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Dr Janet Woollard, Member for Alfred Cove to the Hon Dr Kim Hames, Minister for Health

1. Given that children's health services are considered frontline services, how many new
   (a) School health nurses
   (b) Child health nurses
   (c) Child development services staff

   have been provided for under the 2009-10 State Budget?

2. How many of the nurses from the above will be Aboriginal Health Nurses?

3. How many Aboriginal Health Worker are:

   (a) Currently working in WA; and
   (b) How many will be employed under the 2009-10 State Budget?

- These questions relate the Education and Health Standing Committee Report No 2 – Healthy Child – Healthy State: Improving Western Australia's Childcare Screening Programs and relate to questions 1.
- Question 3
  (a) 22 FTE's – 132 head count
- Dr Woollard also wanted to know how many Aboriginal nurses the state was short of and the Department was unable to advise.

A BN is attached from the Dept – Mrs Woollard is aware of the contents.

24% WHITE

a) School nurses 135 FTE's STAFF
b) 185 STAFF

135 STAFF

BRIEFING NOTE

ISSUE

WA HEALTH'S APPROACH TO ADDRESSING ABORIGINAL HEALTH WORKER DEFICIENCIES

BACKGROUND

As of 2 April 2009 there were 96 Aboriginal health worker (AHW) positions across WA Health. This figure includes positions at all levels, from case work to managerial. Of these 96 positions, 23 were vacant (23.95%). 17% of these vacancies were in the metropolitan area (n=4), with the remaining 83% being scattered across rural and remote locations (n=19).

To address deficiencies in Aboriginal health worker employment, WA Health is taking a multi-strategic approach to creating a robust and supportive career structure. The benefits of this will be improvements in attraction and retention of Aboriginal health workers.

CURRENT SITUATION

WA Health, through the Office of Aboriginal Health (OAH) is actively working with local, state and federal partners to increase employment and retention of AHWs across Western Australia. This work is being driven by three key initiatives.

1. Providing support for the establishment of the national Aboriginal health worker scope of practice

OAH has been working with Western Australian the Kimberley Aboriginal Medical Association, Marr Mooditj Foundation, Bega Garnbirringu Health Services, Aboriginal Health Council of Western Australia (AHCWA), and the Western Australian Aboriginal Health Worker Association to develop the AHW national scope of practice.

To ensure that AHWs continue to be effective and efficient elements of Aboriginal health services, the scope of practice required clarification in relation to scope and limitations of role, education and training requirements.

The objective of developing the scope of practice is to clarify the roles, regulations and recognition of AHWs as key components of the health workforce, and improve vocational education and training sector support for AHWs.

2. Supporting national competency standards

In 2008 the Community Services and Health Industry Skills Council released updated competency standards for AHW training qualifications in Aboriginal and Torres Strait Islander Primary Health Care. As a result, all AHWs who graduated prior to 2009 will have skill gaps from their training.

In order to support the current national competency standards for all AHWs, OAH and the Western Australian Country Health Service are working collaboratively with the AHCWA to conduct state wide competency assessments of all AHWs. Following review of current AHW skill gaps, training will be provided to up skill all AHW

employees. Similar assessments and training of non-government employed AHWs were conducted by AHCWA in 2008.

3. Supporting the establishment of the national Aboriginal health worker association

The Office of Aboriginal Health is working collaboratively with the Aboriginal and Torres Strait Islander Health Workforce Working Group to supporting the establishment of the national AHW Association. The objectives of the national AHW Association are:

- To promote recognition of the AHW profession
- To advocate for industrial arrangements for AHWs, including development of competency standards and wage awards
- To advocate career pathways for AHWs
- To facilitate provision of formalised training
- To facilitate networking, information sharing and other support among AHWs
- To advocate the registration of AHWs

The factors contributing to AHW deficiencies across Western Australia are multifaceted and complex. Through collaboratively working with local, state and federal partners to support AHWs, WA Health will continue to actively strive to improve working conditions for current AHWs, and increase attraction of new graduates into AHW roles.

