EDUCATION AND HEALTH STANDING COMMITTEE

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

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 2 NOVEMBER 2011

Members

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

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Hearing commenced at 10.37 am

POOLE, MS ANGELA
Media Spokesperson, Community Health Nurses WA, 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 its inquiry into improving educational outcomes for Western Australians of all ages. This committee is a committee of the Legislative Assembly. This hearing is a formal proceeding of the Parliament and therefore commands the same respect given to proceedings of the house. As a public hearing, Hansard is making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record. Before we proceed to discuss with you this inquiry today, I need to check whether you have completed the "Details of Witness" form?

Ms Poole: Yes.

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

Ms Poole: Yes.

The CHAIRMAN: Did you receive and read the "Information for Witnesses" briefing sheet provided with the "Details of Witness" form today.

Ms Poole: I did.

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

Ms Poole: No.

The CHAIRMAN: In that case, would you please state your full name and the capacity in which you appear before the committee today?

Ms Poole: My name is Angela Poole. I am here as the media spokesperson for Community Health Nurses WA.

The CHAIRMAN: Thank you. Angela, we are all very happy with first names; it is a bit intimidating in here. We have met before, and I really appreciated that time when I met with you and others and heard about some of the problems firsthand. This is an opportunity today for you to tell other committee members firsthand about your experiences working in the area, any strengths you see in the area and any weaknesses, and, particularly in relation to the witnesses, what you see as the priorities that need to be addressed to help both children and their families. Because you have had an opportunity to look at our terms of reference, I might maybe ask you to describe your role and the role of Child Health Nurses, particularly in describing that role, as a committee, we would be interested in the childhood assessments and how those child and family assessments can really help pick up where there might be problems with a child, to get referrals, so the intervention coming soon and the child can get on track sooner rather than later. If we maybe let you speak first for a while. I am going to give Graham and maybe Peter an opportunity to ask questions first, because they have to leave a little early. I did not discuss this with other committee members. Then the rest of us will continue to ask you questions. If at any time you feel uncomfortable, just say, "That one makes me a bit edgy."

Mr P.B. WATSON: Just do not answer.

The CHAIRMAN: So would you like to make a start?

Ms Poole: Thank you for the opportunity. As I said, I am the spokesperson for Community Health Nurses WA. Basically I have taken on that role because I am no longer working for the health department; I just need to make that clear. I guess from our point of view and certainly from the point of view of our members, as I think you all know from various reports that have been made, we are very low on having child health nurses. Our child health nurses provide an integral support to women and their families after they have had a baby.

The routine that normally happens is that as soon as someone has a birth, the child health nurse is notified and will go and do an initial assessment once that baby and mum come home from hospital. That is really important just to start that relationship. 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. It is not until that first postnatal visit that we go into the home and we do an assessment of mum; how are things obviously post-birth, but also how she is feeling in terms of her mental health issues, because I think, again, we know that there is a lot of anxiety and depression, which can be antenatal or postnatal. So we need to do an assessment to ensure that she is travelling well, that the baby is travelling well, if breastfeeding has been established, and we will do the height and weight and make sure the baby is healthy.

After that we have a series of what we call "universal visits". The first one is just postnatally within the first 10 days, if we can. Sometimes it is a bit longer, because we do not always get notified in a timely fashion when that baby has been born. But after that we do a six to eight-week assessment, we do a three to four-month assessment, an eight-month assessment, 12 months, two years and three years. At the moment, because of the lack of child health nurses that we have got, we are basically very stretched to do anything too much over that first 12 months, maybe even two years, but it is really difficult, because we are so short of staff and we have a lot of families that need a lot of support. By us getting there really early and doing those assessments, doing the developmental assessments, as you said, 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. At the moment, again, particularly speech and OT are the two main areas that we tend to really need that. A lot of families we work with, particularly in the lower socioeconomic areas, do not actually have a good role model of parenting themselves, so they do not know the importance of sitting down and talking with baby or a small child or reading or doing any of those things, so one of our big problems is that when a child goes to school, they are not school ready, as we would say. So they have not got good skills. Some of them might not even be toilet trained. Obviously that way a child is really on the back foot before they start, particularly with our Aboriginal families or some of our ethnic families. There are certain areas that really need much more support.

Certainly the assessments we do are developmental—so making sure that the child is reaching what we used to call "the milestones". Are they sitting up? Are they talking? Are they making adequate noises at different stages? And then the three-year, which is a really important one, is to ensure that they do have all those skills for readiness for school.

There is a lot of other programs that we try to implement. For instance, we have group activities for mums, like for mums to meet other new mums and to have that support. We have a Best Beginnings program, which is for families that really need intensive care. That is in partnership with the department for community development. They will be children who they really see as at risk. In the past we have also had a program called Community Mothers Program, which was a program where the child health nurse visited a family for up to two years. We also had volunteers that were part of that program. Unfortunately that program is not really running in too many areas at the moment.

Part of the issue of having to do the one-to-one and to do the amount of support that we need to provide to a lot of these families is that we do not always get time then to do group activities or to link in and do other things, because, as I said, there are a lot of families out there that do need that extra support. Families with hubbies that come over here for work, so they are fly in, fly out families, so they do not have their networks, have not got family support. They may or may not have a group of friends. That is where those mum support groups are really good to be able to do that.

An example is where I am working at the moment. We have a young mums group. These are for students who would normally be within the education system. We are having them back there and they are doing some further education through TAFE. Their babies are being looked after within the crèche within South Coastal Women's Health. That is really helpful, because it gives their children some social interaction, but it is also good for the mums to increase their education capacity, which obviously, with the new projects that are coming in, we are wanting to look at those young ladies getting back into education and ultimately work.

Is that the kind of thing you are looking for?

The CHAIRMAN: You said previously, and I think it was stated at the last community nurses' forum, that because there is such a shortage of child health nurses, you are only managing now to do the assessments in the first year, so the second year, the 18-month of the two-and-a-half, three-year appointments are being missed. It is known now within the community that the federal government is going to move the four-year health check; it is going to become a three-year health check. They are appreciating the fact that that assessment needs to be made earlier. Could you tell us how many nurses are needed? We know in 2008 it was something like 110 child health nurses. Have you any knowledge of what the current lack of numbers are? And then could you talk a little bit more about—after that first year, those appointments that are being missed—those appointments and the problems of not doing those appointments, what that actually means?

Ms Poole: I think the numbers are probably still around the same, but the numbers are to actually bring the child and school health up to the level where practice would be a good standard. That is not to say that, obviously, each year we would not be looking at more. It is not everywhere that we have a major problem. Certainly some areas—I used to work in the Rockingham–Kwinana–Fremantle area. Rockingham and Kwinana's population growth has just been exponential and we have not had any more resources whatsoever. Certainly in some of the northern suburbs it is the same. But there are some suburbs that are not too bad and then you have to look at how you can really try to reallocate those resources. But, again, you are just spreading everything so thin. The issue is, if you can get in obviously within the first 12 months and have that good rapport, then at least you are more likely to, perhaps, see people. But what is happening now is that we are having to almost have wait lists where we have people on lists like child development services obviously do, which is a major issue for parents who need speech or OT because it becomes a front page —

The CHAIRMAN: What do you mean by the wait list?

Ms Poole: People having to wait to get in.

The CHAIRMAN: Even for that first year or after?

Ms Poole: No, after the first year. So, normally you would expect a mum 18 months or 12 months since you have last seen them. You tell them that in 18 months they should come and have another developmental check. Basically, this is the birth-to-school entry that I have here from community health. Basically, in those 12 months, the 18 months, you are obviously looking for social and emotional health. You are wanting to make sure that they have a good reference of social issues; that they are do not have stranger danger-type things; that they can recognise their own peers; that they can ask for a drink; that they have some language skills. This is where this will have a problem in terms of getting to school. If the children are not developing these skills properly, when they go

to school they are not going to be able to develop their ability to learn at school, so they are going to be behind the eight ball. In terms of their gross motor—to make sure that they can walk around with furniture, that they have not got flat feet—all those kind of OT-type skills, occupation skills, then their fine motor skills, like picking up pencils and being able to draw. Again, if you go into the school system without those skills, the teacher does not have time to do that, necessarily, with you. That can also be picked up again by a school health nurse because we do have school health nurses who look after primary school children and they do a four-year-old preprimary check when the child does come into school and they go through physical and all those things as well. 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. It does make their life very difficult.

Mr P.B. WATSON: Is there a shortage of school nurses?

Ms Poole: Yes, there is a shortage of school nurses as well.

Mr P. ABETZ: Is the difficulty funding or is the difficulty just simply not being able to appoint them because not enough people are applying for the jobs?

Ms Poole: It is basically funding. We do not have positions and funds. The last time we did have some funding was at least 15 years ago. In fact, it is probably more like 20 now.

Mr P. ABETZ: It has been constant.

Ms Poole: It has been constant and because of our population growth. If our growth stopped and nobody had babies, we would be fine. But of course that does not happen. We do find we have a lot more mothers and families who need support. Even areas I have not spoken about, like families who have issues with substance abuse, and alcohol and smoking in terms of antenatally. We know the issues of antenatal substance abuse and certainly alcohol is a major issue. I was at the Marseille conference in Fremantle two or three weeks ago and it was really interesting looking at anxiety and depression and the impact that has on a baby who has not been born. The impact on that child's development is amazing. Again, that child is behind the eight ball. If you are not able to get in there and see them and support them and give them the resources that they need educationally, we are going to have a lot of children who are way behind.

The CHAIRMAN: Angela, do you not think—this is a bit tongue in cheek—that if the child health nurses do not see these children, parents, if they are concerned about their child, will go along and see their GP?

Ms Poole: They may do that 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.

Dr G.G. JACOBS: Cannot write either!

Ms Poole: It is difficult. You might be right. They may well do, but I would say on the whole not. In fact, often they will come to us before they go to a GP for even medical things for us to look at and not to—but I think that relationship with the GP is really important and I guess more and more we are trying to develop a partnership there so that we can make sure that we almost case manage if we have issues with children.

