Parliament of Western Australia

'Inquiry into Child Development Services'

Terms of Reference:

(1) A Select Committee is established to examine child development services in Western Australia.

(2) The Select Committee is to inquire into and report on —

a. the **role** of child development services on a child's overall development, health and wellbeing;

b. the **delivery** of child development services in both metropolitan and regional Western Australia, including paediatric and allied health services;

c. the role of specialist medical colleges, universities and other training bodies in establishing sufficient workforce **pathways**;

d. **opportunities** to increase engagement in the primary care sector including improved collaboration across both government and non-government child development services including Aboriginal Community Controlled Organisations; and

e. **other** government child development service models and programs operating outside of Western Australia and the applicability of those programs to the State.

(3) The Select Committee is to report no later than 12 months after the motion is agreed to.

(4) The Select Committee shall consist of three members: Hon Dr Sally Talbot (Chair); Hon Donna Faragher; and Hon Samantha Rowe.

History:

On Wednesday 31 August 2022, the Legislative Council ordered that a Select Committee be established to examine child development services in Western Australia.

Dear Committee members

Maternal Child and Family Health Nurses Australia (MCaFHNA) welcomes the opportunity to submit views, experiences and suggestions for change for consideration as part of your inquiry into Child Development Services in Western Australia (WA).

This submission is written from the context of the scope of a well child's program i.e., primary health, rather that a medical model of care which focusses on illness and/or disease.

We respectfully offer the following information:

The role of child development services on a child's overall development, health and wellbeing.

The importance of the early years of a child's life is now internationally acknowledged as the time of most rapid learning and development (World Health Organization et al., 2018). There is also strong evidence that the quality of care that a child receives in the early years is key to addressing early life adversity.

To improve outcomes for children and reduce future risk of significant chronic diseases in adults, the challenge is to incorporate more widely the strong evidence about the importance of the earliest years of life for children's health and development, as well as for the health of adults. Prevention and early intervention strategies that are designed to promote the necessary conditions for a child's healthy development and are aimed at alleviating disadvantage during the early years of life are effective in improving child outcomes and are more effective than interventions later in life (Australian Health Ministers' Advisory Council, 2011).

A landmark study by Shonkoff and Phillips (2000) showed that virtually every aspect of a child's capacity to function is influenced by his or her environment beginning with conception and continuing most strongly until around three years of age. Further, they found that these influences extend to school performance, employment outcomes, and also flow on to social and economic outcomes within the community with long-lasting effects on adult health, educational and social outcomes.

Universal child and family health services, together with high quality antenatal services, aim to support optimal health and development to give children the best opportunity to succeed in life and learning (Nossar et al., 2012). Such programs operate within a primary heath model of care with the aim to promote child health and development and early detection of illness to facilitate timely and appropriate secondary or tertiary intervention. The importance of this approach is demonstrated by consistent national health guidelines across multiple countries, which all aim for universal reach and seek to maximize the outcomes for children (Australian Health Ministers' Advisory Council, 2011; World Health Organization et al., 2018).

By providing a platform to build a partnership between the family and the health professional, this process provides the wherewithal to respond appropriately to caregiver concerns and to work in partnership with caregivers and families to achieve positive early childhood development outcomes and address concerns about individual children's development with the aim to improve outcomes for all children and, importantly, to reduce inequalities in outcomes between groups of children (Australian Health Ministers' Advisory Council, 2015).

In Australia, there is no standardisation in the content or context of state and territory child and family health programs. This issue extends further to include the number of contact visits required to achieve outcomes as well as the 'what' within those contact visits. At a state level, the WA service model has not been evaluated since significant changes to the screening schedule were made in 2017.

With no formal evaluation to guide the implementation of the changes to the screening schedule, many child health nurses report that the number of scheduled visits is too few to adequately develop to be too few. Our members report:

"*While attendance at early child health checks is generally high, a low proportion of eligible children in the Perth metropolitan area received the 12-month child health check (44.1%) and the two-year child health check (30.2%) in 2019–20."*

"The proportion of children in the metropolitan area attending each child health check, except for the two years' check, decreased from 2017–18 to 2019–20. The 2019–20 attendance was impacted by the Covid-19 pandemic response."

"The concept of "drop-in services" as meeting additional client needs does not meet the needs of many families for timely appointment with a clinician who can listen and respond to their concerns in a professional manner."

With the understanding that evidence-based practice overlaps best evidence, practitioner expertise and client values; any child development service must consider:

- What are the unique health needs of the WA urban, rural, remote and very remote populations?
- What child surveillance elements research has been demonstrated to optimise the health of children?
- What are the desired health and wellbeing outcomes?

