WA School Health Service Rationale

2013 Review
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Child and Adolescent Health Service
Child and Adolescent Community Health
Statewide Policy Unit

Delivering a Healthy WA
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Executive Summary

School Health Services in Western Australia are delivered using a population-based approach to health promotion and early detection, for children and adolescents as they grow and develop. Schools are ideally placed to support and enhance the health and wellbeing of children and adolescents, and School Health Services are well positioned to support school communities with specialist skills, knowledge and programs.

The review of this Policy Rationale seeks not only to capture current research about health issues, but also to highlight the priorities identified by children and young people in WA and Australia. The most important factors children and young people have identified for a ‘good life’ are distilled into five themes:

- Feeling loved and safe;
- Being healthy;
- Learning;
- Participating, and;
- Having the material basics.

There are some groups of children who are known to be more vulnerable than others, including (but not limited to): Aboriginal children, children with a parent with a mental illness, children in out-of-home care, refugee children, and children living in poverty. While School Health Services are accessible to all, a greater proportion of services should be directed to those who are at risk of poor health and academic outcomes.

In Western Australia there exists some of the most advantaged Local Government Areas in the country. In stark contrast, there are also areas of severe disadvantage and large regions of extreme remoteness. A mix of universal and targeted services, delivered as locally appropriate, is required to improve health across the entire population of school-aged children and adolescents.

The knowledge and expertise of School Health Service staff is valuable in identifying families of high risk groups, understanding their vulnerabilities and offering appropriate support. This often includes support to address risk factors, help to access health and human service, and advocacy to enhance social and health determinants. It is imperative that School Health Service staff have a thorough understanding of the social determinants of health and the impact on disadvantaged and vulnerable families and children.

Children want to feel loved and safe

Children and young people value feeling loved and safe higher than anything else when describing what they need for wellbeing, and they highlight families as the most critical factor when it comes to feeling loved and safe. Improving parenting quality is frequently identified in contemporary research as a key strategy to prevent and address a wide range of child health issues, and improving wellbeing for children and young people throughout all ages of development. Quality parenting is believed to assist children to self-regulate, which over the course of childhood and adolescence, is important in the prevention of conduct disorder, mental illness, obesity, teenage pregnancy, substance abuse, truancy, school disruption and juvenile offending.
Community and School Health Services have important roles to play in assisting parents to help their children feel loved and safe. Ensuring access to quality parenting programs is a critical part of this role. Community Health Services in WA have a long history with Triple P, a well-researched program known to be highly effective. This program, in its various modes, should be highly accessible to all western Australian families, and particularly for the most vulnerable families.

Friendships and a sense of belonging are highly important in establishing feelings of self worth, love and safety. Processes and supportive structures to enhance inclusiveness and prevent bullying, are critical for schools and other places where young people play and work. Research evidence suggests that quality bullying prevention programs which guide school policies and practices, can be adopted to create cultures of nurturing and inclusiveness. Such successful programs adopt a comprehensive model, known as the Health Promoting School Framework. School Health Service staff should be well versed with this Framework so they can provide support and advice to schools seeking to make positive change in a range of emotional and physical health promotion priority areas.

Children want to be healthy

Mental health problems and disorders represent a very significant burden of disease among Australian children. An estimated 20% of children aged 4 to 17 experience a significant mental health issue, with attention deficit and hyperactivity disorder, anxiety and depression the most common conditions. In 2011, it was reported that as many as 30% of Western Australian parents felt their child had an emotional or behavioural problem, with 22% wanting help to deal with it and yet only 4% of these parents had received any help.

Early childhood is a critical stage in the aetiology of mental health disorders. The importance of factors such as secure attachment, self-regulation, resilience and self esteem are well documented in the development of good mental health. If left untreated, problems such as anxiety, poor social and coping skills, behavioural and conduct problems are likely to manifest in as more severe mental health issues later adolescence or early adulthood. The early detection and referral of individuals exhibiting risk factors, and school health promotion initiatives for all are two priorities for School Health Services.

Adolescence is an intense period of development and a time when many mental health disorders emerge. Access to services for young people experiencing mental ill-health, self-harm and/or suicide ideation is critical to improving outcomes. Young men are more likely to complete suicide compared with young women, and Aboriginal youth and same sex attracted youth are over-represented in suicide statistics. Young women in distress are considerably more likely to non-fatally harm themselves. School Health Services are highly accessible to many adolescents, and staff require good skills in identifying problems, counselling, providing advice and referral to facilitate early intervention.

Approximately 26% of Australian children are overweight or obese. There are higher rates evident among Aboriginal, Pacific Islander and middle eastern/Arabic children, however children and adolescents from all backgrounds experience overweight and obesity.

Research indicates that parents do not accurately perceive problems with their child’s weight status. The National Health and Medical Research Council suggests that community health has an important role to play in identifying children who are gaining weight too quickly. Overweight children (and their families) who receive support to make family and lifestyle changes early in the weight gain trajectory have better outcomes which can be sustained. Research indicates that weight management programs are more effective for children prior to puberty. School Health Services are well positioned to improve the early detection of weight problems among school aged children.
Prevention, early intervention and targeted intervention programs for overweight children are similar in content, and all include behaviour change strategies to address dietary and physical activity behaviour. The intensity and duration of interventions need to be commensurate with the severity of the problem. For children who are obese and require targeted weight management intervention, success is most likely gained from programs providing at least 25 hours of contact with the child and/or parent over a 6 month period. Quality parenting programs have been shown to have a positive role in obesity prevention and weight management for children.

School based obesity prevention programs are most successful among primary school aged children. Comprehensive programs which adopt the Health Promoting School Framework are known to be effective. Such programs include; supportive curricula and classroom activities, physical activity opportunities for play, sport and transport, quality food supply within the school, staff development, and support for parents.

During adolescence, relationships, sex and sexuality become more important in a young person’s life. The majority of year 10-12 students have had at least one sexual experience, and most have had intercourse by year 12. Rates of sexually transmitted infections are higher among young people in WA compared to other States, and rates among Aboriginal young people are of great concern, for example, the notification rate of Chlamydia up to 46 times higher in some age groups.

School sexuality education should commence in the early school years and continue throughout the school years developing knowledge, attitudes and skills appropriate to developmental stages. Learning objectives should include; relationships, human development, sexual health, diverse sexuality and help seeking behaviour. Effective programs can result in positive relationships, reduced teen pregnancy and abortion rates, reduced STI acquisition and reduced incidence of sexual coercion and exploitation.

Young people experience many barriers to accessing sexual health services, including concerns about confidentiality, embarrassment, transport and costs. To be accessible and effective, services need to adopt youth-friendly approaches to planning and delivery.

Use of alcohol and other drugs are linked to personal safety risks (intentional and unintentional), mental health issues, physical ill-health, and social challenges such as relationship problems or unwanted pregnancy. Peer relationships and social influences are very influential on an adolescent’s choice to smoke, drink alcohol or use drugs. Adolescent smoking and alcohol use rates have declined over the last decade. However, of those who do drink alcohol often do at high risk levels.

Prevention programs and harm minimisation programs based on social learning principles have been shown to be effective in primary and secondary school settings. Secondary outcomes of these programs include reduction in crime, violence and mental health problems, and improvements in performance and school commitment. Effects are strengthened when a parenting component is included in programs. Caution should be exercised with community drug education or peer education programs as in some instances these have been linked to exacerbating problems.

Adolescents are often reluctant to seek help or reach out when they need it. School Health Services should invest in strategies that both develop relationships with young people in their school, and that support young people to seek help from other health service providers should a substance use or related health issue arise.
Falls are the most common cause of injury hospitalisation for children, many of which occur at playgrounds or schools. As children develop through to adolescence, their injuries become more related to risk taking behaviour. While a lot of injury prevention strategies are out of scope for School Health Services, staff can play a positive role in advocating for and assisting schools to implement effective health promotion strategies.

Most chronic diseases manifest in adulthood after years of poor health and lifestyle choices, and are therefore a key focus for prevention efforts commencing in childhood. However, asthma, diabetes and cancer are conditions that present in childhood and have the greatest burden on Australian children. Children with a chronic condition and their immediate family (including siblings) are at higher risk for negative social, psychological and economic outcomes. In these cases, School Health Service staff have an important role in providing psycho-social support to families and linking them to services. In addition, School Health Service staff have a role in supporting schools to develop care plans and associated training.

Dental decay rates are high among Western Australian children with more than 50% of children experiencing dental decay at ages nine (deciduous teeth) and fourteen (permanent teeth). Children living in remote locations are most at risk. Oral health is an integral aspect of general health with poor oral health associated with an increased risk of chronic disease later in life. There are simple health promotion messages that Community and School Health Service can deliver, along with referral pathways to local services.

If left untreated, middle ear infections, or chronic Otitis Media, can impact on hearing, language development and learning ability. Aboriginal children have an unacceptably high rate of Otitis Media in Western Australia, where it is considered to be among the worst in the world. School Health Service Staff have an important role to play in the prevention and early identification of Otitis Media in children.

In 2013, Western Australia met the goal of 90% children to be fully immunised by five year. This, however, was the lowest immunisation rate for all Australian states. School Health Service staff have an important role in the promotion, and where appropriate, provision of immunisations.

*Children and young people want to learn.*

Early engagement and participation in learning and education is important for the development of children and adolescents. It is an area that children themselves identify as a critical element to their opportunity for a ‘good life’. Children’s vision, hearing, gross and fine motor skills, social and emotional development are critical to their education achievement and wellbeing. School entry screening programs undertaken by School Health Service staff, in consultation with teachers, are an important opportunity to identify early and support children who may not yet have these basic attributes required for learning at school entry.

While Western Australia has made improvements in National literacy and numeracy testing results in recent years and generally meets or exceeds benchmark standards, results are often poorer than other States and Territories. Additionally, one-quarter of children in Australia were developmentally vulnerable on one or more domains of the Australian Early Development Index at school entry in 2012, with Aboriginal and linguistically diverse children more vulnerable in all domains of the Index. School Health Service staff can assist schools to identify challenges and opportunities among the student population and local community, and plan local programs accordingly.
Children and young people want to participate.

Children and young people want to participate, that is, they want to be listened to, supported in expressing their views, have their views taken into account and be involved in decision-making processes that affect them.

The Health Promoting Schools Framework is an integral component to WA School Health Service Policy, and integral to the Framework is the involvement of children and young people in planning and implementing strategies. Children and young people can play meaningful roles on a school health committee by presenting the views of themselves and their peers, and being empowered with new knowledge, skills and confidence in the process.

In the context of health care for individuals, School Health Service staff adopt client-centred approaches to ensure that children and young people participate in their own health care planning. In addition, the engagement of children and adolescents as consumers is important in the planning and implementation of School Health Services and programs on a broad scale.

WA School Health Service Policy

The three existing School Health Policy streams (Health Promotion, Early Detection and Specialist Expertise) continue to be an important means of describing the breadth and quality of work offered by School Health Services in Western Australia.

- **Health Promotion** through comprehensive and well-planned school health promotion strategies support the development of skills, knowledge, attitudes and positive behaviour change. School Health Services advocate for and support school health promotion strategies which enhance the long term health and wellbeing of children and adolescents. Strategies are based on sound research evidence and aligned to the Health Promoting Schools Framework.

- **Early Detection** and intervention are known to be effective in the prevention or minimisation of many diseases and conditions. School Health Services deliver early intervention programs to identify health issues and refer for timely intervention so that children and adolescents may achieve optimal outcomes in health, wellbeing and learning, especially those at risk.

- **Specialist Health Expertise** refers to the knowledge and skills that School Health Service staff bring to a school which are unique to school communities. School Health Services provide specialist health expertise to advise school communities on the care of children and adolescents in order that their health and wellbeing is optimal. Services provide ready access to primary health care and health counselling for adolescents.

While there are many important health issues that School Health Services can positively influence, this review has highlighted a number of issues that are considered of high priority for the review of WA School Health Service policy for 2014-2017. Priority areas include:

- improving access and uptake by parents of quality parenting support services;
- ensuring all school health service staff are knowledgeable so to advocate and support the implementation of the Health Promoting Schools Framework;
- increasing the focus of early detection and intervention for children exhibiting risk factors for poor mental health;
➢ improving early detection rates for children who are overweight;
➢ identifying and prioritising working with families who are more vulnerable than others;
➢ ensuring opportunities are created and promoted for children and young people to participate in school health promotion and their own health care planning.
Introduction

School Health Services have been delivered to children in Western Australia for more than 100 years. While the service has undergone many changes and modernising since its inception, the aim to enhance and develop the health of school aged children and adolescents, has essentially remained unchanged. The Service offers a population based approach to health promotion and early detection for child and adolescent health issues and extends into public and private schools. Since 1998, there has been a broad agreement in place between the Department of Health and the Department of Education, which underpins the delivery of School Health Services in public schools. The School Health Service is jointly funded by the two departments, with staff employed by Area Health Services.

The Statewide Policy Unit of the Child and Adolescent Community Health Service is responsible for writing and reviewing policies related to WA School Health Services, ensuring they reflect current best practice and adequately respond to contemporary needs of children and young people. The review of this Policy Rationale seeks not only to capture current research about child health issues, but also to highlight the views of what children and young people in WA and Australia have identified as their own priorities for wellbeing. In emphasising the voice of children and young people, it is hoped that all community health staff will make every effort to put children and young people at the centre of their work.

The Australian Research Alliance for Children and Youth (ARACY) and the WA Commissioner for Children and Young People (CCYP) have each conducted extensive consultations with children and young people to determine what is important to them in the context of their health. Whilst modifiable risk factors such as diet, physical activity, mental health, injury prevention and sexual health are all critical areas of work when striving to reduce child mortality and morbidity, it is essential we don’t lose sight of what children want to feel like they have a ‘good life’. This 2013 version of the Rationale for School Health Services, proposes that services continue to target well known key indicators for children’s health, but with more emphasis on delivering services within the context of what Australian children have identified as the most important factors that provide for a ‘good life’. These include five key themes close to the heart of children: feeling Loved and Safe; being Healthy; Learning; Participating; and having Material Basics. This contemporary look at School Health Policy is part of a refocused approach to policy development, providing volume and clarity for the voice of Western Australian children to be heard.

Who are the school age children living in Western Australia?

In 2011, WA was home to over 400,000 school aged children (4-17 years), of whom the largest percentage (76%) lived in the Perth Metropolitan area. Of the total metropolitan population, school aged children represented 17% of all people, a slightly higher percentage to that found in regional areas (19%).

Within the metropolitan area, Local Government Areas (LGAs) housing the greatest percentage of school aged children included Wanneroo and Peppermint Grove (23%) (possibly skewed due to large number of boarding schools within the area) from the North Metropolitan Health Service and Serpentine (21%) and Rockingham (20%) from the South Metropolitan Health Service.
The metropolitan LGAs representing the lowest percentage of school aged children included Perth (3%), Fremantle (5%), Vincent (11%) and Victoria Park (11%) \(^8\).

Outside the Perth metropolitan area, the South West accommodates by far the largest number of children and young people (55,769 or 24% of its total population), however despite having the lowest actual number of 9,779 children and young people, the Kimberley represents the regional area with the highest percentage of school aged children (28%) \(^8,12\).

Unlike the overall school aged population, the majority of Aboriginal school aged children live in country areas (62%). Aboriginal children represent 15% of the school aged population in regional areas and only 3% in metropolitan areas. The Kimberley is the regional area with by far the highest proportion of Aboriginal school aged children (13%) followed by the Midwest, Pilbara and Goldfields each home to 3-4% of Aboriginal children within their total school aged populations. Metropolitan LGAs home to the highest percent of Aboriginal school aged children include Belmont, Fremantle, Bassendean, Waroona and Kwinana all with just over 1% of the total school aged population for their areas \(^8\).

In Western Australia, it is compulsory for children and young people aged 5 to 17 years to attend school, and from 2014, compulsory schooling extends to children who are 4 or will turn 4 prior to 1\(^{st}\) July of that year.

In semester 1 of 2013, there were 419,158 students enrolled in Western Australian schools, from Kindergarten through to Year 12. Of primary aged children, 70% attend Government schools, 17% attend Catholic Schools and 13% attend Independent (private) schools. For secondary school children 58% attend Government schools, 20% attend Catholic schools and 22% attend Independent (private) schools. A small number of children are not enrolled in any school at a particular point in time due to the transient nature of their families. Others, typically Aboriginal students, may be enrolled in two or more schools at any given time, under two or more names \(^5\). From the year 2000-2010, twenty two new schools were established in Western Australia, one of only two jurisdictions in Australia to increase its number of schools \(^14\).

A recent report conducted by ARACY on the wellbeing of young Australians, compares the health and wellbeing of Australian children with those in other OECD countries using a wide range of social, health and economic indices. Despite improvements in some indices in recent years, Australia is described as only ‘middle of the road’ or ‘average’ when compared with its 33 international OECD counterparts \(^7,3\). These problems are not equally distributed across our population but are usually concentrated in disadvantaged and other vulnerable groups \(^3,20\).
The good stuff

Western Australian children and young people are faring well on most measures and are similar to children and young people in other Australian states. On a global perspective, WA children live in a strong, developed economy, supported by modern infrastructure.

For many children, their material and physical needs are fully met as a matter of course. For example, all children and young people have access to universal health care and to full secondary education.

There are several areas of wellbeing where WA children and young people compare well against national and international standards. WA has the lowest rate of infant mortality in Australia, at 3.0 per 1,000 births. The rate of smoking during pregnancy in WA declined in the period from 2003 to 2008, falling below the national average to 15.4 per cent. The prevalence of asthma has decreased in recent years, and diabetes and cancer rates have remained stable.

Over 97 per cent of eligible children are enrolled in Kindergarten, and practically 100 per cent in pre-primary education. At the older end of the education spectrum, around 92 per cent of young people over 15 years remain engaged in education, employment or training.

Overall, a low number of WA children and young people have contact with the justice system. The rates of children and young people living in low-income households and in families where parents are jobless are below or similar to national averages.

Who are the most vulnerable West Australian children?

The WA School Health Service provides a level of universal service to WA school aged children, however we know that there are groups of children who require more assistance, support or intervention than others. In an effort to attain parity in health and other outcomes between children of differing demographics, programs and services need to be delivered to all children and their families but with a scale and intensity proportional to individual needs. A small percentage of children and young people require more support than the majority. The groups of children discussed below are known to be particularly vulnerable Western Australian children who may require more targeted care from the WA School Health Service.

Aboriginal and Torres Strait Islander children

In 2009, approximately 31,073 aboriginal children aged 0-17 were living in WA, representing approximately 5.8% of all WA children. An enormous 40.7% of the aboriginal population in WA is younger than 18 years old, compared to 22.9% in the rest of the population. Aboriginal children live in all areas of the State, however 40% live in remote locations, a significantly larger proportion to the 5% of non-aboriginal children living in these areas.
Having material basics were identified by young people as critical for a good life, however many aboriginal families living in remote or very remote locations live in conditions most likely considered uninhabitable by mainstream Australian standards. There is often limited or no access to clean water, inadequate sanitation and unreliable electricity services. Aboriginal health in general compares poorly with indigenous populations in other Western countries.

The child mortality rate of Aboriginal children is more than double that of non-indigenous children in Australia. Despite improvements in recent years, Aboriginal children and young people experience disadvantage across a range of wellbeing measures including physical and mental health, educational and future employment outcomes. This disadvantage starts prior to birth with the incidence of smoking during pregnancy significantly higher for Aboriginal women (51% compared to 13% for non-Aboriginal women). The health of the mother both before and during pregnancy has a close relationship to the likelihood of a baby being born at a healthy weight. Babies of Aboriginal mothers in WA are more than twice as likely to be of low birth weight as babies born to non-Aboriginal WA mothers. Low birth weight is closely associated with fetal and preinatal mortality and morbidity, inhibited growth and cognitive development, and chronic diseases later in life.

The increased health risk behaviours and poor social determinants of Aboriginal children are likely to be linked to deep-seated family and community problems rather than primary causes of physical or mental ill health. Many adult Aboriginal people have experienced major life stressors, such as forced removal from their parents. This is linked to a range of intergenerational psychosocial problems leading to increased risk of emotional and behavioural problems for children and adolescents, contributes to feelings of being frequently excluded from mainstream society and a relatively poor sense of control over their lives.

The wellbeing gap between Aboriginal and non-Aboriginal children and young people is evident at every stage of their development. While not all families are affected in the same way, Aboriginal families are consistently over represented in measures such as infant mortality rates, immunisation rates, overcrowded homes, preparedness for schooling, educational achievement, otitis media and hearing loss, teen smoking rates, contact with the justice system and injury and hospitalisation.

There is a high incidence of sexual and physical abuse, and domestic violence in Aboriginal families and communities. Child protection order rates are 7 times higher for Aboriginal children, with neglect being the leading cause for intervention rather than physical or sexual abuse as found in non-indigenous child protection substantiations.

Aboriginal children are much less likely to attend pre-school activities and so are often less school-ready than other children. While there have been improvements in reducing the gap in recent years, still a much higher proportion of Aboriginal students are not meeting reading, writing and numeracy benchmarks throughout the school years. These outcomes are symptomatic of inadequate educational progress in the early years of schooling.
There have however been some improvements in retaining Aboriginal students in schooling for year 10 and or 12, and the Vocational Education and Training sector provides many Aboriginal people with non-school education opportunities. Within the Aboriginal population of WA, those in cities are more likely to complete Year 12 than those in rural and remote locations.

Of considerable concern in the WA Aboriginal Child Health Survey were the high rates of behavioural difficulties and recent suicide attempts among children and adolescents. Between 2006-2010, males made up 70% of deaths of young Aboriginal people aged 15-24 with suicide and transport accidents as the leading cause. In 2010 suicides accounted for 4.2% of all registered deaths of people identified as Aboriginal and Torres Strait Islander in 2010, compared with 1.6% for all Australians.

Indigenous communities which take steps to preserve their heritage and culture and work to control their futures are more likely to be successful in insulating their youth from suicide risk. Aboriginal and Torres Strait Islander cultural concepts such as connection to land, culture, spirituality, ancestry and family and community are commonly identified by Indigenous Australian people as protective factors, which can serve as sources of resilience and can moderate the impact of stressful circumstances on social and emotional wellbeing at an individual, family and community level. Extreme remoteness also seems to provide some protection for risk of suicide and family abuse or violence.

There are some positive trends for Aboriginal children and young people; including some aspects of National Assessment Program – Literacy and Numeracy (NAPLAN) results and immunisation rates. However, in general, considerable improvement is needed to attain parity between the wellbeing of Aboriginal and non-Aboriginal children and young people, and therefore ensuring that all WA children and young people receive a positive start to life.

Children of parents with a mental illness

Children of parents with mental illness are clearly vulnerable. They are at increased genetic risk of inheriting a debilitating mental illness compared to their peers and they are more likely than their peers to experience adjustment, relationship, emotional and/or behaviour problems. There is also the potential impact of poor attachment and bonding experiences as part of the overall risk for children of parents with mental illness.

Measuring the number of children living with a parent with a mental health concern is not easy as the parental role is often not recorded when a parent accesses mental health services. It is estimated that of the parents who have children living with them, 12% live with poor mental health. These parents are also more likely to be single parents and of lower socio-economic status.

It is estimated that one in five Australian children and young people are living in families in which a parent has a mental illness with most of these children likely to be enrolled in primary or secondary schools. Although likely to be an underestimate, there is currently no better data on the number of children and young people of parents with a mental illness.
The association between children living with a parent with a mental health problem and the child’s increased risk of social, psychological, cognitive, conduct, behavioural and physical health problems is well documented\textsuperscript{3, 17, 19, 20}. Studies have linked parental psychological distress to more hostile or irritable parenting and lower parental warmth which over time may contribute to negative child outcomes. The most detrimental and severe impact on a child is likely to occur when it is the primary carer (usually mother) who experiences the mental ill health and if the mental health issue is chronic and ongoing\textsuperscript{20}. Single parents are nearly 30\% more likely to experience psychological distress than couple parents\textsuperscript{20}. Children growing up with a parent who has long term mental health concerns are more likely to experience a psychological disorder during adolescence or adulthood\textsuperscript{3, 20}. Estimates of the proportion of children and young people of parents with a mental illness who also experience mental health problems range from between one-quarter and two-thirds.

The Western Australian Aboriginal Child Health Survey found that about one-third (33\%) of Aboriginal children and young people whose primary carer had used mental health services were at high risk of clinically significant emotional or behavioural difficulties compared with 21\% of children whose carer had not used these services\textsuperscript{17, 92}.

Children of parents who have a mental illness may experience the trauma of family disruption and out-of-home placement due to the parent’s hospitalisation or inability to care for them on a day-to-day basis. As parental mental health problems are thought to impact negatively on parent-child attachment it is, therefore, extremely important to examine the needs of children in such circumstances in order to enhance ongoing parent-child connectedness for the long-term normal development of the child.

Children and young people who have a parent with a mental illness have indicated they would like their circumstances acknowledged and would like more support including respite, counselling, mentoring, financial assistance and advocacy. This is particularly the case for children or young people who take on a caring role. Schools have the potential to provide support, however some children can find school an additional stressor when staff don’t understand their home and family situation\textsuperscript{11, 17}. Wherever possible, community health nurses in schools should seek to identify children whose parents may have poor mental health and offer appropriate support and advocacy. This is likely to include focusing on increasing the positive determinants likely to impact on child and family wellbeing (eg, improved parent-child relationships, strengthening social supports, improved mental health literacy), while at the same time reducing risk factors for poor outcomes for the child and family (eg, social isolation, family separation, awareness and access to relevant social services)\textsuperscript{18}.

**Children in foster care or other out-of-home care settings**

Some parents are unable to provide adequate care for their children resulting in their children being placed in the care of a relative, foster family or in residential care. Nationally, in 2011 there were 32,000 children (7.5 per 1,000) aged 0-14 who were living within these arrangements, a rate which has more than doubled over the last decade\textsuperscript{3, 23}. Indigenous children are over 8 times more likely to be in out of home care than other children\textsuperscript{3, 23}.
In the financial year 2011-12 alone, the WA Department for Child Protection granted 1,061 protection orders for Western Australian children who were unable to remain safely with their parents. Stability in placement is critical and over the last few years, improvements have been made so that in 2011, 82% of children in care had been in their current care arrangement for the last 12 months, 36% of whom had remained in a single care arrangement for 5 years or more. These children are a vulnerable group, many of whom have experienced family breakdown or situations involving emotional or physical trauma. There is a critical need to provide these children with the opportunity to develop with appropriate care and support.

Refugees and Culturally and Linguistically Diverse children

Whilst more than a third of the WA population were born overseas, the majority of these families have arrived from the United Kingdom, New Zealand or South Africa where English is either the main language or at least a common language spoken. However, the migrant population of greatest interest in regard to vulnerability and priority for School Health Services are migrant or refugee children coming from poverty or war stricken countries who face far greater challenges in their social, emotional, educational and general health outcomes. During 2009-10, 1,304 refugee and other humanitarian entrants were settled in WA. Of these, 42% were children and young people under the age of 18. In 2009-10, Myanmar (also known as Burma) was by far the leading country of origin of children entering WA under humanitarian programs (36%), followed by Afghanistan (18%), Iraq (10%), Sudan (8%) and Ethiopia (5%).

Refugee children and young people face particular health challenges including high rates of infectious diseases; incomplete immunisation; growth and nutrition problems and poor dental health. They commonly have multiple risk factors for educational disadvantage and some have unrecognised developmental delay and disability.

While many refugee children display remarkable resilience and adaptability, mental health problems such as depression, anxiety and post-traumatic disorder are prevalent and often persistent.

Sexual health among young refugee people is a specific area of concern. Young people from refugee backgrounds often have very little knowledge of sexual health or sexually transmitted infections (STIs) apart from HIV/AIDS. Specific barriers to learning about sexual health include concerns about confidentiality, shame when discussing sexual health, and the competing demands of resettlement.

Children living in vulnerable families

Many children living in single parent and blended families fare well, however some experience additional physical, social and emotional risk factors. Single parents are at significantly higher risk of financial problems, with a far higher proportion reporting that they struggle to provide the basic necessities including 25% who live below the poverty line.
Trends in the proportion of single-parent families in Australia show a marked growth in this family configuration over the past three decades, particularly in the number of women acting as the main parent responsible for both childrearing and income support with the proportion of single-parent families likely to continue to increase \(^\text{20}\). Single parent families and blended families report greater problems with bullying, depression, and other psychological problems, exposure to cigarettes, alcohol and other drugs, and exposure to domestic violence. Many such families are in need of parenting support services \(^\text{20, 27}\).

FIFO families (fly-in-fly-out) are another family type common to Western Australia at increased risk. The mining industry in Western Australia requires a large number of people to fly from their hometown to mine sites or other remote locations on a cyclical basis. While these jobs pay well, they require long shifts and separation from family and friends, often for weeks at a time. This lifestyle impacts not only on workers but also on families who are left without one parent on a regular basis. Both workers and their spouses are considered at risk of developing mental health problems. Fly-in Fly-out workers are also considered to be at risk of misusing drugs and alcohol \(^\text{51, 139}\).

**Children with disability or chronic illness**

Chronic conditions can disrupt the normal growth and development processes of children, either directly or indirectly, as a result of ongoing treatment. They can also affect the social and emotional development of children, for example through fear of stigmatisation, school absences or inability to participate in age-appropriate activities. Physical pain and suffering can also negatively affect future physical and emotional functioning \(^\text{3}\).

The 2011 Health and Wellbeing Surveillance System (HWSS) suggests that 8.4% of WA children age 0-15 experience some kind of disability or long term illness or pain \(^\text{4}\). The three main chronic conditions affecting Australian children are asthma, diabetes and cancer \(^\text{3}\) and are discussed briefly under ‘Children and young people want to be healthy’.

**What children and young people want and need to have a ‘good life’**

In the past, School Health Service policy has evolved in response to known causes of child morbidity, mortality and key behavioural risk factors. Whilst this is a credible approach, the revision of this School Health Service Rationale and future School Health Policy development will aim to improve in its capacity to also hear and respond to the needs and wants of it’s main client group – school children and their families.

The Australian Children and Wellbeing Project states that if policies to promote children’s wellbeing are to be implemented, then policy makers need to know how different groups of children understand and rate their own wellbeing \(^\text{15}\).

National and State advocates are urging policy makers, services and programs to consider the views of children and young people to better meet the needs of this important group of our community \(^\text{7, 9, 15}\). Two key documents have been used as a starting point to take a fresh look at School Health Policy and how we can shape policies better to deliver on the key issues that children see as most important to their wellbeing.
In 2009, the WA Commissioner for Children and Young People (CCYP) commissioned a consultation with 959 West Australian children, (with good representation from metropolitan, regional and remote areas), seeking their views on what was required for ‘wellbeing’⁹. The 2012 Report Card by the Australian Research Alliance for Children and Youth (ARACY) sought the views of over 3,700 children across Australia seeking their views on what was required for ‘a good life’⁷.

Many factors that contribute to feeling loved and safe, and having material basics have can be termed as the Social Determinants of Health which were founded by Sir Michael Marmot in the 1990’s. This body of research implies that more important than medical care which can treat or improve prognosis of certain diseases and poor health is the social and economic conditions that make people ill in the first place. The ten Social Determinants of Health include: social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food and transport.¹⁴⁵

Through the work undertaken by ARACY and CCYP, children and young people have instinctively and independently identified many of these social determinants that have a profound impact on their physical, mental and economic health now and in the future. They see them as criteria to ‘having a good life’.

The key themes required for wellbeing and a good life that emerged from these two consultation projects were very similar. The results are most succinctly summarised and represented by the following diagram included in the ARACY Report Card.

Areas and themes contributing to ‘a good life’

Source: ARACY’s 2012 Report Card: The Wellbeing of Young West Australians⁷"
Within the key themes identified by children, conventional key risk factors and health issues can still be incorporated in the development of school health service policy. The following section of this School Health Service Rationale will consider the priority health issues and risk factors for WA school aged children within the framework that children themselves nominated as their essential criteria for wellbeing and a good life. These are:

- Feeling loved and Safe
- Material basics
- Health
- Learning
- Participate

**Children and Young People want to feel LOVED AND SAFE**

*Being loved and safe embraces positive family relationships and connections with others, along with personal and community safety.*

*Children and youth who are loved and safe are confident, have a strong sense of self-identity, and have high self esteem. They form secure attachments, have pro-social peer connections, and positive adult role models or mentors are present in their life.*

*Children and youth who are loved and safe are resilient: they can withstand life challenges, and respond constructively to setbacks and unanticipated events*.

Key to the wellbeing of children and young people is their relationship with their families and peers. For most children and young people their family is the primary source of security, support and development. As children grow, peer relationships also become important sources of support and socialisation.

**Family**

WA children and young people rate their families as a critical factor to their wellbeing. In Mission Australia’s 2011 national survey of young people, 81.7 per cent of 11 to 14 year-olds and 72.5 per cent of 15 to 19 year-olds said they would seek out their parents for advice and support. This places enormous expectations on parents to feel confident and equipped, and free enough from their own life pressures to assist their child to navigate through life’s challenges. Further, family conflict was one of the top three responses given by Western Australian children and young people when asked what issues were of personal concern to them. A key issue is how we can better support families to undertake the demanding, challenging and yet very important role of parenting.
WA children live within a variety of common family structures, however the majority of West Australian children under 17 years live with their mum and dad (74%). Fifteen percent live with only one parent and 10% of children live in other family arrangements including step or blended families. Relationships within a family can have a profound impact on the emotional wellbeing of a child and play a large part in their sense of feeling loved and safe.

Being part of a supportive family has been found to be a key factor in positive resettlement for refugee youth. At the same time, intergenerational issues and loss of trust, discipline and attachment can pose a serious threat to the family unit, and thus the successful resettlement of families. Interestingly, refugee children and adolescents in Australia who have the most positive attitudes towards both their culture of origin and Australian culture have the highest ratings of self-worth and peer social acceptance.

**Child Protection**

Child abuse and neglect cannot be easily disentangled from issues such as poverty, homelessness, drug and alcohol addiction, domestic violence, mental health issues and social isolation.

There has been a significant increase in reporting to statutory child protection authorities across Australia over the past decade, however it is difficult to tell the real rate of child neglect or abuse in the Australian community. There is no reliable Australian information about the prevalence of abuse and neglect, and it is generally assumed that fewer cases are reported than are occurring. Increased reporting can reflect mandatory requirements, an increased awareness of signs of abuse, a greater willingness to report, wider definitions of abuse and neglect, or more worryingly, an actual increase in abuse rates. Sadly, from 2002 to 2007 Australian authorities found there was a 45% increase in the number of children who were or were likely to be harmed, abused or neglected, with the reports for Indigenous children being five times greater than other children.

In WA alone, 17,148 child protection notifications were made to the Department for Child Protection (DCP) during the financial year 2011-12, including over 2,000 reports of suspected child sexual abuse to the Mandatory Reporting Service. There was a 31% substantiation rate for cases investigated in WA with neglect, emotional abuse followed by sexual abuse as the three highest forms of substantiated cases. An average of 65% of children involved in the child protection system across Australia are younger than ten, and the largest portion of children admitted to care and protection orders are between one and four years of age.

Sadly, for some children are removed from their current living arrangements in order to protect them from a neglectful or physically or emotionally unsafe home environment. Whilst decisions are made in the best interest of these children, it is a great challenge to provide an environment and family life that fosters feelings of unconditional love and safety for these children.
Involvement with Justice System

Whilst there are multiple factors that can lead individuals to be involved in crime, children or young people’s involvement with the justice system can be an indicator of situations where children or young people have not felt sufficiently loved, important or respected within their families. Western Australia has the second highest State or Territory rate of youth detention in Australia; only the Northern Territory is higher. In 2008, the WA youth detention rate was 66.4 young people per 100,000, compared to the national average of 37.0 per 100,000 and 14.3 per 100,000 in Victoria.

DCP offer a Parent Support Service to parents whose children have been involved in antisocial behaviour, criminal activity or repeated truancy under the Parent Support and Responsibility Act 2008. This service can include up to 6 months of casework support working with the family. In 2011-12, there were 905 families in WA who received this service, with 94% of families reporting ‘positive’ or ‘some positive’ outcomes for the child. In 2012, DCP had 27 regional and 8 metropolitan offices offering this program in WA.

Parenting Quality

The importance of quality parenting is paramount in helping children learn to self-regulate behaviour, and the value of this can’t be overestimated in the prevention of obesity, conduct disorder, truancy, school disruption, unemployment, juvenile offending, teenage pregnancy, substance abuse and mental illness. Increasing parental knowledge of effective parenting strategies is likely to be more beneficial than simply increasing parent’s knowledge of child development processes and milestones.

The components to parenting have different levels of importance at different child development periods and accordingly, parenting interventions need to address these differences. Long term program effects have been demonstrated for interventions that are delivered during each developmental period.

Interventions targeting parents during infancy or toddlerhood teach parents to support their infant and toddler in achieving the developmental tasks of functional language, cognitive skills such as representational thinking, and basic self regulation skills such as sleep, following rules, focusing attention, and appropriately expressing emotion. The development of each of these skills creates demands on parents including engaging in warm and supportive interactions, cognitively stimulating their child and supporting their understanding of their environment.

Parenting through early childhood builds on skills learnt in infancy and toddlerhood with the addition of planning and problem solving and developing social competencies such as joint play with peers and development of empathy. Critical development tasks include adapting successfully to school and developing non-aggressive relationships with peers, are both common elements in parenting interventions targeting parents of children in this age bracket.
As children move into middle childhood (eight to twelve) they continue to refine skills previously learnt, with a focus on problem solving, social relationships, self-concept, self-regulation and social responsibility. Negative influences beyond the control of the family increasingly emerge such as bullying and violence. Relative to parenting at earlier ages, greater effort is directed to help children regulate their own behavior; greater monitoring of children’s behavior; more emphasis on helping children increase goal-directed behaviors, developing a sense of social responsibility and engaging in prosocial behavior; and greater attention to decreasing antisocial behavior.

Adolescence marks a period of sexual, mental, emotional and physical maturation, which in turn affects how youth see themselves and are seen by their parents and peers. Adolescents think more abstractly and hypothetically than they did when in middle childhood, and are developing an increased sense of autonomy and identity. Adolescents are increasingly influenced by peers and wider society, and are exposed to more opportunities for risky behavior. Despite the increasing salience of these influences outside the family and the challenges that the adolescent’s physical, social and cognitive changes present, adolescents continue to be greatly influenced by their parents. Adolescents with authoritative parents who balance appropriate levels of supervision, nurturance and democratic decision-making tend to achieve better psychosocial outcomes.

Findings indicate that, regardless of age, children of authoritative parents perform better in school, display fewer conduct problems and show better emotional adjustment than those raised in non-authoritative homes.

Effective parent-child relationships and good parenting are most often characterized as having high levels of monitoring and involvement, as well as being warm, accepting and nurturing, and support children in accomplishing normative developmental tasks.

WA Community Health Services (including School Health) and the WA Department of Education have a long standing commitment to delivering and supporting the Positive Parenting Program ‘Triple P’. The Review of Parenting Interventions in Australia commissioned by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) in 2012, declared the Triple P system (a multi level system including universal and targeted programs, with varying modes of delivery) as one of only two programs to have strong evidence at both Australian and international levels (the other being an American based program called Parent-Child Interaction Therapy).
Triple P has an overwhelming body of evidence gathered over many years. The Triple P programs model an authoritative parenting style, characterized as high in parental demand and parental responsiveness, that takes into account the changing needs of children through to adolescents. This style has been linked to wellbeing in areas of social competence, behaviour and academic performance across different family structures and across different ethnic groups. Research suggests that this quality parenting style has the potential to compensate for factors that have a deleterious impact on children, such as poverty and its associated risk factors. These findings suggest that coming from a lower socio-economic background or single parent family structure may elevate a child's risk for poorer social and emotional outcomes, however, processes within the family and child characteristics remain the key factors that are associated with children’s social and emotional outcomes.

Anglicare WA recently conducted a survey of West Australian parents which highlighted their most common parenting concerns as peer conflict and self esteem; family dysfunction; internet, technology and social influences; internal and external pressure for their child to succeed; and common concerns found in everyday life such as finding enough quality time to spend with children, setting boundaries, appropriate discipline methods, effective communication with their children.

The same survey found that among Western Australian parents of school aged children, only one fifth of parents feel they are coping very well and are not experiencing any particularly challenging issues leaving 4 fifths who are finding it a challenge to some degree. This highlights a gap in service provision and/or parental uptake of quality parenting programs.

The Department for Child Protection offers programs to support parents in greatest need and in 2012, 1379 families used the Department's Parent Support and the Best Beginnings programs to improve parenting capacity and family functioning. An additional 342 families benefited from multi-agency services through the Strong Families program.

Unfortunately it is not possible to report on the number of families accessing Triple P services in WA due to data limitations, however evidence suggests that this highly effective, evidenced based program program is only reaching a small percentage of WA parents.

Of the many psychological interventions that can promote the well-being of children, the prospect of quality evidence based parenting programs being readily accessible to all parents holds the greatest promise to produce a future generation of healthy, happy, and resilient children with the social and emotional life skills they need to contribute to the well being of our community. In order to reduce inequalities, it is recommended that parenting programs be delivered under a concept established by Michael Marmot describing proportional universalism, whereby programs must be offered universally, but with a scale of intensity that is proportionate to the level of disadvantage.
It stands to reason that Community and School Health Services have a critical role to play in ensuring that sufficient quality parenting support services are available and that parents who are likely to have the greatest need for these services are encouraged and supported to access them. Government spending should be directed towards services and programs known to produce positive results and equally important is a successful delivery or implementation system. Given the importance and lifelong impact of good parenting practices, the strong level of evidence of Triple P and the experience and long standing delivery models already established in WA there is good justification for WA School Health Services to seek further opportunities to support Triple P delivery in WA. Equipping parents with quality parenting skills is key to ensuring children have the opportunity to grow up feeling loved and safe, the number one criteria that children identified as important to them for having a ‘good life’.

**Friendships and connectedness**

Beyond the family, children’s friendships and relationships with others in their community is of great importance to their sense of feeling loved and safe. All children need to feel that their world is a safe place where people care about them, their needs for support, respect and friendship are met and they are able to get help to work out any problems. A sense of belonging has been shown to improve children’s ability to learn and increase their skills in developing relationships. When children feel included, they are able to develop a sense of pride in who they are, which helps build positive self esteem. It also helps them to appreciate and value differences in those around them. They are more motivated to learn and be more successful with their school work and develop health promoting and pro-social behaviours.

As children reach middle childhood, they place more and more importance on their friendships. In the 2011 National Survey of Young Australians, friends were the number one source of advice for almost all common issues experienced by young West Australian people.

In contrast to the positive ‘inclusive’ belonging where respect is given to everybody, ‘exclusive’ belonging where groups seek to maintain their sense of superiority by excluding those who don’t “fit” can be very harmful and damaging.

When many in a community feel positively connected with each other, a level of social capital in which trust and reciprocity predominate and there is a greater chance of defining and attaining shared goals. In school communities this goes well beyond the wearing of a school uniform and cheering on the sports team.
Research suggests that school connectedness has the potential to be built through two major mechanisms.  

1. Inclusive processes that involve all the different members who make up the community; the active participation of those community members and equal partnerships between them;  
2. Supportive structures (school policies, organizational structures and physical environment) that reflect the values of participation, democracy, and inclusiveness.  

Effective strategies most likely to support these mechanisms for enhancing student connectedness to school include:  

- Implementing high standards and expectations, and providing academic support to all students.  
- Applying fair and consistent disciplinary policies that are collectively agreed upon and fairly enforced.  
- Creating trusting relationships among students, teachers, staff, administrators, and families.  
- Hiring and supporting capable teachers skilled in content, teaching techniques, and classroom management to meet each learner’s needs.  
- Fostering high parent/family expectations for school performance and school completion.  
- Ensuring that every student feels close to at least one supportive adult at school.  

Reassuringly, the 2011 WA Health and Wellbeing Surveillance System (HWSS) found that over 86% of children 5-15 years looked forward to going to school either ‘often’ or ‘almost always’, which is a great reflection on the positive environment schools are providing to children, however it is worth noting there has been a gradual decline in the strength of children’s response to ‘almost always’ over the last decade with a swing to ‘often’ looking forward to school.

**Bullying**

Bullying is a form of aggression in which one or more children repeatedly and intentionally intimidate, harass, or physically harm a victim. Although bullying can take many forms, the key elements of this behaviour often include repetition of verbal aggression, humiliation, ostracism, physical harm, and destruction of property and within the context of a relationship with an imbalance of power.  

Unfortunately, some children have the negative experience of bullying at school or within the school peer context. Bullying can impact the physical, emotional, and social health of the children involved. Victims of bullying more often report sleep disturbances, enuresis, abdominal pain, headaches, and feeling sad than children who are not bullied. Additionally, children who bully also have significantly increased risk for depressive symptoms and suicidal ideation. Bullies and victims alike are at risk for psychiatric problems such as anxiety, depression, substance abuse, and suicide.
Over the last 3 years in WA, the concerns of children and young people regarding bullying have remained relatively constant with approximately 20% having a personal concern about bullying. Parents’ concerns about their child being bullied have gradually reduced over the last decade from 40% in 2002 to 31% in 2011, and similarly, fewer parents report their child as being the bully (13% in 2002 to 8.5% in 2011).

Whilst positive gains have been made in reducing bullying within WA schools, a recent rising trend has been noted for covert (or underground) bullying. Research has found that students who were covertly bullied, or who covertly bullied others, reported higher levels of loneliness at school, felt less safe at school and were more likely to experience difficulties such as emotional symptoms, conduct problems, inattention and peer relationship problems.

There is fairly consistent evidence that children’s bullying behaviour can be significantly reduced by well planned interventions. The chance of success is greater if the intervention incorporates a whole-school approach involving multiple disciplines and the whole school community. The school staffs commitment to implementing the intervention may also play a crucial role in an interventions success.

A program that has undergone rigorous and extensive testing is the Friendly Schools Plus program developed by the Child Health Promotion Research Centre, Edith Cowan University. The program aims to help schools to respond effectively to the social behaviour, strengths and needs of its students while supporting schools to review, plan, build capacity and implement critical evidence-based actions to effectively respond to these strengths and needs. It focuses on building the emotional intelligence of children and aims to teach children who use bullying as a way of gaining status, respect or friends, to achieve this in a healthier, more positive way. The targets of bullying are also given skills so that they can deal more effectively with bullying including techniques to help them discourage the behaviour. Ultimately the program aims to prevent bullying from happening, rather than intervening.

In 2011 a National Safe Schools Framework was launched within the Department of Education. The framework provides schools with a vision and a set of guiding principles that assist school communities to develop effective student safety and wellbeing policies. This vision includes creating learning environments that are free from bullying, harassment, aggression and violence.

**Cyber Bullying**

Cyber bullying is a relatively new form of bullying becoming more prevalent among young people with the increasing use of social media. It differs from the more traditional form of bullying in that a single ‘act’ (e.g. posting a photograph or hurtful comment online) may be viewed multiple times by multiple individuals, thus potentially heightening its impact on the victim.

The term ‘cyber-bullying’ has been used to describe a range of defined behaviours over the internet including: flaming, trolling, harassment, denigration, outing and trickery, exclusion and cyber stalking.
There is no single accurate measure of the prevalence of cyber-bullying in Australia, with estimates ranging from five percent to 21%. A survey of 2,027 11-12 year olds attending Western Australian Catholic schools found that almost 10% had been the victims of hurtful messages on the internet in the preceding school term\(^{141}\).

The American Academy of Pediatrics (AAP) has issued the following guidelines to paediatricians\(^{142}\) which are of relevance to School Health Service staff in their interactions with families and teaching staff:

1. Advise parents to talk to their children and adolescents about their online use and the specific issues that today’s online kids face.

2. Advise parents to work on their own participation gap in their homes by becoming better educated about the many technologies their youngsters are using.

3. Discuss with families the need for a family online-use plan that involves regular family meetings to discuss online topics and checks of privacy settings and online profiles for inappropriate posts. The emphasis should be on citizenship and healthy behaviour and not punitive action, unless truly warranted.

4. Discuss with parents the importance of supervising online activities via active participation and communication, as opposed to remote monitoring with a “net-nanny” program (software used to monitor the Internet in the absence of parents).
Children and young people want to have the MATERIAL BASICS

Children and youth who have material basics have access to the things they need to live a ‘normal life’. They live in adequate and stable housing, with adequate clothing, healthy food, and clean water, and the materials they need to participate in education and training pathways.

The absence of material basics can also be understood as living in poverty. Having material basics is important, because children who experience poverty early in life are at risk of ongoing disadvantage.

For young people, access to material basics supports them to make effective transitions to adulthood: they are able to secure housing and live independently, and receive an income that enables them to provide for themselves.7

The characteristics of children’s homes and family living arrangements, being a large part of their physical and social environment, have important influences on their development and wellbeing.

Children and young people living in families with inadequate income are at greater risk of poor health and educational outcomes in the short and long term. Low-income families are less likely to have sufficient economic resources to support a minimum standard of living. This can affect children and young people in the family through reduced provision of appropriate housing, heating, nutrition, medical care and technology 3.

Economic advantage, disadvantage and poverty

Children and young people from low-income families are at higher risk of psychological or social difficulties, behavioural problems, lower self-regulation and elevated physiological markers of stress. Research has revealed that a primary concern of children and young people in economically disadvantaged families is being excluded from activities that other children and young people appear to take for granted, and the embarrassment this can cause 14, 3.

Socio Economic Indices for Areas (or SEIFA), is an index used by the Australian Bureau of Statistics (ABS) to rank areas in Australia according to relative socio-economic advantage and disadvantage. The ABS defines relative socio-economic advantage and disadvantage in terms of people’s access to material and social resources, and their ability to participate in society 26.

In the 2011 Census, Western Australia recorded four of the top five most advantaged Local Government Areas (LGA) in Australia with Peppermint Grove ranked as the most advantaged LGA in the country. Nedlands, Cottesloe, Cambridge and Claremont followed as the second to fifth most advantaged LGAs in WA respectively 26. The most disadvantaged LGA in Western Australia was Halls Creek, followed by Ngaanyatjarraku, Menzies, Upper Gascoyne and Derby-West Kimberley.
When looking at Statistical Local Areas (SLA) within the greater Perth area, North Coogee was the most advantaged, followed by Iluka-Burns Beach, City Beach, Floreat and Cottesloe respectively \(^{26}\). The most disadvantaged SLAs in the greater Perth area were Mandurah followed by Balga, Mirrabooka, Armadale, Wungong, Brookdale and Girrawheen. \(^{26}\).

A conservative approach to determining the poverty line in Australia is set at 50% of the median (middle) disposable income for all Australian households. In the case of a single adult, in 2010, this poverty line was $358 per week, and for a couple with two children it was $752 a week. A report recently released by the Australian Council of Social Service (ACOSS), suggests that in 2010, one in eight people, including one in six children (approximately 575,000 children), were living at or below the poverty line. WA children fared slightly better than the national average with 12% of its children living below the poverty line. Lone parents face particularly poor financial situations with 25% living below the poverty line. The high poverty risk among children and lone parents reflects the higher costs facing families with children; costs which parents who are not in paid work or on a low wage often struggle to meet \(^{27}\). Single parent families are at particularly high risk of joblessness (42%) \(^{14}\).

Parental joblessness can lead to family stress, conflict and domestic violence, substance abuse and child abuse. A few children grow up never seeing either of their parents work, a cycle that is difficult to break for subsequent generations without intervention \(^{24}\). By contrast, parental employment is associated with higher levels of adolescent psychological wellbeing, sociability, satisfaction and happiness. In WA, couple families usually have at least one parent who is employed. Only 6% of families have both parents unemployed \(^{14}\).

**Internet access**

The level of access to the internet by young Australians is about middle of the road when compared to other OECD countries \(^{7}\); an issue that can only be considered as a problem in developed countries as young people have begun to consider the internet as one of life’s basic requirements. Young Australian’s access to the internet has increased over recent years from 76% in 2006 to 93% in 2012 \(^{7}\). Young people rank the internet highly as a source of advice and support for concerns about sexuality, the environment, discrimination, body image, depression and self harm \(^{18}\). It also serves as an important social platform and is often necessary in completion of school work. In the 2011 National Survey of Young Australians, when asked where they turn to for advice, the internet was the most commonly mentioned answer after friends and family, and appears to be developing as a very important source of advice for children and young people. The survey is conducted annually and the past four years have seen a strong increase in responses reporting similar results, especially for older young people (15 to 19 years) and males. However, the survey does not explore what types of resources or services are accessed \(^{14,18}\).
**Housing conditions**

Children, in particular, appear to be significantly affected by living in overcrowded households which can result in increased irritability, tension and aggression, and poorer educational attainment and mental adjustment.

The ABS considers the following when determining if a house is overcrowded or not; there is to be no more than two persons per bedroom; children less than 5 years of age and different sexes may reasonably share a bedroom; children less than 18 years of age and of the same sex may reasonably share a bedroom; single household members aged 18 years and over should have a separate bedroom.

In WA overcrowding is a serious issue for many Aboriginal families. An average of 31 per cent of Aboriginal children aged 14 years or less live in overcrowded homes. This can range from 19.1 per cent in major cities to 57.5 per cent in remote areas.

In 2010, around 8,400 children in WA were members of homeless families who sought support from service providers. Data shows that the rate of WA children under 18 years who are with a parent seeking housing support increased from 127 per 10,000 in 2006–07 to 158 per 10,000 in 2009–10. The instability and chaotic nature of homelessness can have profound effects on a child’s physical health, psychological development and academic achievement. Significantly, nearly 45 per cent of WA children from homeless families are aged zero to four years, meaning these children are at increased risk at a critical time in their development.

On any given night in Australia, 105,000 people are homeless and nearly half of these people are under the age of 25. The majority of young people who are experiencing homelessness fall under the category of secondary homelessness (often termed ‘couch surfing’). This is also referred to as ‘hidden homelessness.’ Young people from refugee backgrounds are 6-10 times more likely to be at risk of homelessness than Australian born young people.

The National Affordable Housing Agreement makes provisions for young people under ‘Homeless Youth – Accommodation Support and Outreach Services’ and to families under ‘Family – Accommodation and Support Services’. Prior to 2010, these services were known as the Supported Accommodation Assistance Program (SAAP). Often young people who are ‘couch surfing’ are not aware that they could be considered homeless and are therefore eligible for various support services. The report *Seen and Heard: Putting children on the homelessness agenda* by Mission Australia, recommends that a consistent and nationwide framework is required to address the needs of homeless children and should articulate how to prevent families and children from becoming homeless; intervene early to stabilise housing where it is precarious; and better support children and families once homeless.
Children and Young people want to be HEALTHY

Healthy children and youth have their physical, developmental, psychosocial and mental health needs met. They achieve their optimal developmental trajectories. They have access to services which support their optimum growth and development, and have access to preventative measures to redress any emerging health or developmental concerns.

Mental health is a key aspect of what it means to be healthy. Having good mental health is important for all age groups, including in infancy.

In addition to mental health, other risk factors and behaviours help define the picture of the health and wellbeing of children and youth. Preventing ill health and intervening early when illness emerges is important.

Childhood is a period of rapid development, during which time lifelong health behaviours are established. Health and development in childhood and adolescence is critical to positive outcomes for individuals and Australian society into the future. It has been well documented that schools play an important major role in determining a child’s health behaviours. There is also evidence indicating that a child’s health status and academic achievements are closely correlated.

There are currently nine National Health Priorities in Australia: mental health, diabetes, asthma, cardiovascular health, arthritis and musculoskeletal conditions, injury prevention, cancer control, obesity and dementia. Together they represent a large burden of disease, although a significant proportion can be attributed to known avoidable risk factors that can be targeted in childhood. Key reference documents also specifically name mental health, obesity, injury, asthma, diabetes, cancer, tobacco, alcohol and other drugs, sexual health and development delays as key indicators of children’s health.

Children named healthy eating, exercise and physical health; and self esteem, positive outlook and value as being the critical elements under the ‘healthy’ theme of a “good life”.

Mental health, Self Esteem and Happiness

In Australia, it is estimated that during their lifetime, one in five adults will experience serious disruption to their mental well being and more than one million people will have a psychiatric disorder. It is also important to note that among adults who reported a mental illness, more were daily smokers and/or consumed alcohol at high levels compared with statistics for the overall adult population.
Drawing on the most recent available population data (2003), mental health problems and disorders accounted for the second highest burden of disease among Australian children. In keeping with global figures, it is estimated that as many as 20% of Australian children aged from four to 17 will have experienced a significant mental health concern, with ADHD, anxiety and depression the common conditions. This figure equates to in excess of 500,000 individuals nationally. This may be a significant underestimation if the views of parents participating in the WA Health and Wellbeing Surveillance System (HWSS) are to be taken seriously.

Services to support good mental health and wellbeing in young people are underdeveloped in Australia in spite of the fact that it is well known that young people aged 16 to 24 years are particularly vulnerable to developing mental health problems. In Australia, young people in this age group have the highest prevalence of mental disorder of any population group, with more than a quarter (26%) experiencing a mental health problem each year, with an even higher rate in Western Australia (31%).

Mental health problems are the result of interactions between genetic biological vulnerabilities and environmental stress. Early childhood is a critical stage in the aetiology of mental health disorders. It is well documented that experiences in the early years shape the development of a young child’s brain and can have long lasting influences on levels of resilience and response to stress. Another crucial phase is adolescence, a time when some young people will experience the onset of a mental disorder.

Evidence shows that children living in one-parent, step/blended or low-income families are more vulnerable than other children to mental health problems. Other groups such as children in care, young people in juvenile detention, indigenous children and children of parents with a mental illness have higher rates of mental health problems. There are more young males than females with mental health problems.

The effect of mental illness can be severe for the individuals and families concerned, and the impacts are far-reaching for society as a whole. Immediate effects for children suffering from mental disorders may include; poor social and coping skills, reduced social interactions, low self-esteem and lower academic achievement. Young people with mental health issues are more likely to use and misuse drugs and alcohol and are at risk of dropping out of school and losing their job. Conflict with family and isolating themselves from friends and community activities that would usually foster wellbeing is common. Without appropriate support and successful intervention, young people with mental disorders are at high risk of future significant economic, social and emotional costs across all aspects of their life.

Mental illness comprises a wide spectrum of disorders with varying degrees of severity, including anxiety, depression, bipolar disorders and schizophrenia. In America in 2011, the leading mental health concerns experienced by children were Attention Deficit Hyperactivity Disorder (ADHD) followed by depression, behavioural or conduct problems, anxiety, substance use disorders and Autism Spectrum Disorders. Although there is no recent population based data, it is thought that together these mental health concerns similarly affect Australian children.
Depression is currently a leading cause of disability worldwide and the World Health Organisation has identified mental health in the early years as a key time period for intervention. It is well established that mental health status in childhood has a significant influence on whether or not an individual will develop a mental health problem later in life. In the past, people believed that children did not suffer from depression and teenagers with depression were often dismissed as being moody or difficult. More recently, it has been found that depression in early childhood does exist, and can be distinguished from other child psychopathologies\textsuperscript{67}. It has been suggested that preschool children with a depressive disorder exhibit negative emotional states, for example, sadness, irritability, somatic complaints and feelings of guilt that are resistant to change. Guilt and excessive fatigue are also highly specific to the diagnosis of preschool depression, and may present with other more commonly recognised symptoms such as sleep problems, weight changes, lack of enjoyment during pleasurable activities, psychomotor agitation and reduced cognitive performance\textsuperscript{67}.

Evidence suggests that children and adolescents with depression may show signs that are slightly different from the typical adult symptoms of depression. Children who are depressed may complain of feeling sick, refuse to go to school, cling to a parent or caregiver, or worry excessively that a parent may die. Older children and teens may sulk, get into trouble at school, be negative or grouchy, or feel misunderstood. Many of these behaviours occur across a spectrum and are also considered very normal in teens. Depressed teenagers with coexisting disorders such as substance abuse problems are less likely to respond to treatment for depression, however with either medication, psychotherapy, or combined treatment, most youth with depression can be effectively treated. Youth are more likely to respond to treatment if they receive it early in the course of their illness\textsuperscript{56}.

Anxiety is one of the most common psychological disorders in school aged children and adolescents. Anxiety can be a normal reaction to stress. It can help children deal with a tense situation, study harder for an exam or keep focused on an important task. In general, it can be a helpful coping mechanism, but when anxiety becomes an excessive, irrational dread of everyday situations, it becomes a disabling condition. Examples of anxiety disorders are obsessive compulsive disorder, post-traumatic stress disorder, social phobia, specific phobia, and generalized anxiety disorder. Symptoms of many of these disorders begin in childhood or adolescence\textsuperscript{56}.

Emotional and behavioural problems are terms commonly used to describe changes in thinking, mood or behaviour that are associated with distress or impaired functioning in children\textsuperscript{3}. In the WA HWSS, parents' perceptions are gathered on whether they feel their child has any trouble with emotions, concentration, behaviour or getting on with people. In 2011, approximately 30% of parents (of 1-15 year olds) felt their child did have an emotional or behavioural problem to some degree, and 22% of these parents felt they needed special help for these problems. In the same year, when asked how many parents had sought help for these problems, only 4% of children had received any treatment, highlighting a major deficit between those who felt they needed help and those who received it\textsuperscript{4}.
Other Western Australian data obtained from the Raine Study in 2008 and reported in the Inquiry into the Mental Health and Wellbeing of Children and Young People in Western Australia, reported that 11.5 per cent of children aged two years and 20 per cent of children aged five years had clinically significant behavioural problems, with more than six per cent of the children having clinically significant mental health problems at both ages. Only one quarter of children experiencing mental health difficulties receive professional support, and only half of those who have severe problems have access to mental health care.

Every year, nearly 15,000 children and young people up to 25 years are treated in WA community-based mental health services and specialist inpatient mental health services. The majority of adults who experience serious mental illness are first diagnosed in adolescence, many before the age of 15 years. Prevention and early intervention in infancy, early childhood, adolescence and youth has been shown to have the greatest impact on mental health outcomes. Recent reviews of WA Mental Health Services indicated that services for children and youth needed to be more accessible, youth-friendly, specialised and integrated. The WA Mental Health Commission is responding to these findings and has committed to enhancing mental health services for infants, children and youth in WA. Investing in early intervention and prevention is critical if the Government is to reduce the long-term costs associated with mental illness in the community.

To reduce the prevalence and impact of mental health problems across the whole population, it is essential to identify children and young people at an early stage in the developmental pathway of the disorder, and to provide prompt treatment. To be successful, early intervention programs must be comprehensive and use a coordinated approach involving the child or young person, their parents, peers and teachers. Effective early intervention can resolve mental health issues before they become worse or entrenched. This can make a significant difference in reducing behavioural problems and improving social-emotional health, therefore resulting in an increased quality of life for the child and their family and reducing future health and economic costs.

**Suicide**

The impact of suicide is devastating on families, friends and communities. People who die by suicide frequently experience undiagnosed, undertreated, or untreated mental health disorders, most commonly depression.

While youth suicide has declined in recent years, continued attention is required in this area. On average, 240 people (all ages) in WA take their own lives through suicide each year, well above the annual road toll of 191 people. It is estimated that for each suicide, 20-30 people harm themselves in suicide attempts. Young males aged 15–24 years in rural and remote areas, have recorded increased rates of suicide in recent years. A combination of harsh economic circumstances, social isolation, a culture of stoicism, lower levels of access to services and higher access to lethal means present distinct challenges to suicide prevention efforts in this young population.
Suicide among Aboriginal people is twice the rate of the rest of the Australian population and the suicide rate for Kimberley Aboriginal youth is one of the highest rates in the world. In May 2013, the Federal Government announced $17.8 million funding to target Aboriginal and Torres Strait Islander suicide in Australia, with a National Strategy to be developed including establishing a network of local suicide-prevention centres and a national co-ordination centre.

Research indicates that same-sex attracted young people may be up to six times more likely to attempt suicide than the general population, with young people in rural areas particularly at risk. Higher rates of suicide are also associated with transgender youth.

**Self harm**

For many young people self-harm is a coping strategy, however maladaptive and damaging, that allows them to continue to live rather than an attempt to end their life. Common reasons young people give for hurting themselves include: provides them with a sense of control; relieves tension, is a way of punishing themselves, or provides them with a feeling of being more alive. There is a distinct type of self-harming behaviour, termed non-suicidal self-injury (NSSI) in which the motivation is not intention to die.

Whilst self-harm is usually not intended to be fatal, it is however a risk factor for suicide. It is estimated that the number of young people who have engaged in self-harm is 40-100 times greater than those who have actually ended their lives. Girls are much more likely to non-fatally self-harm themselves than boys, however significantly more boys complete suicide. Australian hospital separations in 2011 report an intentional self-harm rate of 39 per 100,000 for children aged 10-14, with 82% of these cases being for girls. While reports indicate that self-harming behaviours among school-age populations have increased, a significant number of people who self-harm go unnoticed by the health system.

**Strategic response for children’s mental health**

The adequacy of mental health services to children and young people in Western Australia has recently received negative attention and scrutiny. The Inquiry into the mental health and wellbeing of children and young people in WA, conducted by the Commissioner for Children and Young People in 2010, found that services are only funded to provide for 20 per cent of the children and young people who required it. This means that four out of five children who required mental health services were unable to access them.

The young people consulted for the Inquiry placed great importance on the need for accessible, responsive, consistent services; being involved in planning their health services; and raising awareness of children and young people about their mental health and where they can go for help. In line with this, the WA Mental Health Commission as part of its Mental Health 2020 Strategy, has commenced planning a comprehensive youth mental health service for 16 to 24 year olds with various funding allocations for specific required services and health care pathways.
The Mental Health Commission funds a small range of school mental health initiatives. The Commission is encourages schools to consider the *Aussie Optimism* program as an evidence based mental illness prevention program that targets upper primary school children and young adolescents. Additionally, funding was provided to Mental Health Carers Arafmi WA Inc for the *Changing Minds School Education Program*, which aims to dispel the myths and misconceptions around mental illness and promote mental health and is presented by people with experience of mental illness.

Within the Youth stream of *Mental Health 2020*, specialist mental health services are encouraged to work closely with the Headspace centres across the state and build on a solid foundation of youth engagement in order to enhance help seeking behaviour. Emergency and crisis response services for young people will include early intervention, outreach services and youth-friendly emergency departments and inpatient facilities.

To have any significant impact on reducing the prevalence and consequence of child and adolescent mental health issues, it is vital to have in place effective prevention and early intervention programmes - early in the life course as well as in the course of illness. Ideally, this means universal implementation of interventions aimed at maximising early mental health, emotional wellbeing and resilience in children in order to prevent the development of a disorder in the first place.

Mental health intervention does not follow an age continuum. It is a common and erroneous assumption that young children need mental health promotion and prevention services while adolescents need early intervention and treatment services. In fact, the full range of interventions need to be available for all children and young people, as children and young people of any age can be positioned anywhere along the wellbeing continuum.

Childhood is a time of rapid development when key building blocks for lifelong health, development, learning and wellbeing are being set in place. Families have significant impact on child development. Children and families need financial security, supportive family, friends and communities and access to health, child care and other key services. The engagement of vulnerable infants, children and their families during the formative early years is imperative and is a high priority. Currently, many children and young people have to wait until symptoms are severe before they are able to access services – a situation that is not only counter-intuitive, but also contrary to the evidence on achieving optimum outcomes.

The provision of universal parenting support and education is highly effective in supporting positive mental health outcomes for both parents and children and the importance of quality parenting programs mentioned earlier in this document cannot be underestimated.
In the school setting

Within the school setting, mental health programs have varying success and it is likely that the implementation factors (school structure, administrative leadership, school norms and policies, and the existing resources at a school) are more critical to success than purely the content of the program \(^{65}\). Research into the health promoting school framework has made similar findings for programs addressing other child health topic areas \(^{85}\). Many depression and anxiety prevention and early intervention programs are successful when delivered under their developmental clinical trial conditions, however when adapting programs for widespread rollout in the ‘real world’ programs report varying success \(^{61, 62}\).

Anxiety programs appear to have positive effects if delivered by a classroom teacher, making them a cost effective intervention in the school environment \(^{61}\). Depression programs, when delivered by a mental health professional also have positive results, however their application was more limited and less sustainable due to the resources required to run them. Additionally, targeted early intervention depression programs appear to have an optimum length of 8-12 sessions, with reduced effectiveness noted in programs with longer or shorter length \(^{62}\).

Widespread delivery of mental health programs for school aged children seem to yield better results if a professional network is established enabling program deliverers to communicate with others also delivering the program in another location \(^{62, 65}\).

Programs with a strong cognitive behaviour therapy component often yield positive results, however lack of parent engagement, competing responsibilities, logistical barriers and lack of support from school administrators are key barriers that can limit the success of evidence based programs \(^{65}\).

Where School Health Service staff are involved in the planning and delivery of school based mental health programs, these barriers should be considered and solutions considered early in the planning phase. As School Health Service staff are often a visitor to a school, or in some locations, not viewed as a ‘school staff’ member, it is particularly important that good relationships are formed with school staff who are able to provide administrative support and also with Student Support Service staff who may be able to provide collegiate professional support. Additionally, school health service staff should seek to form a network with others also delivering the program in other locations to provide professional support to each other.

National programs addressing the mental health of children are being piloted and implemented through the KidsMAtter Early Childhood, KidsMatter Primary and MindMatters programs. These programs aim to identify and address mental health issues early in life and help children and families build resilience to mental health stressors.
**Happiness for children**

Of utmost importance in context of mental health discussions, is that ultimately, children want to be happy. In a report on Measuring Happiness by the Children’s Rights Director for England, children described Happiness as feeling pleasure or contentment; experiencing joy and achievement; feeling cool, calm and collected; feeling satisfied with themselves and their environment; being comfortable in their own skin; and being with people they love and want to be with. For young children, being looked after, being able to try out new things, play with toys and being given plenty of positive attention were thought to be critical elements to feelings of happiness. While teenagers indicated their happiness was related to having freedom and not being too restricted, being respected, being able to develop independently from their parents or carers, being able to make their own friendships and social life and being taken seriously as an individual rather than being seen as a stereotyped ‘teenager’

When asked how to cheer someone up who was unhappy, the responses from the children and young people involved in the Happiness consultation included:

- to be there for them and offer them your support;
- letting them know you care and are listening;
- give advice and support;
- talk to them and see if you can help;
- sharing a problem;
- smiling;
- giving a truthful opinion;
- giving them ‘a good old cuddle’;
- helping them forget something that is making them unhappy, and not keeping on asking someone if they are OK, but waiting for them to feel ready to talk to you.

School Health Service staff are often well equipped and experienced in providing this type of care and support, and highlights the invaluable opportunity that School Health Services have to contribute to the promotion and maintenance of children’s happiness throughout their school years.

**Overweight and Obesity**

Childhood obesity has been identified as one of the most serious public health challenges of the 21st century. In the United States (US) it has been predicted that, due to premature mortality associated with obesity developing at a younger age, the current generation of children will be the first in their country’s history to have a life expectancy lower than that of their parents. Additionally, at the 2006 International Congress on Obesity, it was announced that for the first time in history, the planet wide population of overweight, outnumbered the hungry.

Obesity develops from a sustained positive energy imbalance and a variety of genetic, behavioural, cultural, environmental and economic factors have been implicated in its development. The interplay of these factors is complex and has been the focus of considerable research.
Obesity is an important determinant of a range of chronic health disorders and unless the increasing prevalence of overweight and obesity is arrested it is projected that the burden of chronic disease in future generations will be pandemic and cause a crisis in health and economic systems across the world. In 2008, the Australian ACE report estimated the cost of obesity to be $8.283 billion per year in 2008. This is likely to be even higher today.

Obesity in childhood and adolescence is associated with a number of serious health consequences for physical and mental health, both in the short term (for the child or adolescent with obesity) and the long term (for the adult who had obesity as a child). Short-term complications of childhood obesity include type 2 diabetes, hypertension, hyperlipidaemia, accelerated growth and bone maturation and other orthopaedic disorders, polycystic ovaries, pancreatitis and fatty liver, sleep apnoea and respiratory problems. Obesity in childhood is also associated with several social-emotional problems including poor self-esteem, poorer cognitive development and lower educational attainment in some people, with increased risk of mental health problems in later life.

While overweight and obesity are widely distributed among Australian adults and children, significant variations in its distribution exist across the population.

Among aboriginal people, high body mass is the second highest contributor to disease burden after tobacco use. Overweight among young Aboriginal groups is even more concerning, as evidence suggests that the negative effects of overweight and obesity can occur at a relatively low BMI among Aboriginal children. High levels of early onset diabetes (in the child-bearing years) among Aboriginal women has also been shown to increase the risk of obesity and early onset type 2 diabetes in their children.

Socioeconomic disadvantage has a role to play in obesity rates with the rate of adult obesity in the areas of greatest disadvantage being double the adult obesity rates in areas with the least socioeconomic disadvantage.

Ethnicity is also a risk factor for overweight and obesity, seemingly over and above the effect of socioeconomic status, with boys and girls of Pacific Islander or Middle Eastern/Arabic backgrounds more likely to be obese. WA research indicates that children who speak a language other than English in their home have a slightly higher BMI.

Nationally, the prevalence of overweight and obesity in children aged 5-17 years increased from 21% in 1995 to 25% in 2007-08 and then remained relatively stable to 2011-12 (25.7%), with 17.7% overweight and 7.6% obese. Rates of obesity generally increase with age and the prevalence of overweight and obesity of adults has continued to rise. In 2011-12 there was a staggering 62.8% of the adult Australian population overweight. The 2008 CAPANS study indicated that approximately 23% of West Australian primary school children and secondary school boys were overweight or obese, with 16% of secondary school girls overweight or obese (a drop from 23% in 2003). However the study authors recommend interpretation of these results with caution due to study sampling limitations.
In 2011, 19% of Western Australian children aged 5–15 were classified as overweight or obese (based on crude measures undertaken by parents and then converted to BMI). At the other end of the scale, 5% were underweight. In combination with other psychological and medical indicators, underweight can be a serious concern, however the vast majority of weight related harm is caused by overweight.

Interestingly, the WA Health and Wellbeing Surveillance Study (HWSS) also seeks parent’s perceptions of their child’s weight. In 2011, only 7.6% and 0.2% of WA parents thought their 5-9 year old was overweight or very overweight respectively, and only 12% thought their 10-15 year old was overweight with no parents thinking their 10-15 year old child was very overweight. Furthermore, 12% of parents of 5-9 year olds and 13.4% of parents of 10-15 year olds thought their child was underweight. This data is in contrast to the high rates previously mentioned sourced from reliable population studies and supports the anecdotal evidence often discussed among Community School Health Policy and Clinical staff of parents’ inaccurate perceptions of healthy child weight. Among this same group of parents, seven percent were trying to help their child lose weight, nine percent were trying to help their child gain weight, 19.2% wanted their child to stay the same weight and 64.8% were not trying to do anything about their child’s weight. This highlights the need for further work in the area of raising parents’ awareness of the physical presentation of healthy weight versus overweight and obese. It is also a salient point for consideration in the debate of universal BMI screening of school aged children.

**Screening**

There is often a great deal of pressure on policy makers and health services to introduce universal screening for overweight. A major benefit for a universal screening program is that due to changing social norms it is no longer reliable to visually assess or speculate on the weight status of a child. However, the NHMRC has well defined protocols that need to be met before a universal screening program is introduced. Whilst the NHMRC considers BMI percentile charts an acceptable screening tool for children, the remaining standards for universal screening are not yet fully met due to insufficient research evidence on benefits, cost effectiveness, and lack of suitable widely accessible interventions to offer once a child is identified as overweight. Encouragingly, there is a growing evidence base for interventions that do have promising results for overweight children and their families, however the evidence is not yet strong enough to justify universal screening.

The NHMRC does however recommend that GPs conduct a BMI assessment of their child patients every year, an approach similarly followed by the US. Additionally, in 2008, Targeted Weight Assessment Guidelines were introduced within the School Health Service Policy to encourage staff to conduct BMI and lifestyle assessments with children and families when a concern was expressed by a student, parent or teacher. This approach requires parents to be willing to accept the School Health Nurse’s clinical assessment and be ready to engage and follow through with the recommendations made.
While Australia is largely directed by the NHMRC for analysis of the cost-benefit-effectiveness and appropriateness of screening programs, America is guided by the US Preventive Services Taskforce (USPSTF) which has recently agreed there is adequate evidence that multi-component, moderate- to high-intensity behavioural interventions for obese children and adolescents aged 6 years and older can effectively yield short-term (up to 12 months) improvements in weight status. Given this and the low level risk of harm, the USPSTF recommended that for children over 6 years of age, clinicians should screen for obesity using BMI and provide them or refer them to comprehensive moderate to high intensity behavioural interventions to promote improvement in weight \textsuperscript{44, 77, 81}.

**Healthy Eating**

Most of the burden of disease due to poor nutrition in Australia is associated with excess intake of energy-dense and relatively nutrient-poor foods high in energy, saturated fat, added or refined sugars or salt, and/or inadequate intake of nutrient-dense foods, including vegetables, fruit and wholegrain cereals \textsuperscript{46}.

Nutrition and physical activity are two of the most important factors for developing and maintaining healthy weight and good health in general for children. Healthy eating advice for children and adolescents is routinely centred around the National Dietary Guidelines \textsuperscript{46} and include: enjoy a wide variety of nutritious foods from the five groups every day; drink plenty of water; limit intake of foods containing saturated fat, added salt, added sugars and alcohol; and encourage, support and promote breastfeeding. The guidelines also recommend children to be physically active every day and for their growth to be checked regularly\textsuperscript{46}.

Comparison of the 1995 National Nutrition Survey and the 2007 Australian National Children’s Nutrition and Physical Activity Survey revealed that, overall, reported dietary intake improved from 1995 to 2007 among Australian children, with an increase in the amounts of core foods consumed and healthier types of foods being chosen \textsuperscript{45}.

The Western Australian Child and Adolescent Physical Activity and Nutrition survey (CAPANS) was first completed in 2003 and most recently conducted in 2008. The survey gathers information on physical activity participation, dietary intake and body measurements from randomly selected WA schools, however student participation in the survey within these schools is voluntary\textsuperscript{50}. In 2008 CAPANS reported, two in five WA primary school students and one-quarter of secondary school students usually consumed the minimum recommended amount of vegetables. Since 2003, there has been an increase in the proportion of secondary school students meeting the recommended intake of vegetables. This was statistically significant in secondary school girls, increasing from 18 to 24 percent. \textsuperscript{50}

Overall, at least 3 in 5 primary school students, but only one-quarter of secondary school students reported they usually consume the minimum recommended amount of fruit, reflecting improvements in all children except secondary school boys since 2003 \textsuperscript{50}. 
A vast majority (80-90%) of girls and boys in primary school eat breakfast every day, with the number reducing in high school (72% boys and 62% girls). This also is a significant improvement since 2003.

More recently the WA Health and Wellbeing Surveillance System (HWSS) found nearly 70% of WA children aged 4–15 consumed their recommended daily intake of fruit in 2011, but only half (50%) met their recommended daily intake of vegetables. Older children were less likely to meet recommended daily requirements than younger children.

**Physical Activity**

Physical inactivity accounted for 6.6% of the burden of disease in Australia in 2003. Substantial population health gains are possible when the community adopts more regular moderate physical activity, with the greatest health benefit found among those moving from no activity to low levels of activity. Benefits have been described for all age groups and physically active children are more likely to remain physically active throughout adolescence and into adulthood.

Physical activity has a number of physical benefits that can have immediate and long term positive impacts on physical and mental health. It also helps improve self-esteem, self-image and quality of life.

National recommendations for school aged children state that children need at least 60 minutes (and up to several hours) of moderate to vigorous physical activity every day. Children typically accumulate activity in intermittent bursts ranging from a few seconds to several minutes, so any sort of active play will usually include some vigorous activity. Most importantly, kids need the opportunity to participate in a variety of fun activities that suit their interests, skills and abilities. Variety will also offer children a range of health benefits, experiences and challenges.

An equally important component of the National guidelines relates to reducing sedentary activity, with recommendations stating children shouldn’t spend more than 2 hours a day using electronic media for entertainment (e.g. computer games, TV, internet), particularly during daylight hours.

Recent reports suggest that almost 50% of WA children aged 5–15 were sufficiently active; 50% of children were insufficiently active; and a small percent of children did not engage in any physical activity at all. As children get older their level of intensity and duration of activity declines, and generally boys are much more likely to achieve sufficient activity levels than girls.

According to the WA Health and Wellbeing Surveillance System (HWSS), in 2011, approximately 40% of WA children aged 5–15 spent on average, two or more hours a day on sedentary pursuits (watching television, videos or using a computer). Boys were less likely to be sedentary in 2011 than in previous years, but there was no change in girls’ sedentary behaviour. The 2008 CAPANS results however paint a much gloomier picture suggesting that more than 70% of all children and up to 83% of secondary girls participated in more than the recommended daily 2 hours of screen based recreation.
The available WA data when compared with available National data would suggest that WA children are performing below national average for physical and sedentary activity goals as the 2007 National Children’s Nutrition and Physical Activity Survey found that 69% of Australian children were likely to meet the physical activity guidelines on any given day. Underweight and obese children tended to have lower physical activity levels than children of a healthy weight 46, 47, 50.

For children, screen-based forms of entertainment and socialising via internet and mobile phone, in combination with negative parental perceptions of neighbourhood safety, may have contributed to less active lifestyles 71.

**Childhood Obesity Prevention**

Prevention of childhood obesity is an international public health priority given the significant impact of obesity on acute and chronic diseases, general health, development and well-being. The international evidence base for strategies that governments, communities and families can implement to prevent obesity, and promote health, has been accumulating and improving, but still remains unclear 75.

There are many short-term, behavioural, school-based obesity prevention interventions that have been trialled and shown to be effective, however after meta-analysis of these programs, there is still no clear evidence on which intervention components are most effective and what is cost effective and affordable. 75 Reassuringly however, even if BMI changes are not achieved in programs, the research indicates that obesity prevention programs appear to do no harm, that is they do not increase body image concerns, unhealthy dieting practices, level of underweight, or unhealthy attitudes to weight, and that all children can benefit 75, 76, 77.

Whilst many programs are developed with a focus as either prevention or targeted intervention for childhood obesity, there are enormous synergies between what we know to be effective for both goals. Whilst difficult to capture in evaluation, it is clear that strategies to prevent unnecessary weight gain, also help to treat obesity and also promote health to children in general 76, 77. However with regard to evaluation, the demonstration of weight loss among overweight children is more easily attainable than demonstrating the prevention of weight gain 76.

Whilst there is insufficient evidence to determine that any one particular program could prevent obesity in children, the evidence does suggest that comprehensive strategies to increase the healthiness of children’s diets and their physical activity levels, coupled with psycho-social support and environmental change are most promising 75.

School based interventions with most success have been targeted to children 6-12 years and usually include a selection of the following strategies 75,

- School curriculum that includes healthy eating, physical activity and body image;
- Increased sessions for physical activity and the development of fundamental movement skills throughout the school week. (The availability of non-competitive activities such as dance has shown to be particularly effective for girls.);
- Improvements in nutritional quality of the food supply in schools;
Environments and cultural practices that support children eating healthier foods and being active throughout each day;
- Support for teachers and other staff to implement health promotion strategies and activities (e.g. professional development, capacity building activities);
- Parent support and home activities that encourage children to be more active, eat more nutritious foods and spend less time in screen based activities.

Additionally, training in behavioural techniques (including self-monitoring, goal setting etc) or coping skills (decreasing irrational thoughts, improving self-talk etc), and tailoring programs for cultural relevance appear important in many programs.

A comprehensive school-based physical activity program includes daily Health and Physical Education lessons, recess, and other physical activity breaks; school and interschool carnivals, physical activity clubs; and walk- and bicycle-to school initiatives.

Reviews of school based interventions suggest that pragmatic tailoring of programs may have merit, for example girls are likely to benefit from programs based on social learning theory, and boys are more likely to benefit from environmental reforms that facilitate physical activity. Girls and children (as compared to boys and adolescents) appear to benefit more from the current selection of school based interventions.

No matter how well considered, a single intervention can’t be expected to oppose the current obesogenic flood tide. A common theme throughout reviews of childhood obesity prevention programs is not have too grand an expectation of any isolated intervention, or we may overlook its success as failure. It is important to evaluate programs realistically for the potential contributions they may make as parts of a strategic whole.

Public opinion in WA supports stronger restrictions on advertising and promotion of unhealthy food and drink which is directed at children, including television advertising, sponsorship of children’s sporting activities, and advertising in children’s magazines and on the internet.

Whilst usually out of scope for school health service staff, opportunities for advocacy may also arise to improve other critical settings linked to obesity prevention such as improving access to outdoor recreation facilities, enhancing infrastructure for bicycling and walking, locating schools within easy walking distance, improving public transportation and zoning land for mixed use, changes in food retail venues such as farmers markets and community gardens.

Targeted intervention for overweight children

Targeted weight management programs for children are those that aim to improve weight related measures or reduce BMI of the overweight child (and not necessarily to reduce weight). Effective comprehensive weight-management programs incorporate counselling and other strategies that target diet and physical activity. Behavioural management techniques are also commonly used to assist in behaviour change and interventions that focus on younger children need to incorporate parental involvement as a component.
There is accumulating evidence that moderate- to high-intensity programs, which typically involve more than 25 hours of contact with the child and/or the family over a 6-month period achieve the most promising results. Low intensity programs, typically less than 25 contact hours over a 6-month period, generally do not result in significant improvement in weight status 44, 78, 81 (although these programs may have benefits in the prevention context).

While currently the US and Australian guidelines recommend that GPs conduct a BMI assessment on children annually, given the time requirement, it is unlikely, that GPs in a primary care setting are able to continue to effectively follow through with a moderate- to high-intensity intervention for children identified as overweight. Instead it is recommended that these children can be referred from primary care to these programs 44, 45. WA Community Health Settings are option well worth considering if adequate resourcing were available.

As parental overweight or obesity is associated with increased risk of overweight or obesity in children, a family-focused approach to weight management is beneficial 45, 46 and when in combination with nutrition and physical activity, family based interventions have produced significant weight reductions 76, 77, 81. Research also suggests that obesity interventions in the home environment that focus exclusively on parents are effective 77.

Within the home, in addition to limiting screen time, encouraging portion control, healthy meals and avoiding sweetened beverages, there is also promising evidence that supports authoritative parenting practices to prevent childhood obesity 77.

Multi-component family based interventions that include behavioural and education strategies such as behavioural counselling, promotion of physical activity, parent training/modelling, dietary counselling, and nutrition education are successful in helping children between the ages of 5 and 12. Specific programs that have been explored for use in WA and have good evidence behind them include Lifestyle Triple P and the MEND Program. Several programs of Lifestyle Triple P were delivered under pilot conditions throughout WA from 2009 through to 2011 with positive changes in BMI, behaviour and parenting practices identified at post program and 6 month follow up 80. Fiscal restraints have limited the ongoing delivery of Lifestyle Triple P in the WA Community Health Setting, however resource opportunities will continue to be explored.

Researchers suggest that more studies are needed that address weight management in minority children and adolescents, behavioural interventions in younger children (0-5 years), and behavioural interventions in children who are overweight but not obese 44.

While interventions targeting childhood obesity are delivering more positive results, they represent only some of the factors that are important in tackling childhood obesity and should be considered as part of a suite of interventions including population and targeted measures with action across a range of areas that may include advertising, obesogenic environments and government and school policy 75.
Obesity trends will not change noticeably until the aggregation of obesity control strategies is commensurate with and opposite to the aggregation of obesogenic elements in modern society. To ensure reward is given to the small positive changes made, good obesity prevention and intervention programs should focus on immediate outcomes such as changes in attitudes, knowledge, dietary patterns, or activity levels as early measures of success in obesity control. Activity needs to be across many settings (school, health care, home and community) and through multiple mediums (education, social support, policy, systems, and environmental change) for an effective change in the prevalence of obesity in a population.

**Sexual health**

Sexual development is a normal part of adolescence and involves a complex interaction of one’s physiology, sexual and gender identity, gender role behaviour, relationship experience and other influences such as culture. Negotiating the development of these factors can sometimes be difficult for young people. Generally, adolescents do not experience major difficulties during the normal stages of sexuality development; however, some problems may be experienced that have the potential for far reaching consequences. Some of the main issues experienced during adolescence relate to unplanned pregnancy, sexually transmitted infections (STIs), relationship difficulties, sexual exploitation and confusion about sexual identity and orientation.

Sexual activity is commencing at a younger age in Australia. In 2008, a national survey of Year 10 and 12 students indicated that 78% of students had at least one sexual experience and of the Year 12 students, the majority had experienced sexual intercourse. Furthermore, young people are disproportionately affected by STIs, particularly Chlamydia and Gonorrhoea. For example, in 2012 the Chlamydial notification rate for all Australians aged between 15 and 19 years was 1405.1 per 100 000 population; and this rate has more than tripled in the last decade. Currently, Western Australian youth have a higher than average notification rate for Chlamydia. All STIs can have serious health consequences if left untreated, as well as increasing the vulnerability of contracting Human Immunodeficiency Virus (HIV).

Aboriginal youth have a higher incidence of STIs as compared to their non-Aboriginal counterparts. In 2012, the notification rate of Chlamydia for Aboriginal youth, aged between 15 and 19 years, was 8310.5 per 100 000 population; this rate is five times greater than non-Aboriginal youth. Furthermore, Aboriginal youth aged between 10 and 14 years had a Chlamydial notification rate 46 times greater than non-Aboriginals of the same age. High levels of substance abuse, poor skills for safe sex negotiation and lower health literacy all contribute to the higher frequency of STIs in Aboriginal teenagers.
Aboriginal women generally have their babies at a younger age, with 19% of babies born to Aboriginal teenagers as compared to 3.8% of babies born to all teenage mothers\textsuperscript{122}. This translates to a birth rate almost five times that of non-Aboriginal teenage women. However, as of 2011, the birth rate for all Australian women aged between 15 and 19 years has not increased significantly, with rates remaining at an average of 15 births per 1000 women\textsuperscript{123}. The abortion rate for Aboriginal teenagers was lower than non-Aboriginal teenagers; nevertheless, in 2009 almost 20% of all abortions were performed on teenage women\textsuperscript{124}. Teenage pregnancy and childbirth is an important adolescent health issue in Australia due to its association with detrimental physical consequences and long-term negative psychosocial, education and economic outcomes for both mother and child.

Another group of young people who require specific attention are same sex attracted and gender questioning (SSAGQ) youth. These young people often initiate activity at a younger age and experience higher STI and pregnancy rates than heterosexual youth of a similar age. Additionally, SSAGQ youth are subject to high levels of homophobic abuse. In 2010, a national study of SSAGQ youth, aged between 14 and 21 years, indicated that 61% had been the victims of homophobic verbal abuse and 18% homophobic physical abuse; and 80% of this abuse occurred in a school setting. There are strong links between homophobic abuse and poor mental health, thus highlighting the importance for all inclusive and relevant sexuality education and service provision together with bullying prevention programs. This notion is supported by recent Australian research which indicated that the majority of SSAQG youth felt excluded from school based sexuality education; furthermore, the education provided was not relevant to their lived experience\textsuperscript{126}.

In 2009, the United Nations Educational, Scientific and Cultural Organization (UNESCO) conducted an extensive review of 87 evidence-based sexuality programs and consequently recommended a multifaceted and comprehensive approach to sexuality education. This approach incorporates key learning objectives that are delivered at a developmentally appropriate age, starting from the age of five years. The learning objectives assist young peoples’ skills and knowledge on sexual diversity, relationships, human development, sexual health, and help-seeking behaviour. Additionally, comprehensive sexuality education needs to be delivered sequentially and be ongoing, be culturally sensitive, have strong leadership commitments by principal directors, as well as be delivered by capable and trained teachers and health educators. Sexuality education delivered under these guidelines have been shown to delay the onset of sexual activity, reduce sexual risk-taking behaviour, increase sexual health knowledge and assist the formation of positive social and emotional wellbeing. All of these contribute to a reduction in teenage pregnancy and abortion rates, STI acquisition, as well as the incidence of sexual coercion and exploitation\textsuperscript{127}. The WA Growing and Developing Healthy Relationships follows these criteria and has been well received in many WA schools.
School based sexuality education in Australia is often delivered on an ad hoc basis, however, a national curriculum for sexuality education is currently being developed, and is due to be completed by the end of 2013. When young Australians were asked about the quality and scope of school based sexuality education, the majority felt that it was inadequate. Specifically, they would like to receive more information on sexual pleasure, relationships, service access and sexuality, as well as preferring the use of external health and peer educators when talking about certain topics. Reasons such as little priority being placed on sexual health topics, a lack of time and resources, limited training for teachers and no standards or consistency of delivery have contributed to inadequate sexual health education in Australia. Given that young people are experts in their own experience, their thoughts and opinions should be highly valued in the development and implementation of sexual health policy, education and promotion.

Young Australians access sexual health information from a variety of sources, such as family, friends, youth centres, school and the internet; therefore, a range of health promotion strategies should be used to complement school-based education such as internet support services and support for parents. For example, the ‘Hormone Factory’ and ‘Free 2 Be’ websites are specifically designed for children and adolescents, and provide advice and support for a variety of sexual health issues. Aside from these services, external programs, such as the Aboriginal specific ‘Mooditj’ and ‘Youth Educating Peer’ projects, provide targeted support to school based sexuality education in Western Australia.

All young people require ready access to services if problems arise which require support from health professionals. However, young people face additional barriers that hinder their access to sexual health services, such as confidentiality and privacy concerns. Research has shown that young people are highly concerned about being identified if they enter a health clinic and that their reasons for visiting will be disclosed; thus, deterring them from seeking help. Additional barriers, such as limited transport options, limited availability of sexual health professionals, and cost, all make access to sexual health services and treatment of STIs difficult for young people. These factors are compounded for youth who live in rural and remote areas, and Aboriginal and SSAGQ youth. Health professionals need to be considerate of all these factors when educating and treating children and adolescents’ sexual health issues. In particular, health professionals need to be able to communicate effectively with adolescents in an empathetic and supportive manner. In view of all of the above, it is important to provide young people with accurate information, resources and support so they can have positive, healthy sexual and reproductive experiences, which contribute to future adult sexual health and wellbeing.
Tobacco, alcohol and other drugs

Adolescence is a phase when young people may begin to experiment with alcohol and other drugs. Evidence shows that the use of alcohol and other substances in adolescence can have long and short term affects. Consequences in the short term include risks to personal safety such as intentional and unintentional injuries to self and others; psychosis and reckless behaviour; physical ill-health such as poisoning or overdose, withdrawal symptoms and seizures; and social challenges such as unwanted pregnancy and relationship problems. Prolonged use of alcohol and/or other substances can lead to physical ill-health such as cancers, stroke, liver and heart disease; mental health disorders such as cognitive deficits and mood disorders; legal issues, financial stress and work problems; and family conflicts such as impaired parenting skills, child abuse and neglect.

There are known risk and protective factors for adolescent use of alcohol and other drugs (AOD). Risk include:

• early years factors such as maternal smoking and alcohol use, social disadvantage, family breakdown and child abuse and neglect
• school age factors such as early school failure, child conduct disorder, aggression and favourable parental attitudes to drug use
• adolescent factors such as low involvement in activities with adults, discrepancy between perceived and actual level of community drug use, availability of drugs, parent–adolescent conflict, parental AOD problems, poor family management, school failure, deviant peer associations, delinquency and favourable attitudes towards drugs 107.