Dr G.G. JACOBS: Angela, thank you very much. I have a couple of questions. What is the South Coastal Women's Health Services? That was the first one, but more particularly, the committee has learnt that South Australia offers a universal home visit to all newborns and their families. Could you say that we have that in Western Australia? That achieved about 80 per cent coverage, the committee was told. What is the situation in Western Australia? I know that this could be a difficult question, but from a global point of view we are saying we have a shortage; is there a way of

putting a figure on that? How many other people do we need to provide, for instance, a universal home visit program for if we have not got one or we have a universal home visit program but the coverage rates are very low? Could you make any comment about that?

One issue that I would like you to comment about is also—a girl has a baby and she goes home. How is that communication between King Edward hospital, for instance, or Albany District Hospital or Esperance or whatever—what is the communication between the lady leaving post-natally and the communication with you guys as to at least knowing and following that up? I would just like you to make some comments about that.

Ms Poole: First, the South Coastal Women's Health Services is a not-for-profit organisation in Rockingham and that is where I am doing some work at the moment. As far as child health nurses, yes, we do have a universal home visiting program and have had for many years. It is certainly more successful in some areas than others, but some of that is to do with that communication. What happens when Mrs Brown has her baby, whether it is King Edward, Rockingham or wherever, a notification is sent to the epidemiology department in the Department of Health and they send out a notification to us to say that Mrs Brown has had her baby. Part of the problem is that that can take up to three weeks before we get that and we really try to get to a new mum within 10 days or, if we can, less. We try to ensure we have a good relationship with the hospitals so that the midwives at the hospital will let us know or some of our nurses do actually visit hospitals and go to the maternity ward. So they again would have some communication about particularly at-risk women. Down at Rockingham, for example, we had what was called an early intervention or an early home visiting program, which was run out of the hospital but it was part of community health services. That ran extremely well because the people on that liaised with us every day and saw mums within two or three days of going home and then they passed them on to us. Where we can, we are trying to increase a mechanism for us to know sooner rather than later —

Dr G.G. JACOBS: That is not particularly formal though, is it?

Ms Poole: No, it is formal. It is a formal piece of paper that comes in the mail although most nurses have now got computers so it can come through that system, but not all—it is only really in the last probably couple of years or so that every child health nurse has had a computer. We are now looking at how nurses can get them electronically.

Dr G.G. JACOBS: What do you think the coverage is like? Do you have any feel for what the coverage of the universal newborn program is?

[11.00 am]

Ms Poole: I would say it probably is around 80 per cent. It is patchy. Some of that patchiness is the fact that nurses have to use their own vehicles; they do not have vehicles provided. Now, if those nurses decided at any time that they were not going to do that, then it would be a really difficult situation because we have not got enough vehicles. We have got pool vehicles, but they are not always easy to use. So, for example, if you were in a child health centre in, say, Rockingham and you were going to visit people close to that, you would rather use your own car because it is only about five or 10 kilometres, whereas you might have to drive 10 or 15 kilometres to pick up a pool car to come back again; it is not worth it. But we do not have enough pool cars for child health nurses. That certainly is a drawback.

Mr P.B. WATSON: What about in regional areas, Angela?

Ms Poole: In some regional areas they are better off; they have got cars allocated, and again, of course their birth notifications are much smaller than what they are in the city. We can have nurses, again I am speaking more for Rockingham and Kwinana, because that is the area I know, and certainly I know, Janet, you would be aware of this, we could have some months when nurses are having 40 to 45 birth notifications a month per nurse; that is a lot of new babies.

Dr G.G. JACOBS: One of my questions was: can you quantify the shortage in any way?

Ms Poole: Well, I think the shortage, in most of the reports I think, as Janet said, was around about 108 or 110 that we needed.

The CHAIRMAN: But that was both child health nurses and school health nurses, so that is 220.

Ms Poole: That is to bring us up to a reasonable standard. Certainly, I know that program in South Australia and Victoria, I think, have put a lot of funding into their maternal and child health program, whereas I think here, we have been letting it go and letting it go, and our families are not being supported as well as they should be.

Dr G.G. JACOBS: One last question: if you are trying to tease out school versus newborn screening services, what shortage would you think in the baby space?

Ms Poole: I think the child health certainly would be a higher percentage than school health, although in saying that, you know, again, one school nurse may have 10 schools that she is responsible for, but obviously she, again, has got universal screening that she does through that time frame. But the child health probably would be the most under-resourced.

The CHAIRMAN: We have those statistics, Graeme; I can get them to you from a previous inquiry.

Ms Poole: I was going to say, I do not know whether I have got them in the documents that you were sent.

The CHAIRMAN: We actually have them.

Ms Poole: You would have them, would you not?

The CHAIRMAN: Graeme was not with us for our previous inquiry when we got those statistics.

Mr P. ABETZ: Just a question about the extra funding that was put in place for extra OTs and all that in the previous space: has that made a difference in terms of accessibility for the referrals? Are you seeing shorter wait lists on the ground or has it not really made a lot of difference?

Ms Poole: I think it has in some areas. What they have done is set up a priority system so that obviously the younger ones are the ones that they can turn around quite quickly—get in quite quickly. But the issue is if they are not seen and then they are reaching five or six before they are picked up, then they are not top priority and it is difficult. I recently had a friend whose son has been, not diagnosed, but needs to have some assessments for Asperger's and she has been told she must wait at least nine months for that, which is a long time.

The CHAIRMAN: You mentioned in response to Graeme's question earlier when you were talking about the number of visits that someone has that it is meant to be 10 visits between birth and age three. In South Australia we were told that if a parent is identified as at risk, then that parent could have up to 32 visits within the first two years. If you are short on child health nurses, what flexibility is there for those children who identify at risk? And if you are not able to give that assistance yourself for those children who you perceive to be at risk, what happens to those children?

Ms Poole: I would say that we do not have the flexibility and often those are the children who fall the net. I think we are very lucky: we have a very committed and passionate group of nurses out there who will often be out doing visits and fitting someone in because they know that they need that support, but a lot of them are very stressed and could deal with some more support. But I think that they would probably be the ones that would fall through the net. But as I say, there are programs like the Best Beginnings programs where you might get someone to that program and they have a home visiting service that again, as I said, is under the department of community services and health, and they visit for up to 12 months. But not everyone wants to go on that or really needs to, but they are still needing that extra support. But no, it is really difficult; staff are

very much aware that there are families out there that they would love to see at least every month, if not every week some of them, and it is just too hard.

Dr G.G. JACOBS: Angela, if you recognise that you are limited in resources, what could you cut down in the screening program? What absolutely essential, basically, times and ages, would you actually pick out if you were limited and you had to do something that was very critical at a particular time? You say we do 10 and South Australia does 32; what would you see that would be not negotiable in the timeline of screening?

Ms Poole: A few years go, we did much more than we do now, but we have cut down to the bone I would say even now, and that is doing the 6 to 8 weeks, 3 to 4 months, eight months, 12 months. If we are lucky we can do the 18 months, two years and three years, but it is not really happening in a lot of places. So I think we really have reduced to the bare bone, and you put on top of that that first-time visit and any other support home visits that you need to do—nurses are struggling. I think having 32 visits a year would be fantastic. The Aboriginal health components of child and adolescent health have been streamed into one streaming for metro and they have done that; they actually put in many more visits like we used to have many years ago. They have actually implemented that so that they have put in more visits, but again, it is difficult. They do not have as many births so it is not really as many, but it is difficult still to necessarily get into those families. But we have a lot of families that equally could do with as many visits as they are being able to progress with. Even if we did get some more nurses, one of the big issues that we have got, that I think you might be aware of, is in terms of our facilities. Now some of our facilities are fantastic, but some of them are as old as me—that is pretty old! And I think that the other thing we need to be looking at, I am not sure, but I think South Australia might be doing this, is a co-location model. If you can have a lot of these services under one roof then maybe that interaction and day-to-day—even just having a chat in the corridor about little Mary or John or whatever does help because people get to know what the issues are. And if you have a real family that you need to get into quicker, sometimes you can make that case a little bit more if you have got a good relationship and you know that there is a real issue with that child. So certainly facilities need to be looked at as well, because even if we got 100 extra nurses, at the moment where we would put them; I do not know.

The CHAIRMAN: Why do you think child health nurse numbers have decreased so much? Why do you think that you have not been given the support over the past decade?

Ms Poole: I guess one of the things for most people you might speak with is that community health is not something that you can put on the front of the paper and everyone will say, "Oh, we've got to do something." If you cannot get your knee fixed or you cannot get in to get whatever surgically, medically, then people can see that and everyone gets up in arms. But because we are in the preventative and identification and that referral system, people do not think about prevention in the same way, because we are not illness; we are not disease. I always used to think that instead of the Department of Health, it should be called the department of disease, because it is really about medical issues. So I think it is fantastic in the last few months that we have now actually been in the newspaper and this thing has been written about us and people are doing these kinds of things so that we can actually have a voice, but we have not had a voice. I think it is an area where people think, "Well, you know, you can go to a GP; you do not really need child health nurses." But I think they are an important part of that system and they do an awful lot of good at picking up a lot of issues—supporting families and picking up issues that need to be referred for further intervention. I think it is just because they have not really had the foresight to see the wealth of knowledge that is out there for child health. There has been a lot of restructure over many years now; we used to have many more nurses. 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.

Ms L.L. BAKER: When did that stop, Angela?

Ms Poole: That stopped probably about 8 to 10 years ago now.

The CHAIRMAN: So that is day care centres and childcare centres and family day care centres?

Ms Poole: Yes.

The CHAIRMAN: So all of those areas, previously, a community child health nurse would be able to go in —

Ms Poole: Particularly the day care centres themselves. With the family day care we would have a relationship with the caregivers or whoever was responsible and if there was an issue we would see them, but in the day care centres themselves we used to go in on a regular basis and do the same screening and referrals, but we just cannot do that.