Differences between child health programs can create barriers, so a universal 'child development service' should first consider equality. That is, for all children across all parts of WA to have access to a standardised program with a key contacts schedule irrespective of where they live or the health professional providing the care. Within this system of care, once equality is achieved, equity can be applied where disadvantage is identified.

A well-designed child health program will utilise a population health approach, focusing on child health outcomes and incorporating strategies within a series of key contact visits. Each key contact should include evidence-based activities for physical assessment, nutrition, developmental surveillance, immunisation, universal and age-sensitive anticipatory guidance for caregivers, and maternal health and wellbeing. This approach provides the wherewithal for the health professional to detect deviations from normal growth and development, and the appropriate pathways for:

- Additional consultations;
- Follow up—including further assessment/activities;
- Referral to secondary and/or tertiary services.

Such programs also recognise that some children and families may require additional support (i.e., equity). Therefore, flexibility within a program to respond to any changes in a child or family's level of need is crucial to complement opportunistic activities by health professionals, on the basis of their clinical judgement, in response to other parental concerns and professional observations

Randomised clinical trials have repeatedly found that while development of a positive alliance (therapeutic relationship) is one of the best predictors of outcomes (Kopta et al., 1999), establishing a therapeutic alliance or relationship takes time. Therefore, a robust child health program should have sufficient key contact visits to enable this to offer, especially targeted within the first year of life to enhance the likelihood of embedding the therapeutic relationship with the caregiver as well as providing the opportunity to address age-related issues.

"Many child health nurses consider the number of [current] scheduled visits to be too few."

At the core of these key contacts are surveillance of 'well child' growth and development, parenting education and support, and health promotion. With anticipatory guidance underpinning this framework, it reinforces that families are primarily responsible for raising their children and that health services support this process.

The delivery of child development services in both metropolitan and regional Western Australia, including paediatric and allied health services

Although Australia has a universal health care system, the differences in service availability is frequently an outcome of geographical location, rather than the system itself.

The use of different well child health assessments and schedules create a lack of consistency in what constitutes 'best practice' in child health services and for clients about what is most

important in terms of health care for infants, toddlers and young children. More effective and systematised child health services are required to deliver measurable improvements in the outcomes for children and standardisation in the delivery of a routine child health program is required which incorporated current evidence and provided a more effective, efficient, and systematised child health program.

A universal well child health and development program which incorporates evidence-based practice within a primary health model of care allows for a range of health promotion activities—including proven interventions—to be delivered to all children in the population. However, the detection of growth and developmental problems is complex, as all children develop along a continuum at their own particular pace and there is a wide range of normal (McLean et al., 2014). For some conditions, this may be clear-cut and screening at or near birth may be possible as the condition may be detectable at that time.

While prevention is valued and seen to be good clinical practice, most effort and resources are still concentrated on responding to the presenting problems and illnesses of children. Early intervention can be achieved if the program design includes systems for timely identification of such issues. This is one of the essential criteria for any screening program: being able to identify a problem prior to it causing symptoms.

Issues identified by MCaFHNA members include:

"There is no coordinated program in CAHS such as an enhanced child health schedule (as operates in WA Country Health) to offer extra health and developmental surveillance for these families and children."

"Lack of coordinated early intervention programmes beginning in the antenatal period for families with risk factors (such as the Best Beginnings program that previously ran in here in WA with child health nurses providing intensive home visiting for up to 2 years). No coordinated approach has replaced this model of care in the metropolitan area, meaning that vulnerable families who will have children at high risk of developmental vulnerabilities fall through the cracks."

"Better referral processes/ handover of vulnerable clients from hospitals. Currently there is poor communication between Department for Child Protection, Acute hospital staff and the Child health nurses in the community."

"What is considered an acceptable/safe discharge from hospital of vulnerable babies?"

"CAHS child health nurses are seeing mothers/ families discharged from hospital with newborns having received minimal or no intervention for a range of social issues including domestic violence, mental illness, family instability, alcohol and substance use."

The role of specialist medical colleges, universities and other training bodies in establishing sufficient workforce pathways

Australia has a national system of registration for health practitioners, including Aboriginal health practitioners (AHP), nurses, and midwives.

A major issue is the range of tasks to complete within a schedule of well child assessments. This can be accomplished through a continuum of care and acknowledgement that flexibility to respond to any changes in a child or family's level of need is crucial.

