Enhanced Child Health Schedule Guideline

1. Purpose

The WA Country Health Service (WACHS) offers a program of child health and development services to promote optimum health and development outcomes for all children across country Western Australia (WA). Services are delivered in the context of a progressive universalism model, in which care planning is undertaken and resources are allocated proportionate to need.[1]

Universal services are offered to all children and families; Universal Plus services are offered to those requiring assistance with an identified child health or development issue or a parenting issue impacting on the child. Partnership services are offered to children and their families with complex health and developmental needs requiring intensive support.[1]

The Enhanced Child Health Schedule (ECHS) is designed to offer additional Universal Plus child health contacts to children who, through exposure to risk factors, may experience an increased risk of poorer health and development outcomes. Increased effective engagement offers the opportunity to build trust, identify emerging issues and provide early intervention and referral (refer to Appendix A).

2. Guideline

2.1 Background

Regional WA is home to approximately 131,000 children aged between 0 -17 years, of whom most are healthy and developmentally on track. Approximately one fifth of WA children (20.3%) are developmentally vulnerable in one or more domains, and the proportion increases for Aboriginal children and those who reside in remote and very remote locations.[2]

The first 1000 days of a child's life from conception through to the second birthday is a critical period of development that lays the foundation for an individual's future health, wellbeing, learning and development outcomes throughout their life. [3,4] Children need a safe, secure environment, loving relationships, appropriate nutrition and developmentally appropriate stimulation from parents and caregivers to flourish.[5]

Positive experiences including strong attachment to a caregiver and responsive parenting provide the basis for a great start in life and help children to maximise their potential. [6,7,8] Protective factors include antenatal care and healthy pregnancy, age-appropriate development, consistent caregiving, access to early education and other services, regular attendance at school, transport, connection to community and cultural honouring.[9,10] Additional support during times of transition, for example school entry, can offer additional protection for vulnerable children.

Prolonged stress in early childhood can disrupt brain development and affect nervous and immune system function and can have life-long impacts including chronic disease in adulthood.[6,7,8] Risk factors that may have significant impact on child health development are poor social determinates of health, parent/caregiver use of alcohol and other drugs,

disability and developmental delay, disadvantage, family domestic violence or conflict, family mental health issues, trauma and homelessness, transience and/or overcrowding and remoteness.[11]

Children can recover from stress and adverse experiences, however experiences both negative and positive that occur in the first 1000 days may have more long-lasting impacts than adverse experiences at a later age when children are able to modify their behaviour and thoughts. Children who develop resilience in the face of adversity have been demonstrated to have at least one stable and committed relationship with an adult, who is able to provide positive experiences and support the child to develop skills.[12]

2.2 Implementing progressive universalism through ECHS

In order to optimise the health, development and wellbeing of vulnerable children, the Enhanced Child Health Schedule (ECHS) has been developed to assist families who require Universal Plus and/or Partnership levels of service.

The ECHS offers scheduled contacts with children and families, including the six Universal child health contacts and up to ten additional contacts to provide extra support and developmental guidance. It supports families to raise healthy children with optimal development and wellbeing who are ready to commence school.

The ECHS focusses on issues which commonly arise in circumstances of poor social determinants, including ear, eye, oral, respiratory, skin health and nutrition, especially iron deficiency.

Key prevention strategies for these health conditions should involve culturally appropriate health education to promote immunisation, good nutrition, and prevention of smoking/passive smoking. Refer to Appendix B for information regarding cultural considerations for Aboriginal families and community.

If there are concerns about environmental factors (e.g., power supply, dust control, pest control, waste management, food safety, dog health), obtain consent from the family to initiate a referral for an environmental health home assessment

2.3 Key Principles

Approach to care

Care should be delivered in partnership with families, using a strengths-based and culturally safe approach that demonstrates WACHS values. Taking a strengths based approach recognises that children and families are resilient and are capable of growth, learning and change.

2.4 Program eligibility

ECHS should be offered to families with children aged from birth to five years, living with the following risk factors or circumstances:

- Aboriginal families experiencing disadvantage
- refugee families
- children of teenage parents
- children of parents with mental illness

- children of parents affected by drugs and alcohol
- children with disabilities
- children on Client of Concern list
- children born prematurely and/or with significant health conditions (refer to Appendix C).

Consideration should also be given to offering ECHS to:
- children with an active WebPAS Child at Risk alert
- children with other vulnerabilities who may benefit from additional contacts.

2.5 Offer and enrolment in ECHS

Parents and caregivers can be offered the ECHS at any time during the first five years of a child's life. Research indicates that Australian parents/caregivers respond more positively when communications are focussed on child development and skill building, rather than parenting support.[13] Offers should therefore be focussed on benefits to the child in the first instance.

Consent for participation in child health services is generally implied when parents and caregivers engage with services. Written consent for services is **not** required for ECHS, if a parent or caregiver has accepted an offer of additional support and contacts, and they are aware that they are able to withdraw from the ECHS services at any time.

If a parent or caregiver declines commencement of the ECHS, this should be recorded and the reason documented in CHIS. If a family definitely declines ECHS and there are concerns about the child or family, this should be documented in CHIS and discussed with the Clinical Nurse Manager and a plan developed for future recalls.

2.6 Flexible service delivery

Service delivery should be flexible and tailored to family needs. It is **not** necessary to complete **every** component of **every** contact. It is important to respond to family concerns, presenting issues, and the child's pre-existing health conditions or developmental concerns. Safe sleeping assessment, perinatal mental health screening and family violence screening should be completed in line with policy.

There are ten scheduled contacts in the ECHS. Extra contacts can be offered in accordance with family needs, as negotiated between the family and clinician. The extra contacts can be used to provide goal-focussed brief intervention, for example assistance with establishing breastfeeding, or growth assessments.

Contacts can be conducted in person, or virtually via telephone or videocall. Information can be exchanged via email or text to assist in engaging the family.

If a family declines one contact and there are no immediate concerns, the relevant recall is cancelled, and the clinician should offer the next scheduled contact at the appropriate time. If there are concerns about the child, the clinician should refer to WACHS Engagement Procedure and discuss with Clinical Nurse Specialist or Clinical Nurse Manager (if required).

If children are in the care of the Department of Communities, they should be prioritised for care. Appropriate Children in Care (CIC) comprehensive health assessments are required to be completed in line with policy. CIC assessments can be completed concurrently with ECHS checks to eliminate duplication of effort.

When a child has been identified as being at risk of vulnerability, and the parent or caregiver has consented, the ECHS is to be activated and maintained in the Child Health Information System (CHIS). All contacts and attempted contacts (including correct encounter mode) should be recorded in CHIS.

2.7 Service providers

ECHS is provided by WACHS Community Health clinicians and clinicians employed by contracted services to deliver ECHS on behalf of WACHS. The 0 to 2-year Universal child health contacts should only be delivered by a Nurse or Midwife who possesses a post-graduate Child and Adolescent Health qualification.

ECHS contacts can be completed by multidisciplinary team members working within their scope of practice and competency (refer to Appendix D). The team may include the following roles:

- Aboriginal health practitioners and Aboriginal Health Workers
- clinical nurses
- enrolled nurses
- remote area nurses
- registered nurses
- midwives
- staff eligible to deliver universal child contacts.

2.8 Schedule of Contacts

The ECHS contacts can be completed at the following times:

- antenatal period
- 0 to14 days*
- four weeks
- eight weeks*
- four months*
- six months
- nine months
- 12 months*
- 18 months
- two years*
- 2.5 years
- three years
- 3.5 years
- four years
- 4.5 years
- five years.

* denotes a time when a Universal child health contact is scheduled. Additional actions and assessments may be required to complete the ECHS assessment at this time.

2.9 Cessation of ECHS

If a family's needs decrease, they can be transitioned to Universal services. However, recalls should remain activated on CHIS to enable the offer of additional ECHS contacts to retain engagement with the family.

If a family has additional needs not met by ECHS, additional home visits and referral to appropriate community services should be offered. A flexible approach is required for ECHS service delivery for school aged children.

Clinical handover from child health to school health services is required in line with the WACHS Child Health Clinical Handover of Vulnerable Children Procedure.

3. Roles and Responsibilities

The **managers** of clinicians delivering ECHS are responsible for ensuring that clinicians:

- have achieved the required competencies to deliver the different components of care as per Appendix D
- are supported to work to their full scope of practice.

All **staff** delivering the ECHS are required to:

- identify eligible children and offer ECHS to their parent or caregiver
- prioritise, plan and deliver child health services that meet the needs of vulnerable children and families
- take action to follow-up on vulnerable children and carers who do not attend a child health appointment as per the WACHS Engagement Procedure.

All staff are required to comply with the directions in WACHS policies and procedures as per their roles and responsibilities. Guidelines are the recommended course of action for WACHS and staff are expected to use this information to guide practice. If staff are unsure which policies, procedures and guidelines apply to their role or scope of practice or are unsure of the application of directions they should consult their manager in the first instance.

4. Monitoring and Evaluation

This policy will be reviewed as required to determine effectiveness, relevance and currency. At a minimum it will be reviewed every three years by the WACHS Community Health Nursing Leadership Group and the WACHS Community Health Specialist Nurses Group.

Data relating to ECHS contacts will be reviewed quarterly by the Central Office Coordinator of Nursing Community Health and data trends will be monitored using the Population Health Dashboard. Data from the Population Health dashboard will be utilised to monitor trends in ECHS service delivery.

Data captured in the CHIS Audit for non-referral based services will be reviewed quarterly, and regional action plans monitored by the Central Office Coordinator of Nursing Community Health. Trends in answers to specific questions about ECHS in the CHIS audit tool for non-referral-based services will indicate if staff are implementing the policy appropriately and will indicate gaps in training and compliance.

5. References

1. Child and Adolescent Health Service Community Health Clinical Manual [Internet]. Perth (AU) 2022. Child health services policy; [accessed 12 June 2024]. Available from Child Health Services

2. Commissioner for Children and Young People [Internet]. Perth (AU) 2024. Profile of Children and Young People. [Accessed 1 August 2024] Available from: https://www.ccyp.wa.gov.au/media/5030/children-and-young-people-profile-report-2023-artwork-web.pdf

3. Department of Health, Western Australia. [Internet]. Perth (AU): 2019. Sustainable Health Review: Final report to the Western Australian Government; [Accessed 23 April 2024]. Available from: https://www.ccyp.wa.gov.au

4. Centre for Community Child Health. [Internet]. Melbourne (AU) 2018. The First Thousand Days: Our Greatest Opportunity [Accessed 30 October 2024]. Available from: 1803-ccch-policy-brief-28.pdf

5. World Health Organisation. [Internet] Geneva 2020. [Internet] Nurturing Care for Early Childhood Development; [Accessed 23 April 2024] Available from: https://ww.who.int/health-topics/child-health#tab=tab_1

6. Australian Institute of Health and Welfare. [Internet] Canberra (AU) 2022. Australia's children; [Accessed 12 July 2024]. Available from: https://aihw.gov.au/reports-data/population-groups/children-youth/overview

7. Allowaymei, F, Kalmakis KA Chiodo, LM. Adverse Childhood Experiences and Chronic Diseases: A Cut-off Point for ACE scores. International Journal of Environmental Research and Public Health [Internet] 2023 [Cited 2024 Jun 27],20(2):1651 Available from Adverse Childhood Experiences and Chronic Diseases: Identifying a Cut-Point for ACE Scores - PubMed (nih.gov)

8. World Health Organisation. [Internet] Geneva 2020. Adverse Childhood Experiences International Questionnaire (ACE-IQ); [Accessed 23 April 2024] Available from: https://www.who.int/publications/m

9. Child and Adolescent Health Service. [Internet]. Perth (AU) 2018, Indicators of Need. [Accessed: 12 June 2024]. Available from: https://cahs-healthpoint.hdwa.health.wa.gov.au/cach/resources/Pages/Staff-Resources---Child-Health.aspx

10. Australian Institute of Health and Welfare. [Internet] Canberra (AU) 2024. Social determinates of health [Accessed 12 July2024] Available from: https://www.aihw.gov.au/reports/

11. Child and Adolescent Health Service [Internet] Perth (AU) 2022. Factors impacting child health and development. [Accessed 12 June 2024]. Available from: https://cahs-healthpoint.hdwa.health.wa.gov.au/cach/resources/Pages/Staff-Resources---Child-Health.aspx

12. Harvard University Centre on the Developing Child. Cambridge (USA) [Internet] Resilience. [Accessed 23 April 2024] Available from: https://developingchild.harvard.edu/science/key-concepts/resilience/

13. CoLab Perth (AU) 2019. [Internet] Cultivating Nature: Mapping the gaps Between Expert and Public Understanding of Early Development in Australia [Accessed 23 April 2024] Available from: https://www.telethonkids.org.au/projects/HPER/core-story/

6. Definitions

Term	Definition
Family Partnership	A family partnership approach is an evidence-based approach to providing care that involves helping processes to enable parents and families to overcome their difficulties, build strengths and resilience, and fulfil their goals
Partnership child health services	Partnership child health services is a term used in the CAHS-CH Child Health Services policy to describe child health services providing intensive support to assist parents who require help to manage or resolve increasingly complex physical, developmental, psychological, behaviours and health concerns, which may be complicated by socioeconomic, social, and environmental factors.
Social determinates of health	The World Health Organisation (WHO) describes social determinates as then on-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.
Strengths based approach	The strengths-based approach is a way of working those focusses on abilities, knowledge and capacities rather than deficits, or things that are lacking
Universal child health services	Universal child health services are child health services offered for all children birth to four years and their families to promote child health and development. Services focus on the early identification of health and development concerns, enhancing parenting and child-parent relationships
Universal Plus child health services	The Universal Plus level of child health services offers additional contacts to help parents manage or resolve a particular issue.
Vulnerable	Vulnerable is used to describe children at higher risk of poor developmental, physical or mental health due to circumstances of child, parents, family and/or community

7. Document Summary

Coverage	WACHS wide
Audience	Population Health clinicians delivering the ECHS
Records Management	Clinical: Health Record Management Policy
Related Legislation	*Health Services Act 2016* (WA)
Related Mandatory Policies / Frameworks	• MP 0106/19 Safe Infant Sleeping Policy • Clinical Governance, Safety and Quality Framework • Cultural Governance Framework
Related WACHS Policy Documents	• Child Health Clinical handover of Vulnerable Children Procedure • Engagement Procedure • Iron Deficiency Assessment for Children Procedure • Respiratory Health Assessment for Children 0 to 12 years Procedure • Skin Health Assessment for Children Procedure • WebPAS Child at Risk Alert Procedure
Other Related Documents	• Australian Immunisation Handbook • CAHS Ages and Stages Questionnaires (ASQ) • CAHS Child Health Services Policy • CAHS Client of Concern management Protocol • CAHS Factors impacting on child health and development guideline • CAHS Family and Domestic Violence-child and school health Procedure • CAHS Growth Birth-18 years Guideline • CAHS Guidelines for Protecting Children 2020 • CAHS Hearing and Ear Health Guideline • CAHS Nutrition for children-Birth to 18 years Guideline • CAHS Oral Health Assessment Procedure • CAHS Universal contact 0 - 14 days Guideline • CAHS Universal contact 8 weeks Guideline • CAHS Universal contact 4 months Guideline • CAHS Universal contact 12 months Guideline • CAHS Universal contact 2 years Guideline • CAHS Universal contact School Entry Health Assessment Guideline • CAHS Vision Guideline • WA Aboriginal Health and Wellbeing Framework 2015-2030 • WACHS Enhanced Child Health Schedule Activity Summary • WACHS Enhanced Child Health Schedule Practice Guide
Related Forms	Nil
Related Training	Available from MyLearning:

	• Child Growth Assessment (0-5 years) (CGA EL2) • Child health: Skin Health Assessment (CH02 EL2) • Ear Health: Module 03 Tympanometry (EHTT EL1) • Ear Health: Module 05 Referrals (EHRE EL1) • Respiratory Health in Children Declaration (RHIC EL2) • WA Health Safe Infant Sleeping- 2024 • webPAS: Children at Risk Alert (WCAR EL2)
Aboriginal Health Impact Statement Declaration (ISD)	ISD Record ID: 3711
National Safety and Quality Health Service (NSQHS) Standards	1.15, 2.11
Aged Care Quality Standards	Nil
Chief Psychiatrist's Standards for Clinical Care	Nil
Other Standards	Nil

8. Document Control

Version	Published date	Current from	Summary of changes
5.00	19 November 2024	19 November 2024	• Expanded eligibility criteria. • Addition of appendices re: Aboriginal children and premature children. • Clarification about consent requirements.
5.01	13 February 2025	19 November 2024	• updated link to WACHS ECHS Practice Guide and minor formatting amendments.