Ms L.L. BAKER: So they do not have any facilities in day care centres anymore unless they do it on their own?

Ms Poole: No, they do not.

Ms L.L. BAKER: Interesting; thank you.

The CHAIRMAN: Is the not-for-profit sector able to pick up the huge gap in terms of the number of government employed child health nurses? You now work in the not-for-profit sector. I would like to see more nurses; we would all like to see more child health nurses employed. Personally, as long as the nurses are there, as long as bottoms are on seats, whether it be through the health department or the not-for-profit sector, I think a child health nurse is a child health nurse. What opportunity is there within the not-for-profit sector?

Ms Poole: Again, it comes down to funding, Janet. I mean, I am finding it really interesting working for non-profit sector versus the government, where you had your funding and if your award rates go up you automatically got more money. With non-government, you put in a tender for $100 000 and you have got $100 000 for the next 100 years! And it is really difficult, because you are then trying to reduce people—you are having to say to people, "Well, I can only pay this much, so I have to reduce your hours." Therefore, your services are less. I am really struggling with that and I would agree; I think they could take on that role in many respects, but again it would be funding—if they could be funded. Because again, non-government agencies cannot pay the same or they do not have the funds to pay the same as the government.

The CHAIRMAN: You think it would be a backward step then?

Ms Poole: I do not know that it would be backward; I think if the funding was there then that is fine, but the funding has to keep up. If you are having a professional person and they are on an award, your funding has to keep up with an award.

The CHAIRMAN: What about staff–patient—then over to you Lisa—coming from more of a hospital than the community background that you come from. In the hospital, we have staff–patient ratios, or we had staff–patient ratios, and there are still staff–patient ratios. We know that in 2008 there were approximately 110 or maybe a similar number of child health nurses and school health nurses short, but we do not know how that number was arrived at. Are you aware of any ratios that set a bare minimum for child health nurses and children?

[11.15 am]

Ms Poole: Well my understanding, and I am not sure who the report was sent to because I was not involved in it, but I know Margaret Abernethy did a lot of work on ratios and that was looking at a few things, not just the birth notifications, because that is one number that could be horrendous or

nothing. But it is also looking at those other risk factors. So it was not, as I said, just on the numbers. If it was a single mum, if it was a fly in, fly out mother, if it was drugs and alcohol, substance abuse, it was looking at those kinds of factors that might be built into what extra support you might need. I know that over the metropolitan area they have done a bit of a reallocation of FTE to try to support some of that, but, from my point of view, it has always been robbing Peter to pay Paul, because at the end of the day it might help over here, but this person over there is then going to be stretching themselves a bit. As I said, those other things like getting group activities on board or having some of the things that help support families in a different way, you cannot always get to do that because you are so busy with that one to one.

Years ago we also had a lot of drop-in clinics, whereas now we work from appointments only, which is good because you have got time to give to the lady of the family. We try and do drop-in centres in a different way, so we might have a morning that is a drop in. Mums can come in; they can have a cup of tea and a chat. I know they do this quite successfully up in Armadale, and have been doing it for years. But if you open up to, as we did years ago, having open clinics, you can have 50 people come in the door, and you cannot give people enough time. You only need one or two of them who really need a bit more attention. So child health nurses have tried various ways to assist, but at the end of the day it does come down to resources.

The CHAIRMAN: Two things: the Margaret Abernethy report, and then straight over to Lisa. The Margaret Abernethy report: do you remember when—her name has come up in the past, but I have not followed up on the report that she was involved in, and that would be very useful —

Ms Poole: She is the president of the community nurses association. I have got a few reports here, Janet, that I have scribbled over. I do not know whether you want —

The CHAIRMAN: Could we ask you to provide them to us by way of supplementary information?

Ms Poole: Yes. I was going to say that I could even leave these with you because I can get another copy. One of them that I have got here was certainly to you, and that was done by Margaret and Marie Tyrell Clark. That was talking about acuity in terms of birth notifications. But I could certainly leave these for you. Another one that I have got here that I just picked up this week—I do not know whether you have seen this—is "Prevention and early intervention of mental illness in infants, children and adolescents", and this is from the faculty of child and adolescent psychiatry. But that has got some interesting things in it about looking at CAMHS, which is the child and adolescent metal health services, trying to get involved in doing some early assessments. Again, looking at that, we do do some of that, so again, to me, it is working in a partnership so that we can work together. So if you want me to leave those, I can certainly do that.

Ms L.L. BAKER: I have a couple of quick questions, Angela, on very different subjects. The first one—and you may not be able to answer this for me, and it is quite okay if you cannot—is: when you were talking about the funding for the centre that you are involved in at the moment, you made a kind of general comment about the lack of resources in the not-for-profit sector. One of the banes of my existence in WACOSS was always the health department, because it is the biggest funder of non-government organisations in this state, and it was also probably the only department in government at the time that refused to index not-for-profit funding. Despite the government having a policy saying that you must, it refused to. I do not know how they managed it, but they put it off. What I am hearing you say—and you need to just let me know if this is correct still or not—is that the indexation is still not being applied to the funding in this project that you are working with at the moment.