Members report that some regions in Perth face chronic child health nurse staff shortages with positions left unfilled for lengthy periods meaning that the nurses in those areas face insurmountable workloads with great difficulty obtaining leave replacement meaning staff are stressed when taking leave knowing their colleague's will be under pressure.

"There is low morale that I see in my team and also in my clinical supervision colleagues- across the metropolitan area. Several colleagues are planning to leave, and some early career child health nurses have left already."

With regard to "workforce pathways", MCaFHNA strongly advocates that healthcare must be "appropriate and meet the needs and expectations of the community" through appropriate qualification and expertise in the speciality/specialised field of child and family health nursing. This means that families expect to receive care commensurate with experience and qualifications. They do not expect that they will be provided services by unqualified Child Health professionals. Disappointingly, members report:

We face a preference by management that child health nurses are placed as level one nurses.

We have policies being developed for child health nursing practice by non- nurses.

We need to ensure that child health screening and appointments are conducted by nurses with a certificate in child heath family nursing.

MCaFHNA supports the Australian College of Nurses position statement in regard to what constitutes an "appropriately qualified Child and Family Health Nurse" and offer the National Standards of Practice for Maternal, Child and Family Health Nurses in Australia(Grant et al., 2017) to support and promote ongoing professional development for Child Health Nurses.

Opportunities to increase engagement in the primary care sector including improved collaboration across both government and non-government child development services including Aboriginal Community Controlled Organisations

Across Australia, there are extensive waitlists for all disciplines.

In WA, the Child and Adolescent Health Service CAHS annual report 2021-2022, highlighted the wait times for children who require referrals to child development services such as speech pathology, occupational therapy or Paediatrics assessment. This includes median of 8.7 months for speech pathology but climicians indicate this is more likely to be >12 months while the wait for a Paediatrics assessment is around 2 years.

Members highlighted issues such as:

- Access to General Practitioners

"It is difficult for some families now to even access a GP as costs have risen and many practices now have co-payments.

- Accessing private Pediatrician's or other allied health services.

"*Most have closed their books and costs are prohibitive for the majority of families"*

- Home visit program for children requiring therapy

"many clients don't attend their Child Development Service appointments then the referral (and service) is cancelled. Vulnerable families who need the service the most find appt system difficult. This includes aboriginal families who would benefit from a dedicated team that could home visit for therapy."

- Funded eating management team

"There are no provisions through Child Development Services in the Community for babies and infants with significant eating and feeding issues (unless the child is failing to thrive and needs medical management at PCH). There was previously a multidisciplinary team that managed these babies and children"

- Limited options for infants-children identified with developmental delays

"*Depending on where you live, there are either extremely limited options for referral (or none) for children who score highly on the ASQ SE- long wait times for public funded psychology and very limited child psychology services."*

"Families requiring behaviour support; the CAHS Triple P program has been on hold during the pandemic and no plans for re-introduction are known at this point."

- Need for public education regarding 'normal' child development
- Lack of coordinated early intervention programmes

"Families with risk factors previously could assess the Best Beginnings program with child health nurses providing intensive home visiting for up to 2 years. No coordinated approach has replaced this model of care in the metropolitan area, meaning that vulnerable families who will have children at high risk of developmental vulnerabilities fall through the cracks."

- Limited collaboration between service

"Better referral processes/ handover of vulnerable clients from hospitals. Currently there is poor communication between Department for Child Protection, Acute hospital staff and the Child health nurses in the community."

"What is considered an acceptable/safe discharge from hospital of vulnerable babies?"

"CAHS child health nurses are seeing mothers/ families discharged from hospital with newborns having received minimal or no intervention for a range of social issues including domestic violence, mental illness, family instability, alcohol and substance use."

Other government child development service models and programs operating outside of Western Australia and the applicability of those programs to the State.

For consideration:

Northern Territory "Healthy Under 5 -Partnering families Program".

The Healthy Under 5 Kids-Partnering Families (HU5K-PF) program provides a single, standardised, systematised and evidence-based well child health program for the NT with key performance measures to include program coverage, compliance with program schedules and protocols, and timeliness of delivery of program services.

The systematic approach in the development of the HU5K-PF framework incorporates of three main components:

1. Program

- Set of standardised assessment forms which include developmental surveillance and guidance information
- 'Healthy Under 5 Kids-Partnering with Families Baby calendar' parental app
- Equipment and resources
- Supplementary materials
- Healthy Under 5 Kids-Partnering with Families Training and Education manuals
- Evidence Guide
- Practice Guide

- Data Manual
- Facilitators' Guide
- Program templates
- PowerPoint presentation template
- HU5K–PF program Baby Calendar
- Branding

2. Data systems

- Reproduction of care plans into IT systems (care plan specifications)
- Effective recall processes
- Standardisation of reporting definitions
- Standardisation of reporting parameters

3. Monitoring and Evaluation

Monitoring
- Capacity to audit of any single component of, any or a combination of, the care plan/s
- Systematic and timely provision of essential information at periodic intervals Evaluation
- Process Evaluation
- What intervention can work in this context (interventions that have proven effective in this context)? Are we doing the right things are we doing it right and on a large enough scale?
- Outcome Evaluation
- Is the intervention working, is it making the intended difference in outcomes such as changes in knowledge and behaviour?
- Impact Evaluation
- Are our combined efforts affecting change on a population level

Centre for Excellence in Child and Family Welfare – MARAM Training

The Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM) has been designed to increase the safety and wellbeing of Victorians by supporting prescribed services to identify, assess and manage family violence risk effectively. MARAM has been established in law under Part 11 of the Family Violence Protection Act 2008.

Olga Tennison Autism Research Centre (La Trobe University) – MoSAIC Training

Monitoring of Social Attention, Interaction and Communication (MoSAIC) training builds skills and confidence in detecting the early signs of autism in children under three.

"We are not doing any accurate evidence-based screening for autism as nurses are doing in

Victoria. We have the great programs by Telethon Kids Institute- that is all good, but it is not helping children in the community being able to access timely and accurate diagnosis for autism and other neurodevelopmental issues. We need a more efficient assessment service for Autism / neurodiversity."

In conclusion, MCaFHNA would welcome the opportunity to:

- assist in "workforce planning and redesign and the development of new models of care;
- assist in Recruitment and retention strategies to target; identify and attract the very specialised skills and expertise required by MCaFHNA nurses, including Nurse Practitioner roles especially in community and primary health care settings and MACH nurses working to their full scope of practice;
- ensure timely and accurate customer expectations are considered within this very specialised workforce;
- collaborate to improve health and wellbeing of the population across Western Australia.

Additional information

Policy and other relevant Documents

Community Nursing Policy Documents on child health nurse's role in child development

https://cahs.health.wa.gov.au/~/media/HSPs/CAHS/Documents/Community-Health/CHM/Child- health-services-policy.pdf?thn=0

https://cahs.health.wa.gov.au/~/media/HSPs/CAHS/Documents/Community-Health/CHM/Factors- impacting-on-child-health-and-development.pdf?thn=0

Commissioner for Children report 2019- Vulnerable children

https://www.ccyp.wa.gov.au/media/3718/improving-the-odds-for-was-vulnerable-children-and- young-people-april-2019.pdf

CAHS annual report 2021-2022 (Child and Adolescent Health Service)

CAHS 2021-22 Annual Report

Areas for improvement: Child and Adolescent health service Early and ongoing intervention for families with additional needs

Some families may have periods of enhanced home visiting, but there is limited capacity for this and on discharge from the program, there is no structured way to recall these children if they miss key developmental checks. They then arrive at 4-year-old kindergarten with a range of developmental concerns.

The Enhanced Home Visiting child health nurse service needs to be expanded and to include children who are on waitlists with developmental issues.

Although children in foster care or care of the state are meant to have an annual health and development assessment with a child health nurse, this does not seem to be occurring. There is no publicly available data to show this is occurring.

Role of the child health nurse and access to referred services for families:

Recognition of the role child health nurses play in working with family's promotion of early development and prevention of developmental delays- however our service model has not been evaluated since significant changes to the screening schedule were made in 2017.

https://www.ccyp.wa.gov.au/our-work/indicators-of-wellbeing/age-group-0-to-5-years/developmental-screening

Whilst attendance for early checks is high, this falls off by the age of 2 years:

"While attendance at early child health checks is generally high, a low proportion of eligible children in the Perth metropolitan area received the 12-month child health check (44.1%) and the two-year child health check (30.2%) in 2019–20.

The proportion of children in the metropolitan area attending each child health check, except for the two years' check, decreased from 2017–18 to 2019–20. The 2019–20 attendance was impacted by the Covid-19 pandemic response."

Child health nurses making referrals for babies identified as being developmentally at risk on ASQ at 4 months have these referrals rejected and told wait until 8 months.

Members are not aware of any formal evaluation of the change to the child health universal schedule that was implemented in 2017. Many child health nurses consider the number of scheduled visits to be too few.

The concept of "drop-in services" as meeting additional client needs does not meet the needs of many families for timely appointment with a clinician who can listen and respond to their concerns in a professional manner.