9. Approval

Policy Owner	Executive Director Clinical Excellence
Co-approver	Executive Director Nursing and Midwifery
Contact	Clinical Nurse Consultant Community Health
Business Unit	Population Health
EDRMS #	ED-CO-19-74301

This document can be made available in alternative formats on request.

Appendix A: Engaging with Disadvantaged Consumers

Common barriers to client engagement and strategies to address contributing factors are listed below.

Contributing factor	Strategies
The quality of relationship between the parent or caregiver and the service provider.	Use interpersonal skills to build rapport and establish trust.
Established shared decision making.	Take a respectful family partnership approach to problem-solving and decision making. Offer options, and respect for parent or caregiver decisions wherever possible, except when there is a concern about child and family safety.
Cultural awareness and sensitivity	Wherever possible, utilise the skills and knowledge of Aboriginal Health staff to ensure practice is culturally secure. Undertake training in cultural safety. For CaLD families collaborate with CNS, to identify an appropriate cultural source of information and advice.
Non-stigmatising interventions and settings	Provide services in culturally safe and appropriate settings.
Minimising the practical or structural barriers to accessing services	Offer a range of flexible service delivery options including: • home visit • other community setting • telephone • text • email • telehealth video call via WACHS approved platform.

Reference: Australian Institute of Family Studies [Internet] Melbourne (AU) 2010. Are disadvantaged families "hard to reach"? [Accessed 12 June 2024] Available from: https//aifs.gov.au/sites/default/files/publication-documets/ps1-0.pdf.au)

Appendix B: Key considerations for working with Aboriginal families and community

Collaborating with the Aboriginal community

Effective engagement with Aboriginal families requires an understanding of:

- the holistic framework of health that encompasses connection to country, culture, spirituality, family and community. Integrating Aboriginal perspectives and priorities ensures staff deliver care in a way that is culturally effective
- the importance of cultural honouring and connection to country as a protective factor for Aboriginal children, including children in out of home care
- the impact of colonisation and the legacies of policies of exclusion, segregation, forced removal from family and country that is still experienced as intergenerational trauma in Aboriginal families. This necessitates the delivery of trauma informed care
- kinship structures and the importance of recognising and supporting the appropriate members of the family in decision making about health matters for children
- cultural practices surrounding child rearing and gendered cultural obligations.

Communication can be enhanced by:

- awareness of cultural protocols
- respectful communication in preferred language
- staff awareness of local Aboriginal languages and how to provide language support
- use of interpreters as required
- provision of culturally appropriate, information, support and resources to family and carers.

In addition to enhancing care coordination for families, partnering with Aboriginal Community Controlled Health Services (ACHHS) will provide opportunities to:

- build rapport between mainstream services and community and facilitate cultural learning
- to develop patient education materials about service routines, procedures and processes and what patients can expect when they attend or visit the facility, and how to seek assistance
- translate written materials and posters into local Aboriginal languages
- ensure that all staff are trained in culturally safe communication techniques, including active listening, non-verbal communication, and avoiding jargon.

Strategies for engaging with community include:

- involving Aboriginal community stakeholders in the development and evaluation of communication strategies and messaging
- adapting these materials for local use and seeking endorsement from Aboriginal workforce or partner organisations
- providing opportunities for input and feedback from community.

Key resources

Policies:

- WACHS Cultural Governance Framework
- CAHS Factors impacting on child health and development guideline
- WACHS Child Health Clinical Handover of Vulnerable Children Procedure
- WACHS Engagement Procedure

Learning resources:

- Aboriginal Cultural eLearning (ACeL): Aboriginal Health and Wellbeing accessible via My Learning
- Lung Health in First Nations Children: Improving Outcomes through Culturally Secure Care eLearning. This resources is accessed through the Lung Foundation and providers practice tips for engaging with Aboriginal families in a clinical assessment process.
- Emerging Minds offers a range of courses for practitioners working with Aboriginal families and addresses the impact of trauma on the child and the principles of trauma informed care.