Ms Poole: As you say, we do get different pockets of funding. I know we get funding through national women's health.

Ms L.L. BAKER: No, this is state.

Ms Poole: This is state; okay. Look, I am sorry; I am really not too sure.

Ms L.L. BAKER: That is fine; that is okay.

Ms Poole: I have not been there very long, and I know my CEO talks about the fact that it is difficult to have that passed on. So I am not sure.

Ms L.L. BAKER: That is fine. There is a big problem with federal indexation rates. It is about one per cent, whereas the state was paying about 3.7 per cent. Do not worry about that. That is fine. I have another question, and I do not know whether you will be able to answer this one either. But I am really interested in how the Parkerville Children's Home project out at Gosnells–Armadale is going. Do you have anything to do with that?

Ms Poole: I do not any more.

Ms L.L. BAKER: Have you ever been there?

Ms Poole: I have been there, yes, and I think that is probably a really good model for us to be looking at.

Ms L.L. BAKER: Yes; absolutely. What is its name? I have forgotten.

Ms Poole: Now you are going to ask me.

Ms L.L. BAKER: There you go. You are as bad as I am. I saw Basil last week too. It is a good project, is it not —

Ms Poole: It is.

Ms L.L. BAKER: — because it brings everything together in the one row.

Ms Poole: Yes. And I think more and more we have got to look at co-location of services that pertain to children, particularly the zero and the primary.

Ms L.L. BAKER: Would you see that model being invaluable for use across the state if it was more of a state —

Ms Poole: Yes.

Ms L.L. BAKER: Thank you.

Ms Poole: And there has been a lot of discussion on and off about doing that, and I think that is the way to go. Certainly, in places where we have got people working together, it does make a big difference.

Mr P.B. WATSON: Angela, is there a specialist mental health service that children can be referred to in WA—young children?

Ms Poole: There is the child and adolescent mental health service. Now, this report here is certainly looking at that having more of a universal program. At the moment, with the majority of child and adolescent mental health, it is not for that preventative—it is not for the anxiety and depression. It is more for someone who has got a tag that says, "I've got this, that or the other", and I know, certainly with my partnerships and involvement again at the Rockingham–Kwinana mental health, we work quite closely to engage—for example, if we have an antenatal lady whom we know of who has some issues, we can often bring them in to do a home visit together, but, on the whole, they do not have a universal program—they are not funded for that—and prevention. So this, I think, is quite exciting, if it actually does come to pass. Their services, certainly over the last few years, have improved a great deal. And I cannot speak a lot for mental health because I do not work in mental health, but I know that they have certainly had some issues in terms of their own resources and who they can and cannot see within their program limitations.

The CHAIRMAN: Angela, you said that in some areas the community child health nurses are actually going in for the antenatal visits.

Ms Poole: Yes.

The CHAIRMAN: Can you remember where?

Ms Poole: Can I just say again that the Marcé conference was about perinatal mental health issues. Several years ago in Rockingham—and it must be probably now well over 10; it is probably 12—we were very progressive in that we set up a program between GPs, the hospital, ourselves and mental health looking at postnatal depression. We set up a system where if you went into the hospital and you registered, if you had had any issues with anxiety or depression in the past, you were then set up with the GP and we did a home visit. It was a fantastic program. Now Armadale have a program like that as well, and there are a couple of projects that are being done at the moment, but, again, because we do not have the resources to do it across the whole metro, it is not being done across metro. But, for me personally, because I come from a background, or at least I have worked in countries where you actually did do all that, it just makes sense that you are able to get in there early antenatally and develop that relationship, and then see people through. In, again, Rockingham–Kwinana—and I know in some areas—we have some funding through COAG, where we are providing a similar kind of service for our Aboriginal women. We are seeing them antenatally, they are being delivered at the local hospital, and then through either community health or ourselves they are seen postnatally, so, again, we have really good links, and that is starting to work really well, and I think it would be great if we could do the same thing for everybody.

Mr P.B. WATSON: We talk about Indigenous ones and we talk about up north. I am from down south. We have the same sort of issues, but they are hidden in the community. Do you find that in the Rockingham area you have a lot of the Indigenous problems, but they are kind of hidden because they are not standing out in the open like they are up north?

Ms Poole: When you say problems —

Mr P.B. WATSON: With alcohol.

Ms Poole: Yes, we do have a lot of those problems.

The CHAIRMAN: Foetal alcohol syndrome.

Mr P.B. WATSON: Yes, foetal alcohol syndrome.