RECOMMENDATION/ACTION
For Noting

Prepared by: Aeron Simpson
9222 2137

Date: 12 June 2009

Sign off: Conjoint Professor Ken Wyatt
DIRECTOR
OFFICE OF ABORIGINAL HEALTH

Approved ☐

Not Approved ☐

Noted ☐

Comments:

Signed _____ **Date** _____
MINISTER FOR HEALTH

(d) School health nurses

It is difficult to accurately assess the school health nurse staffing numbers at primary and secondary level, as many Western Australian schools in rural and remote regions encompass classes from Kindergarten through to Year 10. However, the business case prepared by the Department of Health in November 2007 for an additional 135 FTE of school health nurses (112 FTE for primary schools) has not been accepted by government.[97]

Primary schools

The Department of Health reported that in Western Australia's primary schools:

> *nurses have a lesser presence, often visiting schools on a fortnightly or monthly basis only. Nurses visit all schools in the public, Independent and Catholic Education sectors. There are overall school health nursing staffing shortfalls in primary schools in both metropolitan and country primary schools. It should be noted that primary schools have been under-serviced by school health services for many years. It appears that staffing levels have not been increased to accommodate increases in population, and there are historical staffing inequities between primary and secondary schools.*[98]

Table 5.2 School nurses in public primary schools

Region	Ratio of nurses to students	Ratio of nurses to schools
Recommended[99]	1:1,160	N/a
Country WA	1:1,717	1:12.6
Metropolitan	1:3,459	1:11.3

The Department offered no justification for there being only one-third of the recommended number of school nurses in metropolitan primary schools, nor for the perennially recognised "inequities between primary and secondary schools."[100]

97 Submission No. 30 (D), Department of Health, Response to Questions on Notice, 11 May 2009, p 1.

98 Submission No. 30 (B), Department of Health, Response to Questions on Notice, 31 July 2008, p 22.

99 DOH reported in Submission 30 (B), page 22, that "These calculations are based on the number of hours required to complete the various components of school health service provision in primary schools. Time required per 100 primary school students was established to be 93 hours, or 0.93 hours per student, each year. All calculations were based on an average primary school with 300 students including 35 pre-primary students. The calculations include government and non-government schools since the screening and assessment is done for all primary schools."

100 Submission No. 30 (B), Department of Health, Response to Questions on Notice, 31 July 2008, p 22.

Secondary schools

School health nurses have a strong presence in public secondary schools and staff resources in these schools in the metropolitan area appear to be adequate. However, in country areas staffing is less than the recommended level.[101]

Table 5.3 School nurses in public secondary schools

Region	Ratio of nurses to students	Ratio of nurses to schools
Recommended[102]	1:1,020	N/a
Country WA	1:1,394	1:1.75
Metropolitan	1:1,091	1:1.3

The figures provided by DOH are averages across the State and some schools are likely to fare far worse than others. The Department acknowledged this regional variation, especially in accessing appropriate Child Development Services (CDS), by confirming that "access to CDS's across the State is not consistent and dependant on availability of appropriate staff."[103]

Evidence from many submissions claim there has been a 10 to 15 year stagnation in the size of the school health nurse workforce that has coincided with, and been unacceptably strained by, the State's recent rapid population growth.[104] Stuart McKenzie, President of the School Psychologists' Association of Western Australia, corroborated this view when he argued that the School Health Service:

> *has not been resourced to accommodate new schools or increasing student numbers. As a result, some schools do not receive any School Health Service or are grossly under-resourced as the existing service is further stretched.*[105]

DOH itself acknowledged the dire situation in staffing child health services[106], including the school screening program:

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101 Submission No. 30 (B), Department of Health, Response to Questions on Notice, July 2008, p 22.

