine, and of course that is on all the time and you then prioritise those calls. So, you can leave the parents who just want to book an appointment to the next day, but the parents that are in need of help in terms of mental health issues, obviously you deal with those first.

Mr P. ABETZ: You do not have any secretarial help at all in the child health centres, do you?

Miss McLernon: No.

Dr G.G. JACOBS: That would be nice, so you could get on with doing your work, if you could have someone else taking all those calls.

Miss McLernon: Yes, those extra little things that add to your day, I think.

Mrs Griffiths: I think there is going to be a central booking system, isn't there, which will save time when it**Error! Hyperlink reference not valid.** comes in? So that will be quite helpful too.

Mr P.B. WATSON: You have to wait! You are number 126 in the line! I am sure people are going to appreciate that.

The CHAIRMAN: Elise, Ruth said that for 1.2 full-time equivalent child health nurses at Lockridge she would have between 1 400 and 1 700 children between the age of zero and four.

Mrs Griffiths: Yes, that is a rough estimate. I would have to look at that report again.

The CHAIRMAN: We will be happy if you could let us know those full details later.

Mrs Griffiths: Yes.

The CHAIRMAN: How many?

Miss McLernon: So, there are two full-time nurses at my clinic. In terms of children we see, I cannot give you a number for that but in terms of birth notes coming through, we would average between 40 and 50 birth notes per month.

The CHAIRMAN: Could you, by way of supplementary information, get back to us on how many children you would have for your two full-time equivalents between the ages of zero and four?

Miss McLernon: Yes, that would have to be done through my manager.

The CHAIRMAN: That is fine. Ruth again told us a little bit about, I guess, some of the challenges as a child health nurse in dealing with parents who may come in who are very stressed and having various problems.

Miss McLernon: Yes.

The CHAIRMAN: Other than dealing with that individual client, what are the other wider challenges for you working independently as a child health nurse?

Miss McLernon: A lot of my clients are Aboriginal and what we call cold clients: they are culturally and linguistically diverse. With that their babies are generally well but it is a social situation which is surrounding them. So, housing can be a problem for these families, transport can be a problem for these families, and financial situations and relationships within that family are then a result of those problems as well. So a lot of the work is around the actual whole family unit and that seems to impact on child development, I guess, and their access to the clinic.

The CHAIRMAN: And Ruth wanted referrals, particularly for people suffering from depression. And a key area for Ruth seemed to be in terms of referrals that she made. The referrals that you make as a child health nurse in your area, because it seems to be a slightly different clientele that you have, who would your main referrals be to then?

Miss McLernon: Still via mental health and probably the child development service, and definitely social work.

[11.00 am]

The CHAIRMAN: So with mental health, is that for the parents or the children?

Miss McLernon: The parents, for postnatal depression.

The CHAIRMAN: So postnatal depression is the first one. What was the second one?

Miss McLernon: Social work.

The CHAIRMAN: That is because of housing?

Miss McLernon: Yes, the combined situation with the families.

The CHAIRMAN: What was the third one?

Miss McLernon: Child development services.

The CHAIRMAN: For child development services—because there are a lot of people in child development services—have you noticed in your areas any speech problems or behavioural problems?

Miss McLernon: Probably physiotherapy would be the main one that I would refer to.

The CHAIRMAN: Obviously there are referrals for each of those visits. As a committee, we were fortunate to see the DVD by Jack Shonkoff that talked about brain development and pathways from zero to three. That was a fantastic presentation on that DVD. Apart from those early referrals for the mother for depression when the child has just been born, with the other referrals for speech therapy, for physiotherapy or for a paediatrician, would they be spread across each of those universal visits? Accepting that most of the visits that you are doing at the moment are for the first 12 months, would they be spread across those visits in those 12 months? Where do most of the referrals that you make come from? Is there an age?

Miss McLernon: I do not think I could give you exact figures for that. It is across the board. It is pretty even for referrals.