Ms Poole: Foetal alcohol is certainly—we have not seen a great deal who have actually been diagnosed with that spectrum, but, again, more and more work is being done in that area. I used to work for many years in Canada, and there was a lot of foetal alcohol work done there. When I came back to Australia I was not appalled, but thought, "Oh, we're not doing it here", yet now it is, which is really great. So we are doing a lot of education antenatally. With a lot of Aboriginal families there is a lot of what they call shame—what we might call embarrassment—so they do not necessarily come forward to say, "Look, I really think there might be a problem with little Johnny", and again we are realising with the foetal alcohol that there is a big spectrum. It is not just that you would have the actual specific looks that those children have, but you can be very developmentally delayed, and your education system is obviously really difficult for you to fit into, and we are now knowing that a lot of that is through alcohol abuse. Some women do stop drinking, some women do stop smoking, but a lot of women do not, and a lot of women still take drugs. Certainly, in many areas—and I know, again, in Rockingham–Kwinana, we are already putting a big emphasis on that for this next financial year to try and get people to understand how important it is not to have anything in your system when you are pregnant. Even that one drink can make a difference.

The CHAIRMAN: These two —

Mr P.B. WATSON: One is mine and one is Janet's!

The CHAIRMAN: — are models of brains. So this is the size of a baby's brain when they are born, and this is the brain of a child who is three years of age. This is with normal growth and development. Because we now know there are the millions of neurons that the baby is born with, the pathways develop, and they need to have those good pathways at the age of three. As a child

health nurse, if you are meeting with a mother who does not have extended family support, what types of referrals are there? If you do not have the time and are not running extra groups for these young mums, particularly young mums in need, to whom would you be referring and where are the gaps in referrals? Are you given a list of the different agencies in each area that you can refer to? Does the health department provide child health nurses with a list of who can be referred to, and where do you see are the gaps in referrals?

Ms Poole: Yes, the child health nurses do have an extensive list of whom they can refer to. They do an awful lot of networking in that kind of area and have really good relationships on the ground with people. People like CLAN, Red Cross—a lot of those non-government agencies will provide home visiting support for families if they need to. There probably again are not enough of them around, and some areas—for example, Rockingham, Kwinana, Mandurah—may not have some of those agencies that you might do closer to Perth, or they might not visit. Even PMH—if you have a prem baby that was in PMH, the PMH visiting nurse will come to the end of Rockingham, but they do not go any further. So a child health nurse in Mandurah has to take that on because the PMH nurse does not go down that far. So those kinds of things really —

Mr P.B. WATSON: Is that due to lack of staff or just bureaucracy?

Ms Poole: It is bureaucracy really, because they have their cut-off in the areas where they go, and Mandurah—unless it has happened in the last month, they do not go that far. But certainly in terms of those kinds of resources, they do know about them. There are non-government agencies that are getting funded to do those kinds of things. In terms of that kind of support, to be able to know that you can—libraries are really good as well these days. They have a lot of playgroups where they will have things for little young children to do, and reading books and those kinds of things.

[11.30 am]

There are a lot of early years playgroups coming up. Again, down at south coastal we are going to be very lucky next year—we have a couple of speech pathologists who want to give back to the community. They are going to come free of charge and set up a playgroup for us at Rockingham, which will be fantastic. A lot of our young mums will be able to attend that and have some intervention, because speech is a major problem. If the issues are more than that, then they probably need to be referred to our child development centres, whether that is speech, OT or psych. That is where the waiting has to come in.

The CHAIRMAN: We are being told that whereas previously the emphasis was on a child going to school to learn, we are now being told this is when learning starts.

Ms Poole: It does.

The CHAIRMAN: That is why in particular we were asking you about the 18 months, two and three-year appointments because if children are learning at those ages, I would have thought that having a child health nurse identify a gap and looking to see where that gap can be filled would be very important. Referrals would mean a great deal to a young mother at those early —

Ms Poole: Absolutely.

The CHAIRMAN: Do you know if there are any statistics kept by the health department? We basically, from this inquiry, have to be able to show evidence of the need for 18 month, two and three-year visits. We need stats and data from child health nurses in terms of that visit, what that visit means to young mums. How can we get that information? We very much appreciate what you have told the committee this morning, but is there another way that we can try to get that information?

Ms Poole: Certainly there are lots of statistics being kept. Most of course are numbers. I imagine you would be able to go to the health department and ask for those.

The CHAIRMAN: For an 18-month visit, would a child health nurse document in the records that they have made a referral?

Ms Poole: Yes, absolutely.

The CHAIRMAN: It is all there?

Ms Poole: It is all in the records, yes. In the record—I did not bring the record with me—but, say, for that eight or 12-month visit, there is an actual sheet that says what you need to go through. Any comments or any referrals are all put in the document record. At the moment that is paper-based; we do not have electronic records. Certainly that is the way we are hoping to go in the future. Yes, it would all be there.

The CHAIRMAN: You said that apart from additional allied health professionals maybe from a non-government sector they may be employed, but otherwise if it is allied health, they would be referred to child development services?

Ms Poole: Yes.

The CHAIRMAN: Are there any services that you are not able to refer to, as a child health nurse?

Ms Poole: You cannot refer to a paediatrician. That needs to go through a GP. They have to have a GP referral to go to a paediatrician. However, with child development services, if you actually put a referral in to the team, the paediatrician is part of that team. If they feel that they need to see the child, even if it was, say, coming to see speech or OT, that person can internally refer to a paediatrician, but not a child health nurse outside.

The CHAIRMAN: Going back again to that last conference for community health nurses at which community health nurses as a group said, "We can only cope with the visits up to 12 months; we are not able to cope past 12 months." I do not know if you were at that conference, but how long were the waiting lists for community nurses to now be saying they cannot fit in the 12 and 18-month visits? What were the waiting lists like before? Could you maybe describe why that decision was made?

Ms Poole: I do not know that the decision was made. I think nurses still try to do, if they can; in some areas they can. But where they cannot, I think the decision was made that that first 12 months is so imperative that you really need to—certainly for the brain—get in there and provide the information in terms of developmental milestones, making sure parents know what to do at certain times. That was the most imperative. Obviously if we can get in the second year, that is really helpful, and the third year is even more so. I think the decision was made because that was how it was in some areas. It is not everywhere. There are some areas that can still easily do that because they do not have as many, but if there are 40 or 45 birth notifications a month, it is really hard to keep on top of that, even if there were two of you. In some places there are now two nurses working together, which really helps, rather than just having one.

Mr P.B. WATSON: You say they get 45 on their list—do they prioritise those in any way?

Ms Poole: I guess when the birth notification comes, it will say on there if there are issues of substance abuse of any kind or if there is any domestic violence. If that is on the report, the nurse will know that is probably more a priority than someone who has had a third baby and has been doing fine. You may prioritise those. But they do not come with something that says this is more important than that. It is up to the nurse to look at the report and make contact maybe with the midwife at the hospital to see if there are any further issues.

Mr P.B. WATSON: They can do the first check at the hospital. Is there anything that is being missed between that and, say, the three-year check? Are there any things that cannot be diagnosed early, that could be picked up if they had it at one and two, like how you get the first one? You say they are not getting it until three—is there anything in there that might not be diagnosed early but could be missed in those years before they get to three or four?

Ms Poole: One of the biggest ones, particularly for school readiness and obviously education, is in terms of reading. Having someone read to you and therefore then your own literacy skills, you are speaking. We have a lot of families that do not see the importance of that. The child may not have that interaction.

Mr P.B. WATSON: They stick them in front of a TV.

Ms Poole: That is right. Or parents have not been role models themselves—if your own parent did not sit and read with you, did not play games with you, did not interact with you, did not know that is what you had to do. Unfortunately with a lot of our families that is the case. We have inter-generations with some families that have not worked. They are not educated perhaps as well as they could be and do not know what to do.

Ms L.L. BAKER: In respect to Peter's question, would you think that hearing is one of the issues particularly for our Indigenous children zero to three, that we do not pick up if they do not get the right support?

Ms Poole: Absolutely. That is probably more remote than in the metro. Even in the metro, you do get children with that. Down again in Rockingham, we have a great ENT fellow who comes down once every six weeks and does a free-of-charge clinic. He loves that. He picks up quite a few things.

Dental care is another major problem. Down in Rockingham we have a group of people who actually manage the COAG funding and look at what we are doing in Aboriginal health. It is interesting because we might know okay, if you give your kids sweets and chocolates, then they are going to get problems. They cannot seem to say no—if a child wants it, they give it to them. Whereas now, we can see that there are a lot of problems with dental issues. Again, we do not have enough resources to be able to look at those. Just as, again, when you look at long term we have got a lot of people with diabetes.

The CHAIRMAN: Have there been any moves by your professional association to have child health visits an item where child health nurses can come onto Medicare?

Ms Poole: As far as I know, no, they have not. Often with Medicare you need to have a GP or work within a GP framework. Again, with south coastal we have a nurse there who does Pap smears but the doctor has to be around. We have funding through OATSIH for an Aboriginal health program we have with south coastal. One of my FTEs is a child health nurse and midwife. We are looking internally to see if we can use that same system and use the GP we have to cover her. Certainly within health, as far as I know, that has not been done. I always thought that was a government —

The CHAIRMAN: It is the federal government, but I am trying to think how we can get funding for child health nurses. Something that occurred to me the other day is maybe we should start looking at Medicare, like a nurse practitioner–type role for child health nurses. If we could shift the funding, maybe we can get the funding to get more nurses. No stone will go unturned in this area!

Ms Poole: To me it would be really nice to have a state government see the importance of child and school health, and what it provides to families rather than not valuing it. I think staff are feeling they are not valued so therefore families are not valued, even though we know all this research about brain development in the early years. Some states are even taking that up, but we do not seem to be doing that unfortunately; yet we seem to be a rich state.

Ms L.L. BAKER: That was really interesting. Thank you for coming.

The CHAIRMAN: We start Parliament in 15 minutes. Is there anything you would like to say as a final summary before I close off?

Ms Poole: No. I just hope I gave you what you asked. I am very nervous. It is like being at a formal interview!

The CHAIRMAN: I would like to thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for the 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 of evidence. Thank you very much for coming along today.

Hearing concluded at 11.42 am