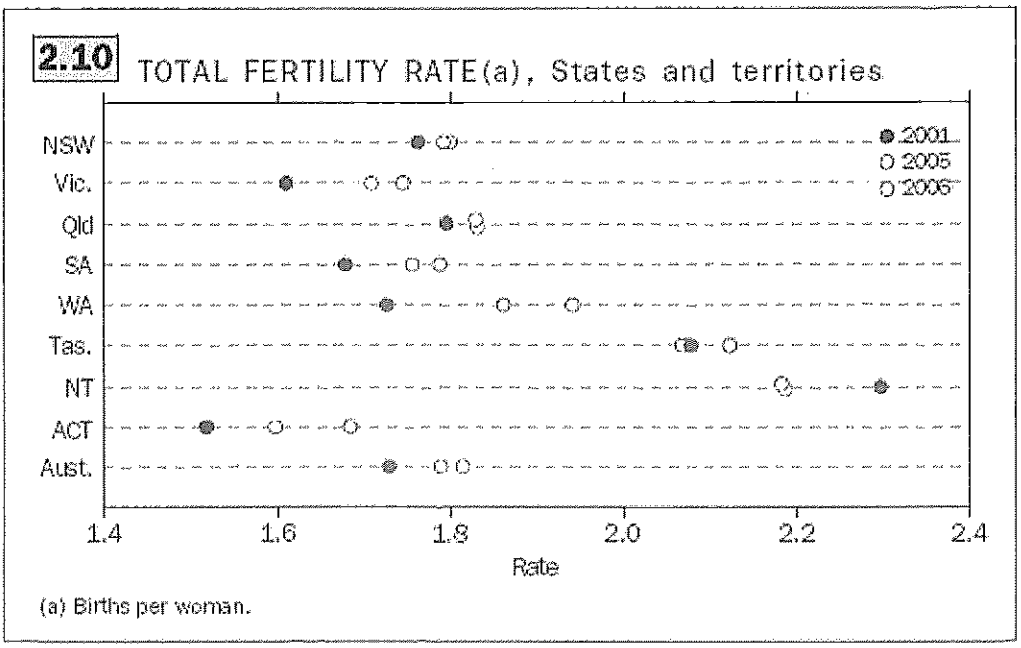
102 DOH reported "These calculations are based on the number of hours required to complete the various components of school health service provision in secondary schools. Calculations were based on an average secondary school with 800 students. School Health Nurse time required per 100 secondary school students was established to be 108.125 hours, or 1.08 hours per student, each year."

103 Submission No. 30, Department of Health, July 2008, p 25.

104 Submission No. 10, Dr John Wray, 8 May 2008, p 2; Submission No. 20, Ms Judy Walsh, OT Australia WA, 8 May 2008, p 3; Submission No. 28, Ms Michelle Scott, Commissioner for Children and Young People, 12 May 2008, p 5.

105 Submission No. 15, Mr Stuart McKenzie, School Psychologists Association (WA) Inc, 9 May 2008, p 3.

Figure 5.2 Fertility rates by Australian jurisdiction, 2001-06



(e) Community Child Health Nurses

There are 196 FTE of Community Child Health Nurses (CHN) who work in Western Australian with children of all ages in their local communities, with a primary focus on preventive and promotional activities.[112] National Investment for the Early Years (Niftey) and RUCSN both argued that the quality and availability of services from Community Child Health Nurses had suffered as a result of staff numbers not matching the recent population surge.[113] CHILD Australia reported that most CHNs are too busy carrying out the basic screening of babies and providing support to new mothers to have the time to check the development of toddlers and pre-schoolers. They suggested it is necessary for a mother to have a concern regarding her child's development before an appointment can be made to visit the CHN.[114] DOH and DET both reported that the

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112 For a fuller description of the role of Community Health Nurses in WA: Community Health Nurses WA, "what is a community health nurse", (2009). Available at: www.chnwa.org.au/index.php?option=com_content&task=view&id=13&Itemid=27. Accessed on 2 April 2009.

113 Submission No. 27 National Investment for the Early Years, 8 May 2008; Mrs Shirley McInnes, Resource Coordinator, RUCSN, *Transcript of Evidence*, 30 July 2008, pp 2-3.

114 Submission from CHILD Australia to the Community Development and Justice Standing Committee's *Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children*, 27 February 2009, p 8.

CHN staffing shortage of 105 FTE was particularly significant for its rural and regional clientele.[115]

Another factor that exacerbates this shortfall in nurses is the growing burden that is placed on staff to cater for, what Niftey termed, the 'changing complexity of developmental concerns'.[116] Conditions such as autism, obesity, and social dysfunction have become increasingly prevalent, and onerous, for child health workers who also have to monitor the health of the broader school-age population. The lack of government support for proposals for additional staff and resources is having a noticeable impact on the spirit of the current CDS workforce. Several submissions referred to a mood of disaffection amongst CDS workers. This was supported by Occupational Therapists Australia, WA:

> *Staff morale within these services is low amongst highly skilled and experienced therapists and staff retention occurs out of a commitment to the children. We cannot 'expect' this of younger therapists entering the DOH services and they will not stay under such pressures.*[117]

The significance of staff retention and recruitment difficulties across all sections of the child health system is augmented by the ageing demographic profile of the workforce. DOH confirmed that there is likely to be a 9.7% shortfall of general nurses and midwives (based on current levels) by 2015-16. DOH reported that the Community Health Nurses are "an ageing workforce - the average age of community nurses is increasing and in 2006 the average age was 54 years. 91% of the community health nursing workforce is over the age of 40."[118]

Even with the current staff levels, lengthy delays for assessment and remedial services are common across all child health programs. A number of submissions said waiting times of between nine and 12 months were commonplace.[119] The HRIT report found that waiting times across all regions varied "between two-18 months."[120] These delays are being compounded by 'wait-list management' strategies that have been adopted in an attempt to meet growing demands for already-stretched services. These strategies include:

- Prioritising children according to the perceived urgency of their condition;

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115 Submission No. 30 (D), Department of Health, Response to Questions on Notice, 9 May 2009, p 1; Submission No. 29, Department of Education and Training, 21 May 2008, pp 5-16; Submission No. 30, Department of Health, 16 May 2008, p 26.

116 Submission No. 27, National Investment for the Early Years, 8 May 2008.

117 Submission No. 20, Ms Judy Walsh, OT Australia WA, 8 May 2008, p 4.

118 Submission No. 30 (A), Department of Health, Response to Questions on Notice, 24 July 2008, p 8.

119 Submission No. 7, Mrs Shirley McInnes, RUCSN, 9 May 2008, p 6; Submission No. 27, National Investment for the Early Years, 8 May 2008; Submission No. 21, Speech Pathology Australia, 9 May 2008, p 4.

120 Department of Health. (2006) *Future Directions of Western Australian Child Development Services*, Health Reform Implementation Task Force, Department of Health, Perth, p 7.

5.4 Lengthy waiting lists

The primary, issue of concern identified by the majority of submissions was that of the long waitlists and waiting times before children were provided with treatment, therapy or appropriate services. The situation is made worse for many children because there are often two waiting lists: the first to obtain a proper assessment and referral for treatment, and the second for the actual treatment of a condition. For example, Dr Ridden, a school principal, confirmed in his evidence that "it takes nine months to get an initial assessment and then, when a course of therapy is recommended, it takes another six months for something to happen. They are not fantastic figures; they are normal figures and they have been confirmed by parents."[154] Speech WA's submission also highlighted the long delay in getting children assessed by the CDCs:

> *Any child who raises concern in the screening process is referred to the state Child Development Centre (CDC) for an assessment. Families face long wait-lists and wait times for such a government service of up to12 months depending on the CDC. The CDC wait-lists exist for children of Pre-primary and Primary school levels and the actual wait time depends on the age of the child and their district of residence. ... Speech WA would argue that the lengthy wait times for assessment needlessly waste the opportunities gained by an early screening process.*[155]

(a) Child Development Services waiting lists

More than half of the submissions received by the Inquiry referred to service provision by the DOH's Child Development Services. Key concerns of these submissions were waiting periods for appointments, waitlist management strategies, lack of staff and resources, as well as the timing and continuation of therapeutic intervention. Dr Wray commented that:

> *After the screening process, the professionals and parents will want to have their child further assessed and managed, if a problem has been identified. Around 20-25% of children have significant developmental or behavioural concerns.*[156] *It is at this stage that the state-funded Child Development Service, various NGOs, or the private sector become involved. In a nutshell, the 'free' Child Development Service tries hard but is unable to adequately meet the demand for services.*[157]

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154 Dr Phil Ridden, School Head, St Stephen's School, *Transcript of Evidence*, 30 July 2008, p 10.

155 Submission No. 23, Speech WA (Inc), 9 May 2008, p 2.

156 In an email of 23 March 2009, Dr Wray breaks-down the figure of 25% of children with development disabilities as: about 10% are language delays, 10% disabilities, 7% physical development issues and about 3% ADHD- but there is some overlap with children having various disabilities. These figures are based on Wood, N. & Daly, A. (2007) *Health and Wellbeing of Children in Western Australia, July 2006 to June 2007, Overview of Results*. Department of Health, Perth, pp 22-28.

157 Submission No. 10, Dr John Wray, 8 May 2008, p 2.

The ECIA submission confirmed Dr Wray's view:

> *that some children in WA have difficulty accessing early childhood intervention services in a timely manner. To this end, ECIA (WA) recommends* [sic] *review of the length of wait-times experienced by families for initial appointment at their Child Development Service and separately, review of the length of wait-times for the commencement of Early Intervention services within the Child Development Service.*[158]

Speech WA highlighted one of the waiting list management practises that seems to create more frustration for families and their children:

> *Once a child reaches the top of the wait-list he receives one block of 5 therapy sessions and then returns to the bottom of the wait list. Children in Kindergarten and Pre-primary are considered fortunate if they receive* ***2 blocks of 5 therapy sessions in a year.*** *School-aged children in Primary class levels are older than the designated age range of priority and thus face even longer wait times and even less frequent blocks of therapy.*
>
> *We at Speech WA feel that the large number of children waiting for such long periods of time for a minimal block of therapy is an intolerable situation. Pertinent to this concern is the broad recognition of the importance of early intervention to ensure literacy development for children with speech and language disorders. Even when such needs are identified early, we feel the inadequacy of access to appropriate services wastes the opportunity to prevent difficulties from jeopardising literacy levels and learning.*[159]

The DOH itself acknowledges that "there will remain a general problem of demand for services exceeding capacity of the CDS to provide."[160] DOH also admitted in questions on notice after public hearings that:

> *Throughout the State there is great variability in CDS waitlist data. The variability reflects resource issues, and also reflects the different ways that the CDS sites deal with waitlists. For example, some centres conduct the initial assessment quite quickly, or the child may be incorporated into a group information session or brief initial assessment. For some children, this superficial service may be all that is required. However, for some children there may then be a significant wait between initial assessment and subsequent individual therapy. In other sites there may be a significant wait for initial assessment, but individual therapy is then available immediately. Wait lists for CDS in country areas do not always provide a true indication of need. For example, the number of referrals for a service may be less because the position within the CDS has remained vacant for sometime because of difficulties in filling the position.*
>
> *Waitlists are sometimes cyclical within a year. For example, there are a large number of referrals at the beginning of each school year, and there is also a high demand for speech*

158 Submission No. 22, Early Childhood Intervention Australia (WA), 9 May 2008, p 2.

159 Submission No. 23, Speech WA (Inc), 9 May 2008, p 2.

160 Submission No. 30, Department of Health, 16 May 2008, p 18.