The CHAIRMAN: So on each of those visits, you are identifying different things that need one or other of those referrals?

Miss McLernon: Yes.

Dr G.G. JACOBS: Elise, with the mental health issues with a mother with postnatal depression, are there other referral pathways that are suitable, and can they respond? Where do you refer people to? Is it the community mental health service? Is it hard to get people in? Is it hard to access that? Just tell us about that experience if you can.

Miss McLernon: There are definitely referral pathways in there, and I believe some work is going on in the background to define these referral pathways a bit more for us. But for my area, we have a postnatal depression clinical nurse, whom I would refer the majority of my post natal depression clients on to. That nurse has been spread a bit thinner now, so she is dealing with more clients; so in terms of her follow-up with our clients, I guess she is not able to see them as much as what she wants.

Dr G.G. JACOBS: So she works in your child health centre, does she?

Miss McLernon: No, she does not. She just works for the Riverlands region.

Mrs Sprigg: She works across the inland zone.

Dr G.G. JACOBS: Is she a community mental health nurse?

Miss McLernon: She is a community health nurse who was a child health nurse. Her particular interest is in perinatal mental health, and she now works in that role across the inland zone, in particular around the Riverlands and Canning area.

Dr G.G. JACOBS: How big an area is that?

Mrs Sprigg: Riverlands is the City of South Perth, City of Belmont and City of Victoria Park area.

Dr G.G. JACOBS: So what is the delay from when you refer to actually being seen by a mental health nurse?

Miss McLernon: I could not tell you that.

The CHAIRMAN: What additional support would be useful to you as a child health nurse, remembering that we are wanting to put recommendations to the government for funding initiatives?

Miss McLernon: I think it is probably more time for education and health promotion. A lot of my referrals, as Ruth touched on, are mums who do not have any expectations of what their kids should be doing by what stage. So if it was possible to have the time to educate these parents, that would be good. We run a new parent group, and we see them for four sessions, and that is the opportunity to education these mums, but down the track there are not necessarily groups that we run to educate the mums to reduce the referrals.

Mr P.B. WATSON: One of the other nurses who came in said that a lot of young kids today go to school and they have not had toilet training, and they do not know how to communicate with other kids, and it is a huge issue, because they reach kindergarten or primary school and they are behind the eight ball already and they will never get that back.

Miss McLernon: Yes. That is largely just because parents do not know where their child should be at, and it is not until they get to school and they can compare their child with where everyone else is at that they know.

The CHAIRMAN: Just following on from that last question, the point that you just made is that when they get to school, they are behind. A principal said to me last week that most children, when they start school, have to complete a 100-metre race to get to school, but sadly for some children it is 140 metres when they get to school. From your role as a child health nurse, how would you describe that kind of inequality for children, where some children are starting behind the eight ball?

Miss McLernon: I think probably the starting behind stems from their bringing up and their lifestyle and their social situation, largely. If everything has been difficult, if they have moved from house to house every year, or mum and dad have not been together, mum and dad have been left, right and centre, and they have not had one sole carer, I think that is largely where the problem comes from in the social situation.

The CHAIRMAN: How can child health nurses help with that?

Miss McLernon: If someone came to me and they were having relationship problems, I would refer them to Relationships Australia. If it was housing or things like that, in terms of a child health nurse, I cannot help much with that, apart from refer them to social work.

The CHAIRMAN: Lynette, do you want to add to that?

Mrs Sprigg: Possibly one of the other things that we could do is if we had, as Elise alluded to, more opportunities for education through the stages, as opposed to just being able to focus on the zero to 12, the new parent groups. Obviously that is important, but perhaps some of that education as they go along would support them through the other developmental stages as well.

The CHAIRMAN: Ruth, you said 45 minutes per visit. Do you know if that is the same in other states?

Mrs Griffiths: We allow an hour for home visits, and 45 minutes for a clinic visit.

The CHAIRMAN: Are those restrictions imposed in other states, do you know?

