GUIDELINE

Factors impacting on child health and development

Scope (Staff):	Community health
Scope (Area):	CACH, WACHS

Child Safe Organisation Statement of Commitment

CAHS commits to being a child safe organisation by applying the National Principles for Child Safe Organisations. This is a commitment to a strong culture supported by robust policies and procedures to reduce the likelihood of harm to children and young people.

This document should be read in conjunction with this disclaimer

Contents

Aim

To provide information that supports holistic community health assessment and care planning for children and their families who are experiencing adverse factors and circumstances that may impact on the child's health and developmental outcomes.

Risk

Children and their families may not receive the support and services they need, with children then being at an increased risk of poorer health and developmental outcomes.

Principles

- The child is the primary client and is the centre of care.

- Child health services aim to improve the health, development and wellbeing of children and families through a model of progressive universalism, delivering services and care planning that are proportionate to client need and circumstances.
- A trauma-aware, healing-informed approach to supporting clients and their families includes consideration of social and emotional wellbeing and the protective and risk factors that may impact on health and developmental outcomes. Consideration of protective factors supports a strengths-based approach which enhances engagement with the family.
- Not all families with complex concerns will require additional services, as the presence of protective factors may reduce adversity and increase resilience. Being exposed to risk doesn't always lead to poor outcomes, as protective factors can lessen children's risk of adverse health and developmental outcomes.
- Nurses are encouraged to adopt a child and family-centred and culturally informed approach to care for a shared understanding of both concerns and resiliency, and to establish goals that facilitate change in modifiable concerns. The child and their family should be active participants and shared decision-makers about their health care[1]. Refer to CAHS Child and Family Centred Care policy.
- Nurses need to provide culturally safe service delivery which demonstrates a welcoming environment that recognises the importance of cultural beliefs and practices of all clients.
- For Aboriginal children and their families, protective factors such as connection to community and culture, kinship, and a sense of belonging can positively influence health outcomes[1-4].
- All nurses will refer to the Nursing and Midwifery Board AHPRA Decision-making framework in relation to scope of practice and delegation of care to ensure that decision-making is consistent, safe, person-centred and evidence-based.

Background

Evidence supports the importance of the early years in providing a strong foundation for lifelong learning, health, and development[1, 5]. Brain development in early childhood lays the foundation for emotional wellbeing, social competence, language and literacy development and cognitive abilities, and influences health, future learning and life outcomes[5, 6]

The wellbeing of children and young people requires appropriate care, development, education, health, and safety. However, almost a third of Australian children in 2024 experienced some form of disadvantage that can have a lasting impact on their development[5]. For example, on census night in 2021 around 17,646 children aged 0-12 years were homeless[7]. In 2020, 17% of Australian children aged 0-14 years live below the national poverty line, about 8% of 0 -17 year olds are in out-of-home care, and just over 3% of 0-17 year olds are receiving child protection services[8].

MP 0097/18 - Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.

Adverse childhood experiences and stress

The World Health Organization states that “where we are born, grow, live, work and age, and our access to power, money and resources influence our health outcomes more than genetic influences or healthcare”[9]. Children may have an increased likelihood of adverse outcomes and the need for additional services when experiencing health and development risk factors[10]. These risk factors are also known as adverse childhood experiences (ACEs), and may include children:[10, 11]

- experiencing trauma
- with a disability or significant developmental delay
- living in out of home care
- who are incarcerated, exposed to criminal behaviour, or with parents in the justice system
- born into poverty, or experiencing socioeconomic disadvantage
- in a household with family and domestic violence or conflict
- in a household with family alcohol or drug misuse
- in a household with homelessness, transience and/or overcrowding and/or remoteness
- where household member has severe and/or untreated mental health issue/s
- experiencing discrimination, stigma, trauma, and barriers to accessing health and support services for those who identity as lesbian, gay, bisexual, trans and gender diverse, intersex or queer[12]
- experiencing social isolation and exclusion
- experiencing racial discrimination
- experiencing sexual abuse

The risks to short and long term health and wellbeing from ACEs are increased when adversities are prolonged, cumulative, severe, or occur during sensitive periods in early neurobiological development[13].

Families experiencing the compounding effect of various concerns may benefit from the additional services of Partnership contacts and targeted referrals where relevant. Offering increased services to families who need a higher level of support improves the long-term health and development outcomes for these children and families by lowering their level of risk for negative outcomes.

Positive childhood experiences

Not all families with complex concerns or risk factors will require additional services or experience adverse health and development outcomes. The presence of protective factors may reduce adversity and increase resilience. The protective factors that can moderate these risks and promote healthy development and wellbeing are also known as positive childhood experiences (PCEs), and include: [3, 6, 14]

- positive parent/care giver- child relationship and kinship care
- nurturing and secure attachment
- family stability and support
- knowledge, attitudes and beliefs
- connection to community/family
- connection to culture
- mother's education level
- high self-esteem and resilience
- social support (mental health)
- social and emotional competence of child
- connection to land and country

PCEs contribute to providing a physical and psychosocial environment that enables children and families to feel strong and resilient and in which a child might achieve optimal growth, development and wellbeing[15]. An environment which optimises children's physical, socio-emotional, behavioural and cognitive strengths, and supports their readiness for school and learning includes a combination of a nurturing, safe and stimulating home, good health, material basics, community environments that provide accessible and culturally safe family services, and engagement in high quality early childhood education and care[14, 16].

Longitudinal studies have shown that children with more PCEs across childhood (0-11 years) have fewer mental health problems and fewer academic difficulties at 14-15 years, even after accounting for ACEs[16].

The correlation is the same for teenagers. Increased adverse youth experiences (AYEs) are associated with poorer health, education, and employment outcomes. A higher number of positive youth experiences (PYEs) correlates with positive outcomes, including significantly greater odds of better general and mental health outcomes, mitigating the impact of AYEs. Reducing adverse experiences and environments and increasing positive ones during the critical developmental stages of adolescence could enhance adult health and wellbeing[17].

Risk factors can accumulate for children and young people across the life span and at key transition points (e.g. starting school, transition into high school). Enhancement of protective factors in care planning and service delivery, particularly during these sensitive periods, can support positive health, development and learning outcomes[6].

Clinical practice implications

The wellbeing of families and children may be adversely impacted at different times by changes in individual, parental or family circumstances that create a risk of poor health or developmental outcomes. Community health nurses can support short and long-term positive health and development outcomes with regular, effective screening, prompt referral and early intervention, appropriate care planning, and an awareness of available local resources and service providers[6].

Engagement with the client and their family is essential to enable meaningful assessment. Rapport and a trusting therapeutic relationship are built by addressing confidentiality issues and concerns, and if possible involving parents/caregivers when working with mature minors.

Active listening and clear, empathic communication with children and families supports assessment of the following factors that impact child health and development: [11]

- Alcohol and other drugs
- Culture and health
- Disability and development
- Disadvantage
- Family domestic violence or conflict
- Severe and/or untreated family mental health issues
- Homelessness, transience and/or overcrowding and remoteness
- Trauma

For detailed information on these factors, see Resource papers - Factors impacting child health and development.

Table 1. below provides an overview of the clinical practice implications for Community health nurses when reviewing factors that may impact child health and development.

Table 1. Clinical practice implications	
Area	**Information**
Relevant screening/assessment	Where appropriate, community health nurses should: • update the electronic health record with appropriate information/flag, to advise other staff of the specific circumstances of client and their families • ensure timely referrals to appropriate services • follow up with clients and their families to ensure that these referrals have been actioned Nurses should refer to the Clinical Nursing Policy Manual and follow the relevant policy processes for guidance, screening and assessment including: • Ages and Stages Questionnaire™ guideline - guidance on identifying developmental delays,

	determining required follow-up and referral actions, and relevant resources. • Family and domestic violence – child and school health - guidance on identifying FDV and determining any actions required, including screening and assessment. • Infant and Perinatal Mental Health - information on assessment of infant attachment, parent-infant interactions and infant mental health, and the administration of the Edinburgh Postnatal Depression Scale (EPDS) • Sexual Assault Response - School-aged clients - including information on Mandatory Reporting of Child Sexual Abuse in WA. • Guidelines for Protecting Children 2020 - information to appropriately address child abuse concerns identified through the provision of health services. • Clients of Concern management protocol - information relating to the identification and support of families with complex needs. • Physical assessment 0 – 4 years - guides comprehensive and systematic physical assessments that focus on identifying key risk and protective factors. Related Forms and Resources include: • Child Wellbeing Guide 0-18 years - tool to assist health professionals to identify neglect and take appropriate action. • Indicators of Need - observational tool to support a family assessment.
Relevant care planning considerations	Parents and carers are key partners in assessment and planning. They are the experts about their child's functioning, and the family history, concerns, home and surrounding environment, and current supports. Nurses should use a family-centred approach to work with parent/guardians to plan their child's health care. Assessing protective factors for health and development as well as risk factors supports positive outcomes for the child and their family. Consider and enhance protective factors when assessing,

	consulting, or planning care. (See individual factor papers for specific protective and risk factors for health and development). Services must be provided at a level proportional to client need. Nurses should consider the client's circumstances during care planning and when referral to services are made, noting that: • the complexity of the client's circumstance may involve a combination of factors impacting the current situation (e.g. homelessness, socioeconomic disadvantage, FDV) • these concurrent and cumulative factors impact on the client and family and may require referrals to external agencies such as housing and social services • additional clinical contacts to meet individual needs should be offered where clinical judgement warrants • long term care planning and support may be appropriate for some clients • barriers to the client accessing services should be explored and addressed in care planning considerations. Consideration of these points enhances the ability and capacity of the client and their family to access necessary services within a timely period to optimise their health and wellbeing outcomes.
Training requirements	Nurses are required to complete training specific to their role and local area need as per CACH Practice Framework for Community Health Nurses or WACHS Nursing and Midwifery Practice Framework and Guidelines and associated individual global learning plans.
Awareness of local service availability	Community Health Nurses can assist clients and their families by informing themselves about local services that provide emotional, financial and practical assistance support. Aboriginal Health Team and Refugee Health Team staff within your service may be of assistance with identifying culturally appropriate local services.

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Related internal policies, procedures and guidelines

The following documents can be accessed in the Community Health Manual: HealthPoint link or Internet link or for WACHS staff in the WACHS Policy link

Ages and Stages Questionnaires®

Children in Care- conducting an assessment
Children in Care- managing referrals for assessment
Clients of concern management
Family and domestic violence – child and school health
Infant and perinatal mental health
Partnership- child health service
Sexual assault response – School-aged clients
Universal Contact suite (Initial interaction, 0-14 days, 8 weeks, 4 months, 12 months, 2 years)
Universal Plus- Child Health

Related external legislation, policies, and guidelines
Mandatory reporting of child sexual abuse
Nursing and Midwifery Board AHPRA Decision-making framework
WACHS Nursing and Midwifery Practice Framework and Guidelines

Internal resources and forms
CAHS – Community Health Practice Framework for Community Health Nurses
Child Wellbeing Guide 0-18 Years (CHS470)
Factors impacting child health and development (resources)
Guidelines for Protecting Children 2020

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

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Appendix A: Alcohol and other drugs

Key Points

- Parental substance misuse occurs on a continuum and can have negative physical, developmental, psychosocial and emotional impacts on the child across the life course
- Timing, length and number of exposures can affect the severity of impact to the child
- The most commonly misused substance in Australia is alcohol
- Parental substance misuse commonly occurs in the presence of multiple complex issues, such as mental illness, family and domestic violence, homelessness and poverty. Children are more likely to be negatively impacted where mental health issues and/or family and domestic violence are present
- The impact of parental substance misuse can vary between children, and protective factors may mitigate negative impacts

Definition

Alcohol and other drugs are psychoactive substances which act on the central nervous system and alter the way a person thinks, acts and behaves.[1] They can include illegal, prescription or over-the-counter substances, for example:

- Depressants e.g. alcohol, benzodiazepines, GHB, kava
- Stimulants e.g. amphetamines, cocaine, ice
- Opioids e.g. heroin, fentanyl, buprenorphine, oxycodone, codeine, methadone
- Psychedelics e.g. LSD, magic mushrooms, DMT
- Cannabinoids e.g. cannabidiol, cannabis, medicinal cannabis, synthetic cannabinoids, butane hash oil
- Dissociatives e.g. nitrous oxide, ketamine
- Empathogens e.g. MDMA, PMA and PMMA, ethylone

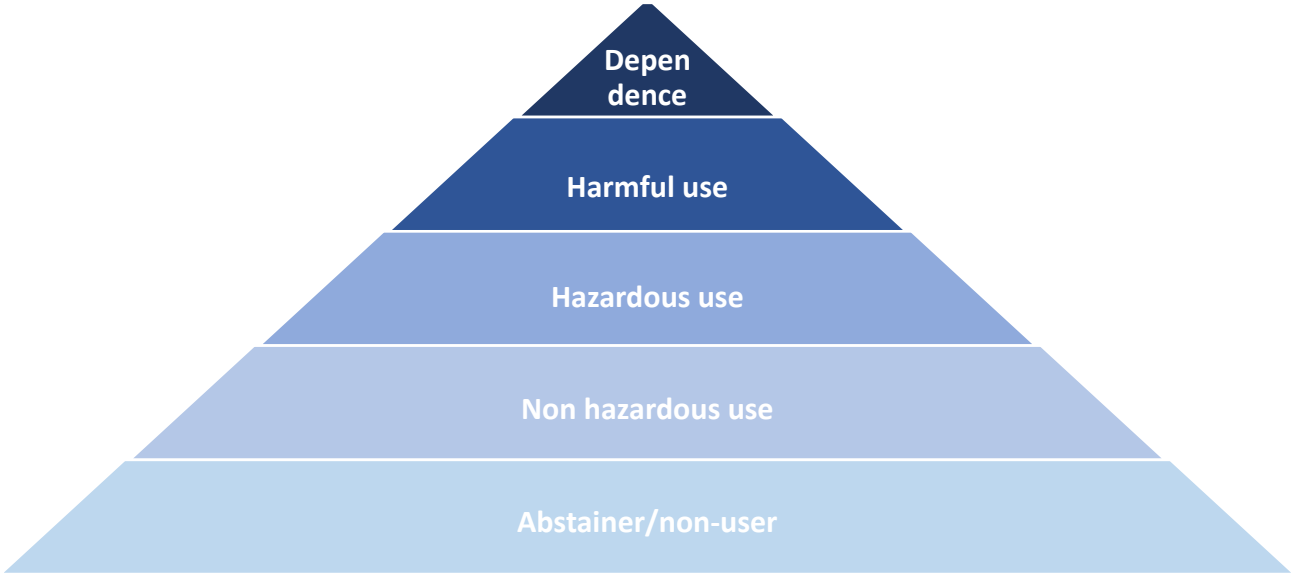
Substance misuse or abuse can be defined as “the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs”.[2] It is important to recognise that substance use exists on a continuum and can be problematic, regardless of whether a person is dependent on the substance.[3]

Signs of dependent use may include:[4]

- A strong internal drive to use substances
- An impaired ability to control substance use
- An increased priority given to substance use over other activities and responsibilities
- Persistent use despite harm or negative consequences

“A harmful use” is described as an episode or pattern of substance use that causes damage to an individual’s physical or mental health or results in behaviours that harm the health of others. “A hazardous use” has not yet reached the level of causing harm to the physical or mental health of the user or others around the user, but increases the risk of harmful physical or mental health consequences.[4]

Figure 1: Spectrum of substance use[3]



Prevalence

According to the National Drug Strategy Household Survey for 2022-2023[5], 1 in 3 Australians (31%) consumed alcohol at risky levels, exceeding the recommended limits of 10 standard drinks per week or 4 standard drinks in a single day. Although alcohol consumption during pregnancy is declining, it still stands at 28% among women aged 14-49 years, and many women drink without knowing their pregnancy status.[5]

Around 1 in 5 Australians used an illicit drug in the previous 12 months in 2022-2023. The most used illicit drug was cannabis (11.5%), followed by cocaine (4.5%) and hallucinogens (2.4%). The survey also noted an increase in the use of hallucinogens and ketamine between 2019 and 2022-2023, while the use of many other illicit drugs remained stable.[5]

The harmful effects of alcohol and other drugs impact individuals, families, and communities in various ways, including health, social, and economic consequences.[6] One in 5 people aged 14 and over in Australia experienced verbal abuse, physical abuse, or fear due to someone under the influence of alcohol.[5] Alcohol was involved in 29% of family violence and 34% of intimate partner violence as reported in Alcohol/Drug-involved Family Violence in Australia project in 2016.[7] Children with

parents or guardians who experience alcohol dependence are more likely to be brought to the attention of child protective services.[8]

Health and developmental impacts/outcomes for child

All areas of a child's life can be negatively impacted by problematic parental substance use across the life course (see Table 1).[9, 10] It is important to note that children of different ages are impacted differently by parental substance use.[9, 10]

Parental substance misuse often co-occurs with other complex issues.[11] The presence of additional issues increases the risk of impact on the child, particularly parental mental illness and exposure to domestic violence. Children of parents who misuse substances are at increased risk of maltreatment, neglect, and abuse.[9, 10, 12]

The risk of impact to the child is cumulative in accordance with the number of factors involved and length of exposure. The presence of problems at key development stages during early life is thought to be particularly influential.[9]

Additional risk factors include:

- Parental mental illness
- Domestic violence/abuse
- Poverty and socioeconomic disadvantage
- Unemployment
- Homelessness/housing instability
- Social exclusion and discrimination
- Family disruption, separation, and substitute care
- Criminal activity
- Absence of stable adult figure

Ways in which parental substance misuse can affect children across the life course include[13]:

- Direct physiological effects (e.g. foetal exposure to substance)
- Direct harm to a child by the intoxicated parent
- Diversion of parental attention due to substance use and associated activities
- Parental modelling of substance misuse behaviours to the child

Table 1: Health and developmental effects of pre- and postnatal substance exposure across the life-course[10, 12, 14-19]

Age of child	Effects/outcomes
Unborn child	• Miscarriage • Still birth • Placental abruption • Premature rupture of membranes • Prematurity • IUGR • SGA • Foetal Alcohol Spectrum Disorder • Neurological damage
Newborn	• Low birth weight • Low APGAR score • Neonatal Abstinence Syndrome/neonatal withdrawal • Increased risk of sudden infant deaths • Foetal Alcohol Spectrum Disorder • Neurobehavioral disturbances • Increased risk of congenital anomalies • Potential for poor adaptation to extra uterine life
Babies/toddlers/pre-schoolers*	• Poor growth • Developmental delays • Increased risk of sudden infant deaths • Poor parental attachment • Cognitive deficit • Hyperactivity • Attention deficit • Leaning difficulties
School-aged/pre-adolescents*	• Mood/anxiety disorders • Anxiety and depression • Aggression & withdrawal • Inattentiveness • Hyperactivity • Behavioural/attentional disorders • Cognitive deficit • Impaired academic achievement
Adolescents*	• Substance use problems • Mood/anxiety disorders • Anxiety and depression • Aggression & withdrawal • Impaired academic achievement

*The cumulative effects of the home environment and surrounding circumstances may confound outcomes

Parental substance use has been linked with negative parental behaviours. The absence of secure attachment with children, appropriate supervision, support, and stimulation for age, and exposure to unsafe situations can compromise child's safety, belonging and well-being.[12]

Psychological/physical effects of living with a parent who uses substance includes[10, 12]:

Child neglect

- Failure to provide for the child's basic needs: shelter, safety, supervision and nutrition

Child abuse

- Physical, emotional, sexual

Increased risk of accidents

Increased risk of infections

Risk of exposure to hazardous environment

- Contact with people using and buying drugs
- Being subjected to drug trafficking
- Ingesting and inhaling drugs
- Witnessing criminal behaviours and interacting with criminals
- Being exposed to violence
- Being exposed to substandard living conditions

Risk of mental health problems

Risk of behavioural problems, violence and substance use

Disengagement from school, poor academic performance

Risk of extensive punishment

Risk of being placed in foster care

Protective Factors

Whilst children who are exposed to parental substance misuse have a greater risk of negative outcomes, protective factors can reduce impact and promote resilience (see Table 2).[9,20, 21]

Table 2: Protective Factors

Individual factors/ child related factors	• Internal locus of control (ability to change their circumstances) • Self-monitoring/coping skills or strategies/self-control • Self-efficacy, self-esteem • Effective emotional expression • Social skills • Hobby/creative outlet • Future planning • Good understanding of parental misuse behaviour • Intellectual capacity • Abstinence from alcohol and drugs
Family factors	• Secure parent-child attachment/ supportive relationship with a stable (non-substance misusing) adult • Family cohesion and adaptability/demonstrations of affection from extended family • Parental self-efficacy/self-esteem • Consistency and stability in everyday/family life • Constructive coping styles and deliberate actions by parents to minimise adversity for children • Strong family norms and morality • Adequate finances and good employment opportunities • Positive care style of parents • Parental modelling of behaviours expected from a child • Absence of domestic violence/abuse
Parental factors	• Parental problems are of reduced severity and shorter duration • Low parenting stress • One parent does not have problems • Parent receiving treatment/willingness to treatment • Drug activity/paraphernalia is kept hidden/drug use occurs away from the home
Community/environmental factors	• Cultural connectedness, values and identity • Support from community adult role models e.g. teacher, neighbour • Strong friendships/peer relationships • Positive school experiences/consistent attendance at school • Support from key community services, e.g. healthcare

	• Information and education about existing support

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Appendix B: Culture and health

Key Points

- Aboriginal[1] people of Australia are not just one group. There are over 200 language groups, each with their own cultural traditions (music, dance, art, stories, language and lore).
- Centrality of Aboriginal culture within health is a protective factor and has a positive effect on the social and emotional health and wellbeing of Aboriginal children and their families.
- Engaging with Aboriginal children and families in a culturally competent and respectful manner is a key success factor for preventative health and service delivery.[1]

Context

In focussing on strength-based approaches, it is important not to ignore or forget the underlying causes of health inequity which stems from imperialism, colonialism and racism.[2]

The social and emotional wellbeing of Aboriginal peoples is affected by the historical impact and ongoing effects of colonisation and dispossession of Country, interruption of culture and kinship structures through the removal of Aboriginal children from their families, persisting interpersonal and institutionalised racism and the unresolved grief and trauma which has been passed on to successive generations[3]. These factors are very much intertwined and affect the social and emotional health and wellbeing of Aboriginal peoples.[4]

Social, historical and political determinants also influence social and emotional wellbeing, which includes physical health.

The health and developmental outcomes of Aboriginal children are affected by social, historical and political determinants as well as the child's and family's level of connection to each of the Social and Emotional Wellbeing (SEWB) domains.

- Social determinants are the conditions in which people are born, grow and live. These determinants include socioeconomic status, educational attainment, employment, housing, exposure to violence, trauma, stressful life events and access to community resources.[5] Addressing the social determinants of health requires cross sector actions across all social services. Some of those social services include health, education, employment and income, housing and food security agencies.[6]

[1] Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community. *
* OD 0435/13 – Use of the Term 'Aboriginal' in all forms of WA Health communication.

- Historical determinants refer to the impact of past government policies, the extent of historical oppression and the cultural displacement experienced.[5]
- Political determinants describe the unresolved issues of land, control of resources, cultural security and the rights of self-determination and sovereignty.[5]

Children born to Aboriginal families who are experiencing poorer health outcomes can have life-long health and wellbeing outcomes, that can affect not only themselves, but also their families and wider community.[7]

Definition

Cultural determinants of health refer to Aboriginal ways of knowing, being and doing that incorporate Aboriginal peoples view of health and wellbeing. Cultural determinants are considered protective factors which enhance resilience, strengthen identity and support good health and wellbeing.[6]

This strength-based approach in health draws on the positive factors of a person's life that keeps them strong[8] and recognises the capacities and capabilities of Aboriginal people[2]. These positive factors are also protective as they are associated with good health outcomes.[8]

Evidence shows that cultural factors such as Country and caring for Country, language, self-determination, connection to family and kinship and cultural expression can be protective and positively influence Aboriginal people's health and wellbeing.[9]

The SEWB of Aboriginal peoples acknowledges,

"Aboriginal health is not only the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their Community. It is a whole of life view and includes the cyclical concept of life-death-life".[10]

For Aboriginal people, culture is comprised of rules or behaviours and standards that guide how they see the world[11]. Culture guides all beliefs related to customs, law and lore, history and traditions, which is passed on through the generations.[12]

Social and Emotional Wellbeing model

Figure 1. Gee, Dudgeon, Shultz, Hart and Kelly 2013[5]

The social and emotional wellbeing model outlines the domains which are optimal sources of wellbeing and connection for Aboriginal people. “Connection to” relates to how people may experience and express these domains throughout their life.[13] Across a person’s lifespan, the way each domain is experienced will vary, with domains experienced as being healthy or experiencing difficulty.

This model is underpinned by the nine guiding principles set out in the *Ways Forward* national consultancy[14] report. These guidelines are:

1. Health as holistic
2. The right to self-determination
3. The need for cultural understanding
4. The impact of history in trauma and loss
5. Recognition of human rights
6. The impact of racism and stigma
7. Recognition of the centrality of kinship
8. Recognition of cultural diversity
9. Recognition of Aboriginal strengths.[13]

Protective Factors

Aboriginal people state that cultural, family and community connectedness is fundamental to their health and wellbeing[15] and is a protective factor for Aboriginal health.

Aboriginal health and wellbeing is everybody’s business, therefore health services play an integral role in actualising this. It has been shown that health services whose employees communicate respectfully, build good relationships, understand the underlying social, cultural, historical and political determinants, have an understanding

of culture and who employ Aboriginal people are more likely to be accessed by Aboriginal people and can be a protective factor.[16]

Supporting families to take a family centred approach in their children's health care is also a protective factor and is supported as a strategic objective by CAHS.

The seven domains of the social and emotional wellbeing model and the protective factors of each as relating to children and families of which CAHS Community Health can help to strengthen are outlined in the following table.

The following table has been populated by considering how CAHS Community Health has impact or can encourage and support Aboriginal children and their families. The green highlights the domains where we can help to support and affect change with Aboriginal families.

Cultural Domains	Protective Factors
Connection to Body (physical health)	• Access to adequate quality nutrition and/or traditional foods
	• Access to culturally safe care from culturally competent health professionals[17] and/or access to community driven, localised health and wellbeing programs
	• Opportunity to move body
Connection to Mind and Emotions (Mental health)	• Cultural attachment/Sense of belonging
	• Safe and secure relationships
Connection to Family and Kinship (Central to Aboriginal society)	• Loving, stable, accepting and supportive family[17]
	• Support of family and kinships networks
	• Knowledge of kinship structure (who's your mob)
	• Strong identity/sense of self
	• Intergenerational knowledge transmission
Connection to Community (Opportunities for individuals and families to connect, support and work together)	• Culturally appropriate family-focussed programs and services[17]
	• Connected to/recognised by community
Connection to Culture	• Culturally safe health services/programs
	• Opportunities to attend/participation in cultural events and ceremonies[17]
	• Contemporary expressions of spirituality[17]

(Sense of continuity with the past and underpins strong identity)	• Parents/carers/Elders transmitting cultural knowledge • Language
Connection to Country (Underpins strong identity and sense of belonging)	• Living on/time spent on Country[17] • Access to traditional lands • Feeling connected to the Country people are living on
Connection to Spirit, Spirituality and Ancestors (provides sense of purpose and meaning)	• Spiritual and religious beliefs • Access to traditional knowledge • Access to traditional healing • Parents/carers are able to pass on Aboriginal ways of knowing, doing and being

Case study

Jodie is a 24-year-old Mum of four children aged, 4, 3, 18 months and 6 months.

She lives in her own four-bedroom Public Housing home with her partner. Her older sister and her three children (aged 10, 12 and 15 years old) also live with them as they moved from up north and have nowhere else to stay. Jodie often has other adult relatives staying over. She says that Public Housing is probably going to evict her if she keeps having other relatives staying with her. Public Housing is ok with Jodie's sister and children staying there.

Jodie's children all have severe dental caries, and all have iron deficiency anaemia (IDA). The Medical Officer has discussed starting iron medication for the 18-month-old, but just wants a review and recheck done in 6 weeks for the other children.

Jodie is struggling financially. Jodie's 3-year-old and 18-month-old are still drinking from a bottle, what looks like cordial. Jodie is really struggling with the 3-year-old's behaviour, with the child being given a soft drink or bottle of cordial to settle her after a tantrum.

The children suffer often from sores and have had many bouts of scabies.

Cultural Domains	Support	Strengthening protective factors in the domain	Reducing risk factors in the domain	Support
Body	• Aboriginal Health Team (AHT)	• Looking after the children's physical health: medication for	• Advice to Jodie on how to make lifestyle changes to help	• Public general dental clinic

		IDA, referral to dentist for children, treatment plan (and health promotion advice) in place for sores and scabies • Whole family health check	increase iron levels • Nutrition advice and/referral to food help agency • Referral to a public general dental clinic	• Medical Officer/GP • Aboriginal Health Team staff (AHW & CN)
Mind and Emotions	• AHT	• 4 & 3-year-old are engaged with the nearest Kindilinks/Child and Parent Centre • ASQ assessment • EDPS	• Work with Jodie's 3-year-olds behavioural issues • Parents and Aunty provided with strategies to support 3-year-old	• CDS staff • AHW • Kindilinks
Family and Kinship	• AHT	• Jodie and father connected into family support/parenting programs • Strengthen support from Aunty and older cousins		• Aunty and other parents • Family • Family support programs
Community	• AHT	• Kindilinks • Linking in with other services (Public Housing, financial counselling)		• Community • Kindilinks
Culture	• Cultural events	• Encourage Jodie to attend cultural events with children		
Country				
Spirit				

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Appendix C: Disability and Development

Key points

- Disability is the interaction between a child's health conditions, body functions and structures, the activities they participate in, and the environmental factors that affect these.[1,2]
- A child may be born with disabilities, or these may develop after birth. Disabilities may be caused by genetics, injury or illness.[3]
- Children with disability may have special needs, and may require early intervention and increased support.[3]
- Children with intellectual disability or mental and behavioural problems have a greater risk of experiencing maltreatment than children without disability.[4]
- The health and development of children with disability can be improved by timely surveillance, thorough assessment, early referral for services, early intervention, inclusive schooling, and support for families/carers. [5,6]

Definitions

Disability is defined by ABS as “any limitation, restriction or impairment which restricts everyday activities and has lasted, or is likely to last, for at least six months”.[7] It refers to any condition that restricts a person’s mental, sensory, intellectual or mobility functions and may be caused by accident, genetics or disease.[5] The impairment can be temporary or permanent, total or partial, visible or invisible, and can be there from birth or occur during a person’s lifetime.

Developmental delay describes a lag in the acquisition of a skill or milestone otherwise expected of a child at a particular age.[8] Developmental delays are measured using validated developmental assessments and may be mild, moderate or severe. While a developmental delay may not be permanent, it can provide a basis for identifying children who may experience a disability.[5]

Developmental disability describes the profile of children with complex and pervasive developmental difficulties that are likely to impact on a child’s ability to participate optimally in functional activities across their lifecourse.[8]

Neurodevelopmental disorders are disorders of early brain development. They include autism spectrum disorder (ASD), intellectual disability, motor disability (e.g. cerebral palsy), seizures, learning disabilities (e.g. dyslexia), and attention deficit hyperactivity disorder (ADHD). Children with neurodevelopmental disorders can experience a wide range of symptoms, including reduced emotional regulation, poor movement (motor) control, problems with language development and social integration, and impacted learning ability.[9]

Limitation means a person has difficulty, needs assistance from another person, or uses an aid or other equipment to perform one or more of the core activities (communication, mobility and self-care). The severity of limitations can be mild, moderate, severe or profound.[4]

Schooling restriction means a child needs special assistance or equipment to participate in a mainstream class or attend a special school or special classes.[4]

Prevalence

In WA in 2018, 7.5 % (43,600) of children and young people aged 0 - 17 years had a reported disability.[7] Around 11.5% (22,400) of children in WA aged 6 - 11 years have a disability.[7] Disabilities in childhood are varied, and include cerebral palsy, intellectual disability, spina bifida, acquired brain injury, visual or hearing impairment, autism spectrum disorder, and rare genetic conditions such as tuberous sclerosis.[9] Boys are almost twice as likely as girls to have a disability.[4]

Across Australia, 70 % of 0 - 5-year-old children with disability have a speech or sensory disability (including loss of sight or hearing). The most common types of disability in the 6 - 11 year-old age group are intellectual (67.8%) and psychosocial (39.3%) disability.[7]

Just over half (52%) of children with a disability have a profound or severe core-activity limitation and require assistance with one or more core activities of daily.[1] The 2016 Census estimated that Indigenous children aged 0 – 14 years were 1.7 times as likely as non-Indigenous children to have a severe core-activity limitation, but considered this to be a significant underestimation.[4]

In 2017, 18.8% of all Australian primary and secondary students received an adjustment at school to address disability.[4] Almost all (97%) children aged 5–14 years with a disability were attending school; 89% were in mainstream schools and 9% were in schools specially designed for students with disability.[3]

The increase in prevalence rates for autism and ADHD has been attributed to improving diagnostic methods and increased awareness.[10]

Health impacts and outcomes

The impairments related to a disability may interact with various barriers to hinder a child's full, effective and equal participation in society.[11] To reach their full potential, all children need good health care, nutrition and safety, responsive care giving, early learning opportunities, inclusive schooling, and opportunities to take part meaningfully in home and community activities. Children with disability have all the same needs but may require extra support to help them have these needs met.

Development proceeds through a series of milestones. Typically, simple skills are mastered before more complex skills can be learned. Developmental delays or disabilities in one area can impact on the child's ability to consolidate skills and progress through to the next developmental stage. Chronic health conditions can also have long-term effects on a child's development and behaviour.[12] The broad range of individual differences between children often makes it difficult to distinguish between typical variations in development, maturational delays, transient disorders, and persistent impairments.[8]

Children with disability are at risk of the same childhood illnesses as other children. They may have specialised health-care needs related to their disability, and other secondary conditions. For example, children who are wheelchair users are vulnerable to pressure ulcers.[5]

Children with disability can be disproportionately exposed to risk factors such as poverty, stigma and discrimination, poor caregiver interaction, violence, abuse and neglect, and limited access to programmes and services. All can have a significant effect on their wellbeing and development.[5]

Families of children with disabilities experience more stress, greater financial strain and poorer wellbeing than families with typically developing children. [13] This is particularly due to the time and emotional commitments associated with raising a child with high support needs. These parents have an increased risk of developing mental health problems such as depression and anxiety, and significant stress on familial and social relationships.[13]

Mothers have described emotional support as possibly the most important influential coping factor.[1] Support is most critical at the time of diagnosis and during medical intervention for their child.[14]

Protective factors

Effective interventions can alter the course of a child's development by positively changing the balance between protective and risk factors within a child's environment.[8]

Protective factors that may reduce the incidence and severity of impact of disability and developmental delay in children include:

- a sense of belonging to home, family and community, and a strong cultural identity
- pro-social peer group
- positive parental expectations and home learning environment
- positive opportunities at major life transitions
- access to child and adult focused services, including general and mental health, maternal and child health, early intervention, disability, drug and alcohol, family support, family preservation, parenting education and recreational facilities
- accessible and affordable child care and high-quality preschool programs
- inclusive community neighbourhoods/settings
- the service system's understanding of neglect and abuse.[12]

Early intervention

Early intervention (EI) is specialised support for children with disability, autism or other additional needs including developmental delay. EI refers to therapies and supports for children and their families in the early years from birth until children start school.[6] The World Health Organization recommends EI as the best way to support the development and wellbeing of children with disability, autism or other additional needs including developmental delay. [5] With family involvement and timely interventions, EI helps children develop the skills they need to take part in everyday activities, and promotes a more stimulating and protective environment.[5] Sometimes children who get EI need less or no support as they get older.[6] There are high economic returns on

early intervention, particularly for disadvantaged children, but EI must be followed up along the life course or the economic returns diminish.[8]

There is evidence that providing support and services for infants and young children with early developmental impairments and their families can alter the child's longer term developmental trajectory and reduce the risk of secondary health and psychosocial complications. Supporting the family is a crucial component of EI programs, as the family has a key role in fostering their child's developmental potential and may experience additional stresses as they meet the special needs of their child.[2]

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Appendix D: Disadvantage

Key Points

- Disadvantage arises from the overlap of multiple factors such as unemployment, low income, and health conditions, as well as from the effects of individuals' living conditions - including weak social support networks, lack of opportunities, and social exclusion.
- Disadvantage can be assessed at an individual, family or community level.
- SEIFA is a widely used measure of advantage and disadvantage in a geographical area.
- Disadvantage can negatively affect children's health and developmental outcomes.

Definition

Disadvantage is a complex notion that affects many aspects of people's lives. It consists of many different dimensions, and there is no single agreed-upon definition or way of measurement.[1]

In the context of health equity, economic disadvantage refers to a lack of material resources and opportunities, such as low income or limited wealth, which can prevent individuals from purchasing essential goods and services. Social disadvantage, which includes economic disadvantage, relates to a person's position within a social hierarchy. This hierarchy stratifies individuals and families based on various factors including economic resources, race, ethnicity, religion, gender, sexual orientation, and disability. These characteristics can significantly influence how people are treated within the society. Environmental disadvantage pertains to living in neighbourhoods characterised by concentrated poverty and the social issues that often accompany it.[2]

According to the Productivity Commission, factors such as poverty, deprivation, capabilities, and social exclusion are various ways to understand and measure disadvantage.[3]

The Australian Early Development Census (AEDC)[4] and the Early Childhood Education and Care National Data Collection[5] assess and monitor inequities identifying groups of children who may need additional support. They use the Australian Bureau of Statistics (ABS) Socio-economic Indexes for Areas (SEIFA) to understand how access to programs and outcomes varies for children from disadvantaged backgrounds. SEIFA comprises four indexes, each summarising different subset of variables from census data.[6] It is important to note that these indexes are assigned to areas rather than individuals, reflecting the collective socio-economic characteristics of the residents in those areas.

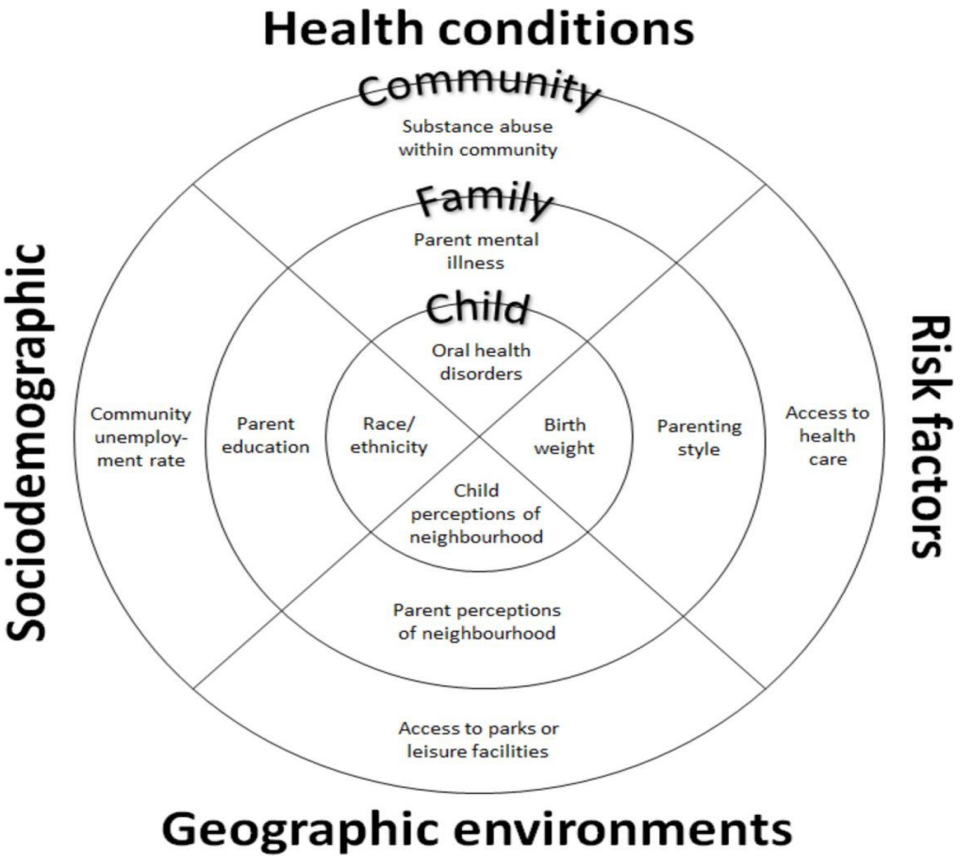
The indexes include:[6]

- The Index of Relative Socio-Economic Advantage and Disadvantage – measures both advantages and disadvantages, considering factors such as income and occupational status. A lower score indicates a greater level of disadvantage and a lack of advantage.
- The Index of Relative Socio-Economic Disadvantage – focuses on measures of relative disadvantage. A lower score means relatively greater disadvantage.
- The Index of Economic Resources – assesses economic advantage and disadvantage, considering factors like income and housing. A lower score indicates a relative lack of access to economic resources.
- The Index of Education and Occupation – focuses on advantage and disadvantage related to education and occupation, using information such as occupation, skill level, and employment status. A lower score reflects lower educational and occupational levels in the area.

SEIFA is a valuable tool for identifying local areas that need of support; however, it does not capture the challenges faced by disadvantaged children at the family or individual level.

The Changing Children's Chance project at The Centre for Community Child Health proposed a framework for understanding child disadvantage (figure 1) that aligns with social determinants (circumstances in which children live, learn, and develop) viewed through 4 perspectives: sociodemographic factors, geographic environment, health conditions, and risk factors. The sociodemographic perspective includes characteristics, such as ethnicity, education level, and income. The geographical environments consider factors like neighbourhood liability, or whether the area is urban or regional. Health conditions encompass the medical issues experienced by the child or caregiver. Risk factors identify characteristics and exposures that increase the risk of poor child health and developmental outcomes for children, such as child obesity, caregiver binge drinking, smoking, and instances of physical arguments between partners. Disadvantages experienced through these various lenses can occur at multiple levels, including individual, family and/ or community.[7, 8]

Figure 1: Framework of child disadvantage aligned with social determinants and bioecological levels (individual, family, and community)[8]



Prevalence

- In 2022, 14.5% of the Australian population was living under the poverty line. An estimated 71,000 children in Western Australia live in poverty, which is nearly one in nine. Additionally, one in three single-parent families (33.4%) is living below a 50% median poverty line.[9]
- In 2021, 122,494 people were estimated to be experiencing homelessness, with 14.4% aged under 12 years and 9.2% aged 12-18 years.[10]
- In 2022, among all children aged 0-14, almost 3 in 4 (72%) lived in major cities while nearly 1 in 5 (19%) resided in the lowest socioeconomic areas.[11]
- According to the 2021-22 Personal Safety Survey, 13% of people aged 18 years and over has witnessed violence towards a parent by a partner before the age of 15.[12]
- In 2020-2022, one in three people (32.6%) living in a one parent-family with dependent children had a mental disorder reported in the previous 12 month, compared to one in five people living in couple families with dependent children (19.4%).[13]

- The percentage of children developmentally on track across the five domains namely physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, and communication skills and general knowledge decreased in all SEIFA quintiles from 2021 to 2024. In 2024, the percentage of children on track in the most disadvantage quintile was 41.2%, while it was 61.1% in least disadvantaged quintile.[4]

Health impacts/outcomes for children

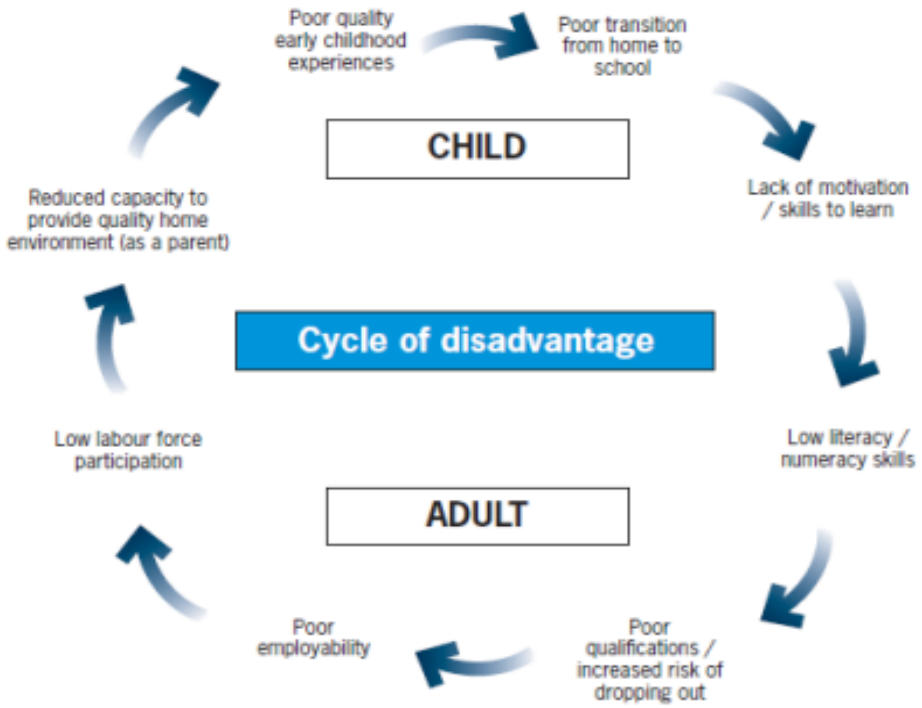
Early childhood development lays the foundation for health, wellbeing, and productivity over the lifespan.[14] While inherited genes play a role in child development, the quality of family environment, and the availability of appropriate experiences at various stages of development are important for child development.[3]

Different facets of the socioeconomic context, both individually and in combination have been shown to influence the brain development throughout childhood and adolescence.[15] Therefore, disadvantage in early childhood can negatively impact child development, with children from the most disadvantaged backgrounds at the highest risk of poor developmental outcomes.[14]

These outcomes are influenced by the wellbeing of families and the conditions in which they live. Income, finance and employment factors can directly and indirectly affect children, by impacting their education, home environment, housing conditions and access to resources.[16] A family's low income can also lead to food insecurity and affect a child's diet and access to medical care. Appropriate housing, heating and clothing provision can also be impacted by low income, as well as the safety of a child's environment, and of the quality and stability of their care.[16]

The cycle of disadvantage, as illustrated below (figure 2), shows that risk factors contributing to disadvantage begin in a child's early years, and adverse early experiences can result in a challenging transition from home to school.[17]

Figure 2: The cycle of disadvantage[17]



Various studies have employed different tools and methods to assess disadvantage and developmental outcomes. A summary of the research evidence is presented in table1.

Table 1: Summary of research evidence on outcomes following exposure to disadvantage

Exposure	Outcome
Low childhood socioeconomic position/ socioeconomic disadvantage	• Greater risk of experiencing Adverse Childhood Events (ACEs)[18] • Overweight or obesity[19] • Lower working memory in children[20]
Low income	• Behaviour problems, and problems with academic skills among children[21] • Higher rates of mental disorders among children and adolescents (reported in the previous 12 months)[22] • Poor educational achievements, risk of smoking, and psychological distress in adolescence[23]

Financial difficulty/poverty	• Poorer cognitive and social-emotional outcomes (conduct problems, inattention/hyperactivity, emotional symptoms and peer problems)[24, 25] • Obesity and lower levels of general health[25]
Unemployment in families	• Poorer cognitive and social-emotional outcomes[3] • Higher rates of mental disorders among children and adolescents (reported in the previous 12 months)[22]
Lower carers education	• Higher rates of mental disorders among children and adolescents (reported in the previous 12 months)[22]
Different aspects of disadvantage: Sociodemographic factors	• Poor socioemotional adjustment (social competence and mental health), physical functioning (motor skills) and learning competencies (literacy and numeracy) in late childhood (10-11 years)[14]
Geographic environments	• Poor socioemotional adjustment[14]
Health conditions	• Poor physical functioning[14]
Risk factors	• Poor socioemotional adjustment[14]
Neighbourhood disadvantage (considering income, education, employment status and housing quality of the area)	• Unfavourable BMI and obesity in childhood[26] • Low cortical thickness in several brain regions across the frontal, parietal, and occipital lobes (measured at 10 years)[15]

Protective factors

A child's early experiences and environment have a profound influence on their health, development, and well-being. There is strong evidence that good education, employment opportunities and good health can serve as buffers against the negative impacts of disadvantage.[3]

Protective factors that support children in the face of adverse experiences include[3]:

- household stability
- a strong early attachment to an adult
- informal support/supportive role model (such as grandparents)
- good parenting.

Additionally, positive parental expectations, strong peer relationships, effective teacher-student relationships, and intrinsic factors such as motivation, and educational aspirations are significant predictors of academic achievement among disadvantaged children.[27]

Children living in disadvantaged circumstances can also experience improved social and behavioural outcomes in the presence of higher IQ, supportive parenting, and positive parent child relationships.[28] Warm and nurturing maternal relationships have been shown to moderate the impact of family financial difficulties on child mental health.[24]

Most refugee children demonstrate normal socio-emotional wellbeing within 2 to 3 years after resettlement. A longitudinal study of newly arrived refugee children in Australia showed that better socioemotional wellbeing is associated with factors such as the presence of a father at arrival, having relatives in the settlement area, living close to their ethnic community and, receiving support from the broader community. [29]

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Appendix E: Family domestic violence or conflict

Key points

- Violence is a gendered issue impacting females and children more than males
- Exposure to and experience of FDV impacts health outcomes in children
- Children impacted by FDV have poorer health outcomes than the general child population

Definition

The term ‘family and domestic violence’ is used in Australia to encompass acts including intimate partner violence, abuse between siblings and other family members and between extended kinship ties.[1]

Family and domestic violence is not only physical- it can also include emotional, financial, sexual, verbal, psychological, as well as neglect, coercive control, and stalking.[2]

Children and young people can experience violence directly (by having violence perpetrated against them) and/or indirectly via witnessing violence being perpetrated against their parent/ or caregiver.[2]

Prevalence

Family and domestic violence is a major health and welfare issue in Australia and although it does affect people of all ages and from all backgrounds it predominately affects women and children.[1-3]

It is reported that in Australia one in three women have experienced physical violence and almost one in five women sexual violence. One in four women have experienced physical or sexual violence from their current or former male partner. These figures are most likely an underrepresentation of the actual physical and sexual violence that occurs against women, as only a small proportion of women ever report the violence.[2]

Children are also victims of violence, either directly or indirectly. Around one in four women report when they experienced violence during a relationship, that children in their care were present and were exposed to the violence, either hearing or seeing the violence.[2, 3]

There is limited data available on the prevalence and impact of family and domestic and sexual violence on those groups most likely to experience to FDV in Australia. However, the following groups have been identified to be at higher risk of experience and exposure to FDV and consequently higher risk of adverse health and social health outcomes:[2, 3]

- young women
- women with a lower socio-economic background
- people with disabilities
- children (witness to and experience of FDV)
- Aboriginal people
- people from CALD backgrounds
- LGBTIQ+ people
- people in rural and remote areas

The 2016 COAG report[2] (pg. 16), noted “the impact of violence against women on some groups of children and young people can be exacerbated by other challenges, including marginalisation and discrimination. This is particularly the case for children who identify as lesbian, gay, bisexual, transgender, intersex and queer or those with parents who identify as such, children from culturally and linguistically diverse backgrounds, and children living in regional, rural and remote areas”.

Health impacts and outcomes- children

Children impacted by FDV are more likely to have poorer health than the general population of children[1] and are more likely to be exposed to other conditions that put them at risk for negative health outcomes.[4]

Children can experience violence as a witness and/or victim.[2, 3] Both these direct and indirect experiences of violence can have long term impact on the child and on the mother-child relationship. Children who are witness to FDV experience similar levels of negative psychological and social issues as those children who are impacted directly by physical abuse.[2]

Violence against women and their children is the leading cause of homelessness in Australia.[2, 3] In Australia during 2017-18, 22 per cent of clients seeking homelessness services as a result of FDV were aged 0-9 years.[3]

The impact on children can occur throughout childhood and later in life.[2, 3, 5, 6] If the violence is chronic or repeated, the symptoms may be exacerbated.[2]

The exposure of family violence can affect all aspects of a child’s health and wellbeing outcomes,[2] including during the perinatal period for those children whose mothers experience domestic violence during pregnancy.[1] It affects a child’s mental and physical wellbeing, and can contribute to behavioural issues and poorer educational outcomes.[2]

FDV does not predetermine outcomes for children and young people; but it can influence them significantly especially when the exposure to the violence occurs in the in early years.[7]

Table 1- Impacts of family and domestic violence on children (adapted from Department for Child Protection[7] Fact Sheet)

Age of child	Impacts of family and domestic violence
Unborn child	• Increased risk of miscarriage, low birth weight and premature birth, foetal injury and death[2, 7] • Weaken developing brains, having lifelong effects on a child's learning, behaviour and health[2]
Babies and toddlers	• Often cry more, show signs of anxiety or irritability • Feeding and sleeping issues • Underweight for age • Neglect • Sexual abuse • Delayed mobility • Often react to loud noises & wary of new people • May be very demanding or very passive • Increased risk of physical injury if in arms of mother whilst assault occurs
Pre-schoolers	• Bedwetting, nightmares, eating issues and trouble sleeping • Behavioural issues[2] such as aggression, lack of emotional control, limited tolerance • Concentration issues • Increased arousal • Physical complaints, fearfulness and numbing • Adjustment problems (i.e. transitioning from kindergarten to pre-primary)
School-age & pre-adolescent	• Withdrawal and avoidance from friends and family • Self-harm • Loss of interest in social activities • School performance affected negatively
Adolescents	Increased risk of: • academic failure, dropping out of school • delinquency/offending • eating disorders • substance misuse • depression, suicide ideation • use of controlling behaviours • early pregnancy • violent behaviours and violence toward a parent (particularly their mother)

Further impacts of family and domestic violence on children include:

- increased risk of experiencing other forms of abuse such as emotional, physical, or sexual
- higher rates of gastrointestinal problems[1]
- higher rates of psychological health issues[1]
- increased mental health hospitalisations[1]
- hospitalisation from injuries due to abuse including assault, malnutrition and neglect[3]
- increase risk of homelessness[2, 3]
- increased risk of poor mental health outcomes, particularly depression, anxiety and alcohol dependence[1, 6]
- increased risk of experiencing interpersonal violence as an adult (for both perpetration and victimisation)[2, 6]

Protective factors

Although not well researched, there are attributes or conditions that can occur at an individual, family or community level (protective factors) that can moderate risk or adversity and promote healthy development and child and family wellbeing with regards to exposure and impact on FDV.[7, 8] Not all children are adversely or affected in the same way as a result of exposure to FDV and it is important to consider how children have coped with the violence thus far, what skills and understanding they have developed and what resilience factors have assisted their coping.[7]

Protective factors that may reduce the incidence and severity of impact of FDV (includes child abuse and neglect)[8] on children include can be grouped into three categories and include:

Individual/child factors

- Social and emotional competence
- Attachment to parent/s

Family/parental factors

- Strong parent/child relationship
- Parental self esteem
- Level of parental education

Social/environmental factors

- Positive social connection and support
- Employment
- Access to health and social services

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Appendix F: Family Mental Health

Key Points

- Mental health concerns and mental illness are prevalent in Australia
- Mental health can be impacted without having a diagnosis of a mental illness
- Children of parent/s with mental illness are at risk of negative health and developmental outcomes.

Definition

Mental health is an essential component of overall health and wellbeing.[1] The World Health Organization defines mental health as

> '*a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community*.'[2]

A mental illness, on the other hand, is a generic term that refers to a group of illnesses. It can be defined as:

> *'a clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional or social abilities'.*[3]

The term mental disorder is also used. Mental illness/disorders include a range of conditions such as:

- anxiety disorders
- affective disorders (e.g. depression)
- psychotic disorders (e.g. schizophrenia), and
- substance use disorders.[4]

It is important to note that a person's thinking, feeling and behaviour can be impacted by their mental health without meeting the criteria for a mental illness/disorder.[4] Likewise, it's possible to be feeling well in many aspects of life while diagnosed with a mental illness [2]

Many factors both affect and are affected by a person's mental health. These include their access to services, living conditions and employment status.[4]

Prevalence

Mental Health concerns affect individuals of all ages and backgrounds. The following table describes mental health prevalence data in Australia:

Persons	Prevalence
Mothers of children aged 24 months or less	In 2010:[5] • 1 in 5 were diagnosed with depression • Over 50% of those diagnosed, reported that their diagnosed depression was perinatal (that is, the depression was diagnosed from pregnancy until the child was 12 months old). • Of all the cases of diagnosed depression, just over 20% were diagnosed for the first time during the perinatal period.[5]
Children and adolescents	In 2013-14:[6] • In the 12 months before the Child and Adolescent Survey of Mental Health and Wellbeing, it is estimated that: ○ 560,000 children and adolescents aged 4 - 17 (14%) experienced a mental health disorder ○ males had a higher prevalence of mental health disorders (16%) than females (12%) ○ attention deficit hyperactivity disorder (ADHD) (7.4%); anxiety (6.9%); major depression (2.8%); and conduct disorder (2.1%) were the most prevalent disorders reported by participants.[6]
Children with parents with a mental illness	• According to population estimates, 23.3% of all children lived in a family with a parent with a non-substance mental illness.[7] • 20.4% of mental health service users have dependent children.[7]
Australians aged 16 - 85 years	• In 2007, an estimated 1 in 5 (20%) people experienced a mental health issue in the previous 12 months.[8] • It is expected that almost half (45%) of people in this age group will experience a mental health issue at some point in their life.[9] • An estimated 2-3% of the population have a severe mental illness (including psychotic disorders and those living with severe depression and anxiety).[9]
People with mental health conditions	• In 2019, those with mental health conditions were more likely to drink alcohol at risky levels than those without mental health conditions (21% compared with 17.1% for lifetime risky drinking, and 31% compared with 25% for single occasion risky drinking at least monthly).[10]

Some Australians are more likely to experience mental health problems than others. These include:

- young people
- single parent families

- those who are unemployed, and
- Aboriginal people.[11]

Health impacts/outcomes for child

Mental health is complex. Mental illness can cause distress, and impact on functioning and relationships. It is also associated with poor physical health and early death from suicide.[2] Mental illness impacts not only the individuals affected, but also those who are around them, including immediate family/children.

The family unit is pivotal for children's development.[12] It is widely recognised that parental mental health difficulties can impact on children's development.[13] Consistent evidence has shown an association between mother's mental health and children's adjustment and behaviour.[14] Exposure to adversity at a young age is an established preventable risk factor for mental disorders.[1]

The risk of mental illness from parents to children may arise through a complex interplay of risk factors - genetics, neurobiological, as well as a range of psychosocial risk factors - directly by a parent's behaviour, thoughts and emotions, or indirectly through multiple stressors (such as conflict, isolation, and poverty). [15]

A more detailed snapshot of the evidence on children's outcomes is as follows:

Factor	Outcome/Impact
Children with parent/s who has a mental illness	• Have a higher risk of having negative mental health outcomes compared to children of parents without a mental illness.[16] • Have a higher rate of behavioural, developmental, and emotional problems compared to children with parents without a mental illness.[12, 16] • Are at risk of a similar mental health disorder as their parents and are at risk of a disorders that are specifically related to the parents' diagnosis.[15] • Core attachment needs (such as love, physical and emotional nurturing, and security) may be at risk.[17] • Parenting skills may be impaired including the quality of care and parent-child interaction, with the risk of neglect and potential abuse.[12] • Children may need to assume caring responsibilities for a parent and/or siblings, impacting on age-appropriate activities or school attendance. [18]
Adverse Childhood Experiences (ACEs)	• Number of ACEs a child is exposed to, is strongly related to the chances of physical and mental health, and social and behavioural problems occurring through childhood into adult life.[20]

(very stressful events or circumstances that children may experience during their childhood).[19]	• Multiple ACEs (eg, mental illness, substance use and violence) also represent ACE risks for the next generation.[20] [21] • The most widely recognised and researched ACEs relate to abuse, neglect and household adversities, and include: ○ parental mental illness, and ○ parental substance use.[19] • Adult mental health problems (such as chronic depression and suicide) are strongly associated with ACEs.[21] [22]
Maternal depression Maternal mental health difficulties in the first-year post-partum	• May lead to impairments in young children's health. • Mothers may experience symptoms such as fatigue, difficulty concentrating, or losing interest in daily activities-may influence caring responsibilities. • Are more likely than other children to have impaired social, behavioural, and cognitive outcomes in infancy, childhood, adolescence, and adulthood.[23] • Has been associated with poor developmental outcomes for children. • Can have short-term effects on infant development and problems with insecure infant attachment. • Can be associated with later child psychosocial problems for some children.[14] • Children of mothers experiencing anxiety during or after pregnancy have an increased risk of experiencing attention problems at 5 and 14 years of age.[24]

Protective Factors

Protective factors can reduce adverse outcomes and strengthen children's resilience. For children impacted by family or parental mental illness, these include:

- adequate parenting/competence of the parent without mental illness and positive parent/child relationship [16, 25]
- strong family communication [25]
- child's stress reactivity (capacity or tendency to respond to a stressor)[16]
- adequate finances [25]
- housing and education [25]
- social connection [25] and social networks[12], and
- support from professionals involved with children and the mental health workforce. [16, 25]

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Appendix G: Homelessness, transience and/or overcrowding and remoteness

Key Points

- Homelessness, overcrowding and housing stress are widespread issues impacting children, young people and their families across Western Australia
- Homelessness, overcrowding and housing stress have both immediate and longer term impacts on a child's development and their physical, mental, emotional and social health.
- There are specific protective factors that can reduce the negative impacts on a child of homelessness, overcrowding and housing stress.
- Clinical staff need to be sensitive to the health, wellbeing and developmental impacts of homelessness, overcrowding and housing stress when planning and delivering care for this cohort.

Definition

Homelessness

There are many accepted definitions of homelessness.
In alignment with the Western Australian government's 10-Year strategy[1] on homelessness, the Australian Bureau of Statistics (ABS) definition of homelessness has been adopted here. The ABS define a person as homeless if they do not have suitable accommodation alternatives and their current living arrangement:

- is in a dwelling that is inadequate,
- has no tenure, or if their initial tenure is short and not extendable,
- or does not allow them to have control of, and access to space for social relations.[2]

Homelessness Australia, in addition to the ABS definition, consider a cultural definition of homelessness which includes three categories of homelessness:[3]

- Primary homelessness – is experienced by people without conventional accommodation (e.g. those who are rough sleeping)
- Secondary homelessness – is experienced by people who frequently move from one temporary shelter to another (e.g. those who are 'couch surfing')
- Tertiary homelessness – is experienced by people staying in accommodation that falls below minimum community standards.

Overcrowding

Overcrowding occurs when a dwelling is too small for the size and composition of the household living in it. The Australian Government uses the Canadian National Occupancy Standard (CNOS) as a measure of overcrowding. CNOS states that an overcrowded dwelling is one that requires at least 1 additional bedroom.[4] The CNOS measure specifies that: [4]

- No more than 2 people share a bedroom
- Parents or couples may share a bedroom
- Children under 5, either of the same sex or opposite sex may share a bedroom

- Children under 18 of the same sex may share a bedroom
- A child aged 5-17 should not share a bedroom with a child under 5 of the opposite sex
- Single adults 18 and over and any unpaired children require a separate bedroom.

Housing Stress

In general housing stress is experienced when housing costs are high relative to income. In these situations, the costs of housing are likely to reduce the household's ability to afford other living costs such as food, clothing, transport and utilities.[5] A household living with housing stress is defined as one that spends more than 30% of their gross income on housing costs.[5]

Prevalence

Homelessness

Some children live in families experiencing homelessness, whilst others experience homelessness on their own.[6] Poverty is a key driver of homelessness for children and their families. Homelessness for children and young people occurs, most commonly, through the following pathways:

- being part of a homeless family,
- leaving the family home with one parent (usually to escape violence or abuse),
- leaving the family home independently,
- exiting the care or youth justice system.[7]

On Census night 2016 there were almost 2000 Western Australian children experiencing homelessness.[2] This figure is known to be an underestimate due to the hidden nature of homelessness.

Australian children are more likely to experience homelessness if they:

- live in remote and very remote areas,
- live in multiple family households (compared to those living in single parent or couple family households),
- live in areas of greater socioeconomic disadvantage,
- identify as Aboriginal or Torres Strait Islander.[6]

In 2020-21, 7102 children aged 0 to 17 years presented at WA specialist homelessness services alone or with their families.[8] The majority of these children were aged under 10 years.[9] The single most common reason for children and young people to need housing and homelessness assistance is family and domestic violence.[9] While the proportion of male and female young people aged 10 to 14 years presenting to homelessness services in WA was relatively even, for young people aged 15 to 17 years the proportion of female clients was greater than that of male clients (61.7% female compared to 38.3% male).[7] Almost 50% of all young people aged 10 to 17 years presenting to homelessness services are Aboriginal.[8]

Overcrowding

On Census night 2016 approximately 18,900 children aged 0 to 14 years were living in overcrowded housing.[2] In June 2020, it was estimated that 8% of households were in overcrowded dwellings.[4] One-quarter of state government owned and managed Aboriginal households were in overcrowded dwellings across Australia.[4] Children living in low socioeconomic areas were 12 times more likely to be living in an overcrowded dwelling as those from high socioeconomic areas.[10]

Housing stress

In WA, 21.3% of WA children aged 0 to 14 years live in a household experiencing housing stress.[5] Almost half of WA single parents who live in rented accommodation experience housing stress, with 40% of WA single parents who are homeowners also experience housing stress.[11] Housing stress is more common in major cities than in remote areas.[10]

Health and developmental impacts/outcomes for children

Homelessness

Homelessness and housing stress have both immediate and longer-term effects on a child's health and wellbeing.[7] Experiences of homelessness affect physical health, educational attainment and social functioning.[7] Families and children experiencing homelessness are likely to experience social exclusion, compromised safety, and lack of connectedness with the school and broader community.[12]

Preschool and school-aged children experiencing homelessness are more likely to experience:

- Mental health problems
- Emotional or behavioural problems and
- Food insecurity (which could potentially lead to adverse physical health).[5]

The overall youth unemployment rate in January 2022 was approximately 9%, with the unemployment rate for adults sitting at 4% for the same period.[13] Unemployment in people who have experienced homelessness as a child is much higher. Children who first experience homelessness under 15 years of age have an employment rate of just 10% by the time they're adults, as opposed to 24% if they're homeless after 15 years.[12] Children experiencing homelessness are also at increased risk of being homeless as adolescents and adults.[14]

Overcrowding

Those living in overcrowded housing may not be able to access basic amenities which are necessary for health, including washing, laundry, hygienic food storage and preparation, and safe disposal of waste.[14] Overcrowding can increase the risk of family conflict or violence, child abuse and neglect.[15] Additionally, overcrowding has been associated with increased risk of emotional and behavioural problems and reduced school performance.[10]

Overcrowding is higher among Aboriginal households. This can have a detrimental effect on Aboriginal children's ear and skin health.[10]

Housing Stress

Children in households not experiencing housing stress often have better health and school engagement.[10] Housing stress can:

- Negatively impact on parental mental health
- Reduce investment in children's food, health and education
- Increase a child's risk of material deprivation and social exclusion.[10]

Protective Factors

The Center on the Developing Child at Harvard University identifies four factors that can lead to positive outcomes when a child is facing adversity;[16]

- The opportunity for the child to improve their adaptive and self-regulatory skills
- Facilitating supportive adult-child relationships
- Spiritual connections and cultural traditions
- Building a sense of self-efficacy and perceived control

There are protective factors that can reduce the negative impacts of homelessness in children and their families. Some of these include:[14]

- Staying with others, such as a partner, friends or family (though not necessarily in accommodation)
- Having activities that they enjoy and having these activities planned
- Having a pet.

Protective factors specifically for young people experiencing homelessness, include:[17]

- Having a connection to an adult
- Having at least a high school education
- Being currently enrolled in school or having a full-time job.

For Aboriginal children and their families, a strong connection to Aboriginal culture is a strength and protective factor against adversity. The values of kinship, interdependence, group cohesion and community loyalty are protective factors for Aboriginal families against homelessness.[1]

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Appendix H: Trauma

Key points

- Trauma can result from exposure to a single event or repeated events that overwhelms a person's ability to cope.
- Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur during childhood, from 0 to 17. For many children, trauma results from ACEs.
- Trauma experiences can affect a child's physical, social, emotional, and behavioural wellbeing.
- Protective factors can help build resilience (ability to adapt well to difficult or challenging life experiences) in children, reducing the impacts of adversity they may face.
- Nurses need to be sensitive to the potential presence of trauma history when working with children and use a trauma informed care approach to practice.

Definitions

Trauma can result from exposure to a single event or compounded cumulative negative experiences that threaten one's personal safety, wellbeing, life or that of another person.[1] It often involves a sense of intense fear, distress, helplessness, and loss of control, and overwhelms a person's ability to cope.[2]

Single incident trauma

Occurs with unexpected one-off event. Examples include natural disasters like bushfires and floods, traumatic accidents, or a single episode of assault, abuse, or witnessing such an event.[1, 3]

Complex trauma

Occurs when a child repeatedly experiences severe stressors of traumatic events over an extended period. These stressors usually start at a developmental time point in childhood when the child is considered at risk.[3, 4] Typically, the events are interpersonal and include complex trauma experiences such as:[1, 3]

- Physical, emotional, or sexual abuse
- Neglect
- Witnessing family and domestic violence

Complex trauma disrupts the development of emotional health and the regulation of emotions. It affects the ability to have clear thoughts or memories and can disrupt a child's sense of safety and trust in important relationships.[4]

Intergenerational trauma

"Is the impact of trauma experienced in parents'/family/caregivers' lives being passed down to their children. Intergenerational trauma is often discussed in the context of Aboriginal children, and among children of refugees. It can also be experienced by children of veterans and other parents continuing to be affected by their own trauma".[1]

Note: 'Child or children' are used to indicate children and young people under 18 years of age.

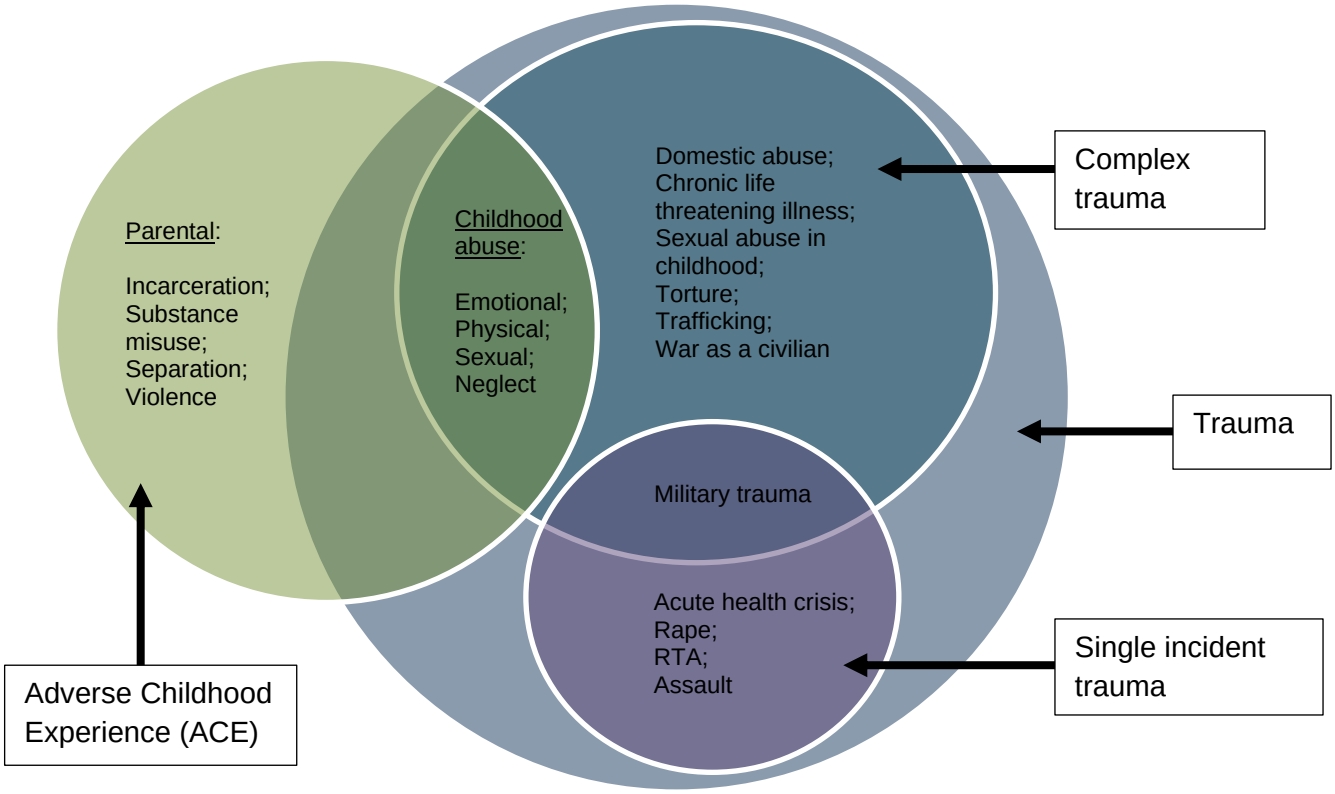
Adverse Childhood Experiences (ACE)

A term used to describe potentially traumatic events that occur in childhood (0-17 years). Examples include:[5]

- Experiencing violence, abuse, or neglect
- Witnessing violence in the home or community
- Having a family member attempt or die by suicide
- Parental substance use problems
- Parental mental health problems
- Instability due to parental separation
- Instability due to household members being in jail or prison.

Trauma is often a result of adverse childhood experiences.[6-8] These experiences can lead to lasting effects on physical and mental health, and social and behavioural problems during childhood and into adulthood.

Figure 1: Relationship between the ACEs and other aspects of trauma[9]



Post Traumatic Stress Disorder (PTSD)

Post traumatic stress disorder may develop following exposure to an extremely threatening or horrific event or series of events. It is characterised by:[10]

- Re-experiencing the traumatic event or events in the form of vivid intrusive memories, flashbacks, or nightmares
- Avoidance of thoughts and memories of the event or events, or avoidance of activities and situations related to the event

- Persistent perceptions of heightened current threat

The symptoms can last for at least several weeks and significantly affect personal, family, social, educational, or other important areas of functioning.

Prevalence

Measuring the prevalence of childhood trauma is challenging. The Australian Child Maltreatment survey, a nationally representative study of Australians aged 16 years and older, studied experiences of childhood maltreatment up to the age of 18 years in 2021. The findings indicated that 39.6% of the respondents reported exposure to domestic violence, 32.0% to physical abuse, 30.9% to emotional abuse, 28.5% to sexual abuse, and 8.9% to neglect.[11] Single type of maltreatment was reported by 22.8% of the respondents while multiple type of maltreatment was reported by 39.4%.[12] According to the National Study of Mental Health and Wellbeing for 2020–2022, 11% of Australians experienced PTSD at some point in their lives.[13]

Trauma exposure is more common among specific groups including:[1, 14]

- Children who experience homelessness
- Children in out-of-home care or under youth justice supervision
- Refugees. See Refugee health service guideline
- Women and children experiencing family and domestic violence
- LGBTIQ young people
- Aboriginal children

For Aboriginal children , the trauma experiences are more likely to have a compound effect with both the impact of intergenerational and current trauma experiences.[1] For more information see the Aboriginal child and school health policy.

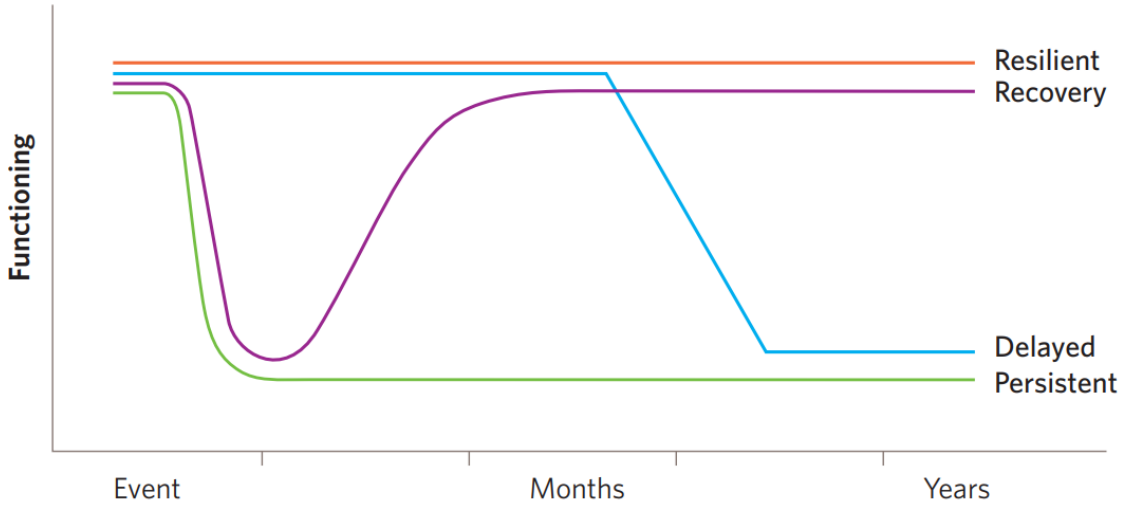
Most infants and young children in Australia grow up in healthy and safe environments. However, some face traumatic experiences that can significantly impact their development.[4] A study conducted in Australia examined trends in perinatal and infant child protection notifications. The findings showed that the rates of prenatal notifications increased by 4% per year, while infant notifications rose by 3% per year. The rate of infants entering out-of-home care also grew by 2% annually. [15]

Parental mental health problems, substance use, maternal history of childhood maltreatment, intimate partner violence and marital distress (e.g. separation, divorce, marital disagreement) increase the risk of childhood maltreatment.[16] However, not every child is negatively affected by trauma and adversity; the presence and reinforcement of protective factors can help in developing resilience and reducing the negative impact of trauma.[6] Data analysis from the Longitudinal Surveys of Australian Youth (recruited at 15 years of age) found that positive youth experiences were associated with significantly better general and mental health outcomes, even in the presence of adverse youth experiences.[17] Additionally, a nationally representative sample of Australian children showed the positive childhood experiences between 0-11 years were associated with fewer mental health problems and fewer academic difficulties at 14 to 15 years.[18]

Health impacts/outcomes
Trauma experiences can affect a child's physical, social, emotional, and behavioural wellbeing, with repeated exposure increasing their susceptibility.[4]

However, reactions to trauma vary widely, and many show resilience and do not develop further problems. Some may even find additional strength and personal resources because of their experiences. However, for others, reactions may persist or worsen over time, or they may only first become apparent much later in life.[1]

Figure 2: Trajectories of trauma[1]



<u>Perinatal trauma-related consequences</u>
Traumatic experiences and stressors that occur during pregnancy and the early postnatal period can affect the child, through the transfer of trauma related consequences from the parent to the child.[19] Structural and functional brain changes in the offspring, increased risk of early delivery, preterm birth, and lower birthweight relative to gestational age has been noted. Additionally, there is an increased future risk for mental health problems, including anxiety, depression, attention deficit, and hyperactivity disorder. [19-21]

<u>Disruptions in attachment</u>
Infancy is a crucial time in the development of attachment relationships and is most vulnerable to disruptions, with complex trauma compromising the development of a secure child-caregiver attachment relationship.[4, 22]

If a child has experienced disruptive attachment in their early years, they may struggle to understand and form subsequent relationships. It may also have a flow on effect on the child's social and emotional development. In early childhood, difficulties in attachment may present as:[4, 22]

- clingy, difficulty with separations
- inconsistent behaviour towards caregiver/s
- lacking in trust towards others

- finding it challenging to seek help from others
- struggling to self-regulate emotions and behaviours

Changes to brain development

Early childhood experiences influence brain development. Traumatic events during this sensitive period (particularly during the first 3-5 years) can disrupt brain structure and function. Changes in brain areas may contribute to many symptoms of complex trauma including:[1, 4, 22, 23]

- social, emotional, and behavioural difficulties
- developmental issues such as speech, language, and cognitive difficulties (such as inability to concentrate, planning, reasoning)

Changes to child's stress response

When there is a real or perceived threat, a child's stress response system is activated to prepare them to 'fight' or 'flee.' When an infant or young child experiences trauma events, their body's stress system may be excessively and repeatedly activated.[4, 22] Additionally, the development and regulation of the body's stress response can be disrupted, this can mean that the reactions to stress can be blunted or exaggerated.

Changes in behaviours

Children exposed to complex trauma may experience problems with sleeping, feeding, or eating. They can present with symptoms such as nightmares, fears of sleeping, refusal to eat, or hoarding food.[4]

Social and emotional well-being and functioning

Social well-being and functioning can be affected by trauma experiences in childhood, impacting a child's ability to form relationships and friendships. In young children, these social struggles may present as:[4]

- difficulty trusting others and feeling safe in a relationship
- feelings of fear, threat, rejection or being unloved when socialising
- vigilance or guardedness when interacting with others
- struggle to interact with authority figures, such as educators
- struggle with social skills

Emotional well-being and functioning are also impacted by trauma, with many people who have experienced complex trauma struggling to regulate their emotions. This can lead to people living with strong feelings of shame, self-blame and low self-esteem.[3]

Trauma and mental ill-health

The literature shows an association between childhood trauma and the increased risk for mental ill-health in adulthood, with many mental health problems having their onset in adolescence or young adulthood. Trauma exposures can:[1]

- increase the risk of mental ill-health
- lengthen the duration of the illness
- compound the severity and complexity of mental ill-health
- impact on treatment responses.

Trauma related mental health diagnoses can include PTSD, anxiety, depression, psychosis, personality disorders, self-harm and suicide related behaviours, eating disorders and comorbidity with alcohol and substance misuse.[1]

Impact of Intergenerational Trauma on child development

The *Make Healing Happen*[24] report states 'adverse experiences in childhood can have lifelong effects. Traumatic childhood experiences, such as those of Stolen Generations survivors, may affect following generations through biological changes in stress responses and by undermining the ability to parent and love freely without fear'.

These traumatic experiences can be transferred from the first generation of survivors that have experienced (or witnessed) it directly in the past to the second and further generations of descendants of the survivors.[25]

This can create developmental issues for children, who are particularly susceptible to distress at an early age. These children may experience difficulties with attachment, shame and grief, unmodulated aggression, disconnection from their extended families and culture, and high levels of stress from family and community members who are dealing with the impacts of trauma. It can also create a cycle of trauma, where the impact is passed from one generation to the next.[25, 26]

ACEs and impact on health outcomes

Exposure to ACEs during childhood and adolescence can result in significant developmental delays, lower educational attainment and social and emotional instability.[6] Research has shown a strong predictive relationship between the number of ACEs one is exposed to as a child and the probability of poor health outcomes occurring through childhood into adulthood. The presence of at least 4 ACEs increase the risk of :[8]

- mental health conditions in childhood, adolescence, and adult life, which can impair social and emotional functioning[6, 8, 27]
- problematic alcohol and drug use
- sexual risk taking
- self-directed violence
- physical inactivity, obesity, and diabetes
- cancer, heart disease and respiratory disease

The evidence on the harms that multiple ACEs place on health throughout the life-course highlights the importance of addressing the various stressors that can occur in a child's life. A reduction in ACEs and building resilience to enable those affected, to avoid their harmful effects could have a major effect on health outcomes.[8]

General protective factors

There are protective factors that if present and reinforced in a child's life, can build resilience. Positive childhood experiences more frequently promote direct positive outcomes rather than moderate the effects of adversity on outcomes.[28]
The protective factors include:

Child[5, 6, 8, 29]

- Safe, caring and supportive relationship with someone they trust
  - research has shown that having one positive caring relationship can improve a child's recovery and healing from trauma
  - having someone who makes the child feel safe and protected helps support their mental health and resilience
- Having a caregiver who promotes and develops a child's resilience
- Having positive friendships and peer network
- Social and emotional competence of children
- Doing well in school

Parent/ Family[4, 5, 29]

- Parental resilience
- Knowledge of parenting and child development
- Social connections
- Concrete support for children
- Steady employment
- Can meet basic needs of food, shelter and access to health services for children

Community[5]

- Access to safe and stable housing
- Access to economic and financial help
- Access to healthcare including mental health services
- Access to safe childcare, preschools, after school programmes
- Have work opportunities with family friendly policies
- Residents feel connected to each other
- Strong partnership between the community and business, healthcare, government, and other sectors

Assessing and identifying both risk and protective factors that may influence child's physical and mental health is crucial for developing effective care plans that foster positive outcomes. Indicators of need provides a checklist to support family assessment.

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