At the other end of the spectrum, social and emotional competence, easy going/shy/cautious temperaments, positive family connectedness, parental harmony and religious involvement all seem to be protective factors against misuse of AOD among young people 107.

The evidence suggests that well-conducted prevention programs in primary schools may be among the best investments for addressing the development of harmful drug use and in secondary schools programs can serve to prevent as well as harm minimise drug use among young people. Further the outcomes from these programs may also be relevant to a range of related prevention priorities, including crime, violence and mental health 108.

Drug education programs based on social learning principles have consistently shown positive short-term effects on both intentions and behaviours including: reducing antisocial behaviour, affiliation with deviant peers and school behaviour problems; and increasing academic performance and commitment to schooling. In general, the effects of these interventions diminish and even disappear by late secondary school unless supplemented by additional program input or supplementary strategies at critical points of developmental transition. Supplementary strategies that include a parenting component and reinforcement of social messages at the broader community level seem to strengthen the effects of social influence school-based programs 108.
A good relationship with parents is particularly important as a buffer against the development of problems and the emotional support provided by such a relationship can also reverse the course of negative peer influences once problems have begun to develop\textsuperscript{107}. Several recent studies have reported that positive parenting practices in the early years as well as in adolescence, combined with positive parent-teen relationship factors reduce likelihood of adolescents forming friendships with substance using peers. This provides significant indirect protective effects on adolescent smoking and other drug use and as such programs that facilitate parents to develop protective parenting practices are likely to have positive impacts on youth tobacco and other drug use\textsuperscript{105, 108}.

Community drug education and peer education interventions have been popular in the past, however these programs have not been well evaluated and some evidence even indicates that in some applications they have the potential to exacerbate problems\textsuperscript{108}.

For adolescents with a high number of risk factors, \textit{targeted intensive interventions} that include family based strategies and preventive case management seem to be promising in preventing the harms associated with illicit drug use\textsuperscript{108}.

Despite few studies testing the impact of health services on early interventions for drug use by adolescents and young people, there is great potential for health services to make an important contribution\textsuperscript{108}. Programs that build relationships with young people at a time in their lives when they can both need help, but find it difficult to reach out are well worth considering. By building relationships between adolescents and health professionals it is likely to encourage young people to seek help when they need it for the many issues they face\textsuperscript{108}. The Centre for Adolescent Health (Victoria) has aimed to increase school students’ help-seeking skills and behaviour by developing the ‘Help 4 U’ program (an evolution of the Health Access Workshop) in collaboration with a Medicare Local and is delivered in partnership by local GPs, school nurses and school staff\textsuperscript{108, 109}.

Health service reorientation appears a promising intervention strategy. There is now reasonable evidence that a variety of strategies can be used to improve the accessibility and effectiveness of existing health services relevant to young people. Ensuring existing services maintain a prevention focus and utilise effective methods of engagement would appear a fundamental step in the process of tackling drug issues\textsuperscript{108}.

\textit{Rates of Tobacco, Alcohol and other drug use among WA adolescents}

The Australian Secondary Students’ Alcohol and Drug survey (ASSAD) has been conducted every three years since 1984 with the latest 2011 survey marking the 10\textsuperscript{th} in the series. The survey seeks information from 12 to 17 year olds on their previous or current use of tobacco, alcohol, analgesics, tranquilisers and illicit substances and related behaviour and is the leading national survey on alcohol and other drug use amongst secondary school students.

Just under 25,000 students participated in the survey nationally in 2011, including 3,371 West Australian students (including 600 from regional WA).\textsuperscript{104}
Tobacco

Tobacco smoking remains the leading cause of preventable drug-related death and disease in Australia. It is the risk factor associated with the greatest disease burden in Australia, causing damage to nearly every organ in the body, and results in considerable ill health. Most tobacco smokers take up smoking in adolescence. Adolescent tobacco use is associated with a range of other social and health problems in early adulthood, such as continued smoking, mental health and sleep problems, problematic alcohol use, and poor academic performance. Preventing the uptake of smoking among young people remains a high-priority public health issue.

In 2011, 22.6% of school students had tried cigarettes at least once in their life, 14.7% had smoked in the last year, 7.5% in the last month and 5.7% in the last week. Significantly fewer students reported ever smoking in 2011 (22.6%) compared to 2008 (25.8%) which continued a trend found in previous years, however the proportions smoking in the last year, month and week remained stable between 2008 and 2011. Overall, adolescent smoking prevalence has dropped by nearly two thirds the rate that was recorded in 1993.

As may be expected, the prevalence of smoking increases with age. Encouragingly, at 12 years of age, less than 1% of West Australian students had smoked in the last year and none had smoked in the last month or week. By 17 years of age, almost one-third had smoked in the last year (30.8%), 16.5% had smoked in the last month, and 13.8% had smoked in the last week. More students from non-metropolitan areas had ever tried smoking compared to students from metropolitan areas in 2011 (30.7% and 21.4% respectively).

Adolescents are particularly susceptible to social influences given their developmental stage and the importance of school and peer groups in adolescent life and the notion of social influence on smoking and other substance use has long been discussed. Further research is warranted to tease out whether socialisation (influence of existing friends) or peer selection (selection of friends with similar interests and beliefs) carries the greatest degree of influence on an adolescent’s choices to smoke, drink alcohol or use other drugs, however it is certainly of concern that 38.7% of students aged 12 to 17 years thought their peers smoked last week but only 5.7% actually did. This discrepancy was highest amongst 14 year olds (40.7% vs. 5.5%) and lowest amongst 16 year olds (38.6% vs. 9.0%).

Not only is peer influence great on the adolescents’ choice to smoke or not, but friends were the most common source of cigarettes for those who smoked (46.4%) with one in five adolescents buying single cigarettes that were not in a full packet.

Smoking prevention and harm minimisation programmes in schools have evolved over four decades and include those providing information about smoking rates and harms from smoking; teaching children how to be more socially competent to avoid starting smoking; teaching skills to refuse offered tobacco and multimodal programmes with parents, teachers, and the community.
A recent Cochrane review found that the positive impacts of school based smoking prevention programs were not usually recorded until at least a year after delivery. Programmes that used a social competence approach and those that combined a social competence with a social influence approach were found to be more effective than other programmes. Only programs which taught young people to be socially competent and to resist social influences had immediate short term effectiveness (within the first year post program delivery).  

**Alcohol**

Each year, alcohol use is directly responsible for around 450 deaths in Western Australia. In 2010, Western Australian residents were hospitalised 15,775 times for conditions related to alcohol, costing approximately $100 million.

For young people under the age of 18 the use of alcohol is particularly harmful. Alcohol is often consumed at risky levels which can have significant detrimental effects on brain development. Recent research has indicated that during adolescence, the brain undergoes a unique period of development and that drinking during this period may be associated with a range of harmful effects. Some areas of the brain, such as the pre-frontal cortex, do not fully mature until approximately the age of 21 in females and 28 in males. Damage to the brain, because of drinking, can affect the ability to remember information and pay attention as well as negatively affecting personality and behaviour. Teenage drinking can also result in poor school performance, an increased risk of social problems, suicidal thoughts and violence. Intoxication during early experiences with alcohol has also been associated with an increased risk of problem drinking in adulthood.

Consumption of alcohol in adolescence may increase the likelihood of other risky behaviours such as drink driving, physical violence, unsafe or unwanted sex and mental health issues. Between 2007 and 2011, 2,484 Western Australian 12 to 17 year-olds were admitted to hospital for alcohol-related reasons and 6,485 bed days were utilised. For the same period, there were 25 alcohol-related deaths.

The 2009 NHMRC guidelines advise that not drinking at all is the safest option for children and young people under the age of 18.

Encouragingly, rates of adolescent alcohol use have been steadily decreasing since its peak in 1999. In 2011, approximately 25% of 12-17 year old students had never consumed alcohol which is a significant improvement since 1993 (10.3%) and 2008 (15.9%). Whilst the number of young people who drink alcohol is declining, alarmingly of those who had drunk in the week prior to the 2011 ASSAD (17.5%), over a third (36%) had done so at risky levels, many to the point of vomiting. Unfortunately this is an increasing trend since 1993 (21%).

Attitudes towards drinking vary by age and are mixed, however most students expect to have a positive experience when drinking alcohol. Nearly a quarter of students had someone buy their last drink for them, and parents and friends were the most likely source to provide the drink.
Reviews conducted by both Lancet (2009) and Cochrane database (2011) indicate there is little conclusive evidence supporting school-based education, with many studies concluding that classroom-based education is not an effective intervention to reduce alcohol-related harm. However, there is evidence that there is a positive effect on increased knowledge about alcohol and improved alcohol-related attitudes may result from school-based alcohol prevention programs, despite little change in behaviour. Whilst some school-based education programs have had positive results, there are little commonalities between successful programs to be able to draw summations on required program characteristics. The Cochrane review suggests that certain generic psychosocial and developmental prevention programs can be effective and could be considered as policy and practice options and goes on to recommend the Life Skills Training Program (US program), the Unplugged program (European program), and the Good Behaviour Game (US program) as promising programs in this regard.

Research suggests that industry-funded educational programmes tend to lead to positive views about alcohol and the alcohol industry.

In the past, many harm minimisation policies have suggested that alcohol use is a part of normal adolescent development and that parents should supervise their children's use to encourage responsible drinking. However the recent NHMRC recommendation of zero alcohol for children under 18 challenges this approach. Interestingly, studies comparing alcohol use behaviours between adolescents who have their drinking supervised by adults compared to those drinking without adult supervision resulted in findings contrary to popular belief. Adult-supervised settings resulted in higher levels of harmful alcohol related consequences. Parental attitudes favouring alcohol and other drug use tend to be linked with a greater likelihood of substance use by adolescents.

**Illicit Drug Use**

Each year, drug use is responsible for around 80 deaths in Western Australia. In 2010, Western Australian residents were hospitalised a total of 5,644 times for conditions related to drug use costing approximately $30 million.

Cannabis was the most commonly used illicit drug among all secondary students in the last year (15.4%), followed by tranquilisers (13.5%) and inhalants (10.6%). While 16–17 year olds are more likely to have used cannabis and tranquilisers compared to 12–15 year olds; use of inhalants was more prevalent among 12–15 year olds (12.3%), compared to 16–17 year olds (5.9%).

Other illicit drugs explored in the ASSAD survey include hallucinogens, amphetamines, steroids, heroin and other opioids, ecstasy and cocaine. Fewer than 1 in 20 students aged 12–17 years reported use of one of these drugs in the last year.

Use of illicit drugs increases with age. In the 2011 ASSAD survey fewer than one-tenth of 12 year olds (8.1%) reported using at least one illicit drug in the last year, compared to more than one-third (35.8%) of 17 year olds. Overall however, there were significant decreases since 2008 in the proportion of students reporting use of at least one illicit drug in the last year (excluding cannabis which remained unchanged since 2008, but had significant reductions in the 12 years prior).

Generally males demonstrate higher illicit drug use across all drugs excluding inhalants, for which females have higher rates of use across all age levels.
**Injury**

Injuries are common among Australian children and are a leading cause of acute care utilisation, long-term disability and mortality. This is justification for injury prevention being a National Health Priority Area.

The events that lead to unintentional injuries often are referred to as ‘accidents’, although evidence indicates that many of these events can be predicted and prevented. Major causes of unintentional injuries include motor-vehicle crashes, drowning, poisoning, fires and burns, falls, sports and recreation related injuries, firearm-related injuries, assault, choking, suffocation, and animal bites.

In 2011, injury deaths comprised a substantial proportion of all deaths among 1–14 year old children in Australia (37%). In the two year period 2008-2010, 662 children aged 0-14 died from injury related causes, a rate equivalent to 5 per 100,000 children.

Injury death rates among children have been decreasing over time, by 50% between 1997 and 2010, from 10 to 5 deaths per 100,000 children. The rate for boys has been consistently higher than for girls over this period, although there have been fluctuations in the size of this gap. Overall, in 2011, boys were 60% more likely to die from injury than girls, although there was some variation by age group. In 2011, the injury rate in remote and very remote locations was seven times higher compared to major cities.

Certain factors can increase a child’s risk of injury at all developmental stages. The likelihood of a child being injured or killed has also been associated with single parenthood, low maternal education, young maternal age at birth, poor housing, large family size, and parental drug or alcohol abuse. A holistic approach to health, safety, security, education and welfare is needed for children and the families and communities in which they live.

Road transport accidents, accidental drowning and assault were leading causes of injury death among children in the period 2008–2010. The majority of prevention work for these injuries is largely out of scope for School Health Services.

Falls are the most common reason for injury hospitalisation of children across all age groups, accounting for around 45% of all injury separations. A large proportion of these falls involve playground equipment at places of recreation or at school.

Assault is also a common cause of injury among children aged 0–14, with a rate of 15 hospital separations per 100,000 children in 2011. Disturbingly, the assault hospital separation rate for Aboriginal children was 7 times the rate for other Australian children. Tragically, in 39% of all hospitalised cases for child assault, the perpetrator was either a parent, carer or other family member. The perpetrator was unspecified in 41% of hospitalised cases and identified as a stranger in 8% of cases. If we are to ensure that children feel ‘loved and safe’, as ardently indicated is so important to them, then prevention work in this area is critical. Community support and quality parenting programs mentioned earlier in this document are reiterated as key prevention and early intervention strategies to reduce these disturbing figures.
By the time children reach school age, they have navigated their way through a period where they rely solely on others for their safety, including the provision of safe products and environments. As children develop cognitively and physically their exposure to different settings broadens from the home, to preschool, school, sporting environments, streets and neighbourhoods. Each setting presents its own hazards and risks of injury. At the same time, ability to make decisions about their safety increases. Injury prevention in the 5-14 age group should focus on preventing serious injury, however with recognition of children’s need for experiences and challenges that, among other benefits, can contribute to the development of positive risk management strategies. Older children begin increasing their independence from families and start to make safety judgements for themselves. Primary influences remain parents, friends, the media and teachers at school.

Many children get hurt at school, particularly during informal recreation activities. Children aged 5-14 years are more likely to have school injuries than older children (aged 15-19 years). The most frequently encountered school injuries are fractures and musculoskeletal injury. The most frequent mechanisms of school injuries were “playing” and “informal sports”. Environmental modification and increased supervision are strategies that may reduce school injuries.

The short term consequences of childhood injury include absence from school, which in turn can impact on learning and development, and economic concerns associated with health care costs and parental loss of income. Injuries which are non-fatal but result in long term disability and disfigurement can have lasting effects on social and emotional development and occupational roles. These effects may also extend to people other than the injured person, for example, the parents of a seriously injured young adult may need to become the ongoing primary caregiver. In 2003, more than 120,000 adult Australians had a disabling condition which was caused by injury that occurred before the age of 20.

Transition to adult activities, responsibilities and privileges tends to occur during the ten years or so from the middle-teens. It is during this period of youth and young adulthood (usually defined as ages 15-24 years) that most people begin to emerge from the family in which they spent their childhood, assuming the independent roles associated with adulthood. In doing so, they are exposed to greater choices in life and greater opportunities for risk.

For adolescents and young adults, increasing independence and responsibility for decision making creates more opportunities to engage in risky behaviours. This independence occurs simultaneously with exposure to alcohol and other drugs, and the development of new skills, such as driving, all at a time when peer acceptance is very important. Young people may experiment with illicit substances and alcohol, which can make them more prone to certain types of injuries, such as falls, road accidents, drowning and accidental poisoning. Adolescents and young people who are newly licensed to drive a vehicle are especially at risk of injury from road accidents for a number of reasons including, inexperience, risk taking, alcohol, high travel speeds, lack of seatbelts and fatigue.

Changes experienced throughout adolescence are rapid and profound and result in a high rate of injury at all levels of severity.
Childhood mortality and morbidity as a result of injury can be effectively reduced through the implementation of prevention strategies. Injury prevention should focus on avoiding serious injury, while recognising children’s and adolescent’s needs for new experiences and challenges. Some of these prevention strategies include education, formal instruction and safety training (for parents and children); safe environments including better planning and design around roads, vehicles and buildings in which we live, work and play; and creating a positive safety culture with a shared set of beliefs, attitudes, values and ways of behaving that support the prevention of injury. In addition to this the link between alcohol and road trauma, drowning, falls and other injuries has been well established. Consequently, the role alcohol plays in injuries cannot be ignored and requires specific attention. Prevention strategies, therefore, intersect with initiatives in the areas of alcohol and other drug use and mental health and resilience.

Schools have a responsibility to prevent injuries from occurring on school property and at school-sponsored events. In addition, schools can teach students the skills needed to promote safety and prevent unintentional injuries, violence, and suicide while at home, at work, at play, in the community, and throughout their lives.

**Chronic Disease**

Most chronic diseases manifest in adulthood after years of poor health and lifestyle choices, and are therefore a key focus for prevention efforts commencing in childhood.

The *National Partnership Agreement on Preventive Health* (NPAPH) is an agreement between the Commonwealth and all States and Territories. It is the largest investment ever made by an Australian Government in disease prevention, providing $932 million nationally between 2009 and 2018.

The aim of the NPAPH is to address the rising prevalence of lifestyle-related chronic diseases and encourage the adoption of healthy behaviours, with a focus on the priority areas of smoking, nutrition, physical activity and alcohol. Under the NPAPH, WA Health and its partners are delivering programs aimed at children through settings such as schools, child care centres, community health centres and other community settings; and programs targeting the adult population via workplace and community-based programs. Local activities complement national level campaigns.

There is, however, some chronic diseases such as asthma, cancer, diabetes, cystic fibrosis, epilepsy and eczema that do present in childhood and are important childhood health issues. Care for a child with a chronic disease is frequently very costly and the costs are magnified because the illness continues over a long period of time. The cumulative toll on children, siblings, and parents is often high in social, psychological and economic terms. Also, because children with chronic diseases are still developing, physically and emotionally, their care needs are very different from those of chronically ill adults.
Care that is oriented to the ‘whole child’ and facilitates ‘family control’ in the various stages of illness and disease promotes better outcomes for all family members. Providing support and assisting with the holistic wellbeing of families (ill children, siblings and parents) rather than a focus on the disease or condition is an area where School Health Service staff may be able to make valuable, positive contributions to affected families.

Community Health nurses in Schools have an important role to play supporting schools to develop health care plans and provide relevant education. In some cases they may also assist in liaison between tertiary level and community health services, however prevention, early detection and/or management of these particular chronic diseases is mostly out of the scope of school health services.

Asthma, diabetes and cancer are noted as the chronic conditions with most significant impact or burden on Australian children.

In contrast to the usual health inequality between aboriginal and non-aboriginal children, cancer and type 1 diabetes are generally lower for indigenous children than the rest of the population. Asthma rates however follow the common trend of being higher among aboriginal children.

Asthma, Cancer and Diabetes have higher prevalence rates in major cities compared to remote and very remote areas, and with the exclusion of cancer, these diseases have slightly higher prevalence rates within low socio demographic areas than in high.