Mrs Griffiths: It is not restrictions. That is the minimum time that you would allow. Sometimes you can do a home visit and it might take you an hour and a half. You do not make your appointments at nine, 10 and 11.

The CHAIRMAN: So, minimum times. Thank you. I misunderstood.

Dr G.G. JACOBS: Ruth, can I just ask you, from your experience about those referral pathways for women with postnatal depression, how do you find those referral pathways, and what is your perception of waiting times, because this can quite crucial. If a woman is suffering from postnatal

depression, we surely need to get on with it, because it can be somewhat disastrous if the woman is not followed up. What is your feeling about that?

Mrs Griffiths: The referral pathways that I use are based on a postnatal depression score, the one we do at six months and three months, or whenever, if we feel that we need to do one sooner. If the score is over a certain figure where I was concerned about the mother's mental health and that it was dangerous, I would certainly refer her straight to a GP and ring the GP, or I would refer her to Swan Mental Health Services. I find that they are fairly good if you ring them personally or the GP rings them. They usually get the mums in straightaway, if it is suicide or if she is going to harm the baby. If the score is above the normal, and she is just having the blue days but there is no threat of harming herself, then the one that I use is the women's health care house in Midland, because we do not have a social worker at Lockridge. We can refer to perinatal mental health as well. So there are a few pathways. But I do find that apart from the GP—and we cannot always get them in on that day—that at the women's health care house, the waiting time can be anywhere from two weeks to six weeks, so you have to really make a judgement there about how urgent each case is. Properly one of my biggest concerns in the area that I work in is postnatal depression.

The CHAIRMAN: There has been a lot about this in the newspapers recently, and I think you first mentioned it, Ruth, and that is the support for families with fly in, fly out. Could each of you tell us a bit about the particular problems that that presents, and should there be additional support for that? You have a nurse for postnatal depression and you have support for breastfeeding clinics and other things. Is there anything that can be done in addition to your role—it might be something that you have heard about in the other states—or with someone else coming on board to support you in your role, to help those mums and those children in those families?

Mrs Griffiths: High Wycombe child health actually runs a playgroup for fly in, fly out parents, and I think that is quite successful. So you have that group of mums who are experiencing the same issues. I do not know of anything else that is available in that area, or in my area, for those mums. But I do think that a lot of depression comes down to that as well—mum is not coping because dad flies out for two weeks, four weeks or whatever it is, and he comes home and wants a holiday, and mum is left with the children but looking forward to him coming back to give her a break. I think that sometimes the men who go up there lead the life of a single man who does not have those responsibilities, and then they come home and they find it difficult, too, to get back into that situation. So I think there is a great need there.

The CHAIRMAN: That is at High Wycombe, that playgroup?

Mrs Griffiths: Yes. I think it is still running. I know that the start-up was very successful.

Mr P. ABETZ: Canning Vale has a group, too. The school actually set that up, and the mums get together for morning tea regularly. It actually has a website.

Mrs Sprigg: I think there are various things and various ways, not necessarily child health due to time commitments. Obviously I am not clinically out there in child health at the moment, but for the staff it would be just supporting those people, usually mums, that are here basically as single mums while the dads are away. Then as Ruth alluded to, the other thing would be supporting the parents who have appointments, if the appointment timing comes at the right time, to enable the fathers to input into that as well. So it is whether you can optimise that. New parent groups are actually open to fathers as well. You do not necessarily often get them there, but the opportunity is there to include fathers as well in anything that we can provide. That would be one way of supporting them.

Mrs Griffiths: I guess that is where more staff would be beneficial as well, because you could run more of those clinics.

Miss McLernon: In my area as well, in Redcliffe, we have a FIFO playgroup that is run there, which I think is very successful too. The main problem with FIFO is that the main support

disappears for a week or whatever it is. I think that is the hardest thing for the families. So family support is very important.