There has been no evaluation of whether the ASQ questionnaire represents a more accurate screening tool then the PEDS which were previously in the parent held child health record. The ASQ tool is often not utilised correctly. We are not investigating applications such as the online use of ASQ screening- but rely on Australia post which means there are often delays and we see some children who have not completed questionnaires prior to appointments, which can delay the referral process. Our referrals are also impacted by slow and old scanners which scan poor images of the ASQ required to be submitted to the child development service

Child Health Nurses are not doing any accurate evidence-based screening for autism as nurses are doing in Victoria. We have the great programs by Telethon Kids Institute- that is all good, but it is not helping children in the community being able to access timely and accurate diagnosis for autism and other neurodevelopmental issues. We need a more efficient assessment service for Autism / neurodiversity.

- Use medical / allied health students in final years for assessments
- Train CHN to attend to certain assessments.

The referral process to CDS needs to be streamlined. Too difficult for CHNs to refer compared with other disciplines (such as GP s).

There are extensive waitlists for all disciplines. The above report highlights wait times for children who require referrals to child development services such as speech pathology,

occupational therapy or paediatrician. It says the wait times for speech pathology are median of 8.7 months, more likely we see children waiting for over 12 months. The wait for a paediatric assessment is around 2 years.

Child health nurses must then spend much time trying to support families to access either private paediatricians (almost impossible due to closed intake) or other allied health services.

Examination of how we can better use private therapy services.

No Home visit program for children requiring therapy – many clients DNA their Child Development Service appointments then the referral (and service) is cancelled. Vulnerable families who need the service the most find appt system difficult. This includes aboriginal families who would benefit from a dedicated team that could home visit for therapy.

Child health nurses require more training on how to refer clients to Early Childhood Access- NDIS program for early intervention

It is difficult for some families now to even access a GP as costs have risen and many practices now have co-payments.

For babies with significant eating and feeing issues there is no public funded eating management team provided by Child Development Services in the Community (unless the child is failing to thrive and needs medical management at PCH) There was previously a multidisciplinary tram that managed these babies and children.

There are extremely limited options for referral for children who score highly on the ASQ SE- long wait times for public funded psychology and very limited child psychology services.

For families requiring behaviour support- the CAHS Triple P program has been on hold during the pandemic and no plans for re-introduction are known at this point.

Limited collaboration with other community health staff e.g.: CHNs and school nurses re clients and education for staff.

Need also for public education regarding child development

Child Health Nurse Staffing

Some regions in Perth face chronic child health nurse staff shortages with positions left unfilled for lengthy periods meaning that the nurse in those areas face insurmountable workloads.

There is also great difficulty in having adequate leave replacement meaning staff are stressed when taking leave knowing their colleague's will be under pressure.

We would not be able to even screen all the children that require screening in WA- there are

just not enough child health nurses. It is not just about screening or ticking boxes- it is about providing holistic and specialised health care for families with young children- and being skilled enough to know how and when to intervene.

It is also about having a therapeutic relationship with families- new practitioners do not have training in Family Partnerships which impacts their ability to provide care which is evidence based for community child health nursing.

There is low morale that I see in my team and also in my clinical supervision colleagues- across the metropolitan area. Several colleagues are planning to leave, and some early career child health nurses have left already.

There is a lack of appropriate professional education for child health nurses; training can be linked to hospital nurses.

New child health programs are just rolled out for child health nurses to implement with no consultation and no explanation of the evidence base for the methodology (Such as the current 3- year-old project)

We face a preference by management that child health nurses are placed as level one nurses- with fewer opportunities for progression.

There is no clear *child health nursing structure* in leadership in CAHS, i.e. clearly identified leaders for our discipline. We also have policies being developed for child health nursing practice by non- nurses.

There are also issues with facilities and space for staff to conduct clinics.

Child health nurses require additional administrative support- why are we still spending time with both paper and online health records.

CAHS still do not have telehealth facilities with video capacity for child health nurses to use.

We need to ensure that child health screening and appointments are conducted by nurses with a certificate in child heath family nursing.

Nutrition in the first 1000 days: key for healthy development - Breastfeeding

There is recognition of the importance of breastfeeding for a child's health and development. Anecdotally child health nurses are seeing the worst exclusive breastfeeding rates in many years in WA. There is no co-ordinated data collection and no plan or overarching strategy for Breastfeeding for WA. A great many babies leave hospital having had some formula in the first few days, and public hospital maternity units are stretched, as parents report limited staff capacity for breastfeeding support in the early days post birth. By 4 months the rate of formula use is huge.

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