Appendix C: Pre-term infants

Advances in maternal and neonatal care have seen increased survival of babies who are born very preterm, two to four months prior to their due date of birth. Many go on to lead healthy and productive lives. However, research also tells us that a proportion of babies born very preterm face challenges in health and many aspects of development compared with their peers who are born at full-term.[1]

Infants born before 37 completed weeks of gestation are considered to be premature. There are three categories of preterm birth:

- extremely preterm (less than 28 weeks)
- very preterm (28 to less than 32 weeks)
- moderate to late preterm (32 to 37 weeks).

Consider early referral to Child Development Services for infants:

- born at 32 weeks gestation or more AND ventilated for more than five days who had an APGAR score less than five at five minutes
- with a history of significant neonatal medical complications (including but not limited to: periventricular leukomalacia, neonatal seizures, hydrocephalus).

Developmental assessment

When undertaking developmental assessments on children born preterm and under two years of age, adjust for age when selecting screening tools.
Use of the ASQ calculator is recommended for accuracy. Refer to Ages and Stages Questionnaires Guideline for further information.

Growth Assessment

Preterm infants grow differently from term infants. The Fenton growth chart is used to plot growth for up to 50 weeks gestational age, and the WHO growth chart is used until the child is two years old. Refer to Growth – birth to 18 years guideline for further information.

Immunisation

Prematurity can increase the child's risk of vaccine-preventable diseases. Despite their immunological immaturity, preterm infants generally respond well to immunisation products. Provided they are medically stable and there are no contraindications to vaccination, preterm infants should receive immunisation products according to the recommended schedule at their chronological age, without correction for prematurity. For further information refer to the Australian Immunisation Handbook

1. Murdoch Children's research Institute [Internet] Melbourne (AU) 2019 Guideline for growth, health and developmental follow-up for children born very preterm.{Accessed 30 October 2024. Available from Guideline for Growth, Health and Developmental Follow-up for Children Born Very Preterm - Centre of Research Excellence in Newborn Medicine (crenewbornmedicine.org.au)

Appendix D: Required skills and knowledge

Staff should have the relevant knowledge and skills to work with vulnerable children and families in both primary prevention and clinical contexts. Staff should be competent in:

- the identification and assessment of health and developmental issues
- delivery of culturally appropriate health information, and
- provision of guidance and support for decision making using a family-centred approach.

Multidisciplinary team members may include community health nurses, Aboriginal health Practitioner and Aboriginal health workers, ethnic health workers, remote area nurses, registered nurses, midwives, graduate nurses and enrolled nurses, and others deemed competent to provide aspects of the enhanced schedule as per their scope of practice and competencies.

Activities performed by all team members where deemed competent may include:

- Family Assessments
  - Genograms
  - Indicators of Need
  - Identification of signs and symptoms of child abuse and neglect
  - Family Domestic Violence Screening (FDV)
- Family goal setting
  - Working in partnership with families
- Physical assessment of infants and young children
  - Hearing and ear health – otoscopy, audiometry, tympanometry
  - Vision and eye health – cover test, red reflex test, corneal light reflex test,
  - Lea Symbols Chart test
  - Oral health assessment
  - Skin
  - Respiratory
  - Hips
  - Haemoglobin (Hb) monitoring
- Nutrition and Growth Assessment
  - Height, weight, head circumference
  - Body Mass Index
  - Nutrition
  - Bladder and bowel output
- WACHS Enhanced Child Health Schedule Guideline
- Developmental Assessment and parenting education to enhance development
  - ASQ-3
  - ASQ:SE-2
  - ASQ-TRAK
- Safe Sleeping assessment
- Detection of Perinatal Anxiety and Depression
  - Edinburgh Postnatal Depression Scale (EPDS) or Kimberley Mums Mood Scale (KMMs) in regions endorsed for use.
- Service planning

A Registered Nurse or Midwife with an additional qualification in child and family health.is required to lead the 0 – 2-year-old Universal Child Health Contacts, provide care coordination for the family and consultancy with the multidisciplinary team.