The CHAIRMAN: I guess this question might be more for Lynette and Ruth, because you have only been in that position for a short time. Do you think there are more at-risk and vulnerable families in the community now than there were in the past?

[11.15 am]

Mrs Sprigg: I think there are probably different at-risk and vulnerable families. There have always been at-risk and vulnerable families that we have dealt with in whatever situation. You have at-risk and vulnerable families going through school systems as well as child health. The changes are the things like the increased FIFO, refugee migrant health changes over time, so different countries that come in and different needs to be catered for, if you like, within the community. Sometimes those sorts of supports are not necessarily always available.

Mrs Griffiths: We have certainly changed since I have started child health. I go back and think that, yes, there has always been postnatal depression, but there seems to be a greater degree of it now or a lot more dysfunctional families. Now I do not know if that is because I have come from the country and come to the city whether that has made a difference, but I have noticed now that our role has changed and sometimes I feel that I am more of a social worker than I am a child health nurse.

Ms L.L. BAKER: I was just going to say to Elise after you have been eight months—did you say—are you going to stay in the career? Do you think it is a good career path for you?

Miss McLernon: Yes, I like that and the reason I moved into it was for lifestyle really, so I did not have to do the shift work at the hospital. Is it something I will stay in long-term? I cannot commit to that but it is something that I will always come back to, I strongly believe in that.

Mr P. ABETZ: How do I put it? I have got to phrase it in a way that you are able to answer the question. Part of our role is, I guess, to advocate for where there are real needs that money is allocated where it should be spent. The picture you painted for me in terms of how the child health care system is running, it seems to be functioning quite well. Every government service and private services as well—I could do with another full-time person in my office and they would have plenty to do. In terms of the staffing levels, as you function within the child health system, is everything getting done that needs to be done or are the waiting lists, say, of the four-year-olds blowing out to the point where it is of real concern, or is the priority the nought to 12 months and the others perhaps are delayed sometimes? Is everything getting done that needs to get done at the moment? Is there a real critical need in all of your clinics to have an extra, say, you have got a 0.2 you really should have a 0.5 to really make it more manageable and do the things that should be happening on time, or is it adequate at the moment? The reason I ask the question is that we keep hearing this massive number of nurses that we are short and yet, from what I am hearing, you guys are doing a great job and it is all happening. So, is there really a need for that extra hundred-and-something child health nurses or would that be a luxury? That is sort of what I am struggling with.

Mrs Sprigg: Can we do it better for your grandchildren, to actually provide them better services and better parenting support to get them in that early brain development, nought to three you have mentioned, that you saw the presentation on? So, can we provide extra services to support that? Yes, I believe we could —

Ms L.L. BAKER: If you had more resources.

Mrs Sprigg: — if we had more resources to do that.

Ms L.L. BAKER: And you are metropolitan based.

Mrs Sprigg: Again, that would be coming back to the evidence and the research that is done that says where we can provide extra services for those. The other services that were probably thought

of as well are the mental health issues. That is widely documented as increasing in young children as well as through adolescence and as well as in parents. Ruth mentioned perinatal mental health issues, obviously, but if you have got young adolescents that are not actually getting on top of mental health issues as well, that is leading into their parenting skills that we are also supporting.

Mr P.B. WATSON: It costs you down the track, does it not?

Mrs Sprigg: So it is costing down there. The three to five-year-olds we were picking up on universal screening obviously, and four that is transitioning from child health to school health, you have still got mental health issues going into young children. Are there services that we could provide that would support better in that age group as well? Possibly.

Mr P. ABETZ: And do you think the child health nurses are best placed to provide that kind of service or are there some other services that should be providing it?

Mrs Sprigg: In lots of areas we are already trying to work in partnerships to actually optimise those existing resources and work in partnerships. Community health has been working in areas with early learning, such as with the Department of Education and working across the early learning sites where we are trying to optimise existing resources, but work with other organisations, other professionals. In partnership, I think child health nurses actually have a lot of skills to offer in that developmental role. So, it is an important part of the role as a variance to the skills offered by purely a person in education and purely an allied health person in supporting parents.

The CHAIRMAN: Ruth, I might just say to you whilst Peter's comment says he believes it is functioning quite well, that is certainly not the picture that is being painted for me in terms of child health nurses, but would you like to respond to Peter's comments?

Ms L.L. BAKER: We are not saying that you are not doing your jobs but that there are gaps.

Mrs Griffiths: I believe child health nurses are doing a really good job but I also feel that we are always working under pressure to try and get as much done as we can. Often the feeling is at the end of the day that you could have done better if you had not been having to do so much in that time.

The CHAIRMAN: Graham just asked me—I thought I had asked this, but possibly I did not—are you, Ruth, for the children that you see from zero to four, able to give us statistics in terms of that zero, six week, three month, eight month, 18 month and three year, the percentage of the children that you have seen for each of those visits?

Mrs Sprigg: Can I answer?

Mrs Griffiths: Yes.

Mrs Sprigg: H-Care stats would actually have your birth numbers, as opposed to those percentages, that would be recorded as six weeks, three months universal home visit as being seen across —

The CHAIRMAN: H-Care stats, so we may need to call someone in who can go through the H-Care stats with us, bring the paperwork in and explain it to us, then.

Mrs Sprigg: Either that or take it on notice, I guess, and ask for that report.

The CHAIRMAN: For which report? Could we ask you by way of supplementary information to provide the committee with the —

Mrs Sprigg: You can ask the organisation, yes.

The CHAIRMAN: We can ask you. We appreciate you have to go up the chain, and you have got some good people up the chain from you.

Mrs Sprigg: Absolutely.

The CHAIRMAN: But some people, I think, maybe are not as supportive as others, but you have got some good people. So, if you could go up the chain and then come back and if you are not able to provide it to us by way of supplementary —

Mr P.B. WATSON: Why can we not do it? These people are saying they have not got enough hours in the day.

The CHAIRMAN: Because, Peter, we do not know exactly what to ask for. Do you know what to ask for?

Mr P.B. WATSON: Lucy was nodding there, so —

The CHAIRMAN: No, she does not. We need to make sure we get the right information.

If you could ask, that would be great.

Dr G.G. JACOBS: To make that clear, in those six weeks, three months, all those different cohorts, how many of the children of that particular cohort per cent are seen? You quoted a figure from another study about —

The CHAIRMAN: The Auditor General says —

Dr G.G. JACOBS: At 18 months, 30 per cent of that cohort was seen, when they got to three years, only 10 per cent of the cohort was seen.

The CHAIRMAN: We want to be able to look at percentages for different nurses. We also want to look at for the different visits, referrals for different nurses so that we can say that last year we were very lucky and we got funding for child development services, but it sounds like we might need more funding for mental health nurses supporting your child health nurses. So, we need to know where your referrals are going and what the waiting lists are like for those referrals.

We have to finish, so before we finish, is there anything—I will probably start from Ruth and go through quickly—in the two or three minutes that you would like to say in the way of summary this morning?

Mrs Griffiths: I guess what I would like to say is I would really love to see a mental health nurse working in Lockridge that I could refer a lot of these mothers quickly for that support. I also think, yes, we are doing a good job, but with extra resources we could do better and perhaps we could detect a lot of these early developmental problems a lot earlier. I think that if we were able to give those mothers support for education, that they understood the development of the children and what is normal, it would be a big step forward.

The CHAIRMAN: Lynette.

Mrs Sprigg: Not really. You have referred to the Auditor General's report a number of times, so I believe the report reflects shortages and that speaks for itself.

The CHAIRMAN: Elise.

Miss McLernon: I think we have all just perfected time management in the child health role. That is all there is to it.

The CHAIRMAN: We thank you for your evidence before the committee today. The transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to it. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript. Again, thank you very much for coming in this morning.

Hearing concluded at 11.25 am