Asthma

Asthma is the most common childhood chronic disease in Australia with approximately 10% of Australian children currently living with the disease. It is also a common reason for hospitalisation and is a problem frequently managed by general practitioners. After a dramatic increase in the 1980’s, prevalence rates of asthma have declined by more than 3.5% over the last decade. In 2011 12% of Western Australian children reported to have ever had Asthma and 8.7% were currently experiencing or treating Asthma at the time of the survey.

Asthma can be mild, moderate, severe, episodic or persistent. For the majority of children with asthma, the condition can be controlled with appropriate use of preventative and relief medication and avoiding or controlling known trigger factors. However for some children, asthma can place considerable restrictions on their physical, social and emotional lives and their families. Asthma is also a major cause of school absenteeism, health-care utilisation and medical expenses.

The reasons underlying the high prevalence of asthma in Australia are not well understood, although genetic predisposition, a westernised lifestyle and high allergen exposure are considered to be important factors. Families who don’t have a regular general practitioner (GP), have a lower socioeconomic status and educational level or those who are newer to the community and have less knowledge about asthma are considered at higher risk of poor asthma control and associated consequences.
It is important for school staff to be aware of the symptoms, triggers and management of asthma in the school environment. In Western Australia, an ‘Asthma Friendly School’ (AFS) is one that adopts and works towards strategies that actively support the whole school community in the management of asthma. Schools can be registered as an Asthma Friendly School by undertaking the free training provided via the Asthma Foundation of WA.

**Diabetes**

Type 1 diabetes is a life-long autoimmune disease that usually occurs in childhood but can be diagnosed at any age. The incidence rate of type 1 diabetes for children aged 0-14 years in 2012 was 22 per 100,000 \(^3\).

Type 1 diabetes is caused by the immune system mistakenly attacking itself, destroying beta cells within the pancreas and removing the body's ability to produce insulin. Insulin allows the body to process sugar to create energy - without insulin, the body literally starves as it cannot process food. It is unknown what causes type 1 diabetes and unlike type 2 diabetes, type 1 diabetes has no known modifiable risk factors.

Insulin levels need to be carefully monitored in children to reduce risks of hypo and hyper blood sugar level reactions and longer term complications. People living with diabetes are at higher risk of developing eye disease, nerve and circulatory damage, heart disease and stroke in their lifetime.

Children living with diabetes attending school need to have a comprehensive, current care plan in place.

**Cancer**

Although cancer is relatively uncommon among children (14 new cases per 100,000 children annually), it is the most common cause of chronic disease deaths among children and in 2011 accounted for a hospital separation rate of 166 per 100,000 children annually. The most common types of cancers affecting Australian children include acute lymphoblastic leukaemia, cancer of the brain and non-Hodgkin lymphomas. The death rate for child cancers is low, and despite prevalence rates remaining constant, death rates have been declining further over the last 10 years due to advancements in early detection and treatment \(^3\).

**Dental health**

Oral health is an integral aspect of general health. Poor oral health in children has been associated with an increased risk of chronic disease later in life. Consequences of dental decay can include pain, problems associated with eating or drinking, loss of sleep, social embarrassment and time lost to work (or school attendance) furthermore, dental decay resulting in tooth loss affects both chewing ability and quality of life \(^99\). Dental disease in children can negatively effect academic performance and can also lead to poor long term nutrition \(^3\). Dental decay is characterised by the loss of mineral ions from the tooth (demineralisation), stimulated largely by the presence of bacteria and their by-products \(^99\).
The Child Dental Health Survey (CDHS) is an ongoing national surveillance program that monitors the dental health of children enrolled in school and community dental services operated by the health departments or authorities of Australia's six state and two territory governments. In all jurisdictions, children from both public and private schools are eligible for School Dental Service care. The care typically provided includes dental examinations, preventive services and restorative treatment as required. However, there are some variations among state and territory programs with respect to priority age groups and the nature of services. The West Australian School Dental Service provides free general dental care to school children throughout the state, ranging from pre-primary through to Year 11 and to Year 12 in remote locations.

Dental decay is relatively common among Australian children who attend a school dental service. In 2009, the proportion of children who had experienced decay in their baby (deciduous) teeth ranged from 42% for 5 year olds to 61% for 9 year olds. The proportion of children with permanent teeth affected by decay ranged from 5% for 6 year olds to 58% for 14 year olds. In WA, there was an increase of 5576 (or 9.1%) in the number of visits to dental school clinics in the December 2012 quarter compared with the same quarter in the previous year.

Data from the Child Dental Health Survey indicates that WA children suffer an average to lower dental decay incidence compared to other jurisdictions, however children who live in Remote/Very remote areas were at increased risk of dental decay compared with those who lived in Major cities. Dental extractions and restorations are the most common reasons for hospital separations among children.

Behavioural risk factors for dental decay include substandard tooth cleaning; poor diet involving high exposure to acidic food stuffs and fermentable carbohydrates such as sugars; and limited exposure to fluoride available in toothpastes, fluoridated public water or other sources. In response to these risk factors, oral health promotion usually includes promotion of brushing teeth at least twice a day using fluoride toothpaste; drinking water when thirsty; attending regular dental check ups; and eating a variety of foods, but avoiding sticky foods such as lollies, ‘health bars’, cakes, and dried fruit as these cling to the teeth and stay in the mouth for a long time, causing decay.

**Otitis Media**

Otitis media (OM) is inflammation of the middle ear and is a common childhood illness, from which most children will recover quickly with appropriate treatment. Some population groups, however, have much higher rates of OM and also have unacceptably high rates of chronic suppurative OM (CSOM) with associated impact on hearing, language development and learning ability. Australian Aboriginal children have the highest prevalence (up to 70% in remote communities) of CSOM in the world.

Children most at risk of OM include all Aboriginal children (and in particular children aged 0-4 years); children in child care centres; and refugee and migrant children from high risk countries.
To ensure that the right care occurs at the right time by the right team, a coordinated model of care was endorsed by the WA Department of Health in 2013. This model of care suggests a three pronged approach addressing: Prevention; Primary health care; and Specialist care of OM. The Community School Health Service has an important role to play in the first two of these prongs.\textsuperscript{143}

Prevention of OM is largely achieved through addressing the social determinants of health; providing culturally relevant and community-driven health promotion and education; and ensuring coordination occurs with other public health prevention programs addressing diseases with similar epidemiology and aetiology.\textsuperscript{143}

Key factors for effective health promotion for Aboriginal communities have been identified and highlight that health promotion strategies need to be based on a community-strengths model:

- Mothers and female carers should be targeted as the primary audience;
- Within this group, mothers of younger children (aged 0-5) should be seen as a critical target group, as early treatment can greatly minimise long-term impacts;
- Children (aged 5+) should be seen as an important secondary audience for health promotion strategies, e.g. through school-based preventive initiatives;
- Intermediaries are a critical channel for ear health promotion as they play a crucial role in delivering information to children and carers and encouraging behaviour change;
- Any national ear health campaign materials (e.g. DVDs) and initiatives (e.g. media campaigns) must be localised if they are to be effective.\textsuperscript{143}

Community School Health Services have an invaluable primary health care role in the identification and management of OM within vulnerable populations. Community Health Nurses and Aboriginal Health Workers are ideally placed to assess speech development and identify behavioural issues which may indicate impaired hearing. This type of assessment is included in the universal and targeted child and school-entry health checks conducted by community school health services. Teachers are also ideally placed to identify school-aged children who may be experiencing hearing loss.\textsuperscript{143}

Otoscopy and tympanometry are simple clinical skills but interpretation of results does require specialist skills developed through regular practice. The 2013 OM Model of Care suggests GPs, community nurses and Aboriginal Health Workers are in ideal positions to perform otoscopy and tympanometry as part of routine and opportunistic clinical assessment but they need to be trained and supported in this skill. ENT specialists and audiologists are highly skilled in otoscopy and tympanometry and should be involved in supporting clinical decision-making face to face or via telehealth (using video otoscopy).\textsuperscript{143}
Immunisation

Immunisation programs against certain childhood diseases are effective in preventing child morbidity and mortality. It increases the protection for individual children and contributes to overall population health by reducing the rate at which those diseases circulate in the community. The National Immunisation Program Schedule is a comprehensive list of the recommended vaccinations for children at particular ages, with the intention of achieving widespread community immunity to certain transmissible childhood diseases, including diphtheria, measles, mumps and polio. In June 2013, 90% of West Australian five year olds were fully immunised, which meets the minimum coverage required to maintain the level of herd immunity needed to interrupt the spread of vaccine preventable diseases, however WA coverage rates are the lowest of all Australian jurisdictions and are a long way from the NHMRC goal of 100% coverage by school entry age.

A number of vaccinations are offered through the School Based Immunisation Program and from time to time changes are made to the schedule as new evidence becomes available. In 2007 the national school-based HPV Vaccination Program, first became available to adolescent girls and was offered with a time limited catch-up program. This program has now been extended to include males, and from February 2013, males and females aged 12-13 years will receive the HPV vaccine at school on an ongoing basis.

Changes and additions to the school immunisation program places increased pressure on school immunisation teams, especially in some country areas where this responsibility may fall to the Community School Health Nurse.

Community Health Services provide a large proportion of immunisations to Western Australian children (19%) with most other immunisations in the State provided by GP practices (65%). WA Community Health Services are one of the highest community health immunisation providers when compared to other jurisdictions with only the NT and ACT Community Health services providing larger percentages of immunisations than WA.

A number of factors influence notification rates for vaccine preventable diseases including the natural history of the disease, the length of time that immunisation program has been in place, the particulars of the vaccination program and immunisation coverage. Aside from one notification of tetanus in 2000, there have been no notifications of polio, diphtheria or tetanus in Australia between 1996 and 2011, and with the exception of pertussis, all other childhood vaccine preventable disease notifications have generally declined in recent years. Unfortunately, the notification rates for Pertussis have increased dramatically since 2008 (from 16 per 100,000 to 411 per 100,000). The reasons for this are unclear but may be associated with waning immunity, improved surveillance and diagnosis, changes to the vaccine and/or adaptation or emergence of new strains.
Children and young people want to LEARN

Early engagement and participation in learning and education is important for the development of children and youth.

Learning is a continuous process throughout life. Children and youth learn through a variety of formal and informal experiences within the classroom and more broadly in their home and in the community.

Effective learning and educational attainment is fundamental to future opportunities, both financially and socially.

Children and youth who are learning participate in and experience education that enables them to reach their full potential, and maximise their life opportunities.

Academic achievement - NAPLAN

Since 2008 Years 3, 5, 7 and 9 students across the country have been assessed annually in reading, writing, spelling and numeracy through the National Assessment Program Literacy and Numeracy (NAPLAN). All Western Australian schools participate in NAPLAN. The most recent results from the 2012 assessment indicated that in general children in WA reached or exceeded the national benchmarks for literacy and numeracy. In some year levels for both reading and numeracy, Western Australian children have made greater gains since NAPLANs inception than children in many of the other jurisdictions. Despite this, WA has a smaller percentage of students achieving at or above the national standards for reading, writing and numeracy than most other states and territories.

Furthermore, Australia performs below average in reading, maths and science when compared to its other OECD international counterparts. Literacy and numeracy levels for Indigenous students are generally lower than for other Australian students, including students who speak a language other than English at home.

The 2011 ABS Childhood Education and Care Survey (CEaCS) estimated that 1 in 5 children (20%) aged zero to two years were not read to or told stories at least once per week.

Developmental Vulnerability

The Australian Early Development Index (AEDI) is a measure of child development used by different communities across the world. It provides a snapshot of how children have developed by the time they start school. Five key areas of child development are physical health and wellbeing, social competence, emotional maturity, language and cognitive skills (school-based), and communication skills and general knowledge. In 2012 almost one-quarter (22%) of children in Australia were developmentally vulnerable on one or more domains at school entry. Almost half of these children (10.8% in total) are developmentally vulnerable in two or more domains.
Developmentally vulnerable groups include boys, Indigenous children, and children who lack proficiency in English. Boys are more likely to be developmentally vulnerable than girls on all of the AEDI domains. Indigenous children are more than twice as likely to be developmentally vulnerable than non-indigenous children. Over 40% of Indigenous children are developmentally vulnerable on one or more of the AEDI domains. More than a quarter (26%) of Indigenous children are developmentally vulnerable on two or more domains. Over 93% of children who have a language background other than English (LBOTE) and are not proficient in English are developmentally vulnerable on one or more AEDI domains. This number drops to 58% for two or more AEDI domains. Children in Australia who only speak English but are not proficient in English are more likely to be developmentally vulnerable on all of the AEDI domains.

Between 2009 and 2012 the proportion of children developmentally on track for school increased for all AEDI domains except ‘communication skills and general knowledge’, which experienced a slight decrease. Domains with the lowest proportion of WA children developmentally on track for school were ‘emotional maturity’ (75.5%) and ‘language and cognitive skills’ (75.8%). Interestingly at a National level these were the domains with the highest proportion of children developmentally on track; emotional maturity (78.1%) and ‘language and cognitive skills’ (82.6%). In WA, physical health and wellbeing was the domain with the highest number of children (3021) developmentally vulnerable and ‘emotional maturity’ was the domain with the highest number of children (4649) developmentally at risk.

In Australia the AEDI is conducted every three years and provides a picture of how well local communities are supporting the early development of their children. It does not provide an assessment on the vulnerability of individual children. The AEDI website provides excellent data on how regions score on the AEDI. Additionally, school principals are provided with a summary report on the performance of their school are able to choose how or if they share this information.

Whilst WA has achieved a significant decrease in vulnerability since the first AEDI in 2009, it is still ranked third poorest when compared to other Australian States and Territories.

School attendance

Regular attendance and participation in school is an important factor in education and life success. A child’s health and wellbeing can affect whether or not a child attends school or not and their ability to participate in school activities. For example a high proportion of aboriginal children experience middle ear infection, hearing deficits and nutritional deficiencies, which adversely affects their school attendance and learning outcomes. Nationally, school attendance rates for year 5 students in 2009 ranged between 92% and 95%, with the attendance of indigenous students in all jurisdictions generally being lower than non-indigenous students. Whilst WA had a comparable State average attendance rate, the 12 to 16% difference between WA indigenous and non-indigenous attendance rates was the 2nd largest difference among other Australian States and Territories.
In 2010, the Department of Education reported 95% of 16 and 17 year olds were engaged in an approved education, training or employment activity, leaving only 5% not adequately accounted for in the final year of compulsory schooling.¹²

**Importance of the School Health Service to ‘Learning’**

The education system in Western Australia caters for children across the age range of 4-18 years, giving schools an unrivalled opportunity to reach children and families, and to create health-promoting environments.⁷¹ Additionally, the link between education and health is well established. Education has been shown to be a prerequisite for health, as throughout the world, higher levels of education are associated with better employment, healthier lifestyles, and higher levels of family and community well-being.³,⁸⁶ Equally, evidence confirms children’s health status directly impacts on their learning outcomes.³,2⁰,⁸⁸

Early detection of problems or difficulties in the areas of vision, hearing, speech and language development, psychosocial, gross and fine motor skill development and general development is an integral function of School Health Services. Children whose development in these areas is not optimal are at greater risk of academic failure, behavioural, and social and emotional problems. Through screening and early detection programs, the School Health Service can support and direct these children and families to services that may be able to support them with the identified concerns, ideally leading to better education outcomes for these children.
Children and young people want to PARTICIPATE

Participating includes involvement with peers and the community, being able to have a voice and say on matters and, increasingly, access to technology for social connections.

In practice, participating means children and youth are listened to, are supported in expressing their views, their views are taken into account and they are involved in decision-making processes that affect them.

It is noted there is a general lack of data on children’s participation with available data mainly focused on the 18-25 age range. Much more work is needed to identify indicators and data sources that adequately reflect this key result area.

WA has one of the highest national rates of participation by children and young people in physical and cultural activities. For example, surveys in 2009 show for WA children aged 5 to 14 years:

- over 60 per cent (63.1%) had played a sport outside of school hours which had been organised by a school, club or association
- over 70 per cent (71.9%) attended at least one cultural venue or event (a public library, a museum or art gallery, or a performing arts event).

Young people appreciate and value the opportunity to be involved in planning, designing and delivery of services and facilities that young people access which in turn helps to ensure they are youth-friendly.

As discussed within the following section on Health Promoting Schools Framework (HPS), School Health Service staff are trained and encouraged to consider their role within the context of the HPS framework. The Model strongly encourages involvement of a school health committee, which should without question include a number of students who are able to represent to the best of their ability the views of their peers, and valuably contribute toward the work of the school health committee. Together with needs assessments, effective evaluation of strategies and general student feedback opportunities, children and young people within a Health Promoting School setting can be provided with a variety of opportunities to feel like they are participating and contributing to the non-curricular health enhancement programs offered at their school.

Community Health Nurses working in schools have a background and strong commitment to working within Primary Health Care principles and as such, see the participation of people either as a group or individually in planning and implementing their health care as a human right and duty. One way of expressing this is through a phrase that originated in the disability movement – ‘Nothing about me without me’. Whether working with a family or directly with a child, Community Health Nurses ensure their clinical practice is client centred which allows the child or family to explore, ask questions, weigh up options and make decisions about their health with the support of the Community Health Nurse.

Most Community Health Nurses have received training for working within this model of family or client centred practice. This enables nurses to be effective helpers and to develop supportive and effective partnerships with children and/or parents so that they are able to explore difficulties they may be experiencing. The client-centred relationship also provides the nurse with opportunity to clarify understanding of individual client situations, set appropriate goals with the client and design long term strategies to enable them to adapt effectively and thereby optimise the child’s psychosocial development. Ideally this should leave children, young people and families feeling they have participated in their future health plan.
Community Health Services across the State provide community based universal and targeted services to children, adolescents and their families. Their vision is to support families to raise happy, healthy children and adolescents. This is achieved by offering a range of health promotion, early identification and intervention services. As the services provided by Community Health Services range from primary prevention to tertiary intervention, they affect not only individuals but also the broader community. The target population for Community Health Services therefore comprises of a diverse range of individuals from different age groups, educational levels, socio-economic backgrounds, levels of risk and from culturally and linguistically diverse backgrounds. In order for Community Health Service to cater for the diverse range of needs of its consumer population, services need to be appropriately tailored to the particular group of consumers.

In order to strengthen consumer partnerships, the Consumer, Carer and Community Engagement Plan was developed by CACH and WACHS has recently endorsed their Guidelines for Partnering with Consumers. These documents promote and request staff to strive for authentic engagement with their service consumers (including school aged children) on a number of levels at multiple points of the Service continuum. If done effectively, it is hoped that services can address the specific requirements of their target groups, and provide services that better suits the needs of their consumers leading to better health outcomes 95, 114.

Unrolling of consumer engagement plans is a current priority across Health, and in addition to this, the Statewide School Health Policy team hopes to seek opportunities for WA school children (and their families) to provide feedback in direct relation to improving School Health Services to further meet their needs and wants in the future.

**Delivering School Health Services for Children and Young People**

School Health Service staff ideally have a functional relationship with members of the Student Support Services team and together they have a shared priority interest in the physical and emotional wellbeing of students. The School Health Service strives to improve health for the whole school and can participate in shaping school policies, ethos and accurate health information to enhance the health and wellbeing of all children and young people in a school.

But, for those individual students who seek or require personal or more targeted support from the School Health Service, the Community Health Nurses in schools are well equipped to assist.

As part of the primary care role to children or young people who for whatever reason require some additional support, a skilled and experienced Community School Health Nurse will listen attentively, observe behaviours and guide conversation with a student so that she can make informed decisions on the best care, support and advice to provide to the child and family. Community Health Nurses working in WA schools are well supported with tools and training to assist them to form an holistic understanding of a childs life and develop a professional relationship which is client centred.
Specifically within secondary schools, School Health Service staff are encouraged and supported to use the HEADSS psychosocial assessment tool when working with young people. This assessment tool has been part of the School Health Service suite since 2007. Staffs ability to adapt their assessments depending on the age and development of the young person and the frequency with which they meet with them is a reflection of the expertise of School Health Service staff. Since its introduction to the School Health Service practice guidelines, the HEADSS assessment has provided a framework that generally enhances all individual school health service interactions with young people. It has refined skills and provided a framework for nurses to:

- develop rapport with a young person, while systematically gathering information about their world, including family, peers, school and their inner world;
- Perform a risk assessment and screening for specific risk behaviours;
- Identify areas for intervention and prevention; and,
- Develop a picture of the young person’s strengths and protective factors.

Community Health Nurses are well skilled in assessing adolescent health needs, and frequently engage in health counselling, brief interventions and assist with access and referral to other services and provide follow-up care.

There is significant evidence to suggest that young people do not disclose sensitive information unless directly asked. A thorough understanding of confidentiality requirements and discussion of confidentiality with both parents and adolescents underpins the process of building trust in the nurse-student relationship in a school setting and is essential in effectively assessing health risk behaviours. While this is a complex area, WA Community Health Nurses working in schools are well supported with legal guidance and training to help them navigate through these issues.

A recent survey of community Health Nurses in WA secondary schools indicated the most common health issues encountered include: anxiety, stress, depression or low mood, relationship issues, sexual health, sexuality and reproductive health issues, nutrition and lifestyle, and drug misuse. It is also common for Community Health Nurses to encounter young people who have considered or attempted suicide, and those seeking help for sexual assault.

In this context, Community Health Nurses in Schools offer an invaluable service to young people who may otherwise not seek health assistance and are therefore ideally situated to communicate new health knowledge, support health education policy, provide screening services, implement health interventions and offer individualised attention and counselling. Young people find the school health service to be a trusted service and one that is relatively easy to access.
Community Health Nurses are the primary category of staff employed by the Department of Health to work within schools. Community Health Nurses in schools are found to have a great ability to communicate with parents and members of the family, especially in rural and remote regions. Parents have been reported to perceive the role of the Community Health Nurses in schools as an advocate for their child and as a positive influence on their child’s decisions. Moreover, there is growing evidence that School Health Services in general are particularly beneficial to girls, those living in rural locations, minority ethnic groups, or young people who are otherwise disadvantaged and vulnerable.

The literature suggests that the contemporary Community Health Nurse role in schools is regarded as one that fits within whole school approaches. More specifically, core elements of the role include:

- Assisting teachers to identify symptoms and behaviours that indicate health related interventions may be required for a child and refer such cases as appropriate
- Liaising with and advocating for children and families to access the health services and resources they require
- Supporting elements of teaching practice e.g. via resource provision and encouragement
- Implementing procedures for control of communicable diseases
- Liaising with community agencies
- Providing leadership to the health education program
- Building capacity among children and their families in relation to self management of health care issues and health service access.

Core policy streams of the School Health Service include the following 3 key domains and are discussed in the remainder of this document:

- Health Promotion
- Early Detection
- Specialist Health Expertise

**The Health Promoting Schools (HPS) framework and School Health Services**

For many young children, school is the first major transition in life from the family home and into other environments, and therefore can be an important influencing agency in a child’s life. It is a crucial time for learning, social and emotional development and social participation, as well as the acquisition of literacy and numeracy skills. Most importantly, it is a critical time for establishing good health behaviours. To achieve education and health goals, schools must be able to promote health as they do learning.

There are several factors unique to schools that make them an appropriate setting for enhancing the health and wellbeing of children. These are:

1. They have an existing infrastructure incorporating educational opportunities, staff trained in the provision of education, environmental services, various structures and supports that can reinforce health messages, and existing links to community based agencies and support services. Health Promotion can therefore be cost effectively incorporated into this pre-existing structure.
2. Schools have links to several influences on children’s health, including family, peers, and the local community. This access puts schools in an ideal position from which to initiate interaction between key influences on children’s health behaviours, to create supportive environments and reinforce messages from outside the school setting.

3. Schools provide an opportunity to reach all children, regardless of socioeconomic background, ethnicity or geography.

The Health Promoting Schools (HPS) Framework was first introduced in WA in the late 1990’s with growing adoption and embracing in varying capacities by most schools since this time 90.

There are three widely accepted interrelated components to the Health Promoting School Framework including:

- **curriculum, teaching and learning**: considers the formal content of teaching and learning approaches, key issues, the developmental and sequential nature of the program, and resources.
- **school organisation, ethos and environment**: considers the school policy and philosophical support for the health curriculum, approaches to health and wellbeing, school community relationships and the school’s physical environment e.g. school grounds, canteen amenities.
- **partnerships and services**: includes the school health service, family consultation and involvement, community based programs and the development of strong community links to the school 147.

HPS can be described as a holistic, whole-school approach in which a broad health education curriculum is supported by the environment and ethos of the school. HPS moves beyond individual behavioural change to consider organizational and policy change such as improving the physical and social environment of the school, as well as its curricula and teaching and learning methods. A positive culture for health would facilitate higher levels of health literacy by helping individuals tackle the determinants of health better as they build the personal, cognitive and social skills for maintaining good health 84.

Many of today’s and tomorrow’s leading causes of death, disease and disability (cardiovascular disease, cancer, chronic lung diseases, depression, violence, substance abuse, injuries, nutritional deficiencies, HIV/AIDS/STI and other infections) can be significantly reduced by preventing six interrelated categories of behaviour, that are initiated during youth and fostered by social and political policies and conditions:

- tobacco use
- behaviour that results in injury and violence
- alcohol and substance use
- dietary and hygienic practices that cause disease
- sedentary lifestyle
- sexual behaviour that causes unintended pregnancy and disease 86
Whilst these issues are addressed to some extent within the National Curriculum, a more holistic and comprehensive approach is required to move from just improving children’s knowledge about health issues and risk factors, to changing their attitudes, skills and behaviours and ensuring physical and social environments are conducive to positive health choices. While the health education approach frequently builds on pre-packaged programmes with clear objectives and activities, and linear step-by-step procedures, the health promoting school framework builds on the notion that schools should develop their change processes based on their individual needs and capacity, involving all relevant stakeholders.

There is reasonable evidence to demonstrate that the whole-school approach using the HPS framework is effective in improving health, ranging from physical activities and healthy eating to emotional health. Schools adopting the HPS framework have demonstrated changes in culture and organizational practice to become more conducive to health improvement. These schools are reported to have better school health policies, higher degrees of community participation, and a more hygienic environment than non-HPS schools, and students in these schools have a more positive health behaviour profile.

The approach links health and education; is evidence-based; recognises and builds on the social determinants of health; is cost effective; offers opportunities for coordinated and integrated responses; and recognises schools as key agents of socialisation and settings for health development.

Despite this there have been limitations to the success of the Health Promoting Schools Framework over the last decade, which can in part be attributed to the difficulty in capturing comprehensive evaluation on the effectiveness of programs within social, complex, adaptive systems such as schools.

According to the World Health Organisation, to achieve its goals a health-promoting school:

- Fosters health and learning with all the measures at its disposal.
- Engages health and education officials, teachers, teachers’ unions, students, parents, health providers and community leaders in efforts to make the school a healthy place.
- Strives to provide a healthy environment, school health education, and school health services along with school/community projects and outreach, health promotion programmes for staff, nutrition and food safety programmes, opportunities for physical education and recreation, and programmes for counselling, social support and mental health promotion.
- Implements policies and practices that respect an individual’s well being and dignity, provide multiple opportunities for success, and acknowledge good efforts and intentions as well as personal achievements.
- Strives to improve the health of school personnel, families and community members as well as pupils; and works with community leaders to help them understand how the community contributes to, or undermines, health and education.
Children have identified that their participation in decision making is a key component to them ‘having a good life’ and in this context the Health Promoting Schools Framework has additional benefits. Students are frequently considered the main target group for implementation of health promoting schools and involving them in the planning and implementation of actions is considered essential in gaining maximum impact of programs and also facilitates the empowering process of participation. Communication based on mutual respect and possibilities of being heard and listened to, is likely to be more effective in stimulating the wanted behaviour change as opposed to top-down instructions being given.

For the health promoting schools framework to be successful, understanding and appreciation of the diverse, complex and context specific nature of individual school systems is required and together with the emergence of key implementation components, flexible approaches and consideration of the individual schools resources are equally important for schools to achieve goals they have nominated using the HPS model.

A number of barriers have been indentified that will limit schools in their success of applying the health promoting schools framework and include: poor understanding of the complexity of schools, and their functioning as complex adaptive systems; lack of acknowledgement of the diversity between schools; inadequate flow of information and experiences about health promoting schools between schools, health sector and parents; lack of feedback loops about schools’ performance on health promoting schools.

Whilst the HPS model has credible evidence supporting it from more than a decade ago it is particularly difficult to evaluate the full impact of the HPS framework, as it moves away from previously popular single issue programs where change in knowledge/behaviour could be identified in pre/post evaluation on a specific issue. Unfortunately, this type of evaluation misses the invaluable process, multi-component and multilevel approach that is central to the HPS model.

Both health and education sectors have the ability to improve on their efforts with the HPS model to maximise opportunities to reduce or prevent undesirable health outcomes for children and young people. The HPS framework has the potential to develop a mechanism of closer integration with the primary healthcare system, making youth health services more school based and student centered.

Within the HPS framework, the role of School Health Services is to work in partnership with school community members to identify and build on the school’s capacity to improve health and achievement at school. There is evidence that effective School Health Services have a significant positive influence on the long term health and wellbeing of children. The scope for action for School Health Services is far ranging, spanning the spectrum of health promotion, early detection, and specialist expertise.
School Health Service policy outlines the importance of health promotion and endorses the Health Promoting Schools Framework. It is acknowledged that school health service human resources are stretched in many regions of Western Australia and involvement in health promotion planning, implementing and evaluation within the school is somewhat limited. With our growing understanding of the complexity of children’s health and development, so too does the complexity of the role of school health service staff increase as services are tailored to look holistically at the health of individuals as well as the universal health needs of the school. At a minimum, the health promotion effort of School Health service staff should include identifying health issues, advocating for change, and linking schools to good evidence based programs. If further resources were available, or more capacity created, School Health Services could potentially have a more profound impact on prevention and early intervention opportunities through more comprehensive participation in school health promotion.

**What School Health Services screen for and why (Early Detection)**

The first few years of a child’s life is recognised as crucial in setting the foundation for lifelong learning, behaviour and health outcomes. Therefore early childhood intervention is a priority for health. Early intervention encompasses the early detection of individuals in the first episode of a disorder or illness, or those who may be at increased risk of developing a disorder or illness. Early detection of problems or difficulties in the areas of vision, hearing, speech and language development, psychosocial and general development including weight issues is an integral function of School Health Services as these children are at greater risk of academic failure, behavioural problems and social and emotional problems.

Early detection includes systems, services, and supports designed to enhance the development of young children, minimize the potential of developmental delay, and enhance the capacity of families as caregivers. There are three broad population groups that can be used to guide School Health Service delivery in early detection:

1. Universal population – this focuses on prevention and early detection within the whole school population
2. Selective population – focuses on groups within the school population who are at increased risk of developing problems
3. Indicated population – individuals identified as having signs or symptoms of a developing problem, therefore requiring a targeted response.

Working at the universal level enables health workers and schools to have a greater capacity to impact on the health of all students, regardless of their individual risk of developing a disease or health problem. CHN’s working in schools offer a universal assessment at school entry which includes hearing and vision assessment as well as eliciting parent concerns about the child’s general development (behaviour, speech, fine and gross motor skills). This universal screen can ascertain a range of child, family and community factors, resources and capacities. This can in turn identify need for referral, further assessment, specific health promotion interventions and services, as well as engage the family in setting goals and making positive choices for health and wellbeing.
An important component of this universal assessment is the use of validated screening tools. Developmental screening tools are very useful in helping health professionals understand the developmental profile of a child and therefore make a more informed decision about the child’s developmental needs.

In 2009 the Parent Evaluation Developmental Status (PEDS) was introduced in CACHS as a universal school health entry screening to be used by community health nurses. The PEDS is a one page 10 item questionnaire which can be administered at any contact with a child’s parent or caregiver. The PEDS has been adapted for the Australian setting, is written in simple language and available in a number of languages. The PEDS interpretation form can be a useful communication tool as it can be used to provide transition information for other service providers involved with the family. The PEDS is easily scored by health professionals and for those children who are identified as having a developmental concern, a secondary targeted assessment tool is recommended before referring onto specialist services.

The Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire: Social Emotional (ASQ:SE) was rolled out across CACHS in 2009 as the targeted developmental assessment tool. The ASQ and ASQ:SE are a series of 19 questionnaires which can be offered at multiple assessment intervals; the age ranges for ASQ and ASQ:SE are 4 months to 5 and a half years. The ASQ has 30 items per questionnaire; the ASQ-SE has varying number of questions (19-33) per questionnaire. The ASQ originated in the USA and has been adapted for the Australian setting by Child and Adolescent Community Health Policy Statewide. Community health nurses who identify children with developmental concerns refer the child to other services for more comprehensive assessment and/or therapy where resources are available. With the introduction of an evidenced based standardised developmental screening tool, staff can confidently refer children to specialist services with preliminary assessment results.

Some evidence suggests that developmental screening tools should not be used as a single measure because they will not capture all children with difficulties. There are many children who are at risk of poor outcomes because of biological or family risk factors, these children may pass the screening tests but would still benefit from intervention programs like language interventions or behavioural management programs. Developmental screening tools should only be included into existing early detection systems where there is ongoing monitoring of children’s development overtime and health professionals are familiar with the child and their family history.
Sharing our Specialist Health Expertise with children, young people and families

Immunisation

School immunisation programs are an efficient means of reaching a large proportion of the school age population to promote, offer and provide free immunisation to prevent disease. The vaccinations are administered by CHN’s working in schools, designated community health staff and, in some cases, by the health staff of local governments. Evidence suggests that immunisation against childhood diseases is one of the most cost-effective public health interventions in preventing childhood morbidity and mortality\(^\text{67}\).

Health counselling

CHN’s in secondary schools provide confidential health consultations for young clients. The majority of clients are self-referred, however teachers and parents can also refer. Most consultations relate to psychosocial concerns, medical problems, sexual health and health surveillance needs. A same day service is important as students generally seek assistance when they are in crisis and need support without delay\(^\text{67}\).

Community Health Nurses working in schools are often the first point of contact for adolescent health concerns, which suggests that presenting problems may be diverse\(^\text{2}\). The overall patterns of use of health professionals such as community health nurses across age groups suggests that females are more likely to consult health professionals than males\(^\text{13}\).

Several barriers prevent young people from accessing information about health care and related issues: concerns about confidentiality, attitudes and communication style of the health professional, clinic hours and the clinic environment, cost, developmental characteristics of young people (e.g. poor understanding of their own health needs and health services and how to use them, difficulties expressing their concerns). It is important to work with young people and their parents to facilitate communication and understanding where possible. Community Health Nurses working in secondary schools are advocates for young people in accessing health and related services and also in providing environments that are youth friendly and assist in addressing the aforementioned barriers\(^\text{49}\).

Health Care Planning

CHN’s can provide input into health care planning for students with a health condition. From this they can assist the school to develop a health care plan for the school year. This requires collaboration with parents, teachers and the individual student, as well as liaison with and referral to other health professionals. A CHN working in schools may facilitate school staff training to support students specific care needs.
School system response to first aid and emergency health care

Community health nurses working in schools assist in the planning of systems for delivery of first aid and emergency health care.

Conclusion

This 2013 version of the School Health Service Policy Rationale compiles current research on child health issues, and for the first time, has also highlighted the views and priorities of children and young people in Australia. Broadly speaking, the priorities for health and wellbeing for our young clients are; to feel loved and safe; to be healthy; to able to learn; to have opportunities to participate; and to have the material basics.

Modifiable risk factors such as diet, physical activity, mental health, injury prevention and sexual health continue to be critical areas of work when striving to reduce child mortality and morbidity. Following the extensive review of the literature and consultation with the (Statewide) School Aged Health Reference Group, new and emerging areas of high priority were identified:

Parenting programs
Quality of parenting is fundamental to short and longer term outcomes across many areas of physical and mental health and wellbeing. The Triple P program has, by far, the best research evidence. Quality parenting programs should be supported and promoted by Community Health staff to parents of school aged children.

Prevention of mental health problems
Mental ill-health is a significant disease burden for adolescents, young adults and older adults. The risk factors for poor mental health are often evident from early childhood. It is proposed that School Health Services increase the focus of early detection for children exhibiting risk factors for poor mental health.

Working with disadvantaged families
There are some groups of children and young people which are more vulnerable than others, and are at higher risk of poor health outcomes. These groups should be provided with greater levels of support from School Health Services.

Overweight and obesity
Overweight and obesity is prevalent among children and adolescents, along with the significant risks of short and long term health problems. Early identification and intervention (before puberty) and initiatives to promote regular physical activity, healthy eating and limited screen time, are all important. To enhance early detection and intervention, it is proposed that School Health Service staff strengthen skills in talking to parents about their child’s weight and linking them to appropriate services and resources.
Otitis media and hygiene

Otitis media is prevalent among Aboriginal children, with deleterious effects on hearing, language development and learning ability. School Health Services have an important role to play in early detection and prevention. It is proposed that standardised health promotion strategies for healthy ears and hand hygiene are developed and well promoted to schools. It is proposed that universal and targeted early detection policies and guidelines are adapted to improve detection rates.

Participation of children and young people

Children and young people want to participate in planning services and activities which affect them. They want to be involved in planning and evaluating health services and programs for their school communities and for their own, individual health care. It is proposed that School Health Services staff are provided with knowledge and tools to enhance consumer participation.

School health promotion

Comprehensive and well-planned school health promotion strategies support the development of skills, knowledge, attitudes and positive behaviour change. The model which appears to be most effective and useful is the Health Promoting Schools Framework.

It is proposed that School Health Service staff become knowledgeable about the Health Promoting Schools Framework, and have access to information about the most effective programs and initiatives in relation to specific issues, i.e. mental health promotion.

School Health Service staff should act as advocates and consultants about school health promotion; encouraging schools to address high priority health issues; promoting the adoption of the Health Promoting Schools Framework; linking schools to effective programs and initiative which are based on sound research evidence.

Addressing these identified priority areas fits well within the three long established broad aims of School Health Services:

1. Deliver early detection programs to identify health issues and refer for timely intervention so that children and adolescents may achieve optimal outcomes in health, wellbeing and learning, especially those at risk.

2. Advocate for and contribute to school health promotion strategies which enhance the long term health and wellbeing of children and adolescents.

3. Provide specialist health expertise to advise school communities on the care of children and adolescents in order that their health and wellbeing is optimal, and provide ready access to primary health care and health counselling for adolescents.
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