

Well Child / Tamariki Ora Programme

Practitioner Handbook

Supporting families and
whānau to promote their child's
health and development

Revised 2014

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How to use the Well Child / Tamariki Ora Programme Practitioner Handbook

This *Well Child/Tamariki Ora Programme Practitioner Handbook* (the Handbook) has been developed to assist and support all providers who deliver Well Child/Tamariki Ora (WCTO) services in accordance with the [WCTO Schedule](#).¹ It merges information from a range of existing practitioner resources including the *Well Child/Tamariki Ora Handbook* (Ministry of Health 2002d), *The B4 School Check: A handbook for practitioners* (Ministry of Health 2008e) and the *National Vision and Hearing Screening Protocols* (Ministry of Health 2009b). It summarises and links to key documents and resources that include but are not limited to *Family Violence Intervention Guidelines* (Ministry of Health 2002a), *Healthy Smile, Healthy Child: Oral health guide for Well Child Providers* (New Zealand Dental Association 2008), NZ–World Health Organization (WHO) growth charts and related fact sheets (www.health.govt.nz/our-work/life-stages/child-health/well-child-services/growth-charts) and guidelines for newborn screening (www.nsu.govt.nz/current-nsu-programmes/antenatal-newborn-screening-programmes.aspx).

The Handbook is complementary to the parent-held *Well Child/Tamariki Ora Health Book*. In most cases (ie, excluding sensitive information), practitioners will maintain documentation of visits, actions taken and so on in the parent-held *Health Book*, as well as in their own records.

The Handbook is divided into six sections.

Section 1, the introductory section, describes the WCTO Schedule and service. It outlines the WCTO objectives and indicates how the service addresses the needs of Māori. It sets out the objectives of screening and surveillance activities undertaken as part of the Schedule, as well as the principles of assessment processes.

Section 2 describes:

- the personnel qualified to deliver aspects of WCTO care and their associated competency requirements
- cultural competency
- the principle of informed consent that underpins the provision of health care services
- the continuum of care between child health care providers, and the transfer of WCTO care from the lead maternity carer to the WCTO Provider
- the needs assessment process, which informs the care plan and possible provision of additional contacts and support.

Section 3 lists the components associated with each of the core visits (except for the final core contact, the B4 School Check, which is covered in detail in section 5). Where applicable, the components link to subsections of section 4, where greater detail is provided.

¹ www.health.govt.nz/our-work/life-stages/child-health/well-child-services/well-child-publications/well-child-national-schedule

Section 4 details the WCTO Schedule components (except for those that are exclusive to the B4 School Check).

Section 5 covers the B4 School Check, the final WCTO core check undertaken before the child begins school.

Section 6 provides information about how to support vulnerable parents with specific needs.

The Handbook should be read in conjunction with the following documents:²

- the Schedule
- *Services for Children and Young People – Well Child/Tamariki Ora Services tier two service specification*³
- *Whakatātaka Tuarua: Māori Health Action Plan 2006–2011* (Minister of Health and Associate Minister of Health 2006)
- *Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2010–2014* (Minister of Health and Minister of Pacific Island Affairs 2010)
- *Child Health Strategy* (Ministry of Health 1998a)
- *The New Zealand Health Strategy* (Ministry of Health 2000)
- *The Primary Health Care Strategy* (Ministry of Health 2001)
- *Family Violence Intervention Guidelines* (Ministry of Health 2002a)
- *He Korowai Oranga: Māori Health Strategy* (Ministry of Health 2002b)
- *The Pacific Health and Disability Action Plan* (Ministry of Health 2002c)
- *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017* (Ministry of Health 2012i)
- *Delivering Better Public Services* (Ministry of Social Development 2012)
- *The DHB Planning Package* and the Minister of Health's Letter of Expectations.⁴

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² The WCTO Quality Improvement Framework, which has been developed and is currently in draft form, is to be added to this list.

³ Available from the Nationwide Service Framework Library website (www.nsf.health.govt.nz/apps/nsfl.nsf/pagesmh/155).

⁴ Available from the Nationwide Service Framework Library website (www.nsf.health.govt.nz/apps/nsfl.nsf/pagesmh/478).

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Section 1:

Introduction

The WCTO programme provides a package of universal health services offered to all New Zealand families and whānau for children from birth⁵ to 5 years. The early years of life set the foundation for lifelong health and wellbeing. The WCTO services assist families and whānau to improve and protect their children's health. They also serve as an important gateway to targeted and specialist health, education and social services for children, families and whānau with additional needs.

The services are set out in the Well Child/Tamariki Ora Schedule 2013 (the Schedule), which is available on the Ministry of Health website (www.health.govt.nz).

The Schedule describes the core screening, surveillance, education and support entitlements (including timing), delivered across a total of 12 universal core contacts that every child (from birth to five years) and their family or whānau are eligible to receive. The Schedule also includes a general practitioner check at six weeks linked to the six-week immunisations, which ensures the connection with primary health services. Additional contacts are allocated on the basis of need.

The Schedule divides the services into three parallel streams that are to be delivered as an integrated package of care. The streams incorporate the key public health concepts of disease prevention, supportive environments and health promotion. These streams are:

- health and development assessments – universal assessments that relate specifically to the child and that are undertaken at each core contact as prescribed
- care and support for families and whānau – assessments, interventions and referrals to services that relate to the context within which the child lives. The strengths and needs of the family or whānau are assessed. Interventions and referrals are offered in response to the assessed needs and care plan agreed with the family or whānau
- health education – a range of health education activities that are delivered appropriate to the core contact age bands. These activities are undertaken at appropriate developmental stages, using professional judgement and the needs assessment and care plan that is reviewed with the family or whānau.

For the three streams of the Schedule to be delivered in an effective, coordinated way, formal links and intersectoral collaboration are required between providers of WCTO services (lead maternity carers, WCTO Providers, and general practice teams), and between these providers and providers of related services.

⁵ While WCTO checks currently begin at birth, development begins prenatally. Where possible, practitioners should guide and support pregnant women to provide a healthy prenatal environment for their unborn child.

Well Child/Tamariki Ora objectives

The primary objective for all providers of WCTO services is to support families, whānau and caregivers to maximise their child's developmental potential and health status from birth to five years, establishing a strong foundation for ongoing healthy development.

To achieve this primary objective, providers of WCTO services will:

- work in partnership with families and whānau to identify their strengths and their needs for support, and either provide that support or facilitate access to support from other health or community services, especially for those children of families and whānau at risk of adverse outcomes
- inform and support parents to gain the knowledge and skills to understand, anticipate and promote the various stages of their child's development
- reassure parents through health screening and surveillance and clinical assessment that their child is developing normally and, if necessary, ensure any health or developmental concerns are referred appropriately and addressed in a timely way
- promote predictable, positive parenting skills supporting positive parent–child relationships
- where children and young people are receiving services from other agencies, refer to and collaborate with other relevant services according to the strengths and needs of the family, whānau and child. This could include referring to a social service, such as Family Start or Women's Refuge or, for complex families with multiple needs, participating in intersectoral activities such as local Children's Teams⁶
- ensure the family or whānau understand the WCTO services available and assist them to access the provider's own services, or alternative services if this is the client's wish
- provide culturally competent services to all children and their families/whānau
- provide services in a way that recognises and addresses the needs of identified priority groups, including Māori, Pacific peoples, children from families with multiple social and economic disadvantage and children with high health and disability support needs
- improve integration, coverage and coordination of WCTO services for the client population, including increasing uptake of immunisation and overall coverage rates.

Māori health

In line with the [Treaty of Waitangi](#) (section 2), an overarching aim of the health and disability sector is to improve health outcomes and reduce health inequalities for Māori. Health providers are expected to provide health services that will contribute to realising this aim. They may do so by using mechanisms that facilitate Māori access to services and providing appropriate pathways of care that might include, but are not limited to:

- addressing matters such as referrals and discharge planning
- ensuring that the services are culturally safe and competent
- providing services that meet the health needs of Māori.

⁶ The Children's Team approach will amalgamate interagency groups such as Strengthening Families, High and Complex Needs, Family Violence Interagency Response, and regional social sector leadership. Children's Teams are being developed as part of the implementation of the Government's Children's Action Plan.

Māori children are one of the four priority populations identified in the Child Health Strategy. They are almost twice as likely to be hospitalised as other New Zealand children. Analysis of the 2006/07 New Zealand Health Survey found that Māori children continue to experience poorer health outcomes than other New Zealand children (Ministry of Health 2009a).

The causes of unequal health outcomes are complex and generally linked to the uneven distribution of the determinants of health, such as income, housing, education and employment. For example, low income or poverty is a key mediator of poor child health outcomes. It often leads to poor-quality accommodation with consequent overcrowding, and susceptibility to infectious diseases. Poverty may also reduce access to health care.

WCTO services are expected to contribute to reducing inequities in outcomes for children including obesity, unintentional and inflicted injuries, sudden unexpected death in infancy (SUDI), differences in immunisation rates, developmental delay, conduct disorder and preventable hospitalisations.

WCTO services need to recognise the cultural values and beliefs that influence the effectiveness of services for Māori. WCTO services must build on the current investment and innovation in Māori programmes and services. They must develop effective models of service delivery that:

- are responsive to Māori
- contribute to whānau ora, meaning Māori families and whānau are supported to achieve their maximum health and wellbeing
- are consistent with the directions set in key strategic documents: *He Korowai Oranga: Māori Health Strategy* (Ministry of Health 2002b) and *Whakatātaka Tuarua: Māori Health Action Plan 2006–2011* (Minister of Health and Associate Minister of Health 2006).

WCTO Providers must offer an integrated service that includes developing and maintaining relationships with maternity services, and other primary and specialist health, education and social services that influence the health outcomes of Māori children and young people. This is particularly important for vulnerable whānau if they are to develop the skills and access the support and resources they need to function healthily on an ongoing basis.

Screening and surveillance⁷ objectives

Child health screening and surveillance activities are designed to identify health, disability and development needs and ensure timely referral and therapeutic intervention if required. To achieve these objectives, as per the WCTO Schedule, service providers will undertake regular assessments including:

- physical examination of each child, including measurement of each child's weight, length/height and head circumference, in order to detect congenital, inherited or acquired conditions (eg, developmental dysplasia of the hips, undescended testes, congenital heart disease, abnormal growth trajectories, hearing and vision problems, visible tooth decay and child abuse and neglect)
- surveillance of each child in order to detect developmental and behavioural concerns.

⁷ In the context of public health, surveillance is defined as the continuous systematic collection, analysis and interpretation of health-related data needed for the planning, implementation and evaluation of public health practice (*Public Health Surveillance: Information for New Zealand Public Health Action*, www.surv.esr.cri.nz/public_health_surveillance/public_health_surveillance.php).

As well as these child health assessments, newborn babies are screened for hearing loss and certain metabolic disorders.

The Schedule also includes screening activities that involve the context within which the child lives (eg, partner abuse enquiry, child abuse and neglect risk assessment,⁸ and screening for postnatal depression). These assessments allow health care workers to identify and respond to issues related to parents or caregivers and family or whānau that influence the child's health and wellbeing.

Principles underpinning the assessment process

The following principles apply to the use of formal assessment tools such as the Strength and Difficulties Questionnaire (SDQ) to assess child behaviour and Parents' Evaluation of Developmental Status (PEDS) to assess development, as well as methods used to assess the child's physical health, their environment and their strengths and needs. Some of the principles will apply to a greater or lesser extent depending on the type of assessment.

The purpose is clear

The aim of any assessment must be clear. Aims can be broad-ranging or focused, depending on the timing and context of the assessment. However, generally a key aim of an assessment is to gather a range of relevant information in a manner that promotes and sustains a working relationship between the health practitioner and the children, families and whānau being assessed.

In most circumstances, information will be of limited use if the health practitioner and the children, families and whānau being assessed are not working in partnership.

Assessment is not a static process

Effective assessment cannot be a one-off action: it is an ongoing process. The assessment process is the beginning of the therapeutic relationship with the child, family and whānau.

An assessment has many purposes. The information gained from an assessment informs future work and helps in the evaluation of interventions.

How an assessment is carried out is also important. It should enable those involved to gain fresh perspectives on the situation of their particular family or whānau and consider opportunities for change.

⁸ The Ministry's Public Health Group has responsibility for implementing the *Family Violence Intervention Guidelines: Child and partner abuse* in district health boards and for training of WCTO practitioners.

Partnership is informed by professional judgement and the family's expert knowledge of their child and family circumstances

Although partnership between the health practitioner and the child and family or whānau being assessed is fundamental, the practitioner must exercise judgement about how and when to share the information obtained with the family or whānau.

Sustaining partnership and having a positive therapeutic impact are overriding principles of assessment. Sometimes an issue will be identified that is difficult for a caregiver (eg, developmental delay, disturbed behaviour or abuse). Communicating concerns in a way that engages families and whānau in addressing the issue can be challenging. Health practitioners should seek support from a senior colleague if they find this difficult.

Assessment does not take place in a vacuum

Assessments benefit from multiple sources of information (eg, parents and teachers may provide different, complementary perspectives on a child's development and behaviour) and multiple assessment methods. Any one type of assessment used alone is likely to give a limited or an unbalanced view. This applies to all the main assessment approaches: interviewing, observation, and standardised tests and questionnaires.

Health practitioners need to recognise the limitations of different assessment approaches, but still be able to compare data from different methods and/or sources. This helps them to develop a deep and balanced understanding of the child's situation.

As the Children's Action Plan⁹ is implemented, health practitioners will be expected to support a Common Needs Assessment for vulnerable children in their care.

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⁹ The Government is currently developing the Children's Action Plan. It will provide an evolving framework of action being taken to protect children and when each milestone will be achieved.

Section 2:

WCTO service providers

This section focuses on those who provide WCTO services, with particular attention to:

- the competencies that members of the multidisciplinary child health team are required or expected to have
- how to establish and maintain an unbroken continuum of care
- the needs assessment and care planning process under development.

Practitioner competencies

WCTO services are provided by a number of people who form a multidisciplinary child health team (see [Providers of Well Child/Tamariki Ora care](#)). These people include:

- lead maternity carers (LMCs – includes midwives, obstetricians and general practitioners)
- registered nurses
- nurse practitioners
- general practitioners
- paediatricians
- community health workers, Karitane and Kaiāwhina
- vision and hearing technicians (VHTs)
- newborn hearing screeners
- authorised vaccinators.

It is the employer's responsibility to ensure that practitioners are competent to deliver WCTO care. WCTO Providers must ensure that registered nurses, nurse practitioners and/or general practitioners who form part of their team have met the competency requirements of their professional bodies as outlined below. All other WCTO practitioners within the WCTO Provider team (eg, community health workers, Karitane and Kaiāwhina) must have received education relevant to the component of care they are providing and must receive guidance and supervision of their practice from the registered nurse, nurse practitioner or general practitioner. VHTs should be professionally supported by an audiologist and orthoptist or optometrist.

Participation in relevant ongoing professional development as well as regular professional supervision is fundamental to maintaining current competence in WCTO care and is the responsibility of the employer, the practitioner and their professional body.

It is expected that all health practitioners providing WCTO services will have specific training in:

- how to identify, support and refer victims of interpersonal violence, with a particular focus on child abuse and on partner abuse. The service must have protocols in place to ensure the safety of children and family members and to support staff in this intervention and the practitioners must receive training in following these protocols

- specific issues in the patterns and identification of abuse, neglect and interpersonal violence for victims of interpersonal violence
- disability awareness to ensure children with disabilities and/or carers with disabilities are given appropriate access and support.

Practitioners also require competencies in assessment skills. Assessment of health need and assessment of child health are distinctive components of a health care model and take into account the environment, community and the family situation as these impact on the health and development of the child. So that practitioners can develop such competencies, baseline knowledge of community health is required. Practitioners need a clear understanding and appreciation of the importance of personal supervision and are aware of who and how they can access such supervision.

As core competencies, all health practitioners delivering WCTO care should also have received education in and demonstrate an understanding of the Treaty, cultural competence, the principles of informed consent and effective communication, and privacy obligations.

Cultural competence

Cultural competence is a requirement under the Health Practitioners Competence Assurance (HPCA) Act 2003. The concept of cultural competence in health care developed as an approach to reduce ethnic disparities in health and health care (Betancourt et al 2003). A broad understanding of 'culture' extends beyond ethnicity to include age, gender, sexual orientation, occupation and socioeconomic status, geographical and physical environment, religious or spiritual beliefs and disability. Culturally competent care acknowledges and respects service users' identity and right to their personal beliefs, values and goals; it includes an understanding of how culture influences health care access and delivery and an awareness of how one's own cultural association helps inform personal values and assumptions related to identified groups.

While the HPCA Act does not include an explicit definition of cultural competence, each professional body has standards of cultural competence for its members. For example, see:

- the Medical Council of New Zealand (www.mcnz.org.nz) Statement on cultural competence
- the Midwifery Council of New Zealand (www.midwiferycouncil.health.nz) Statement on cultural competence for midwives
- the Nursing Council of New Zealand (www.nursingcouncil.org.nz) scope of practice competencies and guidelines – 'Competencies for registered nurses', competency 1.5 and 'Competencies for the nurse practitioner scope of practice', competencies 2.3 and 3.1.

The training for each group – VHTs, newborn hearing screeners, social workers, community health workers, Karitane and Kaiāwhina – includes core components that deal with cultural competence.

At a service provider level, health organisations can improve responsiveness to Māori and others by exploring ways in which their service can accommodate a whānau-centred approach.

Cultural competence is a key element to ensuring health services are responsive and accessible to groups of people with the poorest health status. Māori (Minister of Health and Associate Minister of Health 2006) and Pacific peoples (Ministry of Health 2012k) experience poorer health status than non-Māori and non-Pacific New Zealanders.

Cultural competence with respect to Māori

New Zealand has a distinctive bicultural heritage. The bicultural relationship between Māori as indigenous people and other New Zealanders is based on the Treaty of Waitangi/te Tiriti o Waitangi. The focus of social and health policy is largely to address the disparity of health outcomes between Māori and non-Māori (Midwifery Council of New Zealand nd).

Treaty of Waitangi/te Tiriti o Waitangi

The Treaty of Waitangi, the founding document of New Zealand, represents a framework of rights and responsibilities. It acknowledges the special status of Māori as tāngata whenua (people of the land).

Providers of WCTO services will show the capacity to apply the principles of the Treaty of Waitangi/te Tiriti o Waitangi in the WCTO setting.

Three key principles from the Treaty are:

- **partnership** – working in partnership with iwi, hapū, whānau and Māori communities to develop strategies for the community's health care
- **participation** – involving Māori at all levels in all aspects of planning and delivery of health care services
- **protection** – working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

Māori models of health

Te Whare Tapa Whā (Durie 1998) is the most widely used model of Māori health. It reflects a holistic approach to wellbeing by considering multiple influences as essential components of good health.

Figure 1: Te Whare Tapa Whā



In Figure 1, the symbol of the wharenuī (Māori meeting house) illustrates the four dimensions of health. Each dimension is important; balance in each realm is necessary for optimal health. *Te Whare Tapa Whā* provides practitioners with a model to better understand and work more effectively alongside Māori.

- **Taha wairua – spirituality.** Spirituality is important to many Māori. Taha wairua includes but is not limited to the capacity for faith, which may be reflected in practices such as karakia (prayer), and acknowledges unspoken energies such as the energy of ancestors. Health services based on Western belief systems often fail to recognise the relevance of the spiritual realm to wellbeing. Cultural competence for health practitioners includes respect for Māori spiritual beliefs.
- **Taha hinengaro – psychology.** Te taha hinengaro concerns the psychological or emotional realm. Health workers should consider the psychological and mental health of Māori with whom they work. Thoughts and emotions can affect how information is interpreted or perceived.
- **Taha tinana – physicality.** The focus on physical health is the most familiar territory for practitioners. For Māori, however, physical health is enmeshed with spiritual, psychological and family concerns. Another element of te taha tinana relevant to practitioners in the health setting is the application of tapu to, for example, the head, which is considered sacred. Practitioners should always ask before touching a Māori patient's head. Physical personal space should be respected and this could include making minimal direct eye contact.
- **Taha whānau – extended family.** The wellbeing of a Māori individual cannot be separated from the wellbeing of the whānau. Practitioners should consider the role whānau play in illness (becoming ill) and in the recovery process. When engaging with Māori, where appropriate create an environment and develop an approach that invites whānau participation. Whānau are key participants in the protection and wellbeing of their children.

Māori forms of engagement

Traditional forms of Māori engagement follow many formats that differ from iwi to iwi. Acknowledging and understanding these forms of engagement and incorporating them into practice will strengthen relationships with Māori clients. The following are three appropriate forms of engagement.

- **Pōwhiri and whakatau – welcome.** Māori place a lot of value on welcoming and taking care of their visitors. This is reflected in formal and informal ceremonies, namely the pōwhiri and whakatau. Key principles within these processes are care and safety. Consider practical ways that you can provide a safe environment and show that you care for Māori patients.
- **Whanaungatanga and kanohi ki te kanohi – relationships.** It is important to build a genuine relationship with Māori families. Finding common ground and meeting in person are effective strategies for working with Māori. A practical way to find common ground is to talk about your own family and/or children.
- **Te reo Māori – Māori language.** For many Māori, their language is a spiritual connection to the past that provides guidance and hope for the future. The importance of the Māori language cannot be simply explained; however, it is important to note that for Māori, their language is more than just words and grammar – it is a precious gift from their ancestors.

Many Māori carry the names of their ancestors, which is of great importance to them. Pronouncing a Māori name correctly shows respect for whakapapa (genealogy) and acknowledges the importance of te reo Māori to Māori people.

Some tips when working with Māori whānau and children

- Provide a safe environment by being open, welcoming and inclusive of whānau.
- Show value for the Māori language by pronouncing names correctly. Learn about the concepts of tapu and noa so that you do not unintentionally offend by your actions.

Resources

The following resources may support practitioners in working with Māori whānau and children.

- Downloadable phrase books that introduce te reo Māori in an accessible way can be sourced from the Kōrero Māori website (www.korero.maori.nz/resources/publications).
- A resource booklet, *Best Health Outcomes for Māori: Practice implications*, has been prepared for the Medical Council of New Zealand and is available on its website (www.mcnz.org.nz).
- The Ministry of Health provides information about *Te Whare Tapa Whā* on its website (www.health.govt.nz).

Māori cultural competence training is provided by many health organisations for their staff. Cultural competence courses are offered online and face to face by Mauri Ora (www.mauriora.co.nz). Also refer to the SUDI Toolkit, due for release on the Whakawhetu website (www.whakawhetu.co.nz) in June 2013. It includes video case studies of Māori and Pacific health practitioners who engage with Māori and Pacific health service users.

Cultural competence with respect to Pacific peoples

The term 'Pacific' when applied to a group of people describes people who originate from the Pacific Island region rather than a single homogenous cultural group. There are common threads between Pacific Island cultures but each is unique with distinctive cultural customs and practices, traditions, languages, beliefs and values.

According to Census data, in 2006 there were 265,974 people of Pacific ethnicity living in New Zealand. The largest Pacific ethnic groups were Samoan (131,103), Cook Islands Māori (58,011), Tongan (50,478), Niuean (22,476), Fijian (9864), Tokelauan (6822) and Tuvaluan (2625) (Statistics New Zealand and Ministry of Pacific Island Affairs 2010).

The Pacific population is predominantly young and highly urbanised. Two-thirds of Pacific peoples reside in the Auckland region, particularly in South Auckland (or within the Counties Manukau District Health Board region). Pacific births are expected to increase and the Pacific population will continue to have a younger average age than the overall New Zealand population.

Working with Pacific families

When engaging with Pacific families, health workers are much more likely to make a connection and elicit a real response if they have an understanding of Pacific values, beliefs, cultures and lived realities.

Being culturally competent is an ongoing process that involves a proactive approach to gaining self-awareness and insight in relation to cultural differences.

Some tips when working with Pacific families

- Remove your shoes when entering the home.
- Respect customs and values (eg, ask before you touch or examine a child and explain what you are doing).
- Learn Pacific greetings appropriate to the Pacific culture of the family you are visiting. (If you don't know the family ethnicity, don't guess.)
- Be inclusive of the whole family (aiga in Samoan) where possible and appropriate. (For example, it would not be appropriate when undertaking a family violence assessment.)
- Identify influential family members (eg, grandmothers and aunts) and involve them wherever possible.
- Listen to what family members say. Listen to what the children and young people say as well as observing their body language.
- Give family members time to respond. Wait; don't jump in.
- Don't talk too quickly. Use an interpreter when required. Best practice is to use a trained interpreter rather than a family member. However, there are complex and context-dependent factors to consider in deciding between a trained and an ad hoc interpreter for any particular situation (Gray et al 2012). (For example, in practical terms, there is potential for some family members to assist with translation where appropriate; however it would be inappropriate to use a family member to translate for a family violence assessment.)
- Use ethnically appropriate resources and tools where possible and appropriate.

Resources

The following resources may support practitioners in working with Pacific families and children.

- Ministry of Health. 2008c. *Pacific Child Health: A paper for the Pacific Health and Disability Action Plan review*. Wellington: Ministry of Health.
- Tiatia J. 2008. *Pacific Cultural Competencies: A literature review*. Wellington: Ministry of Health.
- *Best Health Outcomes for Pacific Peoples: Practice implications*, a resource booklet prepared for the Medical Council of New Zealand and available on its website (www.mcnz.org.nz).
- Ryan D, Beckford N, Fitzsimons M. 2010. *Lalaga: Pacific providers making a difference*. URL: [www.moh.govt.nz/moh.nsf/Files/pacifichealth/\\$file/Lalaga-Jun2010.pdf](http://www.moh.govt.nz/moh.nsf/Files/pacifichealth/$file/Lalaga-Jun2010.pdf) (accessed 5 March 2013).
- Ryan D, Teevale T, Southwick M, et al. 2011. *Primary Care for Pacific People: A Pacific and health systems view*. URL: http://0101.nccdn.net/1_5/2e4/21a/15c/Pacific-Care-for-Pacific-People_-A-Pacific-and-Health-Systems-View_15-Aug-20.pdf (accessed 5 March 2013).

Many health organisations provide opportunities for staff training in Pacific cultural competence. The following are some examples.

- The Auckland District Health Board's *Pacific Best Practice* training programme is available for all its staff. Email pacificbestpractice@adhb.govt.nz for more information.
- The Pacific Health Division of Counties Manukau District Health Board provides cultural competence development training once a month to health practitioners. Refer to the Funded Health Services, Pacific Health section of its website (www.cmdhb.org.nz) for contact information.

- Le Va's *Engaging Pasifika* training is available for health and disability workers in district health boards, non-governmental organisations (NGOs), support services and primary health care. See the Training and Careers section of its website (www.leva.co.nz).
- The SUDI Toolkit, due for release on the Whakawhetu website (www.whakawhetu.co.nz) in June 2013, includes video case studies of Māori and Pacific health practitioners who engage with Māori and Pacific health service users.

Cultural competence with respect to Asian people

The definition of 'Asian', as developed by Statistics New Zealand, includes people with origins in the Asian continent, from Afghanistan in the west to Japan in the east, and from China in the north to Indonesia in the south. The Asian ethnic group is the fourth-largest ethnic group in New Zealand, and Chinese and Indians are the two largest Asian communities within that group.

Most Asian groups include both long-established communities and migrants who arrived after 1987. Values such as an emphasis on family and education may be shared among many of these communities. They also share the experience of young people negotiating between traditional values and those of the adopted culture. Migrants, particularly, share the experience of resettlement in a new country and acculturating to a different way of life (Ministry of Health 2006a).

Over and above these stated commonalities, Asian New Zealanders are diverse. They differ widely in, for example, language, culture, settlement history, socioeconomic status and English-language ability. These areas of difference may affect their health status and needs.

Categorising Asian New Zealanders as a homogenous group for the purposes of gathering health statistics brings with it the risks associated with averaging. Chinese newborn babies, for example, are significantly less likely to be of lower birthweight than newborns in the total population while the risk for Indian newborns is significantly higher (Ministry of Health 2006a).

Resources

Waitemata District Health Board's [Asian Health Support Services](#) produce an e-toolkit for health practitioners working with Culturally and Linguistically Diverse (CALD) clients. The toolkit includes information about the cultural mores and beliefs about health care of various Asian groups (ie, Chinese, Korean, Indian, Vietnamese, Cambodian, Laotian and Burmese), as well as information relating to Middle Eastern and African groups, and contact details for interpreter services.

The [toolkit](#) is available on the CALD (Culturally and Linguistically Diverse) Resources website (www.caldresources.org.nz). The website also provides details of CALD courses, which are available free to practitioners working across the Auckland region. CALD resources are available free to all.

Informed consent

Consent is a fundamental concept in the provision of health care services.¹⁰ It is based on ethical obligations which are, in part, supported by legal provisions as outlined in *Consent in Child and Youth Health: Information for practitioners* (Ministry of Health 1998b). It is also a requirement of the Code of Health and Disability Services Consumers' Rights 1996.

Rather than being a single act, consent is a process. In this process, the individual and/or their representative is appropriately informed, and is willing and able to agree to what is being suggested without coercion. The right to agree to treatment/services carries with it the right to refuse treatment/services.

When seeking informed consent for health services for children, the critical aspects are ensuring that parents/caregivers are well informed, have the capacity to give consent and do so freely. Where appropriate, children should be informed and involved in decisions affecting themselves at a level appropriate to their maturity and understanding, regardless of their capacity to consent.

Effective communication

Effective communication is a requirement of the Code of Health and Disability Services Consumers' Rights 1996. Right 5 of the Code requires that information is communicated in such a way that every health service consumer can understand that information. Over and above the use of context-appropriate language, meeting this requirement incorporates providing adequate time for consultations and an interpreter where necessary.

The Code further requires that the health service environment is conducive to open, honest and effective communication between the consumer and the provider.

Privacy obligations and Well Child/Tamariki Ora services

Rules around privacy obligations about health data that are collected, exchanged and stored within the context of WCTO services are covered by the Privacy Act 1993 and the Health Information Privacy Code 1994 (HIPC). The HIPC describes a framework of controls to ensure the protection of individual privacy. The HIPC and Privacy Act 1993 can be accessed from the Office of the Privacy Commissioner's website (www.privacy.org.nz).

Providers of Well Child/Tamariki Ora care

A multidisciplinary team of people delivers WCTO services. Sometimes these people work within the same organisation. For example, WCTO Provider teams include variously general practitioners (GPs), nurses or nurse practitioners, and community health workers, Karitane or Kaiāwhina. Whether providers of WCTO services operate as independent practitioners (eg, as a midwife might) or as part of a WCTO Provider team, the needs of the child and their family and whānau are best met by a collaborative workforce.

¹⁰ Exceptions apply – for example, consent is not required to report child protection concerns to Child, Youth and Family.

All WCTO clinicians should also consider themselves part of a wider multidisciplinary child health team. They are all expected to have a comprehensive understanding of:

- the components of the child health, social service and early childhood education systems (eg, the roles of the child development service, child and adolescent mental health service, Ministry of Social Development-funded non-governmental organisation, paediatrician and the Ministry of Education–Special Education)
- understanding of local referral pathways, inclusion and exclusion criteria
- systems to facilitate intersectoral collaboration, such as Strengthening Families and Family Group Conferences.

A variety of contractual arrangements cover the funding and provision of services specified in the Schedule.

Clinical care under the WCTO contract is a specialist area of practices that can only be delivered by appropriately qualified clinicians working with adequate supervision and support, continuing professional development and quality systems.

The following groups of people with the associated competencies comprise the child health team who deliver WCTO care.

Lead maternity carers

LMCs are responsible for coordinating care throughout a pregnancy and up to around 4–6 weeks postnatally. Postnatal care encompasses the needs of the mother, baby, family and whānau in accordance with the Schedule until handover to the WCTO Provider, which generally occurs at around 4–6 weeks (see [Continuum of care](#)).

LMCs are midwives, obstetricians or general practitioners (GPs). GP LMCs should hold a Diploma in Obstetrics (or equivalent).

LMCs delivering WCTO care are:

- [midwives](#) who are on the register maintained by the Midwifery Council of New Zealand. Registered midwives must also hold a practising certificate issued by that council (www.midwiferycouncil.health.nz)
- [obstetricians](#) who are registered as such in the register of medical practitioners maintained by the Medical Council of New Zealand (www.mcnz.org.nz)
- [general practitioners](#) who are vocationally registered in the vocational scope of General Practice as gazetted by the Medical Council of New Zealand (www.mcnz.org.nz)¹¹ or registered doctors working in the field of general practice under a collegial relationship with a vocationally registered general practitioner
- [paediatricians](#) who are registered in the vocational scope of paediatrics by the Medical Council of New Zealand (www.mcnz.org.nz).

Nurse practitioners

[Nurse practitioners](#) (see www.nursingcouncil.org.nz) are expert nurses who work within a specific area of practice incorporating advanced skills and knowledge. Those working in primary health care can undertake WCTO assessments and checks.

¹¹ www.mcnz.org.nz/assets/News-and-Publications/Gazette/Gazette-2012-A4.pdf

Registered nurses

The Nursing Council of New Zealand (www.nursingcouncil.org.nz) is responsible under the HPCA Act for the [registration of nurses](#) in New Zealand. Under the Act, the Council must be satisfied that each candidate for registration as a nurse:

- is fit for registration
- has the qualifications prescribed for the scope of practice in which he or she wishes to register
- is competent to practise within that scope of practice.

[Registered nurses](#) who deliver WCTO care have completed (or are in the process of completing) the Nursing Council-approved Well Child/Tamariki Ora strand of the [Postgraduate Certificate in Primary Health Care Specialty Nursing](#) (see www.whitireia.ac.nz) and have been assessed as competent to deliver the components of the Schedule.

B4 School Check

Registered nurses (or other registered health practitioners) who have a background in public health, WCTO or primary health care and who have completed B4 School Check training are able to deliver the B4 School Check component of WCTO services, sometimes with help from other health practitioners such as VHTs (Ministry of Health 2008e). Before the registered health professionals deliver any B4 School Checks, they will receive B4 School Check training from an instructor who has received Ministry-approved Train-the-Trainer instruction.

Community health workers, social workers, and community Karitane and Kaiāwhina¹²

Community health workers, social workers, and community Karitane and Kaiāwhina who hold the [National Certificate in Tamariki Ora – Well Child Services](#) (Level 4) (see www.whitireia.ac.nz) can deliver service components that:

- have been included in their qualifications
- they are competent to deliver within a team that includes either a registered nurse, nurse practitioner or general practitioner.

The National Certificate in Tamariki Ora – Well Child Services (Level 4) is a one-year course designed for people who are providing WCTO care for children under five years of age within the context of family and whānau, under the WCTO Framework, and within the requirements of the WCTO Schedule.

Other qualifications, such as those in community health or health promotion, may also provide the competence to deliver service components within a team that includes a registered nurse, nurse practitioner or general practitioner (see www.nzqa.govt.nz).

¹² See the NZQA website (www.nzqa.govt.nz) and Careers New Zealand website (www.careers.govt.nz).

Vision and hearing technicians¹³

Vision and Screening Technicians (VHTs) who provide vision and hearing screening services must have attained or be working towards the [National Certificate in Community Support Services \(Vision and Hearing Screening\)](#) (Level 3) (see www.careerforce.org.nz).

They must also:

- be employed for a minimum of 16 hours per week for vision and hearing screening work
- receive ongoing professional development relevant to the screening processes specified in the National Protocols (Ministry of Health 2014) and attend the annual Training Seminar (at least every second year)
- have a biennial review/assessment of their competence
- have completed training in the use of the Ministry of Education's ENROL database and the Ministry of Health's B4 School Check database.

Where other personnel provide either vision screening or hearing screening alone, they still must meet the above requirements for employment, experience, review and training.

In cases where registered nurses or other health practitioners carry out vision and hearing screening, they do not need to be dedicated to vision and hearing screening for 16 hours per week but must meet all other competency requirements.

Newborn hearing screeners

Newborn hearing screeners are district health board employees who must be trained and assessed under the Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP) requirements to carry out screening. They must have attained or be working towards the [National Certificate in Health, Disability and Aged Support \(Newborn Hearing Screening\)](#) (Level 3),¹⁴ and must also complete an annual competency assessment as per the national requirements.

Authorised vaccinators

Authorised vaccinators are practitioners who have completed and passed a formal vaccinator training programme, who undertake regular re-accreditation and who have been approved by a medical officer of health (refer to Appendix 4 in the *Immunisation Handbook 2011*, Ministry of Health 2011b).

Health professional colleges

Further information about some of these occupational groups, such as professional development and standards, is available at the following websites:

- College of Nurses Aotearoa, www.nurse.org.nz
- New Zealand College of Midwives, www.midwife.org.nz
- New Zealand College of Primary Health Care Nurses, www.nzno.org.nz/groups/colleges/college_of_primary_health_care_nurses

¹³ See Ministry of Health. 2014. *National Vision and Hearing Screening Protocols*. Wellington: Ministry of Health.

¹⁴ A number of recommendations concerning the training and development requirements for hearing screeners were made following a recent quality improvement review of the UNHSEIP. See Ministry of Health. 2012g. *Quality Improvement Review of a Screening Event in the Universal Newborn Hearing Screening and Early Intervention Programme*. Wellington: Ministry of Health.

- The Royal New Zealand College of General Practitioners, www.rnzcgp.org.nz

Refer to the National Health Board website (www.nationalhealthboard.govt.nz) for a comprehensive list of [other health professional colleges](#).

Quality requirements

The WCTO service provider is required to comply with the General Terms and Conditions of the Ministry of Health and the Provider Quality Specifications described in the Operational Policy Framework, or the Section 88 Primary Maternity Services Notice of the New Zealand Public Health and Disability Act 2000.¹⁵

The following specific requirements also apply. Providers of WCTO services must:

- seek informed consent for the medical examination of children from their parents/guardians
- ensure that parents are fully informed of the relevance of collecting information
- comply with:
 - the Code of Health and Disability Services Consumers' Rights 1996
 - the Children, Young Persons, and Their Families Act 1989
 - the Immunisation Standards as set out in the Ministry of Health's current *Immunisation Handbook*
 - section 125 of the Health Act 1956 with respect to the medical examination of children.

Continuum of care

It is important that health services view themselves as components of an unbroken chain of care (CYMRC 2009). It is therefore essential that health practitioners work collaboratively, and that the handover between services is professionally managed.

Complementary roles of general practice and lead maternity carers

The general practice and LMC roles are complementary yet separate. The general practice focus is on the medical and social needs of pregnant women, new mothers and infants while midwife LMCs remain responsible for midwifery care (New Zealand College of Midwives 2008). Both have a mandate to address psychosocial issues for the mother, family and whānau.

The best way to meet the needs of the parent/caregiver and child and to achieve the continuum of care is by having a collaborative partnership between health care providers. For example, general practice has a professional responsibility to maintain communication, collaboration and documentation and to inform the LMC, preferably in writing, of the outcome of any formal referrals made by the LMC to the general practice for primary health care. If general practice confirms a pregnancy, and/or undertakes any antenatal care for the pregnant woman (eg, blood tests or scans), they should work with the woman to ensure she has a LMC and, with the woman's consent, provide all relevant clinical information to the woman's LMC when maternity care is transferred. By the same token, if a midwife LMC takes on maternity care for a woman, the LMC should advise and provide all relevant information to the woman's GP (if she has one).

¹⁵ A WCTO Quality Improvement Framework has been developed and identifies service delivery standards and sets out measures (Quality Indicators) to audit health system performance. The WCTO Quality Improvement Framework and Quality Indicators provide a mechanism to drive improvement in national consistency in the delivery of WCTO services.

If the woman does not have a GP, the LMC should support the woman in enrolling in a general practice.

Enrolment with a primary health services provider

A new pre-enrolment process, implemented in October 2012, facilitates the enrolment of newborns with a GP or general practice as soon as possible after birth through the following process.

At birth, a newborn's parent/guardian submits information on the baby for the National Immunisation Register (NIR) and nominates a general practice to be responsible for their vaccinations. The NIR forwards this information to the general practice who, upon acceptance (ideally within two weeks), enters the newborn's details into its patient management system (PMS).

The pre-enrolment process helps to maintain the continuum of care. That is, according to best practice, once the newborn is pre-enrolled, general practice should contact the parents/caregivers when the newborn is four or five weeks of age to arrange a six-week immunisation appointment and a general health and physical assessment. It should make contact again if the newborn does not attend either of these appointments (Ministry of Health 2012f).

Through pre-empting enrolment, the Preliminary Newborn Enrolment Policy aims to:

- ensure that newborns receive their immunisations on time
- minimise the risk of children falling through the gaps in the health system.

Details about the new pre-enrolment policy and the [pre-enrolment toolkit](#) are available on the Ministry of Health website (www.health.govt.nz).

To best ensure the continuum of care functions effectively, there is an expectation of triple enrolment of newborns (ie, the linked NIR–GP/practice enrolment, enrolment with a WCTO Provider and enrolment with a Community Oral Health Service).

Transfer of care from lead maternity carer to Well Child/Tamariki Ora services

The process of transfer is initiated when the LMC provides a written referral that meets the guidelines agreed by the New Zealand College of Midwives and providers of WCTO services, before the baby is 4 weeks old. There is a standard form, the GP/Well Child Provider Referral Form, for midwives to complete on the New Zealand College of Midwives website (www.midwife.org.nz). The referral must document all key information required by a WCTO Provider as the basis for initial assessment of need and ongoing care planning for the child, family and whānau.

Where the baby has unusually high needs, the LMC may request that a WCTO Provider becomes involved earlier (ie, as early as two weeks from birth) to provide concurrent, coordinated care with the LMC.¹⁶

¹⁶ Refer to Subpart DA09, Maternity Services Notice Pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000.

Needs assessment and care plan

The Ministry of Health and the Children's Action Plan Project Team are currently developing a needs assessment and care planning process. The needs assessment will be undertaken in partnership with the family or whānau and will focus on strengths and resiliency factors in the family or whānau as well as on needs and risk factors.

During pregnancy and the early postnatal period, the LMC will gather information and share it with the chosen WCTO Provider and general practice. Information passed on by the LMC will form the basis for ongoing assessment of a child and the needs of their family or whānau regarding the level of service delivery required. The assessment will also form part of a child's ongoing health record, and should include information about the child and environmental strengths and needs.

Additional contacts may be provided to children, families and whānau where there is a need assessed in partnership with the parent, family or whānau, and where there is an opportunity to improve health outcomes.

In areas where Family Start operates, it is expected that providers of WCTO services will continue to provide the core WCTO service, and additional contacts will be planned between the WCTO and the Family Start provider in response to the needs assessment.

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Section 3:

Overview of the core visits

This section gives a broad overview what is involved in the postnatal, transition and infant and child core visits, as well as a brief introduction to the B4 School Check. At every core visit, the provider will:

- initiate and/or review the needs assessment with the family or whānau, from which a care plan will be developed
- respond to assessments and refer as required.

The components listed in this section all link to section 4 unless otherwise stated.

Postnatal core visits

Birth–24 hours

Health and development assessments

Focus on child health and wellbeing.

- Conduct brief initial examination at birth (see [Neonatal assessment](#) for a list of clinical assessment components).
- Offer vitamin K (oral¹⁷ or IM).
- Facilitate access to hepatitis B vaccine and immunoglobulin for infants of hepatitis B surface antigen positive mothers within 12 hours of birth (refer to the [Immunisation Handbook 2011](#), Ministry of Health 2011b, p 98).

Care and support for families and whānau

Focus on maternal wellbeing. Discuss maternal physical and emotional health and wellbeing, and maternal and family support networks, and offer information as appropriate about relevant agencies and services available within the area. Relevant topics may include:

- [perinatal mental health](#)
- [breastfeeding](#).

Conduct needs assessment and refer as appropriate.

Health education

Cover:

- [breastfeeding](#)
- [nutrition](#)
- [suffocation prevention through safe sleep practices](#)

¹⁷ Requires three doses (birth–24 hours, 2 weeks, 4–6 weeks).

- parenting support, including for dealing with baby's crying and understanding infant development. Relevant topics may include:
 - [shaken baby syndrome prevention](#)
 - [parenting skills and support](#)
 - [development](#)
 - [recognition of childhood illnesses](#)
 - [child safety/injury prevention](#)
- maternal, family and whānau support networks
- [immunisation](#).

24–48 hours

Health and development assessments

Focus on child health and wellbeing.

- Conduct full clinical examination within 48 hours (see [Neonatal assessment](#) for a list of clinical assessment components).
- Facilitate access to BCG vaccine if indicated for infants at risk of tuberculosis (refer to the [Immunisation Handbook 2011](#), Ministry of Health 2011b, p 259).
- Conduct [newborn metabolic screening](#) (heel prick at 48 hours or as soon as possible after this).

Care and support for families and whānau

- Focus on maternal wellbeing (as per birth–24 hours core visit).
- Focus on family health and wellbeing.
- Discuss parental observation and interaction with their infant and parent mental health. Relevant topics may include:
 - [perinatal mental health](#)
 - [infant and preschool mental health and attachment](#)
 - [alcohol and other drugs](#)
 - [parenting skills and support](#)
 - [supporting families to access income and housing assistance](#)
 - [strengthening family relationships](#)
 - [building social connectedness and social capital](#).
- Conduct a [family violence assessment](#).
- Promote a [smokefree environment](#).
- Conduct a needs assessment and refer as appropriate.

Health education

Provide as per birth–24 hours core visit, as appropriate.

Up to 1 week

Health and development assessments

Focus on child health and wellbeing.

- Conduct clinical examination within seven days (see [Postnatal assessment](#) for a list of clinical assessment components).
- Give vitamin K (oral 2nd dose if not given IM at birth).
- Conduct [universal newborn hearing screening](#) (generally carried out prior to discharge from maternity facility, but may be done in an outpatient setting up to four weeks of age).

Care and support for families and whānau

- Focus on maternal wellbeing (as per birth–24 hours core visit).
- Focus on family health and wellbeing (as per 24–48 hours core visit).
- Conduct a [family violence assessment](#).
- Promote a [smokefree environment](#).
- Maintain a [continuum of care](#).
- Conduct a needs assessment and refer as appropriate.

Health education

Provide as per birth–24 hours core visit, as appropriate.

Transition core visits

2–6 weeks (LMC)

Health and development assessments

Focus on child health and wellbeing.

- Conduct clinical examination at discharge from maternity services.
- Give vitamin K (oral third dose if not given IM at birth).

Care and support for families and whānau

- Focus on maternal wellbeing (as per birth–24 hours core visit).
- Focus on family health and wellbeing (as per 24–48 hours core visit).
- Conduct a [family violence assessment](#).
- Promote a [smokefree environment](#).
- Conduct a needs assessment and refer as appropriate.

Health education

Provide as per birth–24 hours core visit, as appropriate.

6–week assessment (GP team)

Conduct limited assessment in addition to giving [immunisations](#). Other components include:

- [hip screening](#)
- [six-week eye examination](#).

Conduct needs assessment and refer as appropriate.

4–6 weeks (WCTO Provider)

Health and development assessments

Conduct comprehensive assessment at entry into WCTO Provider service, including full physical history. Relevant topics include:

- [growth measurement and monitoring](#).

Conduct needs assessment and refer as appropriate.

Care and support for families and whānau

Focus on family health and wellbeing.

- Discuss parenting, the developing infant–parent interactions and relationship, bonding and parental mental health. Relevant topics may include:
 - [perinatal mental health](#)
 - [infant and preschool mental health and attachment](#)
 - [alcohol and other drugs](#)
 - [parenting skills and support](#)
 - [supporting families to access income and housing assistance](#)
 - [strengthening family relationships](#)
 - [building social connectedness and social capital](#).
- Conduct a [PND screen](#) (under ‘Perinatal mental health’).
- Conduct a [family violence assessment](#).
- Promote a [smokefree environment](#).
- Assess [breastfeeding](#) status.
- Conduct a needs assessment and refer as appropriate.

Health education

Cover:

- [breastfeeding](#) and infant/maternal [nutrition](#)
- [immunisation](#)
- [suffocation prevention through safe sleep practices](#)
- [recognition of childhood illnesses](#)
- parenting for child age and stage (see ‘General parenting information and support’ under [Referrals and resources](#) in ‘Parenting skills and support’)
- [child safety/injury prevention](#).

Infant and child core visits

8–10 weeks

Health and development assessments

Assess child for [growth](#) and [development](#).

Care and support for families and whānau

- Focus on family health and wellbeing (as per 4–6 weeks core visit).
- Conduct a [family violence assessment](#).
- Promote a [smokefree environment](#).
- Conduct a needs assessment and refer as appropriate.

Health education

Cover:

- [breastfeeding](#) and infant [nutrition](#)
- [suffocation prevention through safe sleep practices](#)
- [recognition of childhood illnesses](#)
- parenting for child age and stage (see 'General parenting information and support' under [Referrals and resources](#) in 'Parenting skills and support')
- [child safety/injury prevention](#).

3–4 months

Health and development assessments

- Assess child for [growth](#) and [development](#).
- Conduct [developmental surveillance \(PEDS\)](#).

Care and support of families and whānau

- Focus on family health and wellbeing (as per 4–6 weeks core visit).
- Conduct a [PND screen](#) (under 'Perinatal mental health').
- Conduct a [family violence assessment](#).
- Promote a [smokefree environment](#).
- Assess [breastfeeding](#) status.

Conduct a needs assessment and refer as appropriate.

Health education

Cover:

- [breastfeeding](#) and infant/maternal [nutrition](#)
- [immunisation](#)
- [recognition of childhood illnesses](#)
- [suffocation prevention through safe sleep practices](#)
- parenting for child age and stage (see 'General parenting information and support' under [Referrals and resources](#) in 'Parenting skills and support')
- [development](#)
- [child safety/injury prevention](#).

5–7 months

Health and development assessments

- Assess child for [growth](#) and [development](#).
- Conduct [developmental surveillance \(PEDS\)](#).

Care and support for families and whānau

- Focus on family health and wellbeing (as per 4–6 weeks core visit).
- Conduct a [family violence assessment](#).
- Promote a [smokefree environment](#).
- Assess [breastfeeding](#) status.
- Conduct needs assessment and refer as appropriate.

Health education

Cover:

- [breastfeeding](#) and infant/maternal [nutrition](#)
- [immunisation](#)
- [suffocation prevention through safe sleep practices](#)
- [recognition of childhood illnesses](#)
- parenting for child age and stage (see 'General parenting information and support' under [Referrals and resources](#) in 'Parenting skills and support')
- [development](#)
- [oral health](#)
- [child safety/injury prevention](#).

9–12 months

Health and development assessments

- Assess child for [growth](#) and [development](#).
- Conduct [developmental surveillance \(PEDS\)](#).
- Assess [oral health \(Lift the Lip\)](#).

Care and support for families and whānau

- Focus on family health and wellbeing (as per 4–6 weeks core visit).
- Conduct a [family violence assessment](#).
- Promote a [smokefree environment](#).
- Conduct a needs assessment and refer as appropriate.

Health education

Cover:

- [breastfeeding](#) and infant/maternal [nutrition](#)
- [child safety/injury prevention](#)
- [suffocation prevention through safe sleep practices](#)
- [recognition of childhood illnesses](#)
- parenting for child age and stage (see 'General parenting information and support' under [Referrals and resources](#) in 'Parenting skills and support')
- [development](#)
- [oral health](#)
- [early childhood education](#).

15–18 months

Health and development assessments

- Assess child for [growth](#) and [development](#).
- Conduct [developmental surveillance \(PEDS\)](#).
- Assess [oral health \(Lift the Lip\)](#).

Care and support for families and whānau

- Focus on family health and wellbeing (as per 4–6 weeks core visit).
- Conduct a [family violence assessment](#).
- Promote a [smokefree environment](#).
- Conduct a needs assessment and refer as appropriate.

Health education

Cover:

- [breastfeeding](#) and [nutrition](#)
- [immunisation](#)
- [child safety/injury prevention](#)
- [recognition of childhood illnesses](#)
- parenting for child age and stage (see 'General parenting information and support' under [Referrals and resources](#) in 'Parenting skills and support')
- [development](#)
- [oral health](#)
- [early childhood education](#).

2–3 years

Health and development assessments

- Assess child for [growth](#) and [development](#).
- Conduct [developmental surveillance \(PEDS\)](#).
- Assess [oral health \(Lift the Lip\)](#).

Care and support for families and whānau

- Focus on family health and wellbeing (as per 4–6 weeks core visit).
- Conduct a [family violence assessment](#).
- Promote a [smokefree environment](#).
- Conduct a needs assessment and refer as appropriate.

Health education

Cover:

- [nutrition](#)
- [child safety/injury prevention](#)
- [recognition of childhood illnesses](#)
- parenting for child age and stage (see 'General parenting information and support' under [Referrals and resources](#) in 'Parenting skills and support')
- [development](#)
- [oral health](#)
- [early childhood education](#).

4 years: The B4 School Check

The B4 School Check is a comprehensive and distinct WCTO core contact with its own separate consent process and data information system, the B4 School Check National Information System. The B4 School Check aims to identify any issues that may negatively impact on the child's capacity to participate and learn in the school environment to the best of their ability.

Go to [section 5](#) for greater detail about this check.

Reference

Ministry of Health. 2011b. *Immunisation Handbook 2011*. Wellington: Ministry of Health.

Section 4:

WCTO Schedule components

This section details the WCTO Schedule components (except for those that are exclusive to the B4 School Check – see [section 5](#)). Subheadings include the following, where relevant.

- **Component links** – many components are linked. A competent practitioner will have a good knowledge of related components.
- **Purpose** describes the reason or basis for providing the particular component of care.
- **Key messages** support the purpose for providing the service, and include key information to assist the practitioner in understanding the component and its significance.
- **Age of child** indicates the age/s of the child at which the component is relevant and should be delivered.

In some cases, practitioners are guided to deliver the component at times other than those set out in the WCTO Schedule ‘in response to identified needs’. For example, breastfeeding support should be provided if required by a mother of a two-year-old child, even though this is not specifically in accordance with the timeline covered by the Schedule. Ongoing needs assessments will identify particular needs.

‘Anticipatory guidance’ is sometimes referred to under the ‘Age of child’ or ‘Procedure’ subheadings. Anticipatory guidance means the provision of health information to parents in anticipation of significant physical, emotional and psychological milestones for their child. The purpose of such guidance is to help parents foresee approaching changes, anticipate concerns, maximise their child’s development and identify special needs (Tittley 2006).

- **Procedure** includes a step-by-step recommended procedure for delivering the component of care or a summarised procedure with reference to where a more full description can be sourced.
- **Resources** contain references to resources such as key topic-related documents, to help guide the provider’s practice and delivery of the WCTO component. Also outlined under this subheading are some of the resources available to parents or family that may assist the practitioner’s health education approach. Note that the HE code provided for parent/caregiver resources produced by the Ministry of Health and available on the HealthEd website (www.healthed.govt.nz) is for the English version unless otherwise stated.

Health and development assessments

Neonatal assessment

The neonatal assessment is undertaken over two core visits: the first at birth or within 24 hours; and the second within 48 hours.

Component links

This component links to:

- newborn baby vision and eye
- hip screening
- undescended testes
- growth measurement and monitoring
- development
- suffocation prevention through safe sleep practices
- breastfeeding
- parenting skills and support
- family violence assessment
- alcohol and other drugs
- smokefree environment.

Purpose

The purpose of this component is to:

- reassure parents through health screening and clinical assessment that their child has developed in utero normally and is healthy following birth and, if necessary, ensure any health or developmental concerns are referred appropriately and addressed in a timely manner
- detect early any significant clinical illness or congenital abnormalities, or risk of these.

Key messages

A complete examination of every neonate is a required service item and clinically essential in New Zealand. The assessment is a screening procedure with a number of individual components and has a high yield. Parents expect this assessment and value the reassurance it provides.

Following the birth of a baby, skin-to-skin contact should be promoted, encouraged and facilitated to support mother–baby physiology, bonding and breastfeeding. The Baby-Friendly Hospital Initiative promotes uninterrupted skin-to-skin contact between the mother and infant for at least one hour with support for initiation of breastfeeding. If an infant is unwell and/or admitted to Neonatal Intensive Care, then contact with the mother should be initiated as soon as possible. The definition of skin-to-skin is when a baby is held in chest-to-chest contact with their mother. The mother’s naked chest is in contact with the baby’s chest.

Age of child

Conduct a brief initial examination at birth and a full clinical examination within 48 hours.

Facilitate access to hepatitis B vaccine and immunoglobulin for infants of hepatitis B surface antigen positive mothers **within 12 hours of birth** (see Procedure below).

Personnel

The LMC is responsible for ensuring this assessment is undertaken.

Procedure

Refer to the parent-held *Health Book*, page 91.

Record family history and obstetric history including:

- hepatitis B, tuberculosis, other infective illness, in particular in utero illness
- congenital renal, cardiac, hearing or hip pathology
- assessment of psychosocial and environmental risk factors including inadequate support systems, history of mental health problems, alcohol and other drug use during pregnancy, family violence, and Child, Youth and Family (CYF) involvement.

Undertake systematic and thorough clinical assessment including:

colour; tone; skin; **weight, length and head circumference**; Moro and grasp reflexes; movements; respiration; head; fontanelles; **eyes**¹⁸ – red reflex (using an ophthalmoscope) and risk indicators;¹⁹ ears; mouth; lungs; heart – cardiac assessment; abdomen; umbilicus; anus; **testes**; spine; limbs; **hip joints**;²⁰ and femoral pulses.

Facilitate access to:

- hepatitis B vaccine and immunoglobulin for infants of hepatitis B surface antigen positive mothers within 12 hours (see the *Immunisation Handbook 2011*, Ministry of Health 2011b, p 98)
- BCG vaccine if indicated for infants at risk of tuberculosis (see the *Immunisation Handbook 2011*, Ministry of Health 2011b, p 259).

Offer vitamin K (oral or IM) and, if not accepted, discuss options with parents and note in clinical notes that vitamin K was not given.

Support uninterrupted skin-to-skin contact between mother and infant.

Assess parent–infant interaction, bonding and initial parenting response.

¹⁸ Newborn baby vision and eye check is done at either the neonatal or postnatal assessment.

¹⁹ Refer to the indicators at birth for vision and eye problems in the parent-held *Health Book*.

²⁰ Hip screening is done at either the neonatal or postnatal assessment.

Referral pathway

Guidelines for Consultation with Obstetric and Related Medical Services: Referral guidelines (Ministry of Health 2012c), available from the Ministry of Health website (www.health.govt.nz), provide LMCs with information about the categories of referral, referral pathways and criteria on which LMCs should advise women that a referral is warranted.

Resources

Refer to relevant topics in this Handbook as applicable.

References

Ministry of Health. 2011b. *Immunisation Handbook 2011*. Wellington: Ministry of Health.

Ministry of Health. 2012c. *Guidelines for Consultation with Obstetric and Related Medical Services: Referral guidelines*. Wellington: Ministry of Health.

Postnatal assessment

Component links

This component links to:

- newborn baby vision and eye
- hip screening
- undescended testes
- growth measurement and monitoring
- breastfeeding
- suffocation prevention through safe sleep practices
- perinatal mental health
- infant and preschool mental health and attachment
- child safety/injury prevention
- parenting skills and support
- family violence assessment
- alcohol and other drugs
- smokefree environment.

Purpose

The purpose of this component is to:

- reassure parents through health surveillance and clinical assessment that their child is developing normally and, if necessary, ensure any health or development concerns are referred appropriately and addressed in a timely way
- ensure breastfeeding is initiated and establishing well
- promote parents' understanding of and responsiveness to the infant's social and emotional communications, building responsive, positive parenting
- promote optimal caregiving, attending to parental mental health and family environment

- work with families and whānau to identify their strengths and their needs for support and either provide this support or facilitate access to support from other health or community services, especially for those children of families and whānau at risk of adverse outcomes.

Key messages

A complete examination of every neonate is a required service item and clinically essential in New Zealand. The postnatal screening assessment is a safety net to ensure all infants with risk factors and abnormalities are identified. The assessment is a screening procedure with a number of individual components. Fewer new problems are identified than in the neonatal assessment.

Age of child

This component should be delivered when the baby is aged 2–7 days (preferably five days).

Personnel

The LMC is responsible for ensuring this assessment is undertaken.

Procedure

See the parent-held *Health Book*, page 97.

Record family history and obstetric history including:

- hepatitis B, tuberculosis, other infective illness, in particular in utero illness
- congenital renal, cardiac, hearing or hip pathology
- assessment of psychosocial and environmental risk factors including inadequate support systems, history of mental health problems, alcohol and other drug use, family violence, and CYF involvement.

Undertake systematic and thorough clinical assessment including:

colour; tone; skin; weight, length and head circumference; Moro and grasp reflexes; movements; respiration; head; fontanelles; eyes²¹ – red reflex (using an ophthalmoscope and if not undertaken as part of the neonatal assessment) and risk indicators;²² ears; mouth; lungs; heart – cardiac assessment; abdomen; umbilicus; genitalia; anus; testes; spine; limbs; hip joints;²³ and femoral pulses

breastfeeding: ensure the infant is able to latch well at the breast, suckle well and effectively remove milk from the breast. If a mother is experiencing difficulty at this point, referral for further support is indicated. See [Breastfeeding](#) under 'Health education' for more information.

Give vitamin K (oral second dose if not given IM at birth).

²¹ Newborn baby vision and eye check is done at either the neonatal or postnatal assessment.

²² Refer to the indicators at birth for vision and eye problems in the parent-held *Health Book*.

²³ Hip screening is done at either the neonatal or postnatal assessment.

Ensure that:

- infants of hepatitis B surface antigen positive mothers have access to hepatitis B vaccine and immunoglobulin within 12 hours (see the *Immunisation Handbook 2011*, Ministry of Health 2011b, p 98) and infants at risk of tuberculosis are given BCG vaccine if indicated (see the *Immunisation Handbook 2011*, Ministry of Health 2011b, p 259)
- **newborn metabolic screening** is completed between 48 and 72 hours.

At the first home visit, undertake a safe sleep assessment. Refer to **Suffocation prevention through safe sleep practices** under 'Health education'.

Assess parent–infant interaction, bonding and initial parenting responsiveness to infant.

Provide relevant information and anticipatory guidance to parents/caregivers including that concerning child safety/injury prevention (eg, check that an appropriate child car restraint for a newborn, meeting an approved standard is being used; falls and drowning prevention). Refer to **Child safety/injury prevention** under 'Health education'.

Referral pathway

Guidelines for Consultation with Obstetric and Related Medical Services: Referral guidelines (Ministry of Health 2012c) available from the Ministry of Health website (www.health.govt.nz) provide LMCs with information about the categories of referral, referral pathways and criteria on which LMCs should advise women that a referral is warranted.

Resources

Refer to other topics in this Handbook as required.

References

Ministry of Health. 2011b. *Immunisation Handbook 2011*. Wellington: Ministry of Health.

Ministry of Health. 2012c. *Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)*. Wellington: Ministry of Health.

Hip screening

Component links

This component links to:

- neonatal assessment
- postnatal assessment
- six-week assessment
- development.

Purpose

The purpose of this component is to:

- detect early and treat developmental dysplasia of the hip.

Key messages

Developmental dysplasia of the hip (DDH), also known as congenital hip dislocation or dislocatable hip, refers to a range of conditions in which the head of the femur does not fit appropriately into the hip socket at birth. It can affect one or both hips. Many hips are unstable at birth but most stabilise in the correct position. In one in 1000 births, the hips stabilise in a dislocated position.

If untreated, hip dysplasia leads to the child walking with a limp or unusual waddling gait.

Risk factors for DDH include:

- being a first-born female
- being born in breech position
- a family history of DDH, particularly if in mother
- having other congenital anomalies, particularly heart disease
- being of New Zealand European or Asian ethnicity – DDH is more common in babies of these ethnicities. It is uncommon in babies of Māori or Pacific ethnicity.

Detection of this condition in the first six months is preferable to later detection, but can be difficult for the community practitioner – a high level of suspicion is required.

Signs in the first 3–4 months of life include:

- positive Ortolani and Barlow tests with ‘clunking’ sensation on gentle adduction and abduction of the hip in flexion. (Note that these tests only detect about 50 percent of all DDH.)

Note that normal range of motion of the hip and no leg length difference are reassuring but do not rule out DDH.

Signs* from 3–4 months to 12 months may include:

- asymmetry of skin creases in a baby’s thighs, buttocks, groin
- one leg seemingly shorter than the other
- limited abduction of the affected hip.

Signs* after the age of 12 months may include:

- late walking (at 16 months or older)
- toddler walking with a limp or waddling gait or with leg externally rotated.

* **Note:** These signs are not by themselves diagnostic but should still be investigated. Most children will have normal investigations for DDH.

Age of child

Babies should be screened at birth and six weeks using the Ortolani and Barlow tests. Note that Ortolani and Barlow tests should only be done by experienced practitioners.

Personnel

This assessment is provided by the LMC for the check at birth (as part of either the neonatal or postnatal assessment). The screen at six weeks is done by a GP as part of the six-week assessment.

Procedure

The Royal Children's Hospital Melbourne (www.rch.org.au) has produced a DVD, *Developmental Dysplasia of the Hip*, which provides a guide to the hip screening examination, further information about DDH and practitioner resources. It is available to view online and to purchase.

Referral pathway

If there is the slightest suspicion of an abnormality, use the appropriate referral pathway to the orthopaedic service.

There is a range of ways in which orthopaedic services manage hip dysplasia throughout New Zealand. Given service constraints in some areas, not all children with an at-risk history are automatically examined by an orthopaedic surgeon – some services will recommend appropriate investigations for the GP to order rather than providing a clinic appointment. It is important that providers of WCTO services are aware of the local management so they can accurately inform parents/caregivers if they have concerns.

Resources

[Developmental dislocation of the hip](#) from Starship Children's Health, HealthPoint (www.healthpoint.co.nz)

RCH. 2011. *Developmental Dysplasia of the Hip* (DVD). Royal Children's Hospital Melbourne. URL: www.rch.org.au/ortho/education_training/Developmental_dysplasia_of_the_hip_DDH_education_al_resource (accessed 13 March 2013) – content includes pathology of DDH and physical examination of the infant hip.

The following orthopaedic fact sheets for parents/caregivers are available in the resource section of the Developmental Dysplasia of the Hip DVD:

- Developmental dysplasia of the hip (DDH)
- Safe wrapping for hip dysplasia.

Refer also to Wynter M, Gibson N, Kentish M, et al. 2008. *Consensus Statement on Hip Surveillance for Children with Cerebral Palsy: Australian standards of care*. URL: www.ausacpdm.org.au/___data/assets/pdf_file/0007/14569/consensus_statement.pdf (accessed 13 March 2013). Children with cerebral palsy or other abnormalities of tone are in the category of children 'at risk'.

Newborn metabolic screening

Purpose

The purpose of this component is to:

- reduce newborn morbidity and mortality through high-quality screening that facilitates early detection and treatment of specific metabolic disorders in pre-symptomatic babies.

Key messages

Many of the disorders that the Newborn Metabolic Screening Programme screens for can lead to serious illness or mortality within 7–10 days. Samples must be taken between 48 and 72 hours after birth or as soon as possible after this to prevent irreversible damage and life-threatening illnesses (NSU 2010).

It is also critical to ensure the time taken to get the sample to the laboratory is minimal. Blood spot cards must be sent to the laboratory as soon as they are dry (drying time is approximately two hours).

A hard copy result will be received for every sample. If results are not received within 7–10 days, the health practitioner (usually the LMC) must contact the laboratory.

To alleviate discomfort for the infant during the heel prick procedure, the infant may be breastfed. This can be supported by the personnel undertaking the procedure. Skin-to-skin contact, maternal holding and/or breastfeeding have variously been found to reduce distress in babies undergoing procedural pain (eg, see Franck and Lawhon 1998; Efe and Ozer 2007; Kostandy et al 2008).

Age of child

This component should be delivered when the baby is aged 48 hours (or as soon as possible after this) – optimum time 48–72 hours.

Personnel

The LMC is responsible for:

- having a discussion with the parents/caregivers and offering screening
- ensuring this screening procedure is undertaken if consent is given.

If care has been transferred and the woman is in the care of the secondary/tertiary service, that service is responsible for ensuring a sample is taken.

If there is no LMC assigned for maternity care, the antenatal care provider or the secondary/tertiary service is responsible for ensuring a sample is taken.

Procedure

Guidelines for Practitioners Providing Services Within the Newborn Metabolic Screening Programme in New Zealand (NSU 2010) are available from the National Screening Unit website (www.nsu.govt.nz). They include information about policy standards and specific disorder information.

Referral pathways

If the practitioner has clinical concerns about a baby, they must refer the baby to a paediatrician irrespective of the screening result or without waiting for screening results.

If a positive result is received, the laboratory will provide guidance on the appropriate referral and level of urgency.

Resources

The National Screening Unit (NSU) (www.nsu.govt.nz) provides other practitioner resources such as information (eg, [Heel Pricks – Warming, pain relief and lancet use](#)), lancets, and envelopes and postage to send blood spot cards to the laboratory.

Parent pamphlets such as [Your newborn baby's blood test](#) (HE2310) are available from www.healthed.govt.nz or by emailing newbornscreeningresources@adhb.govt.nz

DVDs are also available for both practitioners and parents by emailing newbornscreeningresources@adhb.govt.nz

References

Efe E, Ozer ZC. 2007. The use of breastfeeding for pain relief during neonatal immunization injections. *Applied Nursing Research* 20: 10–16.

Franck LS, Lawhon G. 1998. Environmental and behavioral strategies to prevent and manage pain. *Seminars in Perinatology* 22(5): 434–43.

Kostandy RR, Ludington-Hoe SM, Cong X, et al. 2008. Kangaroo care (Skin contact) reduces crying response to pain in preterm infants: Pilot results. *Pain Management Nursing* 9(2): 55–65.

NSU. 2010. *Guidelines for Practitioners Providing Services Within the Newborn Metabolic Screening Programme in New Zealand*. Wellington: National Screening Unit. URL: www.nsu.govt.nz/files/ANNB/Metabolic_Screening_Guidelines_final_February_2010.pdf (accessed 15 January 2013).

Newborn baby vision and eye

Component links

This component links to:

- neonatal assessment
- postnatal assessment.

Purpose

The purpose of this component is to:

- detect and refer infants with congenital eye abnormalities, including cataracts and glaucoma.

Key messages

External examination of the eye and red reflex screening using an ophthalmoscope are essential aspects of the routine infant vision and eye examination (Fry and Wilson 2005). If the red reflex is **absent**, this means light cannot get to and reflect back from the retina. A white reflex may indicate an intra-ocular mass.

Early detection is critical as some conditions threaten sight or life or have systemic associations. Detected early, many of these conditions are treatable. In the case of infants with congenital cataracts, which are reasonably common, surgery is recommended between **four and eight weeks** of age in order to preserve sight. It is vital therefore that this assessment is undertaken as soon as possible after birth and definitely by the six-week assessment.

New Zealand research indicates that the current quality and coverage of red reflex screening are poor (Fry and Wilson 2005). This assessment should be done by a practitioner trained to use a direct ophthalmoscope.

Another relatively common issue that upsets parents is congenital naso-lacrimal duct obstruction, which causes watery, sticky eyes. In most cases, it improves spontaneously between six and 12 months. If this problem persists past one year of age, medical referral is indicated.

Age of child

This component should be delivered at birth or up to seven days of age.

This assessment is undertaken as part of either the neonatal or postnatal assessment. If for any reason the LMC is unable to undertake a full assessment (which includes a red reflex assessment with a direct ophthalmoscope) at either of these time points, the LMC must make a referral to the infant's general practitioner for the assessment to be included in the six-week assessment.

Personnel

The LMC or GP provides this assessment.

Procedure

Undertake and interpret the assessment and screening procedures (including red reflex and risk indicators). Use a direct ophthalmoscope to check for red reflex.

Physical external eye assessment covers these questions.

- Is the face symmetrical?
- Are the eyes of equal size?
- Is the bulbar conjunctiva white? (It should not be red.)
- Are the corneas clear?
- Are the lids clean? (There should be no discharge.)
- Are the media clear (normal red reflex)?
- Are the pupils round and black?

Complete the 'Indicators at birth for vision or eye problems' in the parent-held *Health Book*, page 92.

Referral pathways

Refer to an ophthalmologist if the answer to any of the physical eye assessment questions is 'no' or where there are concerns.

Reference

Fry M, Wilson GA. 2005. Scope for improving congenital cataract blindness prevention by screening of infants (red reflex screening) in a New Zealand setting. *Journal of Paediatrics and Child Health* 41: 344–6.

Six-week eye examination and vision surveillance

Component links

This component links to:

- six-week assessment
- B4 School Check (section 5).

Purpose

The purpose of this component is to:

- detect suspected visual impairment or defect.

Key messages

The normal history of developmental eye disease is well documented. Amblyopia is an acquired condition in which vision is lost in a healthy-looking eye. This occurs as a result of a poorly focused image in the eye during a critical early period, which is completed by age 7–8 years. There is some evidence that early detection and treatment of refractive error is associated with a decrease in incidence of amblyopia, which improves vision to within one line of the good eye.

Age of child

This component applies:

- at six weeks (vision screen as per the newborn baby vision and eye check)
- during surveillance at core contacts
- at four years (see [Vision screening](#) in section 5)
- on any occasion when the parents or caregivers have concerns.

Personnel

The vision screen at six weeks should be done by a practitioner trained to use a direct ophthalmoscope (eg, by the GP as part of the six-week assessment).

Surveillance is undertaken by personnel delivering WCTO care in accordance with the Schedule, including the general practice and WCTO Provider teams.

VHTs or registered nurses or other health practitioners who have met the appropriate competency requirements deliver the vision component of the B4 School Check.

Procedure

Undertake and interpret the assessment and screening procedures. At each core contact, go through the 'Can your child see' questionnaire in the parent-held *Health Book*. At the six-week assessment, complete a physical external assessment.

Physical external eye assessment covers the following questions.

- Is the face symmetrical?
- Are the eyes of equal size?
- Is the bulbar conjunctiva white? (It should not be red.)
- Are the corneas clear?
- Are the lids clean? (There should be no discharge.)
- Are the media clear (normal red reflex)?
- Are the pupils round and black?
- Do the eyes look straight (ie, point in the same direction)?
- Do the eyes move smoothly?
- Does the child fuss or lose fixation when one eye is covered?
- Do both eyes move to each corner?
- Are corneal reflections central and equal?

Identify the indicators of suspected squint, media opacity or visual impairment.

Referral pathways

Refer to a GP if assessment is unsatisfactory.

Refer to an ophthalmologist if the answer to any of the physical eye assessment questions is 'no' or where there are concerns.

Resource

Refer parents/caregivers to the 'Can your child see' questionnaire by age in the parent-held *Health Book*.

Universal newborn hearing screening

Component links

This component links to:

- development.

Purpose

The purpose of this component is to:

- screen the baby's hearing for risk of congenital hearing loss.

Key messages

The first 6–12 months of a baby's life are a critical period for learning to hear and speak. Lack of exposure to language during this period, due to prolonged hearing loss, can affect a child's development, communication skills and educational achievement. Early detection of hearing loss and the application of early interventions have been demonstrated to significantly improve the baby's language skills and cognitive ability.

Since 2010, the Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP) has been available throughout the country. The goals of the programme are to screen babies by one month of age, to identify hearing loss by three months of age, and to initiate clinical and educational interventions by six months of age. [Newborn hearing screening services](#) are provided by all district health boards.

As part of the screening process, the baby is checked for any risk factors such as a history of severe jaundice, family history of congenital hearing loss, in utero infections, or structural cranio-facial abnormalities that may be associated with later onset or progressive hearing loss. These babies are flagged for a targeted follow-up assessment with audiology by 18 months of age.

The current screening technologies used are Automated Auditory Brainstem Response (AABR) and Automated Otoacoustic Emissions (AOAE).

Age of child

The screen is generally carried out prior to discharge from maternity facility (ie, in the first week), but may be done in an outpatient setting up to four weeks of age.

Personnel

The newborn hearing screener screens the hearing of the baby. The newborn hearing screener, LMC or paediatrician provides the assessment of the risk factors.

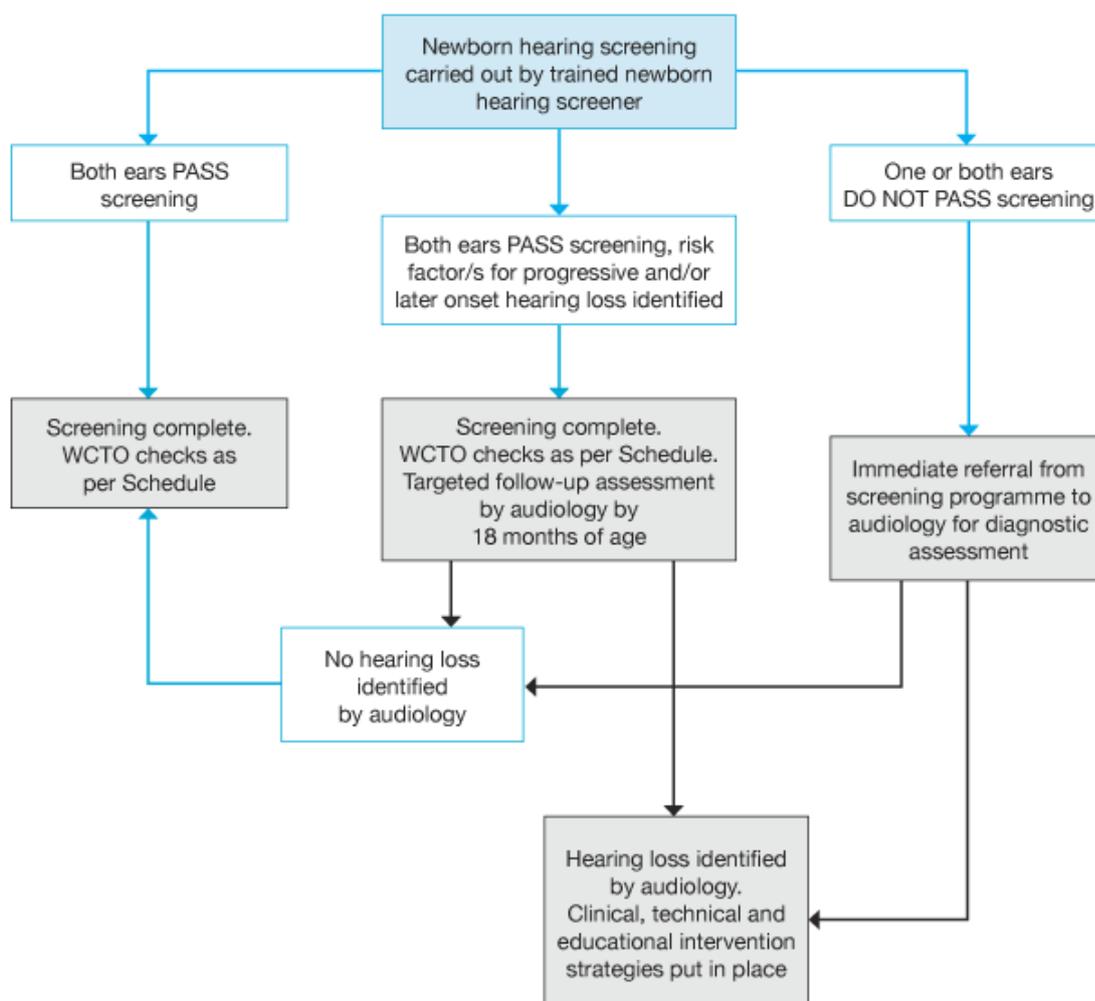
Procedure

The National Screening Unit's (NSU's) *Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP): National policy and quality standards* provides detailed information about informed consent, procedure, guidelines and policy standards.²⁴ This document is available on the NSU website (www.nsu.govt.nz).

²⁴ Following a [recent review](#), a number of recommendations have been made to the National Screening Unit, which oversees the UNHSEIP, regarding the screening protocol and screener training (Ministry of Health 2012g).

Referral pathways

Figure 2: Overview of the Universal Newborn Hearing Screening and Early Intervention pathway



Resources

NSU. 2011. *Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP): National policy and quality standards*. Wellington: National Screening Unit. URL: www.nsu.govt.nz/files/PQS_word.pdf (accessed 15 January 2013).

A number of other resources for health practitioners and parents/caregivers are available from the websites of the National Screening Unit (www.nsu.govt.nz) and HealthEd (www.healthed.govt.nz). The following are for parents/caregivers:

- [Your baby's hearing screen \(HE1921\)](#)
- [Referral to an audiologist \(HE1924\)](#)
- [Hearing checklist \(HE1922\)](#).

See 'Indicators for hearing loss' in the parent-held *Health Book* (page 92).

Reference

Ministry of Health. 2012g. *Quality Improvement Review of a Screening Event in the Universal Newborn Hearing Screening and Early Intervention Programme*. Wellington: Ministry of Health.

Hearing surveillance

Component links

This component links to:

- development
- universal newborn hearing screening.

Purpose

The purpose of this component is to:

- detect suspected hearing impairment and refer appropriately
- promote hearing knowledge for parents/caregivers.

Key messages

Hearing loss is screened for around the time of birth. At any age when parents/caregivers express significant concerns, they should see their GP who can make a referral to audiology.

Age of child

This component applies:

- during surveillance at core contacts
- on any occasion when the parents or caregivers have concerns
- at four years (see [Hearing screening](#) in section 5).

Personnel

The WCTO nurse, nurse practitioner or general practitioner undertakes surveillance and responds to parent concerns as set out under Procedure below.

VHTs or registered nurses or other health practitioners who have met the appropriate competency requirements deliver the hearing screening component of the B4 School Check.

Procedure

Determine if there are any parent/caregiver concerns.

Where relevant:

- undertake the appropriate assessment and screening procedures, interpret the results and discuss significant findings with parents/caregivers (eg, at core contacts, administer the 'Can your child hear' questionnaire from the parent-held Health Book)
- assess parent/caregiver need for information and support, particularly prior to an audiology appointment
- explain the indicators of hearing loss and the difference between conductive and sensorineural hearing loss and how each is managed as necessary
- facilitate access to specific support services.

Referral pathway

Where concerns are raised through questioning, direct observation or parents/caregivers, the child should initially be referred according to the concern. This could be to a general practitioner, ear specialist nurse, otorhinolaryngologist (ORL) specialist or audiologist, depending on the issue. Older children (3+ years) can be referred to a VHT as VHTs have a testing protocol for children with hearing concerns.

Local referral pathways may differ – WCTO practitioners should establish clear referral pathways to specialist services in partnership with those services.

When the ear is normal on assessment but the practitioner or parent/caregiver is concerned, the child should be referred immediately as above.

Where medically treatable conditions are identified, these should be managed appropriately. If hearing concerns persist after the treatment, the child should be referred to audiology.

Resources

Refer parents/caregivers to the 'Can your child hear' questionnaire by age in the parent-held *Health Book*.

The National Foundation for the Deaf has produced a parent fact sheet, [Your child's speech and hearing milestones](#), which is available on its website (www.nfd.org.nz).

Undescended testes

Purpose

The purpose of this component is to:

- detect early and treat undescended testes.

Key messages

Undescended testes occur when one or both of the testicles do not reach the scrotum and remain inside the groin or abdomen. Prevalence is about 3 percent of male newborns, although the percentage is higher in preterm babies.

About half the cases of undescended testes at birth will self-correct by three months. If a testicle remains undescended after this time, a referral is required.

Uncorrected, undescended testes can contribute to infertility and an increased risk of testicular cancer in later life.

Age of child

The male infant is checked at each contact until testes are completely descended.

Personnel

The LMC undertakes this assessment for the first 4–6 weeks. Thereafter, if necessary, the WCTO nurse, nurse practitioner or general practitioner conducts it.

Procedure

Undertake gentle palpitation of the scrotum to define the position of testes (using warm hands).

Note position as undescended, partially descended or fully descended.

Referral pathways

If the testes are not felt in the scrotum and/or remain undescended by three months of age, referral should be made to a paediatric surgeon through the GP.

Resources

For parent/caregiver information, see the HealthPoint website:

www.healthpoint.co.nz/specialists/general-surgery/starship-paediatric-surgery-and-urology/undescended-testes and www.healthpoint.co.nz/specialists/paediatrics/wellington-childrens-hospital/undescended-testes (accessed 18 January 2013).

Transition core visits: 2–6 weeks (LMC)/6-week assessment (general practice)/4–6 weeks (WCTO Provider)

Note: The Ministry of Health is developing procedures around these transition visits. When this work is completed, content for this component will be updated accordingly.

Component links

This component links to:

- continuum of care (section 2).

Purpose

The purpose of this component is to:

- reassure parents/caregivers through health surveillance and clinical assessment that their child is developing normally and, if necessary, ensure any health or development concerns are referred appropriately and addressed in a timely way
- ensure breastfeeding or appropriate form of infant feeding is established
- promote parents' understanding of and responsiveness to the infant's social and emotional communications, building responsive, positive parenting
- promote optimal caregiving, attending to parental mental health and family environment
- work with families and whānau to identify their strengths and their needs for support and either provide this support or facilitate access to support from other health or community services, especially for those children of families and whānau at risk of adverse outcomes
- confirm enrolment with both general practice and WCTO Provider.

Key messages

As per the Schedule, the transition period when the infant moves from the LMC's care to the care of the WCTO Provider occurs around 4–6 weeks. General practice and the LMC (where the former is not providing lead maternity care) hold separate, **complementary roles** in the provision of health care antenatally and postnatally (see section 2).

Three transition checks take place around this time.

- The LMC undertakes a final check at discharge from maternity service.
- The WCTO Provider undertakes a comprehensive assessment to mark the entry into WCTO Provider services.
- One or more members of the general practice team carry out a limited assessment and provide the necessary immunisations.

The **continuum of care** relies on links and collaboration between providers (see section 2). The LMC leads maternity and postnatal care through to around 4–6 weeks. Then, following the transitional period, responsibility for WCTO care is transferred to a WCTO Provider. The general practice team remains the essential health contact throughout this period and beyond, once the child starts school.

The quality of care in the first year of life is dependent on this three-part care continuum functioning well. Gaps in this system can break the chain of care, causing crucial assessments and interventions to be missed. This can have serious consequences for the most vulnerable infants (CYMRC 2009).

Procedure

In addition to the assessment done by each of the health care providers around this period, the following personnel should undertake these specific elements of care:

- LMC:
 - gives vitamin K (oral third dose if not given IM at birth)
 - ensures the relevant documentation and information has been provided to the general practice and WCTO Provider (eg. see the New Zealand College of Midwives website, www.midwife.org.nz, GP/Well Child Provider Referral Form).
- WCTO Provider:
 - undertakes a **PND screen** (see 'Perinatal mental health' under 'Care and support for families and whānau').
- General practice team:
 - carries out the **six-week eye examination** (see above)
 - gives the six-week **immunisations** (see 'Health education').

Reference

CYMRC. 2009. *Fifth Report to the Minister of Health: Reporting mortality 2002–2008*. Wellington: Child and Youth Mortality Review Committee.

Oral health

This component includes information on how to undertake the Lift the Lip check for visible decay in accordance with the health and development assessment stream of the Schedule. It also covers information relevant to the health education stream of the Schedule.

Component links

This component links to:

- nutrition
- breastfeeding
- development.

Purpose

The purpose of this component is to:

- promote, from infancy, healthy teeth along with healthy behaviours that decrease the risk of dental caries and its associated direct and indirect effects on a child's overall health
- check that children are enrolled in their local Community Oral Health Service.

Key messages

Dental caries or tooth decay is the gradual destruction of a tooth that develops in the presence of sugars and bacteria in dental plaque, and affects humans of all ages. Dental caries is a largely preventable disease. The bacterium streptococcus mutans (MS) is involved in the development of dental caries. Circumstances associated with MS colonisation in children are frequent exposure to sugar, frequent snacking, taking sweetened drinks to bed, sharing food with adults and high levels of maternal MS. In its early stages, dental caries can be prevented and even reversed through altering the dental environment – specifically by reducing dental plaque, reducing sugar exposure, using protective modifiers such as fluoride and following preventive treatment options. These measures can reduce the need for fillings and extractions.

Improving and maintaining oral health through prevention and promotion is regarded as one of the most effective ways to achieve oral health over the long term. Promoting oral health, particularly in childhood, is likely to have benefits throughout the child's life as healthy environments and behaviours early in life have been shown to decrease the risk of oral disease in later years (Ministry of Health 2008d).

Teeth are at risk of dental decay from the time they appear in the mouth. Therefore children are at risk of dental caries from approximately six months of age, when the primary teeth start to emerge through the gums and into the mouth. For infants and young children who develop early childhood caries (ECC) (see risk factors below), their growth, development and quality of life can be affected. ECC often leads to significant dental problems with many teeth requiring filling and extraction, sometimes under general anaesthetic. Early detection of decay can therefore help prevent this disease or stop its progression and improve a child's quality of life.

Risk factors for early childhood caries

Factors that increase the risk of ECC are:

- improper use of a bottle when bottle-feeding, for example when:
 - put to bed with a bottle
 - put to sleep after feeding without cleaning the teeth
 - the bottle is used for prolonged periods
 - the bottle is used for feeding sweetened drinks
- snacking with sugary foods and drinks throughout the day
- not starting to clean teeth regularly with a fluoridated toothpaste as soon as the teeth erupt through the gums
- having a history of high levels of tooth decay in the family
- living in a low-income family or in non-fluoridated areas
- being born prematurely or at lower-than-normal birthweight, or being born with developmental disabilities and disorders

In addition, some breastfed babies who nurse for long periods throughout the day and night may develop ECC. However, breast milk is the best form of nutrition for infants and breastfeeding is associated with a lower risk of developing dental decay when compared with bottle-feeding.

A particularly virulent form of dental caries (severe ECC) develops very quickly and teeth may be destroyed within six months of its onset. Severe ECC is characterised by an overwhelming infectious challenge from the bacteria in the mouth, supported by dietary practices that provide frequent and high levels of refined carbohydrates (sugars).

ECC and severe ECC have been identified as a problem, particularly for Māori children.

The most recent national survey on oral health, the 2009 New Zealand Oral Health Survey (NZOHS), found that the oral health of preschool children aged 2–4 years was relatively good. However, on average, 20 percent of preschool children had experienced tooth decay in their primary teeth and 15 percent had untreated decay in the crown of at least one primary tooth (Ministry of Health 2010c).

There are significant differences in the severity of oral disease between young Māori and non-Māori children (Ministry of Health 2008a). The 2009 NZOHS found significant oral health disparities, particularly for Māori and Pacific children, in terms of both oral health status and access to oral health services. Time-trend data, however, indicate that disparities reduce between the start and end of primary school, and that the gap has decreased between 2003 and 2011.

The 2009 NZOHS and Ministry of Health child oral health data show that children from non-fluoridated areas have higher levels of dental decay than children from fluoridated areas.

Early enrolment in a dental service, combined with appropriate preventative strategies such as suitable feeding and nutrition, regular tooth brushing and correct use of fluorides, can significantly reduce this problem.

Preventative measures

Baby teeth are important and need proper care. Teeth not only help in chewing food, but also boost the child's self-esteem, assist in speech development and support proper growth and development of the face, jaws and adult teeth.

Dietary measures

Breastfeeding is the best form of nutrition for infants. If bottle-feeding, only expressed breast milk or formula should be used. Bottle-feeding fruit juices and sweetened drinks may cause sugary fluids to pool in the mouth and create a favourable environment for bacteria to produce the acids that cause tooth decay. These drinks should not be given to infants and toddlers.

Advise families to encourage their child to eat healthy, nutritious, sugar-free snacks. Children should snack at regular intervals and avoid grazing throughout the day. Parents should be discouraged from introducing sugary and acidic drinks to their children at a very young age. Frequent intake of sugary foods or drinks leads to significant damage to dental enamel. Hence, it is important that snack choices for young children are nutritious, non-sticky and low in added sugar.

Cleaning

Regular brushing should be started as soon as the first tooth comes through the mouth at around 6–8 months of age. Teeth should be brushed twice daily with fluoride toothpaste, and brushing at night is very important. A smear of fluoride toothpaste and a small, soft-bristled brush are recommended for children under six years of age.

The Ministry of Health recommends that adults and children of all ages brush their teeth twice a day with a fluoride toothpaste of 1000 ppm or greater. Most fluoridated toothpastes on sale in New Zealand contain 1000 ppm of fluoride, although a 400 ppm fluoride toothpaste is also available for use by children under six years. However, the recommendation of 1000 ppm fluoride toothpaste for both adults and children is based on the consensus of many years of research on the effectiveness of toothpastes with different strengths of fluoride. Toothpaste should be spat out rather than rinsed out after brushing so that the fluoride remains in contact with the teeth for longer and can more effectively prevent dental caries. It is also recommended that children be supervised when using toothpaste to ensure they do not swallow or eat it (NZGG 2009). The 2009 NZOHS, however, found that only 15 percent of children aged 2–4 years brushed their teeth at least twice a day with fluoride toothpaste of 1000 ppm or greater (Ministry of Health 2010c).

Oral health screening

Oral health screening involves a quick check of a child's teeth to identify early or more severe dental decay. It is not a full clinical examination and does not involve making diagnoses or developing treatment plans. Oral health screening should only take two to three minutes.

The Lift the Lip check is a quick and easy technique for non-oral health practitioners to identify visible decay. Lack of visible decay does not mean that no decay is present or the child does not need to go to a dental clinic. The Lift the Lip check provides an opportunity to check that all children are enrolled at a community dental clinic and to remind parents of the importance of taking their child to a dental clinic regularly for a full clinical examination by a dental therapist or dentist.

Age of child

Oral health guidance and education are provided at each contact from 5 to 7 months, and Lift the Lip screen is done at each contact from 9 to 12 months.

Guidance can be provided from birth as per the *Healthy Smile, Healthy Child: Oral health guide for Well Child Providers* (New Zealand Dental Association 2008) in regard to breastfeeding, avoiding the use of pacifiers dipped in honey and so forth.

Personnel

All providers delivering WCTO care – including LMCs, paediatricians, and general practice and WCTO Provider teams – deliver this component.

Procedure

Check the teeth for abnormalities once they have erupted, as per the Lift the Lip programme. (Refer to the *Healthy Smile, Healthy Child* guide, Module 4 for information and go to www.healthysmiles.org.nz to view an educational video on how to undertake the Lift the Lip check.)

Promote good oral health practices to parents, including healthy nutrition and oral health hygiene practices. See the nutrition section in *Healthy Smile, Healthy Child* for further information. The same guide also gives further information about brushing technique.

Facilitate enrolment of the infant to a community dental service from 12 months of age. See Appendix 4 in *Healthy Smile, Healthy Child* for contact information and enrolment forms for Community Oral Health Services or freephone **0800 TALK TEETH** (0800 825 583).

Emphasise the need for regular dental checks at a Community Oral Health Service clinic.

Referral pathways

The Early Childhood Oral Health Toolkit (Ministry of Health 2008a) recommends that WCTO Providers are linked with early childhood dental services in all district health boards, so children with early dental changes or overt dental caries are identified and referred for treatment. All children are entitled²⁵ to be enrolled and to receive free dental services from a community dental service.

After a Lift the Lip screening, if you have observed decay or are in doubt, you should refer the child to a dental clinic promptly.

Follow local protocols and pathways for oral health referrals. Referrals to hospital dental services should also be provided at no cost to the family or whānau.

²⁵ Refer to www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services/guide-eligibility-publicly-funded-health-services-0/people-aged-17-years-or-younger for details about eligibility criteria related to visa status.

Resources

Healthy Smile, Healthy Child: Oral health guide for Well Child Providers (New Zealand Dental Association 2008) was developed by the New Zealand Dental Association, in conjunction with the Ministry of Health. This resource covers child oral health promotion and early detection from birth to five years, including the Lift the Lip oral health check for children, and includes a training DVD. *Healthy Smile, Healthy Child* is also available from the Ministry of Health website (www.health.govt.nz).

A number of educational videos are also available from the New Zealand Dental Association website (www.healthysmiles.org.nz) in the Your Oral Health section. These include videos on [How to brush](#), [How to floss](#) and [Lift the Lip](#).

The following are other resources for health practitioners.

- Ministry of Health. 2008a. *Early Childhood Oral Health: A toolkit for District Health Boards, primary health care and public health providers and for oral health services relating to infant and preschool oral health*. Wellington: Ministry of Health.
- Ministry of Health. 2008d. *Promoting Oral Health: A toolkit to assist the development, planning, implementation and evaluation of oral health promotion in New Zealand*. Wellington: Ministry of Health.
- NZGG. 2009. *Guidelines for the Use of Fluorides*. Wellington: Ministry of Health.

A Ministry of Health resource for parents and families is:

- [Teeth and gums](#) in the Your health section of the Ministry of Health website (www.health.govt.nz).

Ministry of Health resources for parents and families from the HealthEd website (www.healthed.govt.nz) are:

- [It's easy to protect your family's smile](#) (HE2248)
- [Caring for teeth](#) (HE1524) (pamphlet for new migrants)
- [Water fluoridation: let's talk fluoride](#) (HE2308)
- [Dental health and fluoride](#) (HE1253).

References

Ministry of Health. 2008a. *Early Childhood Oral Health: A toolkit for District Health Boards, primary health care and public health providers and for oral health services relating to infant and preschool oral health*. Wellington: Ministry of Health.

Ministry of Health. 2008d. *Promoting Oral Health: A toolkit to assist the development, planning, implementation and evaluation of oral health promotion in New Zealand*. Wellington: Ministry of Health.

Ministry of Health. 2010c. *Our Oral Health: Key findings of the 2009 New Zealand Oral Health Survey*. Wellington: Ministry of Health.

New Zealand Dental Association. 2008. *Healthy Smile, Healthy Child: Oral health guide for Well Child Providers*. Auckland: New Zealand Dental Association.

NZGG. 2009. *Guidelines for the Use of Fluorides*. Wellington: Ministry of Health.

Growth measurement and monitoring

This topic describes the procedure for obtaining weight, length/height and head circumference measurements. It includes details adapted from *The B4 School Check* handbook (Ministry of Health 2008e) for undertaking the growth assessment component of the B4 School Check.

Component links

This component links to:

- neonatal assessment
- postnatal assessment
- six-week assessment
- breastfeeding
- nutrition
- alcohol and other drugs
- smokefree environment
- family violence assessment
- recognition of childhood illnesses
- development.

Purpose

The purpose of this component is to:

- reassure parents through growth surveillance and clinical assessment that their child is growing normally and, if necessary, ensure any concerns are referred appropriately and addressed in a timely way
- detect inadequate nutrition, physical, emotional or growth disorders
- protect, promote and support breastfeeding
- monitor changes in the height, weight and body mass index (BMI) centile of New Zealand children as a population group
- inform public health policy and planning
- monitor the effectiveness of a population-level intervention to reduce obesity in children.

Key messages

Appropriate nutrition during childhood is essential to maintain growth and good health. Achieving a healthy body weight and composition is of importance in preventing disease and promoting wellbeing. Health risks are associated with being both overweight and underweight. Efforts to achieve a healthy body weight should begin in childhood.

The Ministry of Health has adopted the World Health Organization (WHO) Growth Standards, derived from measurements of healthy, non-deprived, breastfed children of mothers who did not smoke. The charts depict a healthy pattern of growth that is desirable for all children, whether breastfed or formula fed, and of any ethnic origin. Refer to the health practitioners' notes in the New Zealand–WHO (NZ–WHO) Growth Charts 0–5 (www.health.govt.nz/our-work/life-stages/child-health/well-child-services/growth-charts) and the WHO website (www.who.int).

It is important to distinguish between a growth standard and an older style 'growth reference' chart. A growth standard depicts how children should grow; a growth reference depicts how the group grew, which may not necessarily result in desirable health outcomes.

The centile lines marked on the charts are divided into even two-thirds of a standard deviation scores, from the 0.4th centile to the 99.6th centile. Measurements that cross over two lines, either up or down, should alert health professionals that further investigation is required.

The prevalence of obesity is increasing in New Zealand as it is worldwide. Over half the adult population in New Zealand is overweight or obese. Action is needed to halt and then reverse the increase in overweight and obesity and this includes strategies for both preventing and managing obesity.

As well as managing obesity issues, growth monitoring and measurement can indicate other health concerns. Growth, for example, is one of the four domains assessed in ascertaining whether a child has FASD.

It is essential that weight, length and head circumference at birth, and weight and height through the early years are accurately plotted. These measurements represent meaningful data that may be needed in a child's further assessment.

Weight monitoring

As part of a comprehensive strategy to prevent and manage obesity and its associated chronic diseases, population monitoring is required. Among the possible indicators of obesity, the BMI seems to be the best available. Although not a perfect measure, the BMI centile is a reasonable indicator of body adiposity or body fatness.

A core part of the WCTO service is for all children to have their weight and height measurements taken and recorded at regular intervals. A BMI centile will be calculated for children over two years of age according to the NZ–WHO Growth Charts and will be used to monitor the weight status of the child population. The health professional will not necessarily discuss this with the parents unless children measure extremely overweight on the weight and/or height chart. In these situations, a BMI centile measurement will be used to determine referrals (see [Referral criteria](#) below).

Weight, length/height and head circumference

While most health professionals support routine measurement of weight, height and head circumference, there is still disagreement about the benefits of this practice, ages when measurements should be made or recorded and the threshold for referral to specialist services. Faltering growth can be a symptom of an underlying medical condition; however, it is generally well recognised that the main purpose of growth monitoring is to reassure parents.

Weight

Measuring birthweight relative to gestational age may indicate a range of in utero pathologic processes and may also indicate the risk of anticipated complications either early (such as neonatal hypoglycaemia in growth-restricted newborns) or later (such as increased risk for metabolic syndrome and type 2 diabetes in later life).

Newborn weighing also gives an initial benchmark against which to compare later weights. Measurement of later weights in isolation from information such as height and previous weight measurements provides little information as a single measurement, other than identifying a particular child as being within, or well outside, the growth standards for age.

Serial weight measurements in the first weeks and months of life give useful information on trends in weight gain and, by implication, nutrition. Inadequate nutritional progress, nutritional deficiencies or faltering growth have implications for a child's long-term potential as well as being indicators for possible underlying illness (eg, heart or kidney disease).

Length/height

Birth length and length at six weeks act as a benchmark for later measurements. As a screening measurement, birth length has little to commend it in isolation and it is hard to get an accurate length at this age. It is clinically useful when compared with birthweight and calculated gestational age to assess in utero deprivation.

In later childhood, single height measurements in isolation have little application. However, it has been suggested that a screen at 4–5 years of age using referral criteria of height less than the second percentile is a rapid and effective screen for children with chronic illness not previously identified.

Head circumference

Head circumference should be routinely measured to one year of age and thereafter as indicated. Disproportionate head circumference, an asymmetrical head or an inappropriate progression of head circumference over time may reflect intracranial pathology or premature fusion of sutures. There are many normal situations in which these findings also arise.

Height and weight trends

Health professionals use serial measurements of both height and weight in order to monitor a child's growth. This is done by plotting serial measurements on the NZ–WHO Growth Charts 0–5 Years, growth standards based on WHO data, with the assumption that children continue to grow along centiles. When a child crosses the centiles, this provides an alert that a fuller assessment may be required.

A child's weight crossing centile lines (up or down) may indicate a normal growth pattern if length/height centiles have similarly changed, but further investigation is warranted. If a formula-fed baby is crossing centiles up or down, health professionals should check whether the caregivers are measuring accurately in making up bottles, volumes taken and so forth, and should take steps to correct over- or under-feeding.

Of the two measurements, height on its own is not a significant indicator but is useful as a comparison and to identify trends. It is uncommon, outside the infancy period, for a child who has an organic condition causing disordered growth to present solely because of abnormal growth measurements. Most have other constitutional symptoms or concerns.

Age of child

Age	Schedule for growth measurements		
	Head circumference	Length/height	Weight
Neonatal* (birth–48 hours)	✓		✓
Postnatal (2–7 days)		✓	✓
2–4 weeks	✓	✓	✓
4–6 weeks	✓	✓	✓
8–10 weeks	✓		✓
3–4 months	✓		✓
5–7 months	✓	✓	✓
9–12 months	✓	✓	✓
15–18 months			✓
2–3 years		✓	✓
4 years		✓	✓

* Note: The neonatal check is conducted over two core visits (ie, there are 12 core WCTO checks in total).

Personnel

Growth measurement and monitoring are undertaken by the LMC at the postnatal core visits and thereafter by the WCTO nurse, nurse practitioner or general practitioner.

Measurement protocols for measuring children up to two years of age

Head circumference (0–1 year)

- Remove any headwear.
- Use a narrow plastic or disposable paper tape.
- Take the measurement where the head circumference is widest.
- Record head circumference as the average of three measurements.
- Also note cranial symmetry noted.

Note: Health workers measuring the head circumference should be aware of cultural issues around touching heads. For example, Māori regard the head as tapu (sacred) – patting a child’s head or placing hats and measuring tapes anywhere near food or on a table is unhealthy. Before taking a head circumference measurement, always check with the parents/caregivers that it is acceptable to touch the child’s head and to remove a hat or bonnet (NZ–WHO Growth Charts: Fact sheet 3, see [Resources](#) below).

Length (0–2 years)

Length measurements should be taken up to two years of age and require a properly calibrated length board positioned on a firm surface to within 0.5 cm. Taking length measurements with tape is not acceptable.

- Remove any footwear.
- Length should be measured without a nappy.

Good practice is to take the average of three measurements (NZ–WHO Growth Charts: Fact sheet 3, see [Resources](#) below).

Weight (0–2 years)

Weight is measured using modern, electronic, self-zeroing scales on a firm surface; and taking the naked weight of infants and children under two years to within 0.01 kg. Remove any footwear and toys in hand.

It is acceptable to place a light sheet or blanket in the scale if it is cold as long the scale is zeroed with this place.

A baby's true weight may fluctuate by several hundred grams, depending on the contents of bowel, bladder and stomach as well as minor fluctuations due to illness. As far as possible, an individual baby should be weighed at the same time of day on each occasion and consistently before or after a feed.

Measurement protocols for measuring children over two years of age

The following protocols and procedures are adapted from the handbook for the B4 School Check (Ministry of Health 2008e).

Before undertaking the measurements, it is essential to have all the correct equipment in place and a working space that ensures the child's privacy. Send enquiries about equipment that falls outside the recommended models (see equipment for [height](#) and [weight](#) below) to the Child, Youth and Maternity Team at the Ministry of Health.

Measurements must be taken with the equipment standing on a hard surface, so make sure the room has a hard floor. If carpet is the only floor covering in the measurement location, put a piece of wood (described in equipment requirements) on the carpet and place the stadiometer or scales on the board.

Explain the procedures to the parent and the child (where necessary). Obtain consent from the child's parent and (where appropriate) the child.

Averaging measurements

Take two readings of each measurement: height and weight then height and weight again. If the two readings do not vary by more than 0.5 cm for height or 0.5 kg for weight, the child's final height and weight readings are the average of the two readings. Record the final reading to the nearest 0.1 cm or 0.1 kg.

If the two readings vary by more than 0.5 cm for height or 0.5 kg for weight, take a third reading. If three readings are taken, the final reading is the average of the two closest measurements.

Measurements will often vary, so do not be concerned when they do. It would be more unusual if the readings were always the same.

Procedure for preparing the child for measuring

Communicate with the child at each step of the process, using age-appropriate language.

1. Explain to the child what you are going to do. For example, say:
'I'm going to measure how tall you are, and then how much you weigh.
'Then I'm going to take those measurements again and, if any of the second measures are not close enough to the first ones, I'll measure you a third time.'
2. In the case of older children, ask the child to take off their shoes, any heavy outer clothing, any headwear and any hair ornaments that could affect the accuracy of the height measurement. For younger children, ask parents to assist.
3. Measure children in light day clothing (eg, shorts or a light skirt and a t-shirt or singlet).

Note: Inform parents about the required clothing when they are making the appointment for the WCTO health check.

Height (2–5 years)

Equipment for measuring a child's height

To measure a child's height you need:

- a Leicester Height Measure portable stadiometer (or a Seca 214 portable stadiometer)
- a piece of wood 18 mm x 50 cm x 50 cm
- recording sheets or a laptop computer.

Assembling the stadiometer

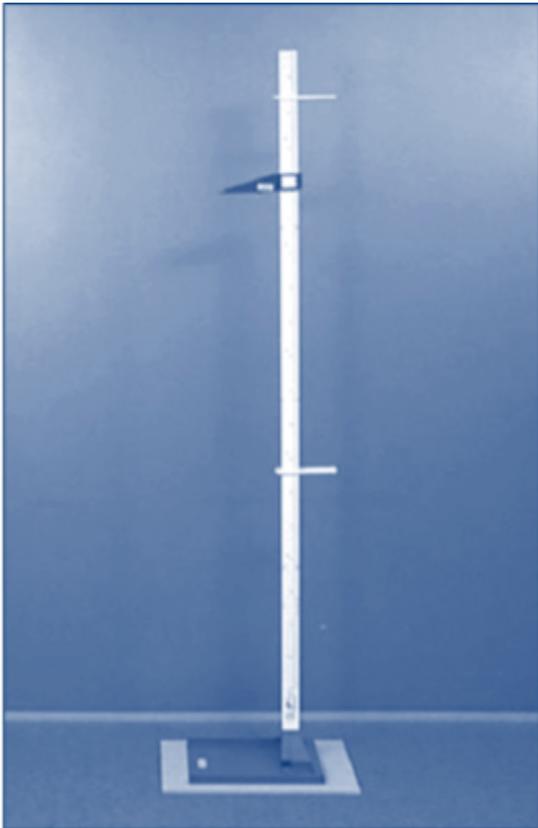
The stadiometer comes in eight pieces:

- a blue base
- four measurement rods
- two white stabilisers
- a blue headboard.

Follow this procedure to assemble the stadiometer.

1. Place the blue base of the stadiometer on the floor, close to a wall.
2. Slot the measurement rods into the base of the stadiometer in the correct order. Start with the rod that has a large arrow facing down. Make sure it is inserted fully.
3. Add one of the white stabilisers with the long arm pointing backward toward the wall, followed by the blue headboard facing forward, and then the second stabiliser facing backward.
4. Connect the next three measurement rods in order, making sure that the symbols match (stars, then circles, then squares).
5. Move the top stabiliser and the headboard above the 2 m mark and leave the other stabiliser down low.
6. Push the completed stadiometer closer to the wall, so that both stabilisers are touching the wall (Figure 3).

Figure 3: Assembled stadiometer



Procedure for measuring a child’s height

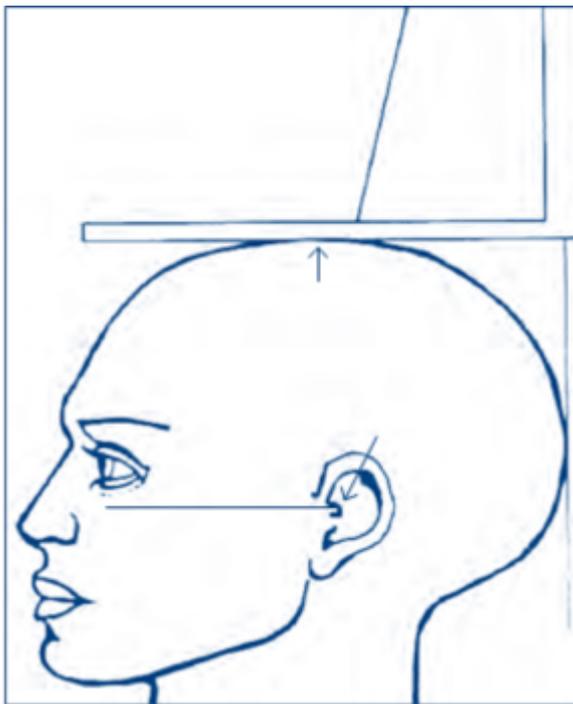
1. Ask the child to stand on the centre of the stadiometer’s base with their back to the stadiometer. For example, say:
‘Please stand on the centre of the base with your back to the measuring machine.’
2. Ask them to stand with their feet 2–3 cm apart and move back until their heels touch the bottom of the stadiometer upright. Their buttocks and upper part of their back should also be touching the stadiometer upright. Their head does not have to touch the stadiometer. For example, say:
‘Put your feet together and move them back until your heels touch the back of the measuring machine. Stand up straight and look straight ahead.’

The child’s head should be in the Frankfort Plane. This is achieved when the lower edge of the child’s eye socket (the orbit) is horizontally aligned with the middle of the child’s ear canal (the tragus) (Figure 4). The vertex is the highest point on the child’s head.

If the child’s head is not aligned properly (and it probably will not be), ask the child to look up or down a little until it is in the Frankfort Plane. For example, say:

‘Please look up (or look down) a little bit.’

Figure 4: Height measurement – Frankfort Plane



3. When you are happy the child is in the correct position, ask them to take a deep breath and hold it. For example, say:
‘Take a deep breath and hold it.’
4. Lower the blue headboard until it is in contact with the child’s head. Compress the child’s hair if needed. Do not bend the headboard from the horizontal or move the child’s head.
5. Hold the headboard firmly at its final position. Your head should be at eye-level with the child to avoid inaccurate readings. Take the reading to the nearest 0.1 cm (Figure 5).
6. When you have completed the reading, ask the child to step away from the stadiometer. For example, say:
‘That’s good, thank you. You can breathe normally now and step away from the measuring machine.’
7. Record your reading straight away.

Refer to [Averaging measurements](#) above to calculate the child’s final height.

Figure 5: Taking a reading from a stadiometer



Weight (2–5 years)

Equipment for weighing a child

To measure a child's weight you need:

- a Seca 862 electronic floor scale or Tanita WB 100 S MA floor scale (or Seca 770 or Tanita HD-351 weighing scale), which is calibrated regularly (at least every six months)
- a piece of wood 18 mm x 50 cm x 50 cm
- recording sheets or a laptop computer.

Procedure for weighing the child

Follow this procedure to weigh the child. Use age appropriate language with the child. For example, the instructions below would suit an older child.

1. Press firmly on the centre of the scales to turn them on. While you are waiting, say, for example:
 'Wait until the scales say zero.'
2. Once the zeros appear, ask the child to stand on the scales. For example, say:
 'Please step onto the centre of the scale with your weight on both feet.'
3. Ask the child to stand on the centre of the scales without support, with their arms loosely by their sides, head facing forward and with their weight distributed evenly on both feet. Tell the child to relax.
4. A reading will appear in a few seconds. The numbers will change, and then stop.
5. Once the numbers have stopped, take the reading to the nearest 100 g (0.1 kg).
6. Ask the child to step off the scale. For example, say:
 'Thank you. You can step off the scales now.'
7. Record the reading straight away.

Refer to [Averaging measurements](#) above to calculate the child's final weight.

Procedure for plotting the height and weight measurements

Follow this procedure for plotting the measurements.

1. Download the NZ–WHO Growth Charts for the appropriate age from the Ministry of Health website (www.health.govt.nz) or see [Resources](#) below.
 - * If data being plotted are collected as part of the B4 School Check, and the child is aged five years (ie, after the child has started school), use the updated WHO growth reference data for 5–19-year-olds (see WHO 2013).
2. Determine the child's age in years and months. Correct for gestational age for children born at less than 37 weeks until they are two years of age. On the height-for-age chart, find the child's age on the horizontal axis. Use a straight edge or right-angle ruler to draw a vertical line up to that point.
3. Find the child's height measurement on the vertical axis. Use a straight edge or right-angle ruler to draw a horizontal line across from that point until it intersects the vertical line.
4. Make a small dot where the two lines intersect.
5. On the height-for-age chart, find the child's age on the horizontal axis. Use a straight edge or right-angle ruler to draw a vertical line up to that point.

6. Find the weight measurement on the vertical axis. Use a straight edge or right-angle ruler to draw a horizontal line across from that point until it intersects the vertical line.
7. Make a small dot where the two lines intersect.

Interpreting the measurements

The curved lines on the growth charts show selected percentiles for the child's measurement. For example, when the dot is plotted on the 98th percentile line for weight-for-height it means that only two out of 100 children (2 percent) of the same age and gender in the reference population have a higher weight-for-age measurement.

On the BMI centile chart, plot the child's height centile on the horizontal axis, and the weight centile on the vertical axis. Mark the point of the corresponding BMI centile on the chart. This is the child's BMI centile.

Referral criteria

See Figure 6 for a flow diagram of the referral process.

Refer for general practitioner review in the first instance, with referral on to a paediatrician as necessary.

It is important to refer if:

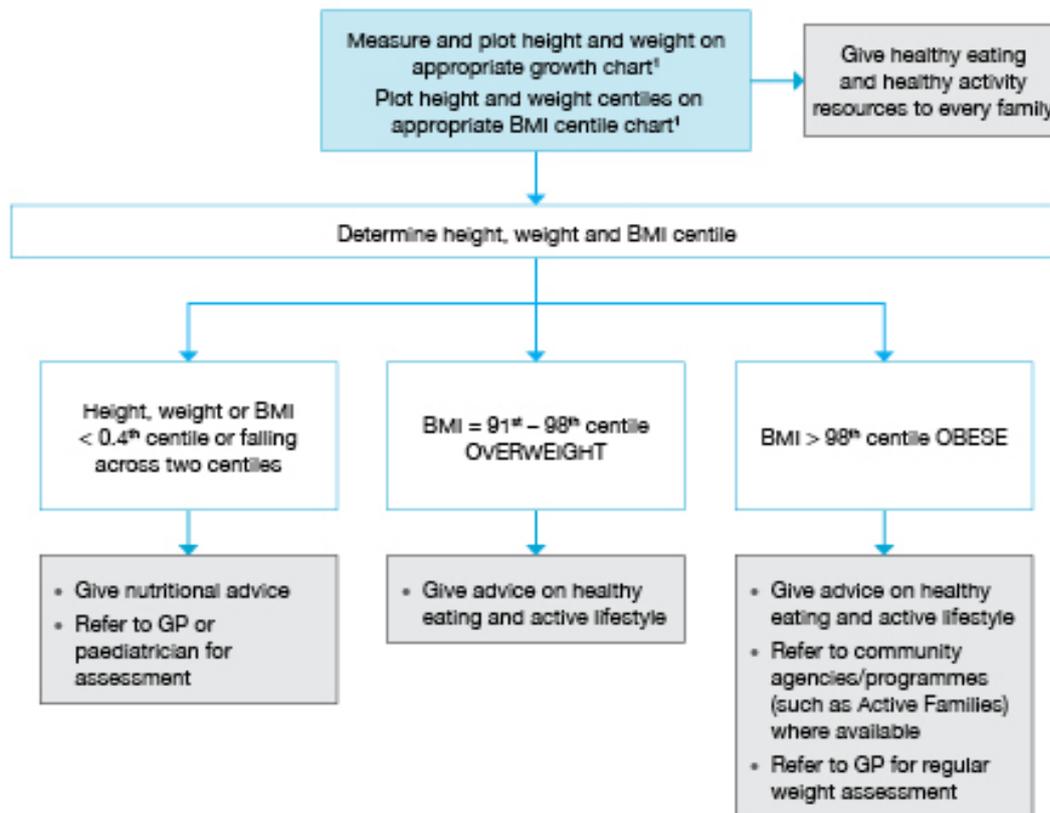
- a measurement crosses two centile lines in either direction
- weight and length/height are disproportionate by more than two centiles in measurements taken one month apart
- there is clinical evidence of malnutrition or obesity
- at four years of age, a child is less than the second percentile for height.

Consultation with a lactation consultant may be considered for breastfeeding complications.

A child's diet is strongly influenced by their home environment and overweight children often come from homes with overweight adults. Consider referrals that include parents or families; for example, Active Families (www.health.govt.nz/your-health/healthy-living/food-and-physical-activity/green-prescriptions/active-families). Become acquainted with local programmes that adopt such an approach.

Also refer to *Food and Nutrition Guidelines for Healthy Children and Young People (Aged 2–18 Years): A background paper* (Ministry of Health 2012b) for a section on the home environment and its influence on what children and young people eat.

Figure 6: Height, weight and BMI referral chart



1 NZ–WHO Growth Charts. Refer to the Ministry of Health website (www.health.govt.nz).

Resources

Ministry of Health. 2012b. *Food and Nutrition Guidelines for Healthy Children and Young People (Aged 2–18 Years): A background paper*. Wellington: Ministry of Health. The guidelines have a number of relevant sections, for example:

- growth and body size
- energy and nutrients
- physical activity
- considerations for tamariki and rangatahi Māori and their whānau
- considerations for Pacific children, young people and their families.

Refer to the WHO website (www.who.int) for child growth assessment [training tools](#). One tool is the downloadable *Anthropometry Training Video* on how to accurately measure and plot a child.

A number of brief [videos demonstrating proper measuring techniques](#) are also available from The Royal College of Paediatrics and Child Health (RCPCH) website (www.growthcharts.rcpch.ac.uk).

The Ministry of Health website (www.health.govt.nz) includes separate growth charts for each measurement by sex and age group (ie, boys weight 0–1 years, boys weight 1–5 years, boys length 0–2 years, boys height 2–5 years, boys head circumference 0–2 years, and corresponding charts for girls) as well as combined charts by sex.

- Weight–height BMI conversion chart
- Combined growth charts and health professionals’ notes – Boys
- Combined growth charts and health professionals’ notes – Girls
- Boys weight 0–1 year
- Boys weight 1–5 years
- Boys length 0–2 years
- Boys height 2–5 years
- Boys head circumference 0–2 years
- Girls weight 0–1 year
- Girls weight 1–5 years
- Girls length 0–2 years
- Girls height 2–5 years
- Girls head circumference 0–2 years.

The Ministry of Health website also provides associated information for health professionals about the growth charts. Fact sheets on the website include:

- [Fact sheet 1: What are growth charts and why do we need them?](#)
- [Fact sheet 2: About the NZ–WHO Growth Charts](#)
- [Fact sheet 3: Measuring and plotting](#)
- [Fact sheet 4: Plotting and assessing newborn infants](#)
- [Fact sheet 5: Plotting preterm infants](#)
- [Fact sheet 6: Plotting and assessing infants and toddlers up to age five years.](#)

Refer to [Nutrition](#) under ‘Health education’ in this Handbook for healthy eating and healthy activity resources.

References

Ministry of Health. 2008e. *The B4 School Check: A handbook for practitioners*. Wellington: Ministry of Health.

Ministry of Health. 2012b. *Food and Nutrition Guidelines for Healthy Children and Young People (Aged 2–18 Years): A background paper*. Wellington: Ministry of Health.

WHO. 2013. *Growth Reference 5–19 Years*. Geneva: World Health Organization. URL: www.who.int/growthref/en (accessed 12 January 2013).

Development

This subsection provides an introduction to the topic of child development and developmental delays. It includes information about the development of bowel and bladder control in children, an area that concerns some parents.

Child development screening and surveillance are discussed. The recommended surveillance tool, the Parents’ Evaluation of Developmental Status, is presented in detail. Guidance on and procedure for administering the questionnaire, and scoring and interpreting the results, are provided.

Component links

This component links to:

- behaviour assessment (section 5)
- child safety/injury prevention
- family violence assessment
- perinatal mental health
- infant and preschool mental health and attachment
- parenting skills and support
- growth measurement and monitoring
- alcohol and other drugs
- B4 School Check (section 5).

Purpose

The purpose of this component is to:

- reassure parents through developmental surveillance and clinical assessment that their child is developing normally and, if necessary, ensure any concerns are referred appropriately and addressed in a timely way
- support parents to take a central role in promoting and encouraging their child's development
- detect early suspected developmental delay or intellectual disability.

Key messages

Normal child development – an overview

Child development is nonlinear. It occurs in spurts and lulls, with peaks and plateaus. These fluctuations will be influenced by child-related factors such as illness and environmental factors such as family dysfunction and the quality of caregiving. Development in different areas will proceed at different rates. Normal development will vary significantly from one individual to the next (NHMRC 2002) but always within the normal range. If any skills plateau for more than a few months, or fall outside the normal range, the cause must be analysed and appropriate referral made.

Refer to the parent-held *Health Book* for a brief summary of normal child development at each age band.

Temperament and the emerging person

Temperament is best described as the characteristics and aspects of personality that we are born with.

Temperament traits that may be noticed from birth include how a child responds to new or fearful situations, how irritable or frustrated they become with pain or annoying circumstances, their propensity for positive emotions, activity level, ability to pay attention and reactivity to sensory input (such as touch or noise).

Most researchers agree that temperament is determined by our genes but there is a strong interaction with the environment to shape how personality develops. Family relationships and stress are among these environmental factors.

What can appear to be a behavioural problem can be a mismatch between the temperament of the child and the parent/s. Recognising the unique temperament of the child can help parents to better understand behaviour, to predict difficult situations and to respond to the child's specific needs (Zentner and Bates 2008).

Promoting physical development

It is widely believed that the children of today engage in less physical activity, both in the preschool years and in school, than children in the past and that this has adverse effects on motor and social development, as well as increasing the risks of becoming overweight or obese. Although there is extensive literature on dyspraxia and on motor skills among disabled children, little is known about the effectiveness of current methods for enhancing motor skills in the early years among the wider population (Hall and Elliman 2006).

Promoting early learning

There is a natural continuity from spoken language acquisition to reading and writing. Learning to talk, to communicate ideas effectively and to listen to others are fundamental skills in their own right and are the foundation on which literacy is built. Some children have major difficulties with mastering language because of global intellectual disabilities, hearing impairment or neurological disorders. Genetic differences and, much more rarely, single-gene disorders play a part in some cases.

Clinicians have observed for many years that children living in deprived circumstances often display poor language skills. There is now ample evidence that environmental and linguistic deprivation of a degree commonly found in the population does contribute to social class differences in language development and literacy. Moreover, it is evident that it is possible, at least in principle, to improve the progress and therefore the life chances of these children (Hall and Elliman 2006).

Early learning and brain development

Brain development in humans is a complex process that starts just after conception and finishes in young adulthood. At birth, the brain is small and undeveloped. It has most of its cells, but only a small number of them are connected into useful circuits. These connections, or synapses, develop as a result of environment and experiences. Simple connections are built on to create more complex connections. The process of making these connections has been referred to as the 'wiring up' of the brain (Center on the Developing Child at Harvard University 2007).

Note: The following are key points about brain development.

- A child's early experiences – both positive and negative – determine how well the brain organises itself, and influence the foundation for all future development, health, learning and behaviour.
- Multiple positive interactions with responsive caregivers for at least the first three years of life are essential for healthy brain development.
- Social, emotional and cognitive development is highly interrelated.
- Toxic stress and neglect can interfere with healthy brain development.

For more information on brain development, refer to the Center on the Developing Child at Harvard University website (www.developingchild.harvard.edu), under the [Science of Early Childhood](#) topic, and the Brainwave website (www.brainwave.org.nz).

Why speech and language development are important

The development of communication is an important part of overall child development. The early childhood education (ECE) curriculum, *Te Whāriki*, states that ‘communication is vital for children to be able to contribute their strengths and interests, to find out what they want to know, and to take increasing responsibility for their own learning and care’ (Ministry of Education 1996).

While not all communication is verbal, speech and language development is an area that needs monitoring because of its ongoing importance, especially to the development of literacy.

Singing and talking to children, using many different types of words, and using language playfully – for example, by making up rhymes – are important ways to help them develop language.

Some children have difficulties mastering language because of global intellectual disabilities, hearing impairment or neurological disorders. If you or parents, family or whānau notice a delay in meeting expected milestones, you should contact your local Ministry of Education office and ask for Group Special Education, or Early Intervention Services, to talk about a potential referral. Parents can also do this.

For more information about the development of communication, refer to [Much more than words](#) on the Ministry of Education website (www.minedu.govt.nz) and The Hanen Centre website (www.hanen.org)

For more information about stuttering, or stammering, refer to the following study <http://pediatrics.aappublications.org/>

The importance of the home learning environment

There is considerable evidence that what happens to children at home can have big impacts on their school success. A common view is that these impacts are related to parents’ incomes or their educational levels. However, research has shown that while parental income and education are important, the home learning environment itself also has an important, separate effect.

A British longitudinal study of 3000 children, the Effective Pre-school and Primary Education 3–11 (EPPE) project, looked closely at the home learning environment. It found this environment was an important predictor of education success to at least school year 5. This project included the following items in its assessment of the home learning environment:

- reading together
- teaching songs and nursery rhymes
- painting and drawing
- playing with letters and numbers
- visiting the library
- teaching the alphabet and numbers
- taking children on visits
- creating regular opportunities for children to play with their friends at home (Sylva et al 2004).

These items form a useful list of examples of how to promote learning at home. You may find it helpful to share it with parents, family and whānau, although you should not treat the list as exclusive or 'one size fits all'.

The study found that 'for all children, the quality of the home learning environment is more important for intellectual and social development than parental occupation, education or income. What parents do is more important than who parents are' (Sylva et al 2004).

In other words, parents, family and whānau do not need to be well-off or highly educated to provide a good environment for learning. Moreover, there are practical steps they can take to support their child's early learning – see the list above.

The EPPE study also found that the combination of quality ECE (see [Early childhood education](#) under 'Health education') and quality home learning environments led to the biggest positive effects on learning (Sammons et al 2007).

What parents and other adults can do to support early learning

The human brain needs reciprocal, responsive relationships and interactions to develop well. Touching, talking and singing with, and reading to an infant or young child are all ways that these interactions can occur. Learning also happens through play – alone, with adults or with other children.

Supporting early learning can therefore be very simple and for many parents completely natural. At its simplest it means holding, touching and talking to their infant or young child.

Literacy is very important for success in 21st century New Zealand. It can be viewed as the gateway to most other kinds of formal learning. As mentioned above, developing speech and language is an important precursor to reading. Hart and Risely (1995), in their major study of 13–36-month-olds, found that the more words per hour the study children heard and the more interactions they had with their caregivers per hour, the better their vocabulary development and later reading ability were.

Reading together is another good way to support literacy and future educational success. OECD (2012) research found that children whose parents read to them before they started school did substantially better on international reading tests at age 15 years.

Note: Share these tips for reading together with parents, family and whānau.

- Cuddle up with your child to read, or sit in a position so that they can see your face.
- Let your child choose the book they want to be read, and be prepared to read the same one over and over and over again.
- Don't just read the words. Pause to comment on the pictures. Ask open-ended questions and what, when, where and why questions. Repeat and expand on your child's comments.
- Connect the story to your family's daily life.
- Read with expression, have fun and don't be afraid to 'do the voices'.
- Let your child decide how long they want to be read to. A few minutes is fine.
- For older preschool children, you can point to the words as you read them, and explain that they usually go left to right, and top to bottom. (You can tailor this idea to the language you're reading in.)

Research has found that the combination of quality ECE (see [Early childhood education](#)) and quality home learning environments led to the biggest positive effects on learning (Sammons et al 2007).

Early learning for tamariki Māori

For tamariki Māori (Māori children), the process of learning te reo Māori me ōna tikanga (Māori language and customs) provides the complete speech and behavioural patterns necessary for a secure, confident identity (Durie 2001; Smith 2003). A secure cultural identity is recognised as an important protective factor for all tamariki and particularly assists tamariki who experience various forms of socioeconomic deprivation (Atwool 2010). Through te reo Māori me ōna tikanga, the deeper values of Māori society can be learnt through speech and modelling in an integrated and seamless way.

The teaching and learning of te reo Māori me ōna tikanga do not occur in a single place: it is a relational process and occurs in everyday practices within the home, the wider whānau, the marae and in places such as kōhanga reo and kura kaupapa (Cooper et al 2004). In practice, it requires a purposeful and collective partnership between the whānau and non-whānau. The tamariki ora (child health) programme can encourage and support this relationship. Through partnerships with kōhanga reo, Māori immersion ECE services and kura kaupapa, it is possible to richly nurture the full spectrum of tamariki Māori wellbeing: tinana (physical), hinengaro (intellectual), wairua (spiritual), whatumanawa/ngākau (socio-emotional), auaha (creativity) and pūmanawa (talents, intuitiveness, cleverness).

Developmental delay

Child development is a powerful determinant of health in adult life, as indicated by the strong relationship between measures of educational attainment and adult disease (Anderson et al 1999, cited in Anderson et al 2002). Early identification of developmental delay is important because it may be possible to correct an underlying cause (eg, hypothyroidism) and ensure normal development, or intervene early and prevent complications from an uncorrectable condition such as development of limb contractures in severe spastic cerebral palsy. Early diagnosis also permits genetic counselling of parents and ensures that a child is fully assessed for conditions such as hearing or vision loss which may impair socialisation, communication and learning.

Services and systems required for early identification of disabilities and disorders (Hall and Elliman 2006)

To identify disabilities and disorders early, it is necessary to have:

- competent, thorough neonatal examination
- planned follow-up of newborns judged to be at high risk
- follow-up of infants and children suffering any form of neurological insult
- a core programme of professional reviews and contacts at agreed ages, with inclusion of both open and structured questions for parents about the child's progress
- recognition that parents are often right when concerned about their child's development, coupled with easy access to specialist assessment when needed
- a holistic approach to assessment that recognises how the impact of several minor problems can be cumulative and cause significant disability
- training and support for health practitioners to identify possible problems and act appropriately when concerned
- networks of health, social and education services that can provide a prompt, coordinated response to referrals.

Definition of developmental delay. The term 'developmental delay' is frequently used to describe children who experience delays in meeting developmental milestones in one or more streams of development. These streams of development usually encompass motor skills (fine and gross motor), language, development, cognitive skills and culturally defined social skills. Various assessments are used to identify children with developmental difficulties. These range from simple screening parent questionnaires, such as Parents' Evaluation of Developmental Status (PEDS), to a formal Griffiths or Bayley scale assessment undertaken by a highly trained health practitioner.

It can also be useful to distinguish between two broad groups of developmental problems:

- low-prevalence, high-severity conditions – this group includes conditions for which a pathological basis has been demonstrated or can be presumed; for example, cerebral palsy, aphasia and severe learning disabilities
- high-prevalence, low-severity conditions – this group includes delayed speech acquisition, clumsiness and minor psychological pathology. In these children, a pathological basis for the child's difficulties is rarely found. They are best understood as an interaction of genetic predisposition, environmental factors and ill health of various kinds. For example, a child may have a family history of slow language acquisition, live in poverty and suffer repeat episodes of respiratory infection associated with conductive hearing loss.

This distinction is made solely to assist in defining differences in approaches to prevention, detection and management (Hall and Elliman 2006). Severe and relatively obvious impairments are not usually the target of developmental screening programmes. Rather, developmental screening is focused on identifying less severe problems that are not immediately obvious (NHMRC 2002).

Risk factors for developmental delay

In addition to known risk factors for developmental dysfunction such as premature birth and low birthweight, exposure to an impoverished environment is recognised as a sociocultural risk factor (Behrman et al 1987 and Brooks-Gunn et al 1999, cited in Anderson et al 2002). Children in poverty are particularly vulnerable. Low socioeconomic status during childhood interferes with a child's cognitive and behavioural development and is a modifiable risk factor for lack of readiness for school (Hertzman 2001, cited in Anderson et al 2002).

The quality of caregiving the infant receives is another key modifiable development-related factor. Abuse and/or neglect have a profound effect on the development of the brain (refer to [Infant and preschool mental health and attachment](#)). Intervention to change and improve the caregiving/parenting relationship is a key approach to improving developmental outcomes for some infants and young children. For example, a significant finding at six-month follow-up of the Watch, Wait and Wonder intervention was the improvement in infant cognitive function (Cohen et al 2002).

Danger signals for development

- **Global developmental delay** is a descriptive term for children who have developmental skills, in most or all domains of development, which fall outside the normal milestone range. In some cases, the cause may be known, for instance a chromosome disorder such as Down syndrome (caused by an extra copy of chromosome 21), or may be identified following professional assessment and investigation (a gene defect, or a disorganisation of anatomical brain development seen on MRI head scans). In many cases, no cause is identified despite investigation, and the cause is presumed to be a single undetectable gene mutation. In a small number of cases, an inherited pattern is identified, and significant environmental adversity such as neglect or abuse can also result in treatable global developmental delay.
- **Cerebral palsy** is not a term for a single condition, but instead describes a persistent disorder of movement and posture caused by an insult to the developing brain. It may present at any time after birth, but for many children the cause remains unknown, even after extensive investigation. Although perinatal asphyxia is often presumed to be the cause, in fact it only accounts for around 10 percent of confirmed cases. Prematurity is commonly associated with cerebral palsy, often on the basis of cerebral haemorrhages that occur despite the best possible neonatal intensive care.

The cardinal features of cerebral palsy in infancy are disorders of tone and posture, and abnormal persistence of primitive reflexes. Initially the baby may be floppy, but over time the tone may become more mixed with increased tone in lower and sometimes upper limbs, associated with reduced core tone. Adductor spasm in the lower limbs may be an early sign and lead to 'scissoring' of the legs.

- **Autism** is part of a spectrum of neurological disorders characterised by impairments of social interaction, communication, and restricted, repetitive and stereotyped patterns of activities, behaviour and interests. The condition of children with autism ranges in severity from severe intellectual and physical disabilities through to 'high functioning' autism with mildly impaired social skills, no language impairment and normal or above average intellectual functioning. Some children with high functioning autism are described as having Asperger syndrome.

Although screening tools are available for autism, it is not currently screened for as the tests are not yet sufficiently sensitive and specific to use at a population level. They are more suited for children with concerns about development and language delays.

Some children with autism may be identified by 15 months as part of normal developmental surveillance. A key language milestone at this age is the development of gestures that direct the parents' attention to objects (protodeclarative pointing). If a child has failed to demonstrate this skill by 18 months of age, especially if verbal expressive language is also delayed, refer them for a formal developmental assessment.

Development of bladder and bowel control: Normal bowel and bladder control

Bowel and bladder control is an area that concerns a number of parents. Bowel maturation typically precedes bladder maturation (Issenman et al 1999) but there is a wide range of normality in the acquisition of these developmental milestones.

With respect to bladder control, an estimated 15–20 percent of children will become partially toilet trained but continue to have wetting accidents after age five years (Koff 1988; Rushton 1995). An estimated 5 percent of 10-year-olds and 2 percent of 12–14-year-olds are estimated to have nocturnal enuresis (Doleys and Dolce 1982; Howe and Walker 1992). Boys are twice as likely as girls to have nocturnal enuresis.

Daytime wetting occurs in 3.5 percent of healthy children. Two-thirds of these – more commonly girls than boys – will have nocturnal enuresis as well. Daytime wetting would need to be addressed before attempting to control bedwetting. A treatable condition is more likely to be found for daytime than nocturnal enuresis. All these children should be referred for a review with a medical practitioner.

Soiling (encopresis) in an older child is much less common, and is present in around 1–2 percent of school-aged children. Soiling is when a child passes a bowel motion in their pants after the age when they would be expected to be toilet trained (usually four years is taken as a cut-off). It usually reflects an overloaded bowel from constipation with overflow diarrhoea. Emotional and behavioural issues can often contribute to or result from soiling. Such children and their families need lots of support and guidance along with management of their constipation under guidance from a specialist. Very occasionally soiling can be due to psychiatric, behavioural or developmental problems, but these children often present with unusual features such as smearing or hiding of faeces (see [Signs suggesting need for intervention/referral](#) below).

Most children who have problems with toilet training do not have functional, anatomic or neurologic/psychiatric disorders and do not require extensive work-ups or treatments. As with other developmental milestones, transient regressions or delays in toilet training may be related to significant stressors for the child such as new baby, new house or new partner for parent. Advice and reassurance are needed in these circumstances. More significant delays in achieving bladder and bowel continence may occur in children who experience physical or psychological disturbances around the time of toilet training, for example, the loss of a loved one, medical illness or natural disasters such as the Christchurch earthquakes. Reassurance after careful evaluation would be appropriate in most circumstances. Appropriate referral may be required if there are concerns regarding child's behaviour and development in other areas, either voiced by the caregiver(s) or picked on an SDQ or PEDS assessment.

Signs of readiness for toilet training

A number of factors may influence toilet training behaviour and must be taken into account while giving advice to parents. These factors include but are not limited to the gender of the child, their birth order, having an older sibling who is already potty trained, attending child care, having both parents working, parental attitudes/responses to accidents, and individual family's beliefs and practices.

If the child is not already toilet trained, check for the following signs which may help in reassuring parents and deciding that no intervention is required. Namely children are likely to become toilet trained successfully if they:

- are developing normally in other areas
- have bowel movements on a regular, somewhat predictable schedule
- do not have bowel movements occur during the night
- are able to stay dry for at least two hours at a time
- are able to follow simple instructions
- are able to tell a parent when they have a bowel movement
- are uncomfortable with dirty nappies and want them to be changed
- ask to use the potty
- ask to wear regular underwear.

Tips for success

Where children appear to be at low risk for a significant problem, offer advice and tips (such as the following) for success.

- Do not start toilet training until the child/parent is ready for it.
- Use consistency and positive reinforcement rather than punishment.
- Make the toileting experience fun rather than a power struggle.
- Do not impose time pressure or set a date for success.
- Praise success and ignore accidents; do not punish the child for accidents.
- Keep up the child's self-esteem.
- Make sure the toilet is safe (eg, use of a footstool, keeping household cleaners and toiletries out of reach).
- Dress the child in easy-to-remove clothing.
- Provide a regular, well-balanced diet and plenty of fluids to prevent constipation.
- Reduce fluid intake in the 2–3 hours immediately prior to bedtime at night.

Development of bladder and bowel control: Signs suggesting need for intervention/referral

Most preschool children with wetting or soiling accidents are normal with no underlying organic disease or serious behaviour disorder, although the accidents can greatly concern parents.

In a very few instances, untreated toileting problems can spiral into physical, behavioural and developmental difficulties that disrupt toilet training and maintenance of bowel and/or bladder continence. Chronic wetting and soiling may persist well into the school years and may become refractory to empirical medical treatment.

Interventions emphasise early anticipation, and breaking predictable behavioural and dietary cycles that can turn acute problems into chronic problems. This is especially important during the toilet training years.

A review by a medical practitioner would be indicated in the following situations:

- concerns with development or behaviour in other areas (use [PEDS](#) and/or [SDQ](#) assessment)
- frequent smearing and/or hiding of faeces, which may require an assessment regarding family violence and quality of parent–child interaction
- frequent daytime urination
- polyuria (overly frequent) or infrequent voiding
- dribbling or constantly wet underwear
- urgency or urge incontinence
- frequent or severe stress or giggle incontinence
- weak or intermittent urinary stream, straining to void
- signs of constipation (eg, hard bowel motions, blood in stools)
- signs of a urinary tract infection (eg, change in colour or smell of urine, change in frequency of urination, pain during passing urine, blood in urine)
- emergence of enuresis or encopresis in a child over four years who has previously been continent
- persistence of daytime wetting in a child of four years or over
- chronic faecal soiling (encopresis) in a child of four years or over
- extreme parental anxiety or effect on child’s self-esteem
- habitual holding-on behaviour or toilet refusal.

Providers of WCTO care should be alert to and concerned by parenting that is harsh and/or reliant on punishment. Children’s soiling is commonly cited as a precipitating factor for severe physical abuse.

It is not appropriate to recommend bedwetting alarms (publicly or privately funded) in children younger than four years of age as there is limited evidence of success with this age group. If the parents and the child are keen to try something before the age of five years, behavioural approaches such as star charts can be used.

Child development screening

For many years WCTO programmes have screened children for developmental difficulties using a range of screening tools. In New Zealand the most popular was previously the Denver Developmental Screening Tool (DDST), but this has recently fallen out of favour as the DDST screening characteristics were shown to be poor.

Because children’s development occurs along a continuum, it can be difficult to separate ‘normal’ from ‘abnormal’ presentation at any precise age (Allen and Clarke 2006). Although routine developmental screening may detect extreme variations from ‘normal’ development, most disabilities and disorders are found by other means. They are often identified in a health practitioner’s examination of the child in the period immediately after their birth. They are also often detected by a child’s parents, family or whānau or by practitioners who are in regular contact with the child, closely observing the child, and/or following up children at risk, or who note developmental issues opportunistically when a child is presented to health services for other reasons.

Developmental surveillance

Developmental surveillance is the process of eliciting and attending to parents' concerns, making accurate and informative longitudinal observations of children, and promoting children's development. Developmental surveillance may include the use of developmental screening tests. Through this process, health practitioners and parents continuously monitor children's developmental trajectories over time, in much the same way as they monitor physical growth.

Although developmental delays may occur and be identifiable from birth, they often develop or become identifiable as a child ages. Changes to a child's environment, and potentially the environmental risk factors to which they are exposed, may also require screening to be repeated (Allen and Clarke 2005).

The age of presentation of developmental delay in different areas is influenced by the nature of the child's delay. Delay in walking, for example, is usually not considered before an age by which the majority of children have already started walking (eg, 18 months). Developmental problems are often identified at times when normally there is rapid progress, so that difference between normal and delayed development becomes more obvious. For example, language delay often presents towards the end of the second year of life following an obvious rapid burst in vocabulary in the great majority of children (NHMRC 2002).

Children who diverge from the expected developmental trajectory can be identified and referred for further assessment. This approach, while not fully validated, utilises the expert knowledge of health practitioners and parents about the child, and has the potential to identify significant developmental problems at an early stage. Further research needs to be undertaken in the New Zealand context to show the effectiveness of this developmental surveillance.

Parents' evaluation of developmental status

The Parents' Evaluation of Developmental Status (PEDS) is a questionnaire for parents to detect developmental and behavioural problems in children from birth to eight years.

The PEDS has 10 general questions about behaviour, development, speech and language, and fine and gross motor skills (eg, 'Do you have any concerns about how the child talks and makes speech sounds?'). Parents fill in the questionnaire, and scoring is relatively easy with guidelines included with the questionnaire. The PEDS response forms are available in English, Arabic, Chinese, French, Haitian, Hmong, Indonesian, Portuguese, Russian, Somali, Spanish, Swahili and Thai. It is not available in Māori or Pacific languages.

The PEDS, and the scoring form and interpretation form are reproduced in Appendices 1, 2, and 3.

The advantages of the PEDS over other screening tools are that it:

- is much shorter and simpler while being no less sensitive and specific than other tests
- involves parents in the process
- covers an age span of birth to eight years
- is relatively low cost
- is generally well accepted and used by Australian and New Zealand health practitioners.

Although the questionnaire is short, it is highly sensitive and specific.²⁶ PEDS is norm referenced, and was developed out of four cross-validated studies on a representative sample of American families. The authors claim sensitivity of 74–79 percent and specificity of 70–80 percent (Glascoe and Shapiro 2004). For parents with low IQ, limited language, a poor relationship with the child or suspicion of services, clinician assessment remains important. The WCTO Provider must ensure its clinicians are well trained in using the PEDS and that referral pathways are clear.

The PEDS has recently been adopted with small adaptations in Australia, which accepts the PEDS as a reliable way to elicit information from parents and undertake developmental surveillance. In Melbourne, early childhood educators have been trained in and have been trialling the PEDS since 2003. Initial feedback indicates that educators are finding the tool useful in their interactions with parents as it allows the discussion of concerns in a focused way (Australian Institute of Family Studies 2004). The PEDS was used in the Fit 4 School programme in the Waikato district, as well as in B4 School Check pilots in Counties Manukau and Whanganui districts. The PEDS has also been rolled out as part of the national B4 School Check programme.

In the context of the WCTO Framework, the PEDS is a surveillance tool rather than a screening tool. In addition to being part of the B4 School Check at age four years, the PEDS is used for child developmental surveillance at five WCTO core contacts from age 3–4 months to 2–3 years.

Evaluation of the B4 School Check pilot sites suggested that the behavioural and developmental questionnaires should be completed in a face-to-face interview with the nurse doing the check to mitigate any literacy or language barriers and to answer parents' questions.

For comprehensive guidance and more information about administering, scoring and interpreting the PEDS, see the PEDS booklet and training materials provided as part of the Ministry of Health train-the-trainer programme. Note the following points.

General guidance on administering the questionnaire

- **Time required** to complete the questionnaire: The PEDS takes only a few minutes to administer.
- **Do not reword** questionnaire and answers: Do not change the wording of the questions or answers, because this will change the validity of the tool.
- **Supporting parents** to use the PEDS: Explain where and how the PEDS fits into the overall WCTO assessment.

Parents may be intimidated by the PEDS or it may raise anxieties about their child. Introduce and communicate about the PEDS in a way that minimises parental anxiety and reassures parents about the purpose of the questionnaire.

Emphasise to parents that the purpose of the PEDS is not to judge or label children, but to make sure the child has no problems that might hold back their learning and, if any problems are identified, to get appropriate support and help for the child, family and whānau.

²⁶ www.pedstest.com/LearnAboutPEDS/IntroductiontoPEDS.aspx

- **Completing the questionnaire:** The PEDS should be filled in as part of a face-to-face interview.

Ask the parent whether they would like you to go through the questionnaire with them or whether they would prefer to fill it in on their own. If the parent wants to complete the questionnaire on their own, do not assume that the parent is literate or illiterate.

- **Discussing and communicating results:** Try to keep any discussion until after the parent has finished the questionnaire, although sometimes you will need to acknowledge what the parent is saying immediately.

It is vital to fully discuss the results of the questionnaire with the parent for three reasons.

- It is important to establish the level and nature of any difficulties clearly. (Information from other sources is also relevant for this purpose.)
- Even if the child's overall score is below the cut-off point indicative of a problem, some issues may still be important to the respondent. The parent's response to a single item might provide the cue.
- It is crucial you understand how the child, parent and other family or whānau members are responding to how the child is and what the child is saying.

Procedure for administering the questionnaire

Have the PEDS questionnaire ([Appendix 1](#)) ready.

1. Briefly explain the PEDS to the parent (or other caregiver) and answer their questions.
2. Ask the parent whether they would like you to go through the PEDS with them or whether they would prefer to fill it in on their own.
3. If the parent wants you to go through the PEDS with them, read the 10 questions and record the parent's answers by circling 'No', 'Yes' or 'A little'. Note any comments from the parent in response to the questions.

Procedure for scoring the parent questionnaire

Have the score form ([Appendix 2](#)) ready.

1. On the score form, fill out the child's name and date of birth and the date of scoring.
2. Locate the correct age column on the score sheet (eg, 4 years equals 48 months).
3. Categorise parents' concerns into the most appropriate domain (ie, match their comments with the appropriate category, such as 'global/cognitive', 'expressive language and articulation', 'fine motor').

Use your skills and knowledge to make a judgement about the domain in which the concern fits. See the PEDS training booklet for more guidance.

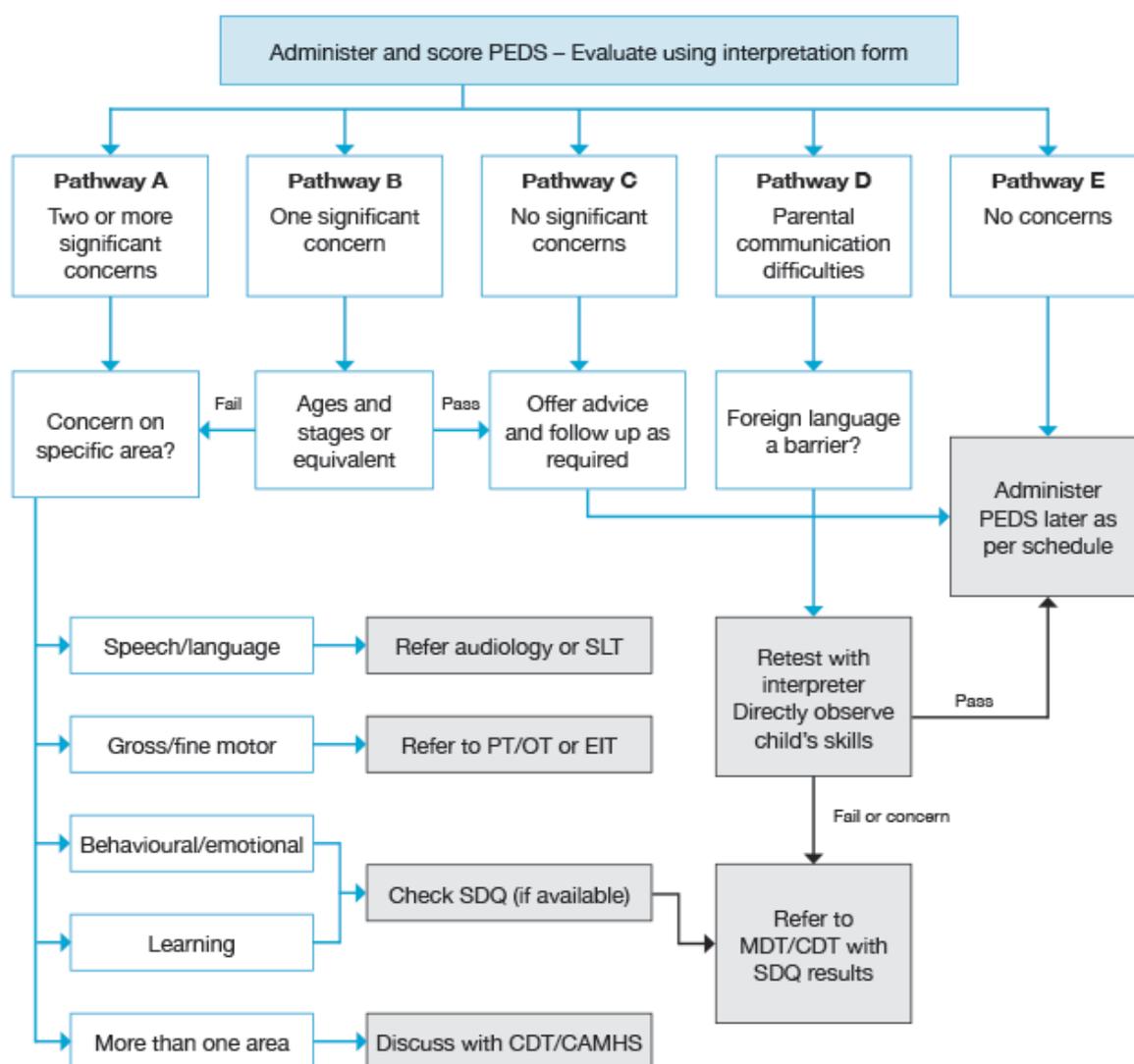
1. Transfer the parent responses to the score form.
2. For every concern that is 'Yes' or 'A little', tick the appropriate domain box.
3. Summarise concerns on the score form: significant (shaded boxes) and non-significant (non-shaded boxes).

Procedure for interpreting the score

- Determine the appropriate clinical referral path from the interpretation form (Appendix 3). Also refer to Figure 7.
 - Two or more significant concerns – decide whether audiology and speech or cognitive or both: follow Pathway A.
 - One significant concern – a secondary screen is needed (refer to your district health board’s referral pathway for PEDS): follow Pathway B.
 - Non-significant concern – counsel the parent in the area of difficulty and arrange follow-up if necessary: follow Pathway C.
 - Parental communication difficulty – you may need an interpreter or to consider a different screen (refer to your district health board’s protocol): follow Pathway D.
 - No concerns – no further action required: follow Pathway E.
- Discuss the results of the PEDS with the parent, and offer advice or referral if necessary, as determined by the referral pathways.

See the PEDS training booklet for more guidance.

Figure 7: Parents’ Evaluation of Developmental Status clinical referral pathway



For further information see the PEDS interpretation form in Appendix 3.

Secondary assessment and referrals

No recommendations about type of secondary assessment

If the PEDS raises concerns about the child's development, then a more formal developmental assessment is needed before clinical conclusions can be drawn.

There is an emerging consensus that the Ages and Stages Questionnaire (ASQ) is the most appropriate second screen for children who have a Pathway B on the PEDS. This could be administered immediately after the PEDS assessment or alternatively a referral could be made for a retest at a later date.

Ages and stages questionnaire

The ASQ is a parent-completed questionnaire designed for children aged from 4 months to 5 years. It asks about communication, gross motor, fine motor and problem-solving skills, and personal and social development (Squires et al 1995).

The ASQ also has a social–emotional (ASQ–SE) component, which is again a parent-completed questionnaire, although this is less commonly used. The questionnaire covers self-regulation (ie, the ability to calm down when upset), compliance, communication, adaptive functioning (ie, sleeping and eating), autonomy, affect and interaction with people. It asks about both positive and negative characteristics, and is highly sensitive and specific.

Scoring of the ASQ–SE is simple after some training. It complements the Ages and Stages Questionnaire which assesses development – see [The ASQ:SE User's Guide for the Ages and Stages Questionnaires: Social Emotional \(ASQ:SE\)](#) (Squires et al 2002).

Local referral pathways may vary. It is essential that the WCTO Provider has clear pathways for referral of children with developmental and behavioural concerns to the relevant secondary services (eg, Ministry of Education: Special Education, child development team or paediatric outpatient department).

Age of child

Formal developmental assessment (the PEDS questionnaire) is completed with the parents as per the Schedule (ie, at 3–4 months, 5–7 months, 9–12 months, 15–18 months, 2–3 years and as part of the B4 School Check).

Practitioners should be attentive to development-related issues (eg, speech–language; bladder and bowel control) at all other visits.

Personnel

All providers delivering care in accordance with the WCTO Schedule – including LMCs, paediatricians, and general practice and WCTO Provider teams – can deliver the education aspect of this component. The assessment component is administered by a health practitioner registered by a WCTO Provider.

Procedure

A detailed development history should form the basis of the initial assessment. This should include all information that may be relevant to development, including information about the in utero environment (eg, any exposure to alcohol and other drug use during pregnancy including prior to pregnancy confirmation). Any concerns should be accurately documented. Even if concerns are not thought to be at a sufficient level for a referral at the time, noting them may prove important for a full assessment later in childhood.

Where assessments identify development delay, children should be referred to a paediatrician. However, if the delay may be related to the child's environment, information should be provided to the parents to improve the development of the child and then the child should be reassessed in a timely manner to check whether their development has progressed. The practitioner should be aware that chronic neglect may present as developmental delay and if this is a concern then a discussion with a CYF social worker should be considered.

The [PEDS-specific procedure](#) regarding administering the questionnaire, interpreting scores and referral processes is covered above.

Resources

The SKIP (Strategies with Kids/Information for Parents) website (www.skip.org.nz) contains resources for organisations supporting parents and families, such as a module on [Child development and behaviour](#). It also has a child development and behaviour section with resources for parents, including on [children with special needs](#) and [ages and stages](#).

Also on the SKIP website, [Whakatipu](#) is a resource to support whānau in parenting. It covers pregnancy, birth and child development.

On the Plunket website (www.plunket.org.nz), the [You & your child](#) section is presented by age bands and covers development.

The Zero to Three website (www.zerotothree.org) has information and resources for parents/caregivers. It also presents topics for health practitioners, such as social and emotional development, promoting positive parent–child relationships, and brain development.

Brainwave Trust (www.brainwave.org.nz) is a charitable trust that aims to raise awareness about research in early brain development. Its services include providing educational programmes and related resources.

Raising Children in New Zealand (www.raisingchildren.org.nz) describes developmental stages under Mind and Body.

Refer to [Referrals and resources](#) under 'Parenting skills and support' (in 'Care and support for families and whānau') for further resources. For further information about developmental disorders (eg, associated support groups), refer to the Kidshealth website (www.kidshealth.org.nz).

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Care and support for families and whānau

There is increasing recognition that health status and behaviour are influenced by a range of environmental, social and economic factors, rather than just having biomedical causes (Pridmore et al 2007). The components included in this section reflect that understanding. Other than perinatal mental health, which includes a routine screen for depression at two particular time points, none of the components is specifically relevant to children at a particular age. Nor are they considered the domain of any particular personnel who deliver WCTO care.²⁷ Rather, the components provide background information for the WCTO carer in order to better support the family and whānau. The components should be delivered if a need is identified. In cases other than those where the child's safety is at significant risk (eg, in the case of child abuse), need will be determined with the family and whānau in the ongoing needs assessment process.

²⁷ Community health workers, social workers, Karitane and Kaiāwhina deliver those services that have been included in their qualifications (eg, smoking cessation support) and that they are competent to deliver within a multidisciplinary team that includes a nurse practitioner, registered nurse or general practitioner. It is the employer's responsibility to ensure that practitioners are competent to deliver WCTO care.

The nature of the topics covered in this section highlight how important it is for the provider to establish trusting working relationships with families and whānau. Working in partnership with families and whānau in a respectful, non-stigmatising way is critical to effective service delivery.

Where parents/caregivers have good social supports, minimal stressors and minimal risk factors and their parenting is demonstrably warm, predictable, sensitive and adaptive to their child's needs, the role of the LMC and WCTO Provider is most likely to be supporting the current function of the families and whānau. They will probably give information about specific aspects of care in a collaborative manner.

For families and whānau with identifiable risk factors, consider referral. The pathway for referral will need to take account of programmes and services offered locally including those that have been developed for Māori and Pacific peoples (eg, Whānau Ora services).

Some families and whānau may find a more holistic, coordinated approach to accessing health and social service better meets their needs. They may benefit from either of the following approaches.

Whānau Ora

Whānau Ora is an inclusive approach to providing health and social services and opportunities to all New Zealand families and whānau in need. Whānau Ora's holistic strategy involves multiple agencies working together with families. It aims to empower whānau by taking a collective approach rather than focusing on the individual. Whānau Ora enables whānau to set their own direction and promotes self-determination by whānau. The approach is focused on outcomes that include: whānau who are self-managing, live healthy lifestyles, participate fully in society, participate in te ao Māori (the Māori world), are economically secure and involved in wealth creation, and are cohesive, resilient and nurturing.²⁸

For more information about Whānau Ora and for [a list of provider collectives](#), refer to Te Puni Kōkiri website (www.tpk.govt.nz). For a booklet about the approach, [Whānau Ora: transforming our futures](#), visit the Ministry of Health website (www.health.govt.nz).

Strengthening Families

Strengthening Families is a strengths-based, coordinated process for families and whānau who need multiagency support. Local Strengthening Families coordinators bring families and whānau together with various organisations to generate a holistic plan to meet multiple, integrated needs. Involvement in the Strengthening Families process is voluntary for families and whānau: they can refer themselves or agencies can refer them. The Strengthening Families website (www.strengtheningfamilies.govt.nz) has a number of forms and brochures as well as a DVD featuring participants of the Strengthening Families process. Also see the website for a [list or coordinators and their contact information](#).

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²⁸ See the [Whānau Ora fact sheet](#) – Kohi-tātea/January 2013 on Te Puni Kōkiri website (www.tpk.govt.nz).

Parenting skills and support

Component links

This component links to every other component in section 4.

Purpose

The purpose of this component is to:

- help parents have realistic expectations of their child's behaviour and to understand that their own behaviour can be key to guiding their child²⁹
- promote parenting that positively impacts on the child and family
- enhance parenting confidence as well as competence
- assess the quality of current parenting and provide support and information to parenting strategies where needed
- reduce the likelihood of adverse childhood events.

Key messages

The key roles of parenting include the provision of basic needs (eg, food, shelter, clothing), love and nurturing, stimulation, a safe environment, guidance and boundaries. Some parents at some time may need support to fulfil these roles. Parenting support may include information, skills training and counselling. It may occur in a universal (designed for any parent) or targeted (designed for specific populations) fashion through media, individual or group format.

The overall aims of parenting education and support are to enhance parents' knowledge, skills and confidence in providing environments conducive to promoting children's development and behaviour.

Most parents welcome support (Moran and Ghate 2005). Providing support, such as in the form of information, to all parents irrespective of their level of need is a primary prevention approach to achieving better health outcomes for families. For example, providing parenting skills information that covers child development, developmental stages and typical behaviour associated with any particular stage can help parents have realistic expectations of their child's behaviour. Holding unrealistic expectations of a child's behaviour has been identified as one of the risk factors associated with the maltreatment of children (WHO 2006).

Some families are more vulnerable than others to experiencing adverse events such as child maltreatment. While there is no doubt that some families are more vulnerable than others, it is also true that any family can become vulnerable. For example, illness and traumatic events, like the death of their own parent or developing postnatal depression, can happen to any parent and can significantly interfere with their capacity to care for their child. Vulnerable families need to be supported with early and appropriate intervention to reduce vulnerability. Evidence suggests

²⁹ Child behavioural issues are not always environmentally driven. A disability may be behind the behaviour. Behaviour that is outside the usual behavioural range can be assessed using the Strengths and Difficulties Questionnaire (see Behaviour assessment in this document), from the age of 3 years. Early assessment is important to ensure that parents/caregivers are appropriately supported. (Note that an elevated score on the SDQ does not necessarily imply a disability; it merely indicates it is at a higher level than would be expected for this age, and that a more intensive parenting programme to further assessment is required.)

Infant Mental Health Services can assess children younger than 3 years. Refer to Infant and preschool mental health and attachment (page 106), Referrals and resources under 'Parenting skills and support' (page 86) and/or Section 6.

that families facing adversity in multiple domains of their lives may benefit from more intensive 'wrap-around' services (Moran and Ghate 2005).

WCTO practitioners are well placed to identify risk and protective factors for families, whānau and parents and to link parents with appropriate support.

Working in partnership with families and whānau to assess their needs in a respectful, non-stigmatising way is a key characteristic in service efficacy.

Procedure

1. Determine what information and support the family or whānau needs at every check by reviewing the needs assessment.
2. Work in partnership with the family or whānau to set goals and plan care.
3. Document the extent of the need, and record the goals and plan.
4. Provide relevant information and guidance to parents/caregivers about:
 - evidence-based parenting courses and programmes
 - parent support networks in the community
 - positive parenting strategies.³⁰
5. Facilitate access to support services as necessary.
6. Use the appropriate referral pathway.
7. With the family or whānau, evaluate whether the care and support it receives are achieving stated goals.

Referrals and resources

Home-based parent support

- Family Start is a home-based programme that is funded by the Ministry of Social Development and designed to support families and whānau who are struggling with challenges that may make it difficult to care for their baby or young child. Involvement with Family Start is voluntary but health care providers can provide referrals for expectant mothers (from three months pregnant) and mothers of children up to one year of age. For information about Family Start as well as the [Family Start brochure](#) and [referral information](#), visit the Family and Community Services website (www.familyservices.govt.nz).
- Early Start (www.earlystart.co.nz) is a long-term family support programme that is research based, evaluated and modelled on the Nurse Family Partnership programme. Currently it works only with vulnerable Christchurch families caring for children under five years of age; it is part of the wider national Family Start network.
- Parents As First Teachers ([PAFT](#)) is a home visiting programme focused on parent education and support that helps parents understand how their infant develops and learns, and how they can best help their child reach their full potential. For more information, visit the Family and Community Services website (www.familyservices.govt.nz).
- The Home Interaction Programme for Parents and Youngsters ([HIPPY](#)) supports parents in becoming actively involved in the learning of their four- or five-year-old child (see www.familyservices.govt.nz).

³⁰ For a review of parenting programmes and support, see Kerslake Hendricks and Balakrishnan (2005).

Evidence-based parenting programmes

Evidence-based parenting programmes³¹ available free of charge within the community include the Incredible Years and Triple P.³²

- **Positive Behaviour for Learning** supports the Incredible Years parenting programmes for parents of children aged from three to eight years, delivered by the Ministry of Education. Parents can contact their nearest Ministry of Education district office for more information.
- Incredible Years 14-week parent programmes are available nationwide. More than 50 NGOs are contracted to deliver the programme in partnership with the Ministry of Education. See, for example, Family Works (www.familyworks.org.nz), Incredible Families Charitable Trust (www.incrediblefamilies.com) and St John of God Waipuna (www.sjog.org.nz).
- Longer Incredible Years parent programmes (18–20 weeks) are available through Child and Adolescent Mental Health Centres within many district health boards.
- Primary Care Triple P is one level of the multilevel **Triple P– Positive Parenting Program**. As part of a Ministry of Health-funded project, Primary Care Triple P is currently available free of charge in the Bay of Plenty, Counties Manukau, MidCentral and Waitemata district health board areas. Refer to the **Triple P Stay Positive** website (<http://new-zealand.triplep-staypositive.net>) for information for parents, practitioners and trained providers. Other levels of the Triple P programme are available at various locations in New Zealand. Stepping Stones Triple P, for example, supports parents of children with an identified disability. Refer to the Triple P Centre website (www.triplepcentre.net.nz).

General parenting information and support

- The Zero to Three website (www.zerotothree.org) has information and resources for parents/caregivers and health practitioners on various behaviour and development topics such as challenging behaviour, temperament and behaviour, and sleep challenges in infants and toddlers.
- The SKIP (Strategies with Kids/Information for Parents) website (www.skip.org.nz) is administered by the Ministry of Social Development. It is based on research, such as *The Discipline and Guidance of Children: A summary of research* (Smith et al 2004), about effective parenting. SKIP provides funding for community projects and support for project evaluation. It also provides a range of free resources for parents/caregivers, families and whānau, as well as resources to assist community groups to conduct workshops and training.

Resources for parents, families and whānau include practical ideas and strategies to assist them with:

- [preparing for toilet training](#)
- [staying calm](#)
- [effective discipline](#)
- [getting their baby to sleep](#).

The SKIP website also contains information (in English and te reo Māori) to help parents, families and whānau to understand child development and behaviour. Its topics include:

³¹ An evidence-based approach reflects a prevention science methodology in which effective programmes are identified based on review of the available scientific evidence. This approach emphasises the need to implement programmes and interventions after adequate evaluation, including well-designed pilot studies and randomised trials (Blissett et al 2009).

The Families Commission is undertaking a review of effective parenting programmes. The resulting report is due for release on its website (www.familiescommission.org.nz) by the end of 2013.

³² Some recent publications have challenged the effectiveness claims of Triple P parenting interventions. For example, a systematic review and meta-analysis of studies evaluating Triple P interventions reported ‘an absence of evidence of sustained benefit from Triple P interventions compared to control conditions, and no evidence that Triple P is superior to any other active intervention’. See Wilson et al (2012). This is an area for ongoing review.

- ages and stages
- managing behaviour
- jealousy and fighting
- children with special needs.

A set of three stand-alone modules has been developed specifically for organisations supporting parents, families and whānau:

- [conscious parenting](#)
- [children development and behaviour](#)
- [the six principles of effective parenting](#).

Other resources available on the SKIP website include:

- [Aroha in action](#) – a booklet about nurturing and protecting children, for whānau and people supporting whānau to keep children safe
- [Whakatipu](#) – a resource to support whānau in parenting, which covers pregnancy, birth and child development to the age of five years.

- The Raising Children in New Zealand website (www.raisingchildren.org.nz) is produced by Homegrown TV in partnership with Barnardos, Plunket, Family and Community Services (Ministry of Social Development), TVNZ 7 and the Lion Foundation. Raising Children focuses on parenting the under threes.

The website offers guidance presented in age bands (newborn, infant, crawler, toddler, two years). Topics related to encouraging good behaviour include:

- [playing with others](#)
- [going to bed](#)
- [going to the supermarket](#).

These topics cover practices, principles, and ‘additional thoughts’. Each module is accompanied by a supporting video. Raising Children in New Zealand produces and sells a self-titled DVD. See the website for costs and ordering details. It also has a limited number of DVD copies of the *Nought to Five* TV series for sale.

- Information on the Plunket website (www.plunket.org.nz) under the ‘Parenting’ section includes:
 - [effective parenting](#)
 - [developing your relationship with your child](#)
 - [parenting apart](#).

Other topics relevant to parenting skills can be found in the [You & your child](#) section, the electronic version of the *Thriving Under Five* book. In the section presented by age bands, topics include:

- connecting and communicating
- sleep
- development.

- The Family and Community Services website (www.familyservices.govt.nz) is funded by the Ministry of Social Development. In turn, Family and Community Services funds health and parenting support services such as:
 - [Early Years Service Hubs](#), which operate in high-needs areas and provide a central point for families to access health care and early childhood education
 - [Family Service Centres](#), a precursor to Early Years

- **Parents Centre**, which operates 51 centres nationally, and provides support and education to parents and communities in a diverse range of areas such as: antenatal and postnatal care; parents in prison; teenage parents; coping skills; and practical parenting
- **SAGES** (older people as mentors), a community-based mentoring programme that operates in a number of agencies nationwide.

The Family and Community Services website provides information for families and whānau about raising children. It covers **child support**, **managing child behaviour** and **connecting with your community**. Its section on **everyday families** provides information and practical guidance and strategies to support families with everyday concerns that impact on a family's capacity to function smoothly. Topics include managing finances, nutrition, family relationships and managing your household.

- The Office of the Children's Commissioner website (www.occ.org.nz) provides free brochures on parenting and child behaviour.
 - The Salvation Army (www.salvationarmy.org.nz) services include life skills and parenting programmes.
 - Family Works (www.familyworks.org.nz) delivers a range of services in communities throughout New Zealand. These include parenting programmes and support.

It is recommended that providers of WCTO care supplement the above list of resources to include local resources such as church/community parenting and education programmes.

For families who have multiple needs and for whom many of the resources suggested here are inadequate, referral to an Infant Mental Health Service may be required. These services are available from birth and in some cases antenatally. See **section 6** in this Handbook. For more information about infant mental health services in New Zealand, refer to *Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand* (Ministry of Health 2011a). For information about the Gateway Assessment, for children known to CYF, also refer to **section 6**.

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Supporting families to access income and housing assistance

Component links

This component links to:

- parenting skills and support
- strengthening family relationships
- building social connectedness and social capital
- perinatal mental health
- family violence assessment
- alcohol and other drugs.

Purpose

The purpose of this component is to:

- help families meet their basic needs for income and housing
- encourage families who are not in paid work to explore ways in which they might increase their chances of gaining employment (ie, through training or further education).

Key messages

Socioeconomic deprivation influences health. People living in the most deprived areas usually experience poorer health and a greater level of unmet need for primary health care than those living in less deprived areas (Ministry of Health 2012j). Some families require assistance to meet their basic housing needs. Poor housing results in poor health outcomes for families.

Overcrowded, damp and cold houses directly worsen the physical and mental health of occupants. Children and infants are particularly vulnerable to their effects, which include respiratory diseases and meningitis.

Being in paid work is an important factor in breaking aspects of the poverty cycle, and reducing or stopping reliance on benefits can improve family income and life chances. Approximately one in five children in New Zealand lives in a family where no one is in paid work. Providers of WCTO care have a role in encouraging work as a solution to some of the social factors that prevent families from reaching their optimal level of health.

Where families receive their income from state benefits, providers of WCTO care can work with families through facilitation and advocacy to ensure they are receiving all their income entitlements.

(See section 6 for more information about [supporting families experiencing significant financial difficulties or poverty](#).)

Procedure

1. In assessing a family or whānau to determine what information and support it needs in relation to income and housing, key issues to be aware of are:
 - what concerns the family or whānau has (if any)
 - what the sources of income for the family or whānau are

- whether the family or whānau is receiving all of its income entitlements (if it receives state-subsidised income)
 - whether any member of the household is in paid employment
 - whether any member of the household is in a training programme or has educational qualifications
 - if the house is overcrowded, damp and/or cold
 - whether low income limits access to health care or essential utilities (power and water).
2. Set goals and plan care with the input of the family or whānau.
 3. Document the extent of the need, and record the goals and plan.
 4. Provide relevant information and guidance to parents/caregivers about:
 - budgeting services
 - income entitlements, community resources and agencies
 - training, educational or voluntary opportunities in the community
 - housing-related support such as heating and insulation options.
 5. Facilitate access to support services as necessary.
 6. With the family or whānau, evaluate whether the care and support it receives are achieving the stated goals.

Resources

The Work and Income website (www.workandincome.govt.nz) covers a number of topics for families. Information includes financial assistance (eg, housing and accommodation costs, childcare subsidies and benefit entitlements) and looking for work (eg, writing CVs and cover letters, where to look for work).

- The **Community** section contains information for health practitioners (eg, advocacy advice, access to Work and Income manuals and procedures, forms and brochures).
- Also see **Welfare Reform** changes that will affect parents on a benefit.

Inland Revenue (www.ird.govt.nz) provides information about, for example, parental tax credit, Working for Families tax credits, child support and tax credits for child care.

Housing New Zealand (www.hnzc.co.nz) (freephone 0800 801 601) manages state houses and tenancies.

The Ministry of Business, Innovation and Employment administers the Residential Tenancies Act 1986. Its website (www.dbh.govt.nz) provides information for tenants.

The Salvation Army (www.salvationarmy.org.nz) services include budgeting advice, assistance by way of food, clothing and furniture, and housing. Several of the centres run a mentoring service for low-income families.

Family Works (www.familyworks.org.nz) delivers a range of services in communities throughout New Zealand, which include budgeting advice and foodbanks.

The Family and Community Services website (www.familyservices.govt.nz) includes:

- a **family finances** section, which deals with understanding money and finance, and contains budgeting tools, tips and useful related links

- a comprehensive list of [budget service providers](#)
- an [everyday families](#) section, which provides information and practical guidance and strategies to support families with everyday concerns that impact on a family's capacity to function smoothly. Topics include family relationships and managing your household.

Reference

Ministry of Health. 2012j. *The Health of New Zealand Adults 2011/12: Key findings of the New Zealand Health Survey*. Wellington: Ministry of Health.

Strengthening family relationships

Component links

This component links to:

- parenting skills and support
- family violence assessment
- development
- perinatal mental health
- infant and preschool mental health and attachment
- alcohol and other drugs.

Purpose

The purpose of this component is to promote:

- warm, positive parent–child relationships
- positive family relationships.

Key messages

Multiple relationships exist within a family, such as between parents, between parent/s and infant or child, between siblings, and parental relationships with the extended family or whānau. The quality of all of these relationships has a significant impact on a child's wellbeing.

A child's relationships in the early years influence all aspects of their development, including intellectual, social, emotional, physical, behavioural and moral aspects (National Scientific Council on the Developing Child 2004).

A relationship is of significant concern if:

- caregiving includes persistent features of being unpredictable, frightening, sexualised, rejecting or abusive
- the caregiver withdraws from the relationship (through neglect and/or withdrawing in the face of the child's needs for care)
- the caregiver is frightened of the infant/child.

Interparental wellbeing and conflict also impact on children (Cowan and Cowan 2008). Families tend to fare better in terms of child development and adjustment where interparental relationships are positive.

Environmental factors or events outside the family can affect relationships within the family. Stressors, such as poverty, can negatively influence how family members interact. Their effect can be particularly severe when the family faces several different stressors and/or when it lacks protective factors like adequate support.

Procedure

1. In assessing a family or whānau to determine what information and support it needs in relation to strengthening family relationships, key issues to be aware of are:
 - what concerns the family or whānau has (if any)
 - who the members of the family or whānau are
 - the nature and quality of the relationship between the infant/young child and the primary caregivers
 - the nature and quality of the relationship between parents/caregivers
 - the nature and quality of relationships between parents/caregivers and the family or whānau as a whole
 - what external stressors the family or whānau is exposed to and what (if any) protective factors there are.
2. Set goals and plan care with input from the family or whānau.
3. Document the extent of the need, and record the goals and plan.
4. Based on the assessed need, provide relevant information and guidance.
See the [Component links](#) above for a list of other topics that are potentially relevant to the information and guidance you provide.
5. With the family or whānau, evaluate whether the care and support it receives are achieving the stated goals.

Referral pathway

Where families and whānau identify a desire for counselling, and where the child is not at risk and referral not required, refer to Resources below for counselling services.

Resources

Refer to [Infant and preschool mental health and attachment](#) in this section. It explains relationship and attachment concepts (as the most studied aspect of the parent–child relationship) and will help practitioners to look at the nature and quality of the relationship between the infant/young child and the primary caregivers.

Also in this section, [Referrals and resources](#) under ‘Parenting skills and support’ identifies parenting skills programmes and other resources that may be useful in this context. For example, [Positive Behaviour for Learning](#) supports the Incredible Years parenting programmes for parents of children aged 3–8 years, delivered by the Ministry of Education. Parents can contact their nearest Ministry of Education district office for more information.

Counselling services

[Relationships Aotearoa](#) is a not-for-profit counselling service that operates throughout New Zealand. Its counsellors have expertise in working with Māori, working with couples, individual and family therapy, and violence and abuse. [Free counselling sessions authorised by the Family](#)

Court for couples are available. Subsidies are available for low-income families. Relationships Aotearoa also delivers the Parenting Through Separation programme.

For further information about the **Parenting Through Separation** programme, see the Ministry of Justice website (www.justice.govt.nz).

Family Works (www.familyworks.org.nz) operates in centres throughout New Zealand. Its services include counselling for children and their families.

It is expected that WCTO practitioners will supplement this list with information about local agencies and church/community groups that provide counselling services.

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Building social connectedness and social capital

Component links

This component links to:

- parenting skills and support
- supporting families to access income and housing assistance.

Purpose

The purpose of this component is to:

- improve people's social connectedness and social support
- increase social capital by enhancing people's social connectedness within the community.

Key messages

Social connectedness and social capital are related concepts. **Social connectedness** refers to the relationships people have with others and the benefits these relationships provide to the individual as well as to society. It includes relationships with family, friends, colleagues and neighbours, as well as connections people make through paid work, voluntary work, community service, sport and other leisure activities. Social connectedness helps people feel they belong and have a part to play in society (Spellerberg 2001). People who feel socially connected are more likely to contribute to building communities and society than those who do not feel socially connected.

These relationships and connections with others can be a source of enjoyment and social support, which are important components for maintaining wellbeing. Social support includes functional dimensions such as instrumental (eg, direct assistance), emotional (eg, having someone to talk to who conveys emotional concern for the recipient) and informational (eg,

sharing of information that is useful to the recipient) dimensions. Informal social networks, such as those made up of family and friends, are especially important for many people and likely to be the key source of instrumental, emotional and informational social support.

Social connectedness is fostered when family relationships are positive, and when people have the skills and opportunities to make friends and to interact constructively with others. Having good health, being employed, and feeling safe and secure all increase people's chances of developing positive social networks that help improve their lives. Adults are important models of social connectedness for children.

Social connectedness is identified as a determinant of health status and contributes to social capital (Ministry of Social Development 2010).

Social capital refers to the benefits of positive interaction with individuals, community networks and social organisations and institutions (Putman 2000). It is a feature of societies rather than of individuals. Social capital can be generated through people's involvement in both formal and informal social networks. Among the benefits attributed to social capital are improved health and child development (Twigg and Mohan 2010); it is also associated with perceptions of trust, promotes family resilience and helps people cope with adversity (Mackay 2003).

Social connectedness and thus social capital may be enhanced when, for example, people are involved in community and church groups, and participate in sports and leisure activities and in preschool, school and community associations (such as parent-help groups).

Procedure

1. With the family or whānau, use the needs assessment and care plan review to assess what information and support it needs.
2. In partnership with the family or whānau, set goals and plan care.
3. Provide relevant information (based on the identified need) to family or whānau about:
 - local and community groups
 - parent support networks in the community.
4. Facilitate access to community groups and support services as necessary.
5. With the family or whānau, evaluate whether the care and support it receives are achieving stated goals.

Resources

Refer to [Referral and resources](#) under 'Parenting skills and support' in this section for relevant parent groups.

The Family and Community Services website (www.familyservices.govt.nz) provides information about [connecting with your community](#). It covers how to access community groups, offers a comprehensive directory of groups and associated services, and provides information about volunteering and links to relevant websites.

A number of [early childhood education services](#), including playcentres, playgroups and kōhanga reo explicitly involve families. See the Ministry of Education website (www.minedu.govt.nz) under the Parents section.

It is recommended that providers of WCTO services supplement this information with their own list of local organisations, community groups and early childhood centres that offer the opportunity for families to build social capital and connectedness.

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Perinatal³³ mental health

Component links

This component links to:

- infant and preschool mental health and attachment
- supporting vulnerable parents with specific needs (section 6)
- development
- family violence assessment
- needs assessment and care plan (section 2)
- alcohol and other drugs
- privacy obligations (section 2).

Purpose

The purpose of this component is to:

- promote and support the mother's social and emotional wellbeing with early recognition and appropriate intervention, including referral, for mothers who:
 - experience antenatal and postnatal distress including depression, anxiety and moderate–severe adjustment difficulties to traumatic events around the birth
 - have a history of severe mental health illness prior to pregnancy or in previous pregnancies, or who become unwell with bipolar affective disorder or postpartum psychosis during this pregnancy/puerperium

³³ Perinatal refers to the period of time immediately before and after birth. The accepted timeframe is from pregnancy to one year postpartum. See Ministry of Health. 2011a. *Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand*. Wellington: Ministry of Health.

- recognise that although not every infant is affected when their parent has a mental health problem, generally the relationship is affected, and support and appropriate intervention are indicated for the mother–infant/child dyad, family and whānau
- promote and support the universal need for secure and nurturing caregiving relationships for all.

Key messages

Mental health problems and disorder are common both antenatally and in the early months/years of child rearing.

Without identification, support and treatment:

- mothers become overwhelmed and isolated and their sense of competence as a parent is undermined
- infants and children in the family are distressed and normative development is affected
- the child–parent relationship is distressed and, for infants in particular, ongoing relationship disturbance is prevalent
- depression in the early weeks/months can affect the parent’s ability to provide physical care of infants and children
- partner relationships are stressed.

Although parents rarely harm themselves and/or their children, suicide is the leading cause of maternal death.³⁴

Depression in the antenatal period

About 10 percent of pregnant women experience depression, often with anxiety symptoms, but not all remain depressed after birth.

Risk factors similar to those for postnatal depression (PND) have been identified (see below). Also associated with the condition are that a woman with antenatal depression:

- is more likely to smoke tobacco, use alcohol and other substances, neglect her diet and self-care and be in a relationship involving domestic violence
- is less likely to attend antenatal care and education
- may be negatively affected in the way she perceives her foetus as well as in subsequent bonding and the relationship between the infant and parent.

When a parent is depressed antenatally, infants can be affected in utero; intrauterine growth restriction, low birthweight and preterm delivery are linked with untreated depression and anxiety disorders. Some of these effects will be direct results of smoking, alcohol and drug exposure antenatally.

- In utero the foetus moves more.
- After birth these infants have elevated levels of stress hormone (cortisol). They may be irritable and hard to settle, and may have trouble maintaining an alert settled state (they are dysregulated).
- Through the first year these infants may continue to be irritable and unsettled.

³⁴ See NZGG. 2008. Assessment of suicide risk for questions to assist in assessing risk. *Identification of Common Mental Disorders and Management of Depression in Primary Care: An evidence-based best practice guideline*. Wellington: New Zealand Guidelines Group.

Depression in the postnatal period (the first year of infant's life)

Around 10–15 percent of women experience depression after having a baby. Half of these episodes develop within three months and about three-quarters develop within six months of the birth. The incidence of postnatal depression is noted to increase threefold within five weeks of childbirth.

Risk factors include:

- previous episodes of depression; where this has included an episode of PND, the risk is increased to one in three
- a family history of depression/PND
- anxiety and/or some symptoms of depression antenatally
- concurrent stressful life events
- a traumatic birth experience
- lack of social supports
- being a single parent.

About 15–20 percent of women experience significant anxiety during pregnancy and after childbirth. Some anxiety over pregnancy and parenthood can be expected but, if it persists and interferes with managing everyday tasks, further assessment and probable referral are indicated. Anxiety symptoms are common in PND.

Around 2–3 percent of women experience bipolar affective disorder (BPAD). For 1–2 percent within this group, this disorder begins (either for the first time or as a recurrence) during pregnancy or after delivery; childbirth is the most significant trigger for an episode. In these cases, urgent treatment is required. Generally but not always there will be a family history of BPAD. In some cases a woman may have had a previous episode of depression but not been diagnosed with BPAD. To determine the severity of an episode and whether an undiagnosed BPAD is involved, ask for information that includes:

- onset before 20 years
- presence of psychotic symptoms
- severe symptoms and signs – significant feelings of worthlessness, guilt, hopelessness, marked sleep disturbance, poor self-care including severe lack of appetite and weight loss, significant slowing in thinking and movement (this is called psychomotor retardation)
- elevated mood and energy
- any period when they required considerably less sleep than usual accompanied by a sense of increased productiveness and energy
- family history of BPAD.

Postpartum psychosis is relatively rare, experienced by about five in 1000 women. Nonetheless this condition is serious and potentially life-threatening and requires urgent treatment. Generally symptoms begin very soon after the birth of the baby.

Around 10 percent of women continue to experience depression after the first year postpartum. Ongoing awareness of the need to check their social and emotional wellbeing for the four years following childbirth is important.

Mental health difficulties impact on the child–parent relationship and the child’s development. Observations of infant care from a depressed parent (most studies are with mothers) note:

- low levels of sensitivity to the infant
- a reduced range of emotional expression, especially positive affect
- low attunement to their infant’s emotional expression (seen with depression) or inconsistent attunement (more often seen with anxiety)
- more negative comments about and to their infants
- less touching/physical contact
- more withdrawn (depression) or intrusive (more often with anxiety) behaviour. With intrusion a parent may begin an interaction with their infant and, as soon as the infant becomes engaged, they change the activity by moving a child from one bodily position to another, tickling, introducing another toy when the first has barely been explored, picking the toddler up who has just crawled away and pulling them back into their lap. This intrusion on the child’s state will be seen repeatedly as you observe for 5–10 minutes. A withdrawn state is probably clearer with observations of limited engagement, no joy in the interactions, care that is ‘mechanical’ and an infant who may be similarly withdrawn/shut down or very irritable, fussing a lot.

The effect is a disruption in the interactional relationship that supports early infant regulation and management of stress, as well as their cognitive, socio-emotional and physical development.

Thus longitudinal follow-up studies of children whose mothers had PND/depression has demonstrated less than optimal outcomes. In particular, these children show:

- a higher incidence of regulatory problems – problems with sleeping and eating, irritability, temper tantrums
- more emotional and behaviour problems in preschoolers
- a higher incidence of insecure attachment patterns – specifically, a consistent increase in the incidence of disorganised attachment (from 17 to 28 percent)
- poorer outcomes with social and emotional skills – for example, infants at nine months have significantly lower capacity for social engagement
- negative effects on cognitive development.

The accumulating evidence is that a two-generational intervention is required for infants and toddlers when maternal depression is moderately severe and persists beyond 3–4 months. Similarly, evidence is building around the impact of paternal depression. It is not enough to just treat the parent; additional interventions need to be directed to the relationship (see Figure 8).

For children from two to three years, treating a parent’s depression successfully is associated with improvement in the toddler’s emotional and behavioural difficulties. Where problems continue for the child and/or the depression has been very chronic, referral for interventions directed to parenting or the parent–child relationship is warranted.

Fathers

The research literature on fathers is less extensive but is demonstrating the importance of assessing their mental health. In particular, fathers should be assessed for depression, given its impact on the individual, partner, the parent–child relationship and the child’s development.

Depression in fathers in the postnatal period is common, with an incidence of 8–10 percent. Fathers at risk of developing depression:

- have a past history of severe depression
- may have developed depression and/or anxiety during the antenatal period
- have partners who have developed PND
- have limited secondary education
- have other children in the family.

Paternal depression also has the following implications for children:

- there is a significant association with behaviour problems at three years
- they are more likely to be diagnosed with a psychiatric disorder, particularly oppositional/conduct disorders, and social difficulties at seven years.

It is reasonable to use the Patient Health Questionnaire (PHQ-3) with a father if there are concerns and follow through with referral to their GP if the responses suggest depression.

Age of child

Alongside regular review of parent/caregiver mental health at all visits, the PHQ-3 will be administered postnatally at the six-week and the 3–4-month checks to assess the possibility of depression.

Personnel

All qualified providers involved in delivering WCTO care, including the LMC and GP, should review the mental health of the parent/caregiver as part of checking their wellbeing. The WCTO Provider administers the PHQ-3 as care is transferred from the LMC to the WCTO Provider at around 4–6 weeks.

Procedure

All care must be provided in a culturally appropriate manner. Where possible, offer women, families and whānau a choice of services.

Beginning antenatally, engage the woman in the assessment interview process as this work is about providing the best possible care for mothers and giving their infants the best start. Outside the formal PHQ-3 assessment, check wellbeing by generally engaging the parent and asking, for example, 'How's your sleep?', 'How's your mood?', 'How are you managing?'

Facilitate access to services that are needed or will strengthen the resources of the family or whānau.

By identifying risks early, you can develop a comprehensive care plan with the parent, family or whānau. In particular, discuss with the woman/parents:

- any previous history of depression, how serious the episode was and how they were treated; whether there has been a history of previous antenatal and/or postnatal mental health problems; whether there is a history of bipolar affective disorder (a parent may talk about experiencing a manic episode)

- the family history of mental health problems (this is important)
- whether there is any alcohol and drug abuse
- whether family violence is a factor.

There should be ongoing assessment of social and emotional wellbeing, with a well-documented handover from the midwife to the WCTO Provider.

Assess for the presence of depression using the PHQ-3. A positive response to one of the questions detects most cases. If the parent wants help, refer them to their general practitioner.

PHQ-3³⁵

1. During the past month, have you often been bothered by feeling down, depressed or hopeless?
2. During the past month, have you often been bothered by little interest or pleasure in doing things?

If yes to either question, ask help question:

3. Is this something with which you would like help?

Observe interactions between parents and infants/children and ask about any concerns a parent may have. For example, in the first three months when the focus includes supporting a parent to identify their baby's cues, temperamental characteristics and settling, a depressed, withdrawn parent can be supported to identify when their infant is alert and ready for interaction and guided to 'get your baby's attention', which activates the parent, and to use infant massage. An intrusive, anxious parent can be guided to imitate their baby's behaviour supporting an infant/child-led approach.

Intervention will involve:

- building supportive relationships and acknowledging strengths and needs of mothers, fathers and extended family or whānau (eg, who in the family can provide additional help, how can the family be supported to ask for help?)
- providing concrete assistance and advocacy for families with few resources to reduce the impact of poverty on the parent's mental health, their parenting relationships and relationships with partner, family and whānau – this may involve linking with Relationships Aotearoa, Work and Income, Housing New Zealand and budgeting advice
- providing information and contact details for the local antenatal and postnatal depression support groups – this information may be accessed from the national PND organisation PMHNZ Trust (www.pmhnz.org.nz)
- where appropriate, supporting social strategies like exercise, rest/relaxation and meditation, while recognising that for some parents this may be too difficult if they are depressed

³⁵ NZGG. 2008. *Identification of Common Mental Disorders and Management of Depression in Primary Care: An evidence-based best practice guideline*. Wellington: New Zealand Guidelines Group.

- taking a flexible approach to supporting breastfeeding for mothers with mental health problems. With its effects on oxytocin and the immune system, breastfeeding can have some mild protective effect against depression, and mothers who are depressed and who breastfeed have been shown to have better feeding interaction behaviour with their infant than those who bottle-feed (Field et al 2010). However, problems with breastfeeding are known to exacerbate depression. Depression generally involves symptoms of guilt and self-criticism so it is particularly important that issues around breastfeeding decisions are managed well and don't increase guilt. Where mothers with mental health problems decide to breastfeed, it is essential to put into place structured, individualised services for breastfeeding support
- providing developmental guidance around, for example, how to manage the infant's needs for interaction when depression can make social interaction very difficult.

Referral pathways

When findings from the PHQ-3 or interview indicate possible maternal (or paternal) depression, discuss referral to the caregiver's general practitioner and, with consent, make the referral (Figure 9).

Referral may be made for:

- psychological intervention – cognitive behaviour therapy, interpersonal psychotherapy
- medication
- relationship-based (parent–infant) interventions – accessed in some Infant Mental Health Services (IMHS), which are based in NGOs and district health boards. The latter may be stand-alone, or operate within a Child and Adolescent Mental Health Service or with Maternal Mental Health Service.

All women who have been identified antenatally as having a past history of a serious mental health disorder need to be referred to their general practitioner so that a management plan anticipating the high risk of recurrence postpartum is in place. A serious mental health disorder in this context is any one of the following:

- a previous episode of postnatal depression
- a previous depression requiring medication and/or assessment and treatment through a mental health service of a district health board
- having a diagnosis of BPAD
- a previous episode of postpartum psychosis.

Where a woman has a family history of BPAD, this needs to be noted. It is important that she has support for discussing the possible implications of this history with her GP.

Very rarely an urgent referral to an acute/crisis assessment mental health service may be required. It is vital that both family or whānau and health practitioners are aware of the woman's mental health needs, early signs of deterioration and how to seek help, including through referral to acute services.

Refer to [Alcohol and other drugs](#) below for information on assessment and intervention when these issues have been identified.

Refer to [Family violence assessment](#) below when these issues have been identified.

It is the responsibility of the LMC or WCTO Provider to ensure that the woman and, when appropriate, her partner, family and/or whānau have information about community agencies available for support and the capacity to attend appointments following up on referrals.

Referrals will be made as assessment indicates to:

- general practitioners
- local community services – postnatal depression support groups, playgroups
- quality child care within the community
- Adult, Infant and/or Maternal/Perinatal Mental Health Services, and Whānau Ora Mental Health Service
- agencies, generally NGOs, that provide home visiting initiatives, including Family First, Early Start and Family Start which all prioritise parents with mental health problems or a mental health disorder
- lactation consultant specialist services if the mother has decided to breastfeed (see [Referral pathways](#) under Breastfeeding).

Some NGOs will provide more targeted interventions for mothers and their children or families so it is important to be aware of what is available in the local area.

Further management will be in line with the evidence-based best practice guideline *Identification of Common Mental Disorders and Management of Depression in Primary Care: An evidence-based best practice guideline* (NZGG 2008).

Where there are concerns about the level of a parent's anxiety or response to a traumatic birth, it is again appropriate to refer them to the GP for further assessment.

Figure 8: Parent–infant relationship – referral pathway for depression or postnatal depression that lasts longer than four months

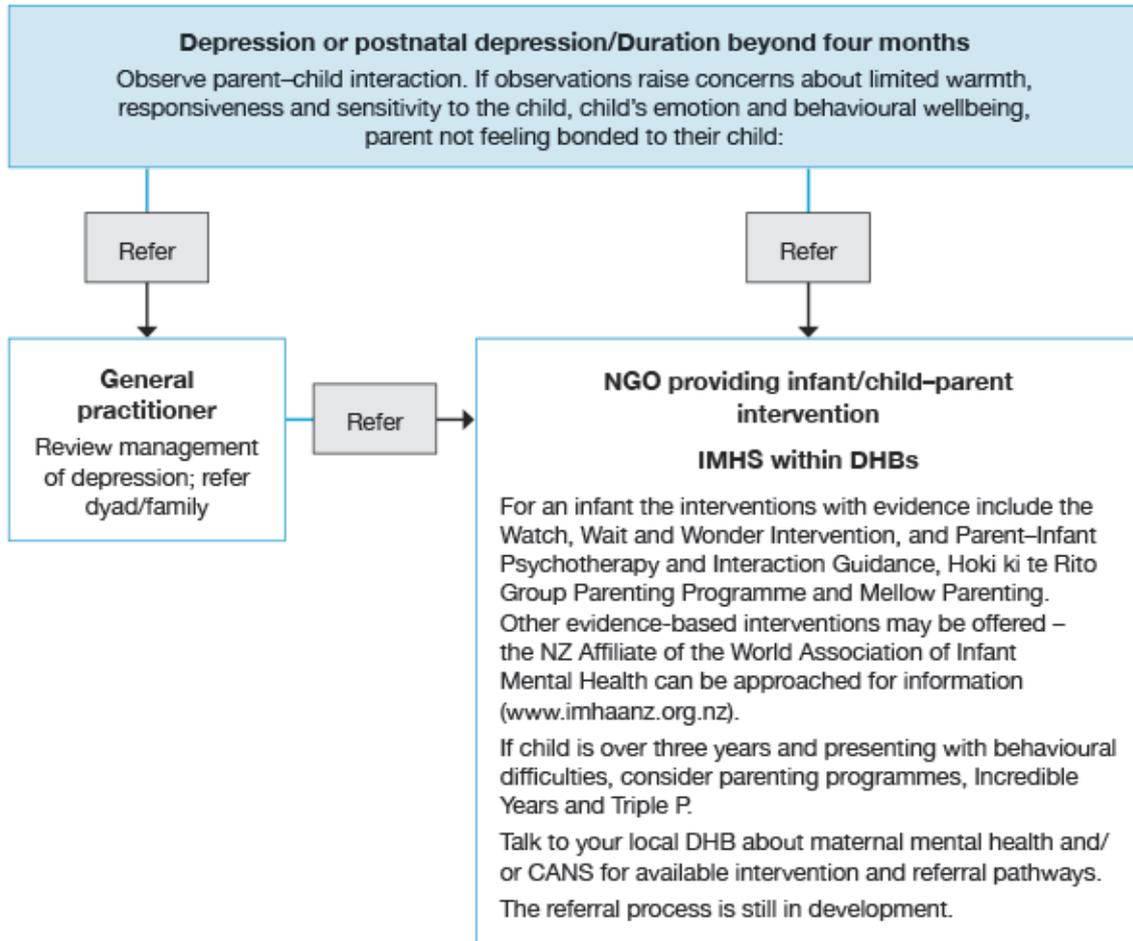
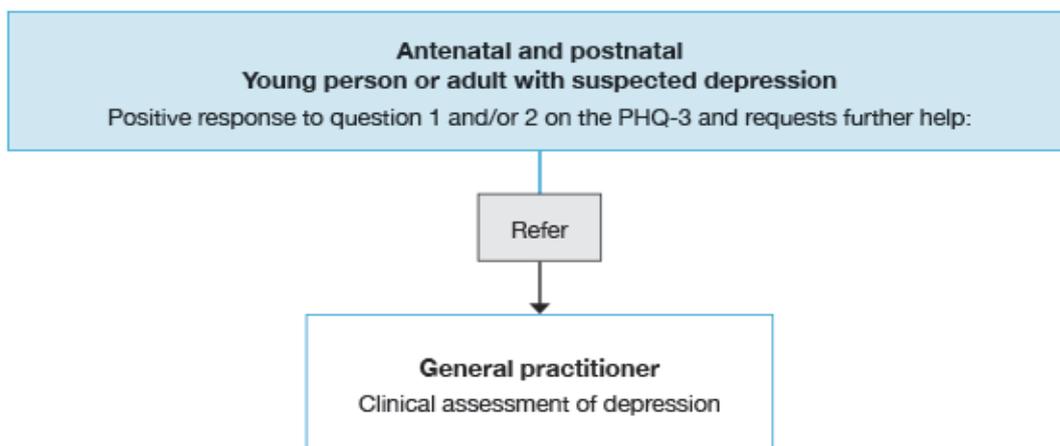


Figure 9: Referral pathway for suspected depression



Resources

Ministry of Health. 2011a. *Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand*. Wellington: Ministry of Health – provides guidance to district health boards, other health planners, funders and health practitioners on ways to address the mental health, alcohol and other drug needs of mothers and infants.

Best Practice Journal (available at www.bpac.org.nz) published a special edition in 2010 on *Depression in the antenatal and postnatal periods*, which examines the assessment and management of depression in women in these periods.

Mothers Matter (www.mothersmatter.co.nz), developed by the Postnatal Depression Family–Whānau New Zealand Trust for health practitioners and families, is focused on New Zealanders. It is comprehensive and up to date especially in regard to medication.

NZGG. 2008. *Identification of Common Mental Disorders and Management of Depression in Primary Care: An evidence-based best practice guideline*. Wellington: New Zealand Guidelines Group – provides guidelines to help practitioners and consumers make decisions about health care in specific clinical circumstances.

The New Zealand Guidelines Group published the following two brochures in 2006: *Depression: there is a way through it* is a resource for family, whānau, friends and support networks; and *Depression: information for primary health practitioners*.

Raising Children in New Zealand (www.raisingchildren.org.nz) provides resources, including a video, for dealing with the challenges of *postnatal distress*.

For sufferers of depression, postnatal support groups around New Zealand have established the National Depression Initiative website (www.depression.org.nz) and postnatal depression website (www.pmhnz.org.nz).

The Mental Health Foundation of New Zealand (www.mentalhealth.org.nz) provides a resource and information service for health practitioners and mothers/families. Its resources include pamphlets (eg, *Postnatal depression: getting the support you need*), factsheets (eg, *Postnatal depression – Māori version*), a reading list, and links to *postnatal and perinatal depression/mental health websites* and *support groups*.

The New Zealand Affiliate of the World Association of Infant Mental Health (www.imhaanz.org.nz) can be approached for information and referral options regarding the social and emotional wellbeing of infants and young children.

References

Field T, Diego M, Hernandez-Reif M, et al. 2010. Depressed mothers and infants are more relaxed during breastfeeding versus bottlefeeding interactions: brief report. *Infant Behavior & Development* 33: 241–4.

Ministry of Health. 2011a. *Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand*. Wellington: Ministry of Health.

NZGG. 2008. *Identification of Common Mental Disorders and Management of Depression in Primary Care: An evidence-based best practice guideline*. Wellington: New Zealand Guidelines Group.

Infant and preschool mental health and attachment

Component links

This component links to:

- parental mental health³⁶
- supporting vulnerable parents with specific needs (section 6)
- development
- family violence assessment
- parenting skills and support
- alcohol and other drugs
- privacy obligations (section 2).

Purpose

The purpose of this component is to:

- promote and support optimal social and emotional development of the infant/preschooler in the context of the child's family, whānau, culture and community
- identify and refer infants who are at risk of or show evidence of poor or very poor developmental and health outcomes. The earlier they are identified and referred, the greater the gains they make with intervention.

Key messages

Infant mental health (social and emotional wellbeing) is a subspecialty area of child mental health and applies to the child from birth to their fourth birthday.

Mental health for a child in this age grouping is:

the ability to develop physically, cognitively, and socially in a way that allows mastery of the primary emotional tasks of early childhood without serious disruption caused by harmful life events. The infant and young child grows in a nurturing environment so mental health involves the psychological balance of the infant-family system.³⁷

Parenting and the family environment are the most significant influences on the social and emotional health of infants and preschoolers.

The young child has a number of important developmental tasks to consolidate including developing the:

- capacity to experience, regulate and express emotions
- ability to form close and secure interpersonal relationships
- capacity to explore the environment and learn (Zero to Three Infant Mental Health Task Force 2002).

³⁶ Unlike perinatal mental health, which is specific to the period from pregnancy to a year postpartum, parental mental health refers to the mental health of the parent or parents of the infant/preschooler more generally, without a time parameter.

³⁷ Adapted from the World Association for Infant Mental Health website (www.waimh.org/i4a/pages/index.cfm?pageid=1).

Early chronic, uncontrollable stressful experiences in the absence of supportive care (known as toxic stress) adversely impact on an infant's brain architecture. In cases of severe chronic abuse and/or neglect, the result is a smaller brain. Toxic stress has consequences for physical and mental health throughout life. Possible consequences include cardiovascular disease, diabetes and strokes, and depression, anxiety disorders, and alcohol and drug abuse.

Experiences in the first years are pivotal in establishing the building blocks for ongoing development (National Scientific Council on the Developing Child 2004). Interventions can make a difference.

Intervention

The relationships infants and preschoolers have with their caregivers are critical in mediating the effects of stress, either exacerbating them or having a protective (regulating) effect. Because sensitive, responsive care prevents elevations of cortisol, a primary focus of intervention is to improve the quality of caregiving in the child's relationships. This will involve addressing difficulties that impact on parents including, for example, grief, mental health problems, alcohol and drug abuse, problematic parenting when they were children, social isolation and poverty. It is also important to think about the fit between parents and infants/preschoolers, as well as about those children who may have additional needs for care including those with developmental difficulties or prematurity or who are temperamentally anxious.

Although every parent begins with the best of intentions in their parenting, for some parents acting on these intentions will be difficult. However, given that they are highly motivated to do the best for their infant, a valuable technique is to use that motivation to build a relationship with these parents. The following are likely to be useful practices in supporting optimal emotional and social development (also refer to [Parenting skills and support](#) above).

- In the early months, support parents, family and whānau to observe and then understand their infant's signals/cues (eg, when the infant wants interaction, when they are using their own early capacities for reducing stimulation and when they are tired and need settling) and to respond consistently in a sensitive, 'tuned in' way.
- Specifically support parents in managing their infant's distress and discomfort with responses that soothe their infant. Support parents in managing separations by clearly saying goodbye and on reunion being warm and comforting. This will:
 - help to settle the infant's stress and support the infant's developing capacity for self-regulation, confidence and with age (+3 years) self-control
 - promote the development of a positive relationship between the infant and their parent/s.
- Provide information about social and emotional development in infants and preschoolers.³⁸ This developmental guidance gives parents the knowledge they need to see the world from their child's perspective. For example, when a:
 - parent is angry or upset, no matter what the reason a young child will think it's their fault
 - child becomes upset over separation, they are expressing their love and fear of loss rather than being manipulative.
- Support the parent to spend some face-to-face time with their infant or preschooler following their child's lead (ie, resist the urge to direct the child's play/activities). Encourage them to play games, read, talk and be interested in their child's talking.

³⁸ Refer to the Zero to Three website (www.zerotothree.com) for *Your Child's Development* handouts for parents. They deal with, for example, [social and emotional development](#), [ideas for parents to support learning](#) and family/peer relationships.

- Promote links and/or referrals that decrease social isolation – for example, playgroups, early childhood education services like the SPACE programme with playcentre (for parents with infants from birth to 12 months), playcentre in general, kōhanga reo, Pacific Island early childhood centres and kindergartens.
- Provide concrete assistance and advocacy to ensure families living in financial difficulty are able to access resources to assist with parenting and parental relationships – for example, links with community toy libraries, Work and Income, budgeting advice and relationship services.
- Support early identification of risk factors and problematic parent–child interactions (as discussed in ‘Supporting evidence’ below) that are unlikely to support the infant’s overall healthy development and promote a secure attachment relationship. Where dyads, families and whānau show evidence of moderate to severe risks and concerning interactions, early referral is to be encouraged.
- Encourage early referrals where an infant or young child has persisting behaviour problems including with crying, eating difficulties, sleep problems, tantrums, head-banging, aggression and sadness.

Refer to [Family violence assessment](#) below when concerns encompass suspected child abuse and/or neglect and/or partner violence.

Refer to [Development](#) under ‘Health and development assessments’ to clarify concerns about developmental difficulties and delays such as whether an infant or preschooler needs to be assessed for social and communication problems, which may indicate autism.

Supporting evidence

General infant mental health

It is important to understand each family’s strengths and the difficulties that are known to impact on the infant’s development. It is not inevitable that the outcome for the infant will be poor but the following factors can interfere with optimal infant health.

When visiting and assessing parent–child interaction, child development and behaviour and parental wellbeing, parental difficulties or vulnerabilities that need to be understood and taken into account are:

- current stressors – poverty, illness, parental conflict, family violence and losses/deaths
- maternal and/or paternal mental health disorders, alcohol and other drug abuse, and personality disorder
- a parent whose own childhood included experiences of neglect, physical abuse, sexual abuse, being in foster care, and/or being exposed to severe family violence or significant loss and death
- where the pregnancy and/or birth were traumatic and contribute to a parent being withdrawn, hostile or ambivalent about the baby
- being socially isolated or unsupported, abandoned by family or separated from family, or being disconnected from their cultural community – whether that community is, for example, Māori, Samoan, Tokelauan, Pākehā, Indian or Chinese
- developmentally disabled parents

- teenage parents, who are a risk group. Risks known to be associated with this group include lack of adequate antenatal care, poor nutrition, negative responses from their families, high levels of depression and stress. In interactions with their infant teenage parents are less likely to express less positive and more negative emotions, and, especially through the second half of the first year, support more punitive child care attitudes.

Some infants because of genetic, antenatal and/or postnatal problems are vulnerable in that their difficulties place considerable demand on the parent's caretaking abilities. These infants include those who:

- are premature, of low birthweight or have medical problems
- have physical and/or developmental disabilities
- are temperamentally 'difficult' or 'slow to warm up'
- are physiologically irritable, restless or sensitive to touch, or are difficult to console, feed or settle to sleep, or have sensory processing difficulties.

These difficulties will be compounded if the infant experiences trauma and neglect and/or the relationships between the infant and the parents are disturbed, and parents are isolated and struggling financially.

Most infants have more than one carer (Mum, Dad, Grandma, Aunty, early childhood carer)³⁹ with whom they develop a relationship. These early relationships need to be valued and supported so that they are as beneficial as possible. These relationships have been most commonly researched within the framework of 'attachment and caregiving' and it is useful for WCTO practitioners to have some understanding of this area.

The following information provides some background to understanding attachment but is not intended to be used to determine or diagnose attachment patterns in infants and young children.⁴⁰

Attachment

An attachment is a tie between an individual (the infant or child) and an attachment figure (generally a parent). It is a tie based on the need for safety, security and protection, all of which are critical to infants and children.

- Most often the child's birth mother is the **primary attachment figure** but this varies and most children have a number of attachment figures.
- The parent's tie to the child is termed the **caregiving bond**. It is incorrect to use the term attachment to mean this relationship as attachment is not a complete description of this relationship.
- The quality of day-to-day interactions in the first 7–8 months becomes the basis of the attachment pattern an infant develops with their parents/caregivers.

³⁹ Many young children in New Zealand are cared for by more than one adult in outside-of-family arrangements, either in informal child care/babysitting or in early childhood education. Quality early childhood education does not damage attachment to the primary attachment figure, but poor-quality care by a series of adults who do not care for the child regularly or develop reciprocal responsive relationships with the child should be avoided.

⁴⁰ For further information, refer to Appendix 2: Attachment in *Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand* (Ministry of Health 2011a).

- You cannot assess the infant's attachment pattern in the first months.
- Importantly an attachment pattern can change as a consequence of environmental changes that lead to a consistent shift in caregiving behaviour.

We can observe the attachment tie in action from about seven months when the child begins to seek proximity to the attachment figure if their **attachment behavioural system** is activated by fear/threat or anxiety/distress. How close the child needs to be to feel safe, secure and protected depends on the intensity of activation of their attachment system. A toddler may need to be back in the arms of their parent when hurt after a fall or they may be sufficiently settled by making eye contact with the parent. When the attachment figure soothes a child emotionally, protects the child or ensures safety, they are providing a **secure haven** for the child. Soothing in this context regulates the child's emotional state. The repeated experience of having their emotional states accurately understood and settled, most of the time, provides the support for the child to gradually develop self-regulation, self-confidence, self-control and resilience.

The attachment system is reciprocally balanced with the child's **exploratory system**. Both systems are responsive to internal and external cues. It is very difficult for a child to confidently play and learn (explore) if they are anxious or fearful; however when the attachment figure is present and responsive to the child's distress, the soothed child can then confidently move away to explore. In this way the attachment figure encourages and supports the child's discoveries and is providing a **secure base** for the child to explore.

Secure attachment in early childhood is associated with good functioning across the following areas.

- Across home and school settings, these children are more positive and less negative emotionally (less likely to say no, cry, whine) and are more compliant.
- They are less emotionally dependent on teachers, demonstrating greater self-reliance, and are more positive in their interactions with peers and adults.
- Extending into adolescence they show greater interpersonal competence.
- Secure children rate higher on their capacity for empathy and as adolescents use more positive defences when dealing with difficult experiences (are more resilient).

There have been no studies of attachment in New Zealand populations but many have been conducted in different cultures across the world and all have found attachment theory to be applicable. There are cultural differences in how a parent expresses their sensitivity (eg, the amount of touch that may be used) and supports the child's exploration (eg, verbal encouragement versus non-verbal smiles) but all infants are identified as developing attachment relationships when they have available attachment figures.

Attachments emerge from interactions with abusive caregivers as readily as with sensitive responsive carers. Children work hard to keep connected with their parents, learning very quickly what works to reduce risks – for example:

- if it's important to smile and pretend you're happy ('Stop crying or I'll give you something to cry about'), they smile and look happy
- looking after a neglectful or withdrawn parent gets some interaction even if it is at the expense of the child's needs.

If a parent is to support their child in developing a secure attachment to themselves, the parent must **not** have prevailing interactions that:

- are unpredictable
- frighten their child – threatening, screaming, hitting, shaking, physical and sexual abuse
- show hostility to their child, or consistent criticism or rejection of them
- are withdrawn, uninvolved, passively rejecting and unresponsive to their child
- interfere with their child's self-soothing – for example, some parents may:
 - want their infant when awake to continually look at them so the infant can't use looking away as a strategy for managing being overwhelmed by sensory input or when they feel tired
 - intrusively touch and poke their child when the child is trying to disengage from interaction
 - tease persistently
- indicate that they are frightened of their child – for example, something their infant/young child does (lift an arm, frown) reminds the parent of their abusive father so the child's action is misperceived as an angry assault and the parent becomes fearful and may withdraw or, in more severe circumstances, dissociate (an apparent trance-like state, which is highly distressing for an infant)
- demonstrate a gross mismatch between the child's emotion and the parent's – for example, the child's crying after a fall is met by parent's laughter and refusal to soothe
- reflect care that elicits and rejects the child's needs for soothing and protection (attachment). For example, a parent may get considerable comfort themselves by feeding a baby for a long time (closeness around that task) but be rejecting and hostile when the baby cries for rather too long in attempts to get some comfort as well.

In all these situations the infant becomes highly stressed and exposed to changes in cortisol, yet the source of help and care is also the source of fear and discomfort. The relationship disturbance has a serious neurochemical effect on the developing child.

Consider referral for assessment and intervention if any of these problematic types of care are a feature of the families you are seeing.

Age of child and procedure

Contacts from birth–seven months

All parents, and especially those whose infants are unsettled, can improve their caregiving if they are supported to observe and understand:

- not all infants are the same – for example, about 20 percent of infants fuss and cry for longer and more often through the first three months or so. This is neither the infant nor the parent's fault
- infant states – recognise them and know what works best to support the infant; for example, recognise when an infant is in an alert, settled state and ready for interaction or is overstimulated and needs help to settle
- infant behaviours – watch for their baby's own unique behaviours in different situations
- infant cues – these are non-verbal behaviours and it is important to understand what they may be communicating
- effective ways of managing and comforting the infant when distressed and/or tired

- effective ways of noticing their own distress and irritability/anger and managing these feelings
- feeding – holding, relaxing and enjoying feeding using the ‘suck–pause’ rhythm so that the infant is supported emotionally during the feed
- the role of non-nutritive sucking (NNS), which is sucking for purposes other than feeding and may include sucking on thumb, pacifier or breast. NNS provides an early step in an infant’s emotional self-regulation
- from the age of three months or so, the infant becomes interested in the world beyond their parents, siblings, family and whānau and so supporting them in their exploring, play and early speech becomes important. Give information about child development and parenting and promoting positive relationships. Observe and solve problems with parents who are anxious about parenting, may be rejecting at times or are struggling to deal with their own feelings.

Contact at 15–18 months

How well is the home environment supporting wellbeing or are there concerns about dysfunction?

- A toddler’s relationship with their parent/caregiver can be observed so referral for parent–child intervention should be made if you are concerned about a problematic relationship, particularly if you are identifying risks and parental behaviour that may contribute to emotional and behavioural problems. Are there joy and warmth in the relationships? (See additional comments under [Attachment](#) above regarding problematic behaviours that are linked with the development of significant attachment disturbance.)
- How is the toddler developing with feeding themselves, playing and speech?
- How are parents managing behaviours like temper tantrums, sleeping and feeding, crying when separated and setting limits?
- How are the parents day to day lives? Think about the wider environment and its impact on a parent’s capacity to think about and care for their child: mental health, alcohol and other drugs, partner relationships, losses and deaths, supports and finances.

Contact from 1½–3½ years

Similar observations of the home environment, the child’s development and interactional patterns are made alongside discussions with parents regarding their concerns about their child, parenting issues and relationship difficulties.

- Be aware of the issues arising with a toddler’s growing sense of autonomy. Toddlers need a lot of adult support to manage their strong feelings without getting overwhelmed; providing this support is challenging and hard when the word ‘no’ may be their main way of asserting autonomy.
- Support the family’s strengths; be aware of community services such as evidenced-based group parenting programmes (eg, Hoki ki te Rito, Mellow Parenting, Incredible Years, Triple P).

Contact at four years

For many children in New Zealand, discussion with the family and observations will now include additional information from an early childcare setting.

Developmentally preschoolers need support in their growing capacity for expressing thoughts and feelings in words and pretend play; managing feelings like sadness, anger, loneliness, jealousy and failure; developing friendships where they are able to cooperate and learn skills to deal with conflict; and having a positive view of themselves.

- Continue to provide developmental guidance and consider community supports. Make referrals to community NGOs or specialist IMHSs when development is off track; for example, severe aggression, running away, hyperactivity, stealing, anxiety, depression, concerning response to significant events (death, traumatic injury/health problems, parental separation, earthquakes), ongoing problematic parent–child relationship.
- Remain alert to continuing hostility or rejection, emotional unavailability, neglectful and/or physically abusive caregiving. In such cases, refer for infant mental health intervention and/or notification to CYF. (Refer to [Family violence assessment](#) below.)

Referral pathways

For those families where parents have good social supports, minimal stressors and minimal risk factors and whose parenting is demonstrably warm, predictable, sensitive and adaptive to their child's needs, the role of the LMC and WCTO Provider is most likely to be to support the families in their current function and work collaboratively to give information about specific aspects of care.

For families with identifiable risk factors, consider referral for additional support and intervention.

- The pathway for referral will need to take account of programmes and services offered locally, including those that have been developed for Māori and Pacific peoples.
- Families for whom risks and vulnerabilities have been identified need to be referred to a service offering assessment and evidence-based interventions⁴¹ (eg, Incredible Years Parenting Programme and Watch, Wait and Wonder). Such a service is particularly important where the risks and vulnerabilities identified place an infant in an environment of severe stress and/or there are probable antecedents increasing the risk that the young child will have a disturbed attachment relationship (insecure – disorganised, controlling) such as:
 - parental mental health disorder (most commonly persistent depression or PND)
 - exposure to family violence
 - parental alcohol and substance abuse
 - physical, emotional and sexual abuse, and neglect
 - the child has experienced repeated separations and/or has lost their primary attachment figure.

Referral is required for infants and preschoolers where there are significant risks and/or the children have persisting difficulties with social, emotional and behavioural problems such as:

- persistent aggression, oppositional behaviour, running away
- listless, depressed, apathetic
- anxious
- post traumatic stress problems

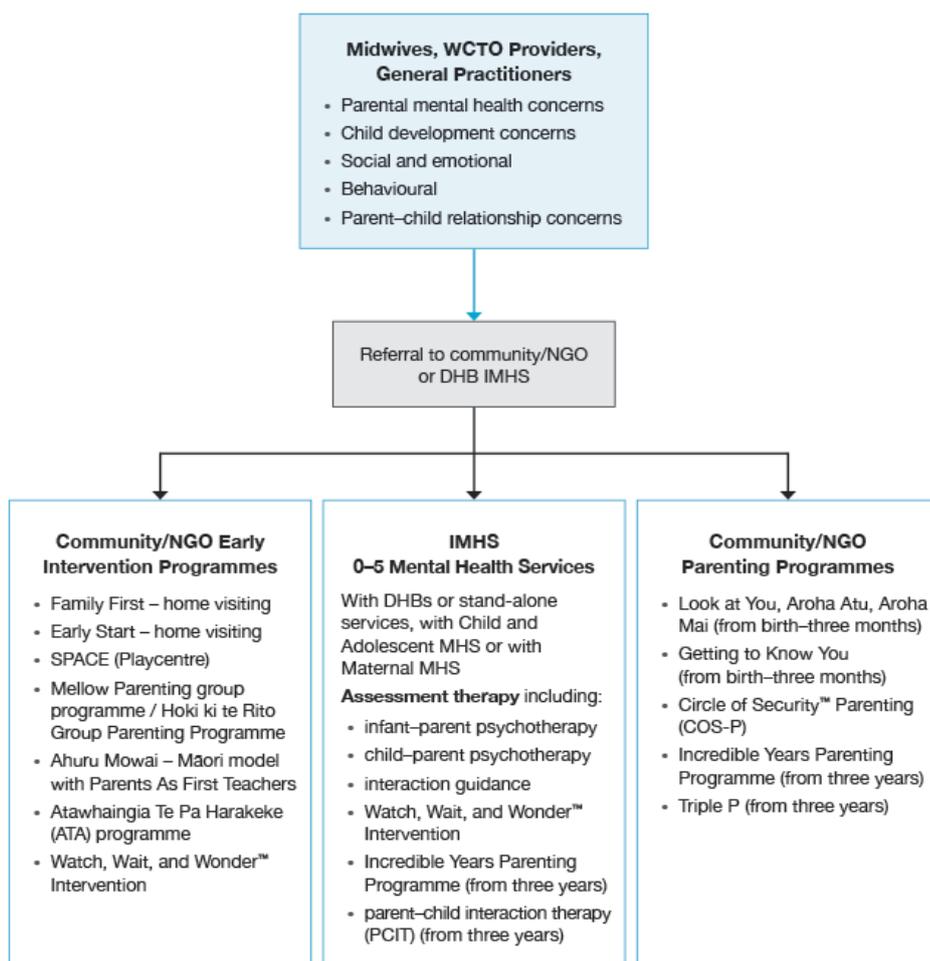
⁴¹ An evidence-based approach reflects a prevention science methodology in which effective interventions are identified based on review of the available scientific evidence.

- failure to thrive (require GP/paediatric review first)
- regulatory problems as a consequence of the disturbed relationship – may be evidenced in sleep and/or eating difficulties, prolonged tantrums and self-harm.

Referral for assessment and intervention as appropriate should be made for families where parents identify they are fearful of abusing their child, don't feel bonded, dislike their child or may fear repeating with their child, abuse they experienced as children.

Refer to Figure 10 for a template you can use to identify suitable referral resources in your community or district health board.

Figure 10: Template for identifying referral resources in your community or district health board



Add resources, programmes or services being offered in your community/district health board. (The examples given may or may not be available in your area.)

Resources

- Ministry of Health. 2011a. *Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand*. Wellington: Ministry of Health – provides guidance to district health boards, other health planners, funders and health practitioners on ways to address the mental health and alcohol and other drug needs of mothers and infants.
- For newborns to three months the DVD made by Counties Manukau District Health Board *Look at You, Aroha Atu, Aroha Mai* based on the Australian film *Getting to Know You*.

- Nursing Child Assessment Satellite Training (NCAST) (www.ncast.org) parent booklets: *Keys to Caregiving*.
- Three useful websites are: Zero to Three (www.zerotothree.com), Centre for Attachment (www.centreforattachment.com) and Infant Mental Health Association Aotearoa New Zealand (www.imhaanz.org.nz).
- Resources from the Ministry of Social Development's SKIP website (www.skip.org.nz) on development and play.
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Zero to Three Infant Mental Health Task Force. 2002. *What is Infant Mental Health?* Washington DC: Zero to Three Infant Mental Health Task Force.

Family violence assessment: child and partner abuse⁴²

New processes for dealing with child abuse and neglect are currently being developed within the Children's Action Plan (refer to www.childrensactionplan.govt.nz). The related pathways for responding to child abuse and neglect will be updated in the Handbook as these new processes and reforms are implemented.

Note that the Ministry of Health has clear expectations of providers of WCTO services to support their clinicians in the management and referral of family violence identified during routine practice. This support includes having clear partner abuse and child abuse policies, training and supervision for staff, safe documentation, resources to support good practice and clear referral pathways. If WCTO service managers are uncertain about their role, they are encouraged to contact the Ministry of Health for guidance.⁴³

Component links

This component links to:

- parenting skills and support
- infant and preschool mental health and attachment
- perinatal mental health
- child safety/injury prevention
- alcohol and other drugs
- shaken baby syndrome prevention.

⁴² Content for this component is summarised from the *Family Violence Intervention Guidelines: Child and partner abuse* (Ministry of Health 2002a) and the revised draft (unpublished) of the guidelines.

⁴³ Refer to the Ministry of Health website (www.health.govt.nz/familyviolence).

Purpose

The purpose of this component is to:

- ‘open the door’ and provide information and support for women making disclosures, so they know their rights and appropriate sources of help
- identify, assess and refer vulnerable children and caregivers
- inform and educate parents/caregivers about violence as a health issue and where to get help if needed.

Key messages

WCTO Providers, LMCs and other health practitioners have a key role to play in the prevention and early identification and referral of family violence, including child abuse and neglect and intimate partner violence (IPV).⁴⁴ This group of health practitioners also has a responsibility to detect family violence and respond promptly and appropriately. WCTO Providers and LMCs come into contact with the majority of children and develop trusted relationships with families, and so they are in an ideal position to assist victims of family violence before it reaches crisis point.

Agencies such as CYF and the New Zealand Police and non-governmental organisations such as Women’s Refuge have an important role in responding effectively to family violence identified by health practitioners. These groups need to be engaged early when child protection issues are identified and are critical partners when violence/abuse escalates. Due to the high prevalence of family violence in the population and increasing evidence of the negative health and social effects of partner and child abuse, WCTO Providers and other health practitioners need to become competent in identifying and responding appropriately to abuse. This includes knowing how to ask questions to identify the presence of abuse, and having procedures in place to offer effective support and appropriate health care and other service referrals if required. WCTO Providers are part of a national health sector response that has been developed over many years to reduce and prevent family violence. Providers of WCTO care, like other practitioners, should be trained to make identifications, assessments and referrals competently and safely according to organisational policies and procedures (such as documentation).

Providers of WCTO services should be aware of a variety of individual responses that may colour their view, and affect them in dealing with a suspected case of abuse. Issues such as ‘professional dangerousness’ should be addressed in both the training they receive and in accessing personal supervision.

Co-occurrence of child abuse and intimate partner violence

Evidence indicates that there is substantial overlap between the occurrence of child abuse and IPV, with between 30 and 60 percent of families who report one type of abuse also experiencing the other type (Edleson 1999). The co-occurrence of child abuse becomes more likely as IPV intensifies. Specific information about the co-occurrence of child abuse and IPV in New Zealand is not available; however, in almost two-thirds of notifications to CYF, there is some element of family violence (Nixon 2012) and New Zealand Police report that in about 70 percent of families where IPV occurs, children are also victims of some form of violence (as cited in Murphy et al. 2013).

⁴⁴ Because of the extent and pattern of violence committed by men against women, in this Handbook, victims of IPV are usually referred to as female. In the more unusual cases where IPV is perpetrated against male partners, the same procedures should be applied.

Given the frequent co-occurrence of child abuse and IPV within families, the issues cannot be addressed in isolation. In all cases, the emphasis should be on keeping the child or children safe and enabling the abused partner to get real and appropriate help.

This emphasis also applies where perpetrators of abuse (physical, sexual and emotional) are outside the immediate family. All care must be taken to protect the child.

Child abuse and neglect

As stated in the Child, Young Persons, and Their Families Amendment Act 1994 (section 2), the legal definition of child abuse is the harming (whether physically, emotionally or sexually), ill-treatment, abuse, neglect or deprivation of any child or young person.

In a well-known New Zealand longitudinal study, participants were asked to recall parental disciplinary methods from their childhood. Six percent of participants recalled extreme physical punishment and a further 45 percent recalled being hit with an object (Millichamp et al 2006). Earlier studies indicate approximately 4 percent of the population have experienced harsh or severe physical parental punishment, and 20 percent regular physical parental punishment in childhood (Fergusson and Lynskey 1997).

Recent research on child sexual abuse among New Zealand women found a prevalence of 23–28 percent (Fanslow et al 2007). Among females alone, the lifetime prevalence of sexual abuse may be as high as 30 percent (Fergusson et al 2000).

No New Zealand studies estimating the population prevalence of psychological/emotional abuse or child neglect have been conducted. Limited information is presented in the study by Martin et al (2010).

The majority of perpetrators of child abuse are family members (although child abuse also occurs outside the family context). Males are more frequently responsible for the most serious and fatal forms of child abuse (Featherstone 1996; Cooney and Baun 1997; Chalk and King 1998)⁴⁵ and for the perpetuation of sexual abuse (Anderson et al 1993).

Child neglect is a form of abuse. Although the effects may not always be as obvious as physical abuse, they are just as serious.

The early and long-term health effects of child abuse and neglect have been documented in the Adverse Childhood Experiences (ACE) Study (Felitti 2002).

Neglect can consist of:

- **physical neglect** – not providing the necessities of life like a warm place, enough food and clothing. In babies or young children, this may present as poor growth ('failure to thrive')
- **neglectful supervision** – leaving children home alone or without someone safe looking after them during the day or night
- **emotional neglect** – not giving children the comfort, attention and love they need through play, talk and everyday affection
- **medical neglect** – the failure to take care of their health needs
- **educational neglect** – allowing chronic truancy, failure to enrol children in school, or inattention to special education needs.

⁴⁵ See also C Langdon. 'Child killing: our grim role of shame'. *Dominion*, 16 May 2001, pp 1–2.

Child neglect includes both isolated incidents and a pattern of failure over time on the part of a parent or caregiver to provide for the development and wellbeing of the child in one or more of the following areas: health, education, emotional development, nutrition and safe living conditions (WHO 2006).

Child abuse in all its guises has detrimental effects on children's physical, cognitive, emotional, behavioural and social development. The long-lasting and pervasive nature of the effects warrants a strong approach to prevention, early identification and intervention (Eiskovits et al 1998).

The impact of family violence and child abuse on children can be devastating.

- Witnessing family violence harms children by causing a persistently heightened physiological and stress response with potentially long-lasting adverse health effects.
- It affects children by severely disrupting parenting capacity, family functioning and living circumstances.
- Child abuse causes profound and lifelong damage to children and potentially severely compromises development across all domains.
- Child abuse can be intergenerational, as abused children may not develop into adults who are capable of protecting and adequately nurturing their own children.

Intimate partner violence

In New Zealand there is evidence that IPV affects a substantial number of individuals. In a recent study of New Zealand women, 55 percent reported they had experienced physical, sexual or psychological/emotional violence by a male intimate partner in their lifetime and 33 percent had experienced more than one of these forms of IPV. Eighteen percent had experienced one or more forms of IPV in the 12 months prior to the study (Fanslow and Robinson 2011). Psychological/ emotional violence was the type of violence that women most commonly reported experiencing and, among those who reported it, most indicated it was a repetitive experience.

Data from the New Zealand Crime & Safety Survey indicate that 18 percent of men have experienced IPV in their lifetime, and 6 percent have experienced physical IPV within the previous 12 months (Mayhew and Reilly 2007). Available data indicate violence by women against their male partners is less prevalent and less severe (Lievore and Mayhew 2007).

Age of child

It is expected that a routine enquiry for IPV will be undertaken antenatally and postnatally as part of the needs assessment process, at any new intimate relationship and any time that IPV is suspected.

Routine enquiry about child abuse and neglect is **not** recommended. Providers of WCTO services need to be alert for signs and symptoms that require further assessment, or that might indicate violence and abuse.

'Family violence assessment' is included at each core check in the Schedule as a reminder to be aware of signs and symptoms indicative of child abuse and neglect and/or IPV. Providers of WCTO services should use their informed professional and clinical judgement as well as training to make assessments safely. If unsure, discuss your concerns with a senior colleague.

Procedure

Child abuse and IPV are sensitive subjects to discuss. It is therefore important that guidance is followed when discussing it with the parent/caregiver. There are six steps to address child abuse and IPV.

Summaries of the six-step process and corresponding flowcharts for child abuse and IPV follow. (Refer to the *Family Violence Intervention Guidelines: Child and partner abuse*, Ministry of Health 2002a, for further detail.)

Summary of risk assessment for child abuse and neglect

See Figure 11 for a flowchart representing this process.

1 Identification/observation of signs and symptoms

It is important to realise that very few signs and symptoms are specific to abuse. In addition, children may experience abuse and neglect but show no obvious signs or symptoms at all. If you are concerned about a child, consult with practitioners experienced in child protection, or with CYF.

You should remain alert for signs and symptoms that require further assessment or that might indicate violence and abuse.

- Consider cues related to physical, sexual, emotional/or behavioural aspects (see [Appendix 4: High-risk indicators associated with child abuse](#); [Appendix 5: Signs and symptoms associated with child abuse and neglect](#); [Appendix 6: Assessing for child neglect](#)).

CYF's *Working Together to Keep Children and Young People Safe* also provides information about warning signs associated with different kinds of abuse (see [Resources](#) in this section).

- Consider cues related to parent–child interaction (see below).

Observations of child–caregiver interactions can provide additional information that may be helpful in determining future courses of action (eg, by providing clues about who the child is comfortable with and seeks support from, or adults whose behaviour towards the child raises some concerns).

The following are **cues/signs and symptoms of issues of concern in the parent–child interaction**.

- Parent or caregiver is lacking in emotional warmth towards the child.
- Parent or caregiver behaves in dismissive and unresponsive ways rather than responding sympathetically or comfortingly.
- Interaction between the child and parent or caregiver seems angry, threatening, aggressive or coercive.
- The child states that they are fearful of parent/s or caregiver/s, or have been hurt by parent/s or caregiver/s.
- Multiple risk indicators exist (eg, partner abuse in a caregiver's relationship, alcohol/drug use by a caregiver, a caregiver's avoidance of health agency contact, or a caregiver has a prior history of harming and/or neglecting children).

- Indications that may raise concern are: parent/caregiver calling the child names, using harsh verbal discipline, telling the child that they will harm something that is important to the child, threatening to seriously hurt or abandon the child, mocking the child or putting the child down in front of others.

You should familiarise yourself with the signs and symptoms talked about in the Handbook and the documents above. If you'd like to know more about the signs and symptoms of child abuse, phone CYF (0508 326 459).

Also review the previous records and other information on the child and family (eg. notes transferred from the LMC, needs assessment information).

2 Health and risk assessment

Following a safe process means never making decisions about risk in isolation.

Your employing agency will be able to provide information about relevant policies, management, documentation, monitoring, and other support systems and processes that are available, as well as appropriate training.

Senior colleagues, paediatricians, health social workers, Youth Health Service providers, and duty social workers at CYF are examples of people who may help, as you work to determine what level of risk a child might be facing.

Immediate protection of a child is required if the child has suffered harm that, in your view, is a result of child abuse, and the environment to which the child is returning is unsafe.

Assess risk to other children in the house, and other adults in the house, particularly for co-occurrence of IPV.

3 Support and validation

In the event that a child discloses, you should ensure the child's immediate safety. Try not to alert the alleged abuser. Seek advice and assistance, and find support for yourself.

4 Intervention/safety planning

If there are concerns about immediate safety (including your own), contact the Police and CYF.

Working as part of a multidisciplinary team can help to meet the safety needs of children and of the non-abusing parent/caregiver.

5 Referral and follow-up

Make referrals as appropriate, and ensure that relevant information is appropriately and accurately transferred to receiving individuals/agencies. Referral pathways established with your district health board may also be appropriate.

External referral agencies are vital in providing support to actual or suspected victims of abuse. It is strongly recommended that you or your agency meet and develop referral relationships with local staff from the organisations listed here and others.

Child abuse and parent support services are:

- CYF
National Call Centre, freephone 0508 FAMILY/0508 326 459
Intake social workers will take direct referrals about cases of concern, and are available to discuss possible courses of action if you think child abuse or neglect is a possibility or if you are uncertain about what to do next.
- New Zealand Police
- other social support and child health agencies; for example (some are not available in all areas):
 - Family Start
 - Barnardos
 - Jigsaw
 - Shine
 - Open Home Foundation.

Refer to [Appendix 7](#) for a referral agency template for you to complete when making a referral.

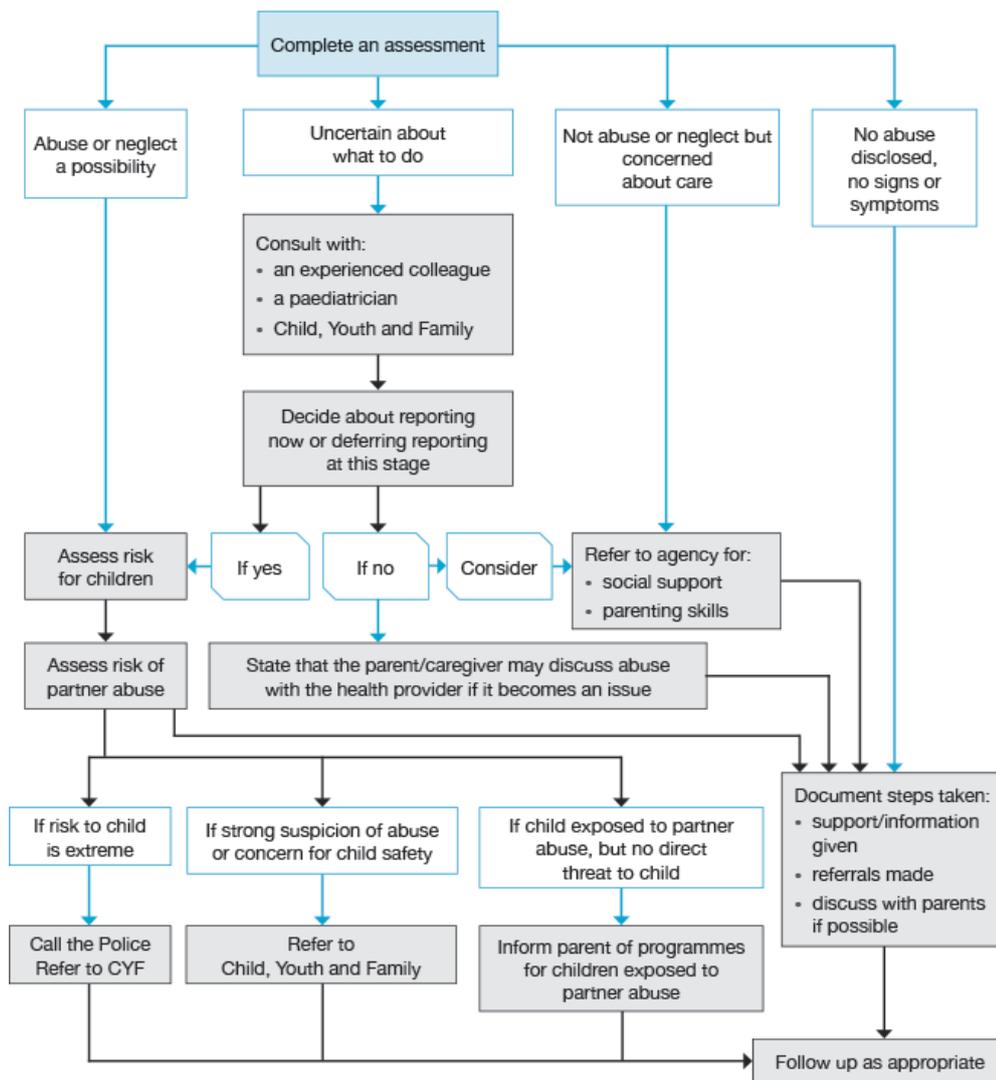
Ensure there is a plan for review and follow-up. (For example, what is the timeframe for the referral and follow-up plan? Who will review the plan; when and how?)

6 Documentation

Document your concerns, relevant history, results of risk assessment, and the referral process and details (where applicable).

Each provider of WCTO services is expected to have its own policy on assessment, management and referral of child and partner abuse. This includes procedures to safely document the abuse. Note that violent and controlling partners commonly demand to see the clinical record of the victim or child, who can be placed at great risk if the partner sees it. Providers are expected to have a separate system for recording details of family violence. See the Ministry of Health Violence Intervention Programme website (www.health.govt.nz/our-work/preventative-health-wellness/family-violence) for guidance or contact the Ministry.

Figure 11: Child abuse – assessment and response flowchart⁴⁶



Summary of an enquiry about partner abuse

See Figure 12 for a flowchart representing this process.

1 Routine enquiry

Ask simple, direct questions in a non-threatening manner.

- **Routine enquiry about IPV should be conducted with all female caregivers.** At a minimum, women should be assessed for current (past year prevalence) physical violence, sexual violence and psychological abuse. Asking whether the woman is afraid of a current or former partner is also important.

Note that:

- research has shown that health care provider enquiry about IPV is acceptable to women
- multiple, direct questions about IPV elicit higher levels of disclosure than single, general questions about home life
- your way of introducing the questions can facilitate disclosure
- your initial supportive, non-judgemental and informative response to initial disclosure is an important source of help and validation.

⁴⁶ Fanslow JL, Kelly P. 2012. Child abuse and intimate partner violence. *Family Violence Assessment and Intervention Guidelines*. Wellington: Ministry of Health. Manuscript in preparation.

- **Male** caregivers who present with **signs and symptoms** indicative of partner abuse should be questioned.
- Questioning should take place in private with the woman on her own or with non-verbal children. The enquiry should not take place when the woman's partner, verbal-aged children, other family or friends are present.
- In many health care settings, confidentiality may have been explained or be understood already. Establishing confidentiality before routine enquiry about IPV is **not recommended**, however. If information disclosed during routine enquiry indicates that there is sufficient risk to warrant further action, there is scope to point out the limits of confidentiality of information (eg, 'What you have told me is concerning. I think it is important that we talk to some other people to help make sure you (your child) can stay safe').
- For signs and symptoms associated with partner abuse, refer to [Appendix 8](#).

The following are examples of framing statements to introduce IPV enquiry questions.

- 'Because we know family violence can have bad effects on your health, we always ask about it.'
- 'Many of the women I see are dealing with abuse in their homes, so I ask about it routinely.'
- 'The staff of this service are concerned about family violence and the impact it has on women and children. Therefore we routinely ask all women about violence in the home.'

In asking **routine enquiry questions**, you need to ask directly about all three major types of violence: physical violence, sexual violence and psychological/emotional abuse. Asking specifically about each type is necessary in order to get a clear understanding of the scope of the violence the person may be experiencing, and to enable you to respond appropriately to it. Questions about feelings of safety are also relevant for identifying situations of stalking or other experiences that are creating unease.

Note that while the labels 'physical violence', 'sexual violence' and 'psychological/emotional abuse' are useful as conceptual frames for what might be going on, they are terms that should not be used in routine enquiry questions. The following are examples of acceptable ways of wording the questions.

Questions about physical violence

- Within the past year have you been hit, pushed/shoved, slapped, kicked, choked or otherwise physically hurt? (If so, who did this to you?)

Questions about sexual violence

- Within the past year have you been forced to have sexual activities against your will? (If so, who did this to you?)
- Have you been made to do anything sexual at a time or place, or in a way that you did not want to?

Questions about psychological/emotional violence

- Within the past year, did anyone insult or swear at you? (If so, who did this to you?)

Questions about stalking/other feelings of not being safe

- Is there a current or past partner who is making you feel unsafe?
- Are you afraid of what your current (or ex-) partner might do to you or someone else?

Note that consistent with good clinical practice and communication skills, you may need to ask these questions in slightly different ways, using different words (the words of the woman you are talking with if possible), and check that you each understand what is being said. For example, be prepared to pick up clues from what the woman is telling you, and seek clarification or expansion as appropriate, such as ‘What do you mean by “grumpy”?’.

2 Validation and support

- Listen and express empathy.
- Do not over-react, panic or criticise (eg, avoid comments such as, ‘You should have told me sooner’ or ‘Why did you let him do that?’).
- Acknowledge what they tell you (eg, ‘Thank you for telling me’).
- Note that supportive responses are important throughout, not just at the point of disclosure.
- Inform: let them know that their experiences of violence may be relevant to their health, that help is available, and that you will support them and help them to consider their options.
- Seek advice and assistance and find support for yourself.

If you suspect IPV but the woman does not acknowledge abuse as a problem:

- respect this response
- let the woman know that, should the situation ever change, you are available to discuss it with her if she would like you to
- make a note in the medical record to assess for violence again at future presentations.

3 Assess risk

Assess risk (refer to [Appendix 9](#) for greater detail) in terms of:

- immediate safety (lethal factors, eg, presence of weapons in the home)
- children’s safety
- homicide, suicide or further assault.

4 Safety planning

- If safety concerns are acute, follow your organisation’s policy (if imminent safety concerns exist for either the adult or the children, consent to contact the police is not required).
- If safety concerns are ongoing, assist the woman to develop a safety plan, in consultation with specialist family violence support agencies.
- Educate and support the person, regardless of their choices.

5 Referral and follow-up

For all identified victims of IPV, it is necessary to make appropriate referrals and to plan follow-up. Except in the rare cases where victims of partner abuse are in immediate danger, remember that for most adult victims of partner abuse the most powerful interventions you can offer are letting them know that they are not responsible for and do not deserve the violence they have experienced, and assisting them to contact support services and access legal options for protection.

If the person is in imminent danger, or at high risk, you need to make sure the appropriate referral and support agencies are contacted at the time of your visit.

If the person is at moderate risk, or might benefit from early intervention, you need to make sure they have the information necessary to contact appropriate health, social support or community services.

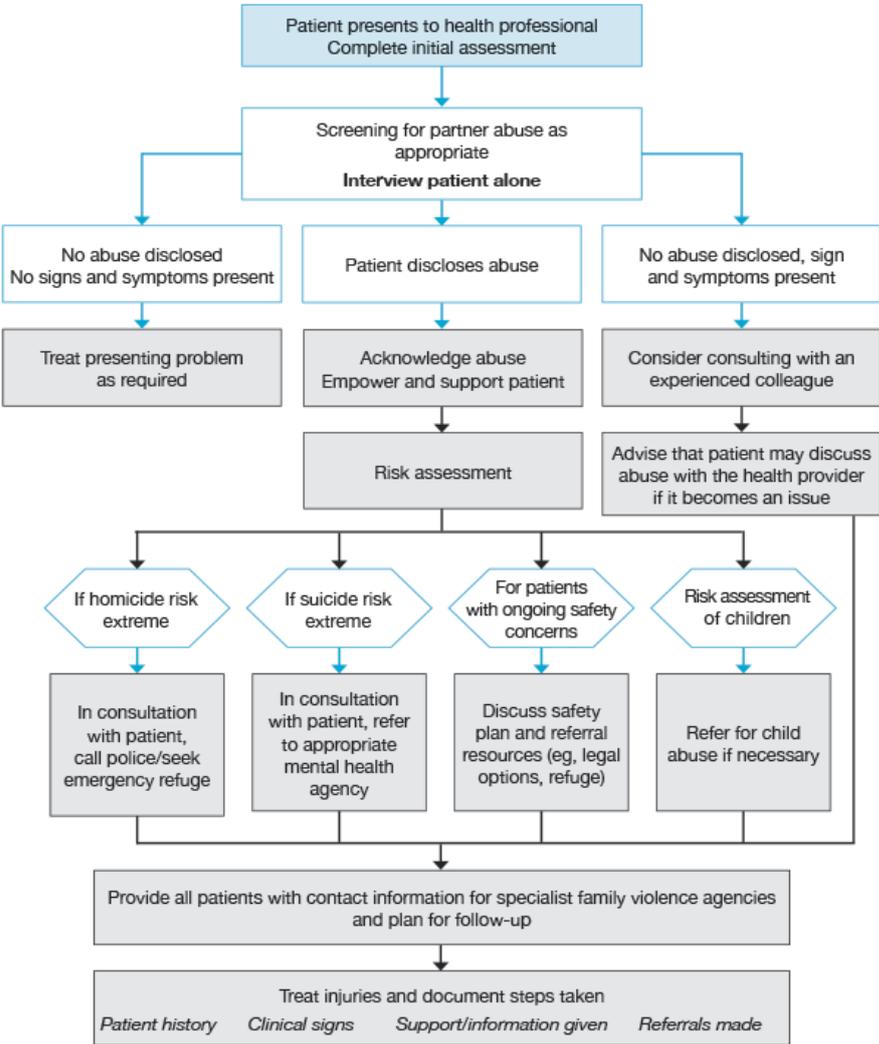
Refer to [Appendix 7](#) for a referral agency template for you to complete in making a referral.

Appropriate follow-up is also needed. Where an active referral to another service has been made, the follow-up process should ensure that the woman has engaged with that service as planned. Additionally, the presence/history of IPV may affect future WCTO checks. If IPV is currently an issue, safety procedures for future contact with the woman and family need to be considered.

6 Documentation

Document any current or past injuries thoroughly. Each provider of WCTO services is expected to have its own policy on assessment, management and referral of child and partner abuse. This includes procedures to safely document the abuse. Note that violent and controlling partners commonly demand to see the clinical record of the victim or child, who can be placed at great risk if the partner sees it. Providers are expected to have a separate system for recording details of family violence. See [Establishing a Violence Intervention Programme \(VIP\): Part Two – What can health services do to respond to victims of family violence](#) on the Ministry of Health website (www.health.govt.nz) for guidance or contact the Ministry if needed.

Figure 12: Partner abuse – assessment and response flowchart



Resources

Practitioners should follow the protocols of their employing agency. If in doubt, a practitioner may consult with CYF through the 0508 FAMILY call line.

Ministry of Health

For the Ministry of Health's (2002a) *Family Violence Intervention Guidelines: Child and partner abuse* (FVIG) and other family violence-related documents, refer to the Ministry's website (www.health.govt.nz/familyviolence). Aimed at health practitioners, the FVIG considers key populations and prerequisites for identifying and responding to family violence. It includes:

- high-risk indicators of child abuse
- signs and symptoms of partner abuse
- a safety plan
- information to give to victims of partner abuse
- education, resources and information
- sample documentation forms and referral agency information.

Violence Intervention Programmes in district health board resources are available from the Ministry's website (www.health.govt.nz/familyviolence). These resources include:

- pamphlets on 'Partner abuse: This is not love, this is control'
 - English HP4096
 - Maori HP4437
 - Samoan HP4433
 - Tongan HP4436
 - Korean HP4434
 - Farsi HP44235
 - Chinese HP4432
- information on establishing a VIP programme, questions and answers and health practitioner resources for service providers
- links to national and international websites on family violence.

Shaken Baby Syndrome Prevention resources and information are available from www.powertoprotect.net.nz

Child, Youth and Family

Working Together to Keep Children and Young People Safe, produced by CYF and available to download from its website (www.cyf.govt.nz), is an excellent resource for health practitioners. *Working Together* includes descriptions of the different types of child abuse, how to identify child abuse and what to do if you suspect a child is being abused or neglected.

CYF is an interagency partner, along with the Ministry of Health and the Ministry of Education, in the Gateway Assessments initiative. This interagency process aims to ensure every child in care receives an assessment that helps build a complete picture of their needs, and sees that they get access to the right health and education services to address their needs. See the CYF website (www.cyf.govt.nz) for more information about [Gateway Assessments](#).

CYF also provides resources, such as seminars, for practitioners including health workers, teachers and social services providers, who work with children. Refer to [working with others](#) on its website (www.cyf.govt.nz). From the CYF knowledge and practice centre, refer to www.practicecentre.cyf.govt.nz/knowledge-base-practice-frameworks/care-and-protection/resources/index.html for an extensive list of resources and www.practicecentre.cyf.govt.nz/knowledge-base-practice-frameworks/family-violence/resources/violence-in-families-the-context.html for more information about family violence and its impact on children.

Other organisations

The New Zealand Family Violence Clearinghouse (www.nzfvc.org.nz) is the national centre for collating and disseminating information about domestic and family violence in Aotearoa New Zealand. It provides information and resources for people working towards the elimination of family violence.

Information booklets and leaflets in multiple languages are available for download and order from www.areyouok.org.nz

Parent resources available from the Family and Community Services website (www.familyservices.govt.nz) include:

- [Seeing, hearing and feeling violence changes the way your child's brain grows](#) (pamphlet)
- [Family violence can harm your child for life](#) (pamphlet)
- [Being sorry is not enough](#) (booklet for men).

Child Matters is a registered charitable trust dedicated to preventing harm to children. The resources and information on its website (www.childmatters.org.nz) include *How Can I Tell?* and *Hidden in Front of Us*. Child Matters also offers training and education related to child protection.

Jigsaw (www.jigsaw.org.nz) is a network of 44 organisations that works to stop child abuse, neglect and family violence. Its website provides information and resources for parents. One of its campaigns, [Extra Ordinary Dads](#), celebrates fathers.

The range of services from Barnardos (www.barnardos.org.nz) includes the CYF-approved [Footsteps to Feeling Safe](#) family violence programme for children aged 5–14 years who have been exposed to family violence. Call Barnardos on freephone 0800 BARNARDOS/0800 227627367.

Shine (www.2shine.org.nz) provides a free national helpline (freephone 0508 744 633) and delivers training programmes and seminars on family violence. Its family violence-related resources include those developed in partnership with the Mental Health Foundation, the Deaf community, Outline and Rainbow Youth, and the Department of Ethnic Affairs.

The Open Home Foundation (OHF) of New Zealand (www.ohf.org.nz) provides Christian social services (eg, home-based social work, parenting education and mentoring) for children, young people and their families. The OHF has a strong cultural focus and provides information from a Māori perspective.

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Smokefree environment and smoking cessation support

Component links

This component links to:

- SUDI and suffocation prevention through safe sleep practices
- recognition of childhood illnesses
- growth measurement and monitoring
- development.

Purpose

The purpose of this component is to:

- ensure smokefree environments for children and their families, and positive role models for children
- protect infants and children from the harmful effects of environmental tobacco smoke (ETS)
- support pregnant women, breastfeeding mothers, parents/caregivers, families and whānau who smoke, to stop.

Key messages

The harmful effects of ETS are well documented. Infants and children are particularly vulnerable to the effects of ETS; they have smaller airways and a higher breathing frequency than adults, meaning that in the presence of ETS they inhale ETS at a higher rate than adults (Thomson et al 2005). Smoking around infants and children increases their risk of middle-ear infections and serious respiratory tract conditions. It also dramatically increases the risk of SUDI. Moreover, smoking during pregnancy is associated with risks to the pregnancy (eg, premature birth) and to the newborn (eg, low birthweight).

In response to the 'real and substantial threat to children's health' of ETS (WHO 1999), the World Health Organization identified increasing the number of tobacco-free homes and reducing parental smoking as key strategies for improving health and developmental in early childhood (Johnston et al 2010).

About 18 percent of New Zealand adults are current smokers. Smoking prevalence varies significantly by ethnicity. The smoking rate among Māori is 41 percent whereas for Pacific peoples in New Zealand it is 25 percent. Among Māori women of childbearing age (18–45 years), smoking prevalence is higher (52 percent) than among non-Māori woman of childbearing age (20 percent). Smoking is also much more common among socially disadvantaged than socially advantaged people (Ministry of Health 2012j). Māori, Pacific peoples, pregnant women and breastfeeding mothers are priority population groups for cessation support (Ministry of Health 2007b).

Health care workers, irrespective of their particular area of specialisation, have a responsibility to assist people to stop smoking. Cessation efforts should be directed particularly at all pregnant women who smoke, at any time throughout a pregnancy, and at women in the postpartum period. The *New Zealand Smoking Cessation Guidelines* (Ministry of Health 2007b) recommend the ABC approach to cessation.

A – Ask about smoking status.

B – Give Brief advice to stop smoking to all people who smoke.

C – Provide evidence-based Cessation support for those who express a desire to stop smoking.

Procedure

The following are questions and issues related to a smokefree environment to discuss with families and whānau.

- At each contact, ask about the amount of smoke the child has been exposed to in the past 48 hours.
- Explain about the effects of smoke inhalation on infants and children.
- Encourage and support families and whānau to make their child's environment smokefree. Document the level of smoke exposure the child is exposed to and plan with the family to decrease this.
- Give positive reinforcement for any behaviour change identified.

Households where individuals smoke may be at increased risk of fire hazards. For safety and injury prevention purposes, ensure the household has a working smoke alarm.

For smoking cessation support, implement the three-step ABC approach (Ministry of Health 2007b):

A – Ask

- Ask about and document smoking status for all people in the household. (For those who smoke or have recently stopped smoking, check smoking status and update the information regularly.) For example, you could ask:
‘Do you currently smoke cigarettes?’

B – Brief advice

- Provide advice to all people who smoke. For example, you could say:
‘You may know the risks involved with smoking, but do you realise how harmful it is? I cannot stress enough how important it is to stop smoking. Stopping is the best thing that you can do to improve your health. I understand that it can be hard to stop smoking, but if you want to, I can help you.’
Include advice about not smoking with a child in a vehicle.
- Personalise the advice (for example, if relevant explain how smoking is related to existing health problems and how stopping smoking might help). Highlight the benefits of quitting smoking (see Appendix 1 in the *New Zealand Smoking Cessation Guidelines*, Ministry of Health 2007b).
- Acknowledge that some people make several attempts to quit before stopping for good.
- Document that advice was given.

C – Cessation support

There are two options for providing cessation support.

- Refer: Health care workers **without** the expertise or time to help people to stop smoking should refer smokers to smoking cessation services such as the Quitline (freephone 0800 778 778 or www.quit.org.nz). For example, you could say:
‘Give the Quitline a call. They can help you and provide you with medication that will make quitting easier. The number is 0800 778 778.’
- Provide support: Health care workers who are able to provide support should do so. Support can include setting a quit date; advising the smoker that complete abstinence from smoking is best; arranging medication to aid the quit attempt; and arranging for a follow-up consultation within a week. Assessment of the degree of nicotine dependence helps guide treatment (see Appendix 2 in the *New Zealand Smoking Cessation Guidelines*, Ministry of Health 2007b).

Referral pathways

See ‘Cessation support’ above and ‘Resources’ below for cessation services for referral. Supplement this list with local cessation services and programmes.

Discuss with the parents, families and whānau the range of services available and which services would be of most use to them. Refer and follow up.

Resources

The Ministry of Health publication, *New Zealand Smoking Cessation Guidelines* (Ministry of Health 2007b) for health practitioners, is available from www.health.govt.nz. Also on the Ministry of Health website, see [Smoking](#) in the Your health section.

Other Ministry of Health resources available from www.healthed.govt.nz include:

- [Protect the health of your children: a guide to making your home and car smokefree](#) (HE1802) – for families and whānau
- [Time to quit](#) (HE1109) – for families and whānau
- [Yes, you can!](#) (HE2328) – about the use of nicotine replacement therapy in pregnancy.

The following are some other resources available.

- Quitline (www.quit.org.nz, 0800 778 778) provides guidance and resources both for health practitioners who want to help people stop smoking and for people who smoke.
- Aukati KaiPaipa (www.aukatikaipaipa.co.nz) is a face-to-face service offering Māori and their whānau the opportunity to stop smoking.
- Tala Pasifika (www.talapasifika.org.nz) is a national Pacific tobacco control service. Its website provides contact details for Pacific quit smoking services.
- General practitioners can prescribe nicotine replacement therapy such as nicotine patches at the subsidised rate of \$3 per item. They can also prescribe subsidised non-nicotine cessation medication such as Zyban, Norpress and Champix. Many general practice teams include trained cessation support nurses.
- Smokechange (www.smokechange.co.nz) specialises in education and training for midwives.
- Ministry of Health. 2009. *Implementing the ABC Approach for Smoking Cessation: Framework and work programme*. Wellington: Ministry of Health.

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Alcohol and other drugs

Component links

This component links to:

- family violence assessment
- child safety/injury prevention
- parenting skills and support
- behaviour assessment (section 5)
- development
- suffocation prevention through safe sleep practices
- infant and preschool mental health and attachment
- perinatal mental health
- nutrition
- breastfeeding
- smokefree environment
- growth measurement and monitoring.

Purpose

The purpose of this component is to:

- reduce the prevalence and impact of alcohol and other drugs (AOD) including the prevention and early detection of fetal alcohol spectrum disorder (FASD)
- identify parents/caregivers experiencing drug and alcohol problems and provide early referral.

Key messages

Parents/caregivers who are affected by alcohol and other drugs are linked with child abuse and neglect, family violence, and poor developmental outcomes and intentional/unintentional injuries (eg, SUDI) for their children.

The nine months of pregnancy and the first three years of life are key for a child's brain development; the structure and function of a baby's brain start to form at conception and continue to grow and develop until the child turns 4 years approximately. There is an important relationship between healthy social and emotional development in these early years of life and later health and wellbeing.

When a child is parented by caregivers with AOD problems, the child's development (emotional, social and cognitive) can be affected by problematic parenting (eg, inconsistent, unpredictable and/or neglectful) and in utero exposure to alcohol and other drugs. Infants and toddlers who do not have a positive early relationship with a caregiver are at greater risk for a range of mental and general health problems, both in the short term and later in life. Refer to [Infant and preschool mental health and attachment](#) above for further information.

Fetal alcohol spectrum disorder is the result of in utero exposure to alcohol, and is recognised as the leading preventable cause of mental retardation in the developed world. Women with a history of alcohol abuse are likely to be at risk of having a child with FASD. These women are compromised in their ability to parent such a child, and the family is likely to be less able to support a child with a disability.

Accurate documentation and recording of information about AOD, including exposure during pregnancy, can assist in later developmental assessment of conditions. The consequences of not accurately assessing FASD, for example, can be profound for the child, family and whānau. A study of secondary disabilities demonstrated how an early diagnosis of FASD can be a protective factor, without which the risk of secondary disabilities increases – mental health problems, school disruptions, unemployment and trouble with the law (Streissguth et al 1996). The children who remain misunderstood and mismanaged throughout childhood miss out on vital services that would assist them to reach their potential. As a result, they are further marginalised and re-victimised.

Surveillance should take into account the trans-generational nature of alcohol harm. A study found that mothers of children born with fetal alcohol syndrome had multiple issues in addition to their own addiction and half had intellectual and functional deficits consistent with their own exposure to alcohol before birth (Astley et al 2000). Such families are usually poorly connected to services and lack adequate support. They need a special 'circle of care' approach rather than any single line of intervention.

Women should be asked about AOD in a sensitive and non-judgemental way. They are more likely to give accurate information if seen on their own. They may not disclose at first visit and so should be routinely asked at each visit. Women dealing with substance abuse will respond better to an approach that can meet them where they are at, not where they should be. The approach needs to be inclusive of their children to be truly effective.

For more information on how to support parents with moderate to severe AOD problems, refer to [section 6](#) (especially 'Parents with moderate to severe or untreated mental illness and/or addiction').

Procedure

Take a detailed drug and alcohol history at first contact, including pre- and post-pregnancy confirmation, and at relevant contacts after this.

Provide information and anticipatory guidance to pregnant women, those considering or at risk of becoming pregnant, and breastfeeding mothers. (Where necessary, for referral information on a lactation consultant who can provide guidance on how to manage breastfeeding, see [Breastfeeding](#) under 'Health education'.)

Helping with Problem Drinking, a booklet produced by the Alcohol Advisory Council of New Zealand (ALAC), includes sections on taking a drinking history, screening questionnaires and helping problem drinkers.

People screening for alcohol and drug issues should be familiar with standard units of alcohol (refer to the ALAC website, www.alac.org.nz).

Two commonly used screening tools for alcohol use are [AUDIT](#) (see [Appendix 10](#)) a 10-item questionnaire that has been validated for Māori, Pacific peoples and Europeans, and the [CA GE](#) (see [Appendix 11](#)) four-item questionnaire. The [Leeds Dependence Questionnaire](#) screens for alcohol and other drugs.

Providers of WCTO care should develop strong relationships with practitioners from the drug and alcohol counselling and support sectors, so that the safety of the child can be preserved.

Referral pathways

If a parent/caregiver or practitioner has concerns about a child's development based on the above screening, then a more formal developmental assessment is needed. Ideally, refer to a developmental assessment service that is skilled in assessing for early signs of neurodevelopmental problems such as those associated with FASD. However where this service is not available, the WCTO Provider will need to negotiate a referral pathway with appropriate secondary services, such as the child development service, paediatric outpatients or Ministry of Education: Special Education.

For parents/caregivers with AOD problems, you should identify specialist services in your locality so you can offer a referral if necessary.

Information about drug and alcohol treatment services can be provided by the Alcohol Drug Helpline (freephone 0800 787 797).

Families concerned about FASD can be directed to the Fetal Alcohol Network NZ website (www.fan.org.nz) for further information and resources.

Refer to regional community drug and alcohol services.

Resources

Ministry of Health. 2011a. *Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand*. Wellington: Ministry of Health – provides guidance to district health boards, other health planners, funders and health practitioners on ways to address the needs of mothers and infants in relation to mental health and alcohol and other drugs.

Ministry of Health. 2010. *Alcohol and Pregnancy: A practical guide for health professionals*. Wellington: Ministry of Health – covers asking about and advising against alcohol use before and during pregnancy, and assisting women to stop drinking while pregnant. It also deals with referral advice for women who can't stop drinking.

Ministry of Health. 2006b. *Food and Nutrition Guidelines for Healthy Pregnant and Breastfeeding Women: A background paper*. Wellington: Ministry of Health – provides information for health practitioners and includes a section on alcohol.

Other Ministry of Health resources are available from www.healthed.govt.nz, including:

- [Alcohol and pregnancy: when you drink alcohol so does your baby](#) (HE4160) – a health education pamphlet
- [Eating for healthy pregnant women](#) (HE1805) – a health education pamphlet
- [Your pregnancy](#) (HE1420) – an information booklet for women, about pregnancy.

Pregnancy and Alcohol Cessation Toolkit: An online resource for health professionals is an education resource available from www.akoatearora.ac.nz It is designed to assist those working with women of childbearing age to apply the Ministry of Health guidelines and engage with the topic confidently and competently.

The Alcohol Advisory Council of New Zealand (www.alac.org.nz) provides a number of services including research and treatment information.

- Its six-booklet series, Alcohol and Your Health, includes four booklets aimed at people who drink and one for family and friends. The sixth booklet, [Helping with problem drinking](#), is for practitioners working in a brief intervention setting and is recommended for those taking alcohol histories.
- [Drinking and your baby](#) (ALAC) is available in English, Māori and Pacific languages.

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Astley SJ, Bailey D, Talbot C, Clarren SK. 2000. Fetal alcohol syndrome (FAS) primary prevention through FAS diagnosis: a comprehensive profile of 80 birth mothers of children with FAS. *Alcohol and Alcoholism* 35(5): 509–19.

Streissguth A, Barr H, Kogan J, et al. 1996. *Understanding the Occurrence of Secondary Disabilities in Clients with Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE). Final Report to the Centers for Disease Control and Prevention*. Seattle: University of Washington School of Medicine.

Health education

Breastfeeding

Component links

This component links to:

- growth measurement and monitoring
- nutrition
- suffocation prevention through safe sleep practices
- immunisation
- perinatal mental health
- alcohol and other drugs.

Purpose

The purpose of this component is to:

- protect, promote and support exclusive breastfeeding until babies are ready for and need extra food at around six months, and continued breastfeeding once complementary foods have been introduced until at least one year of age and beyond.

Where health practitioners protect, promote and support breastfeeding, they have been shown to improve breastfeeding rates. It is also critical to make timely referrals when there are breastfeeding challenges and to ensure women can access appropriate support when necessary.

Key messages

Breastfeeding is the biological norm and is universally accepted as giving infants the best start in life. Breast milk not only provides optimum nutrition for infants but also includes other functional components that contribute significantly to the prevention of illness and disease in the infant, toddler, child and adult.

The Ministry of Health recommends that babies are exclusively breastfed until they are ready for and need extra food at around six months of age, and that breastfeeding continues once complementary foods have been introduced until at least one year of age and beyond.

The continuity and quality of care received (especially at birth and in the immediate postpartum period) are vital to establishing and maintaining successful breastfeeding. During this crucial period, growth is faster, protection against illness (including malnutrition) and infections is most needed, mother–child bonds are formed and good health practices are established.

Scientific evidence indicates that breastfeeding has a wide range of health, nutritional, developmental, immunologic, psychological, social, economic and environmental benefits for the infant. It is an important protective factor against, for example, respiratory infection, gastroenteritis, glue ear, urinary tract infection, meningitis, SUDI and diabetes, enhances cognitive function in later childhood and can help reduce the risk of metabolic syndrome in adulthood.

Breastfeeding contributes to maternal health as it reduces postpartum bleeding, and reduces the risk of pre- and postmenopausal breast cancer, ovarian cancer and heart disease. In addition, the hormones induced by breastfeeding provide an emotional support for the postpartum mother. Breastfeeding also aids maternal bonding.

Breastfeeding definitions

In 1999 the Ministry of Health adopted the following standard definitions for New Zealand.

Exclusive breastfeeding	The infant has never, to the mother's knowledge, had any water, formula or other liquid or solid food. Only breast milk, from the breast or expressed, and prescribed ⁴⁸ medicines have been given from birth.
Fully breastfeeding	The infant has taken breast milk only, no other liquids or solids except a minimal amount of water or prescribed medicines, in the past 48 hours.
Partial breastfeeding	The infant has taken some breast milk and some infant formula or solid food in the past 48 hours.
Artificial feeding	The infant has had no breast milk but has had alternative liquid such as infant formula with or without solid food in the past 48 hours.

Formula feeding

New Zealand is a signatory to the WHO International Code of Marketing of Breast-milk Substitutes (the WHO Code). The WHO Code aims 'to contribute to the provision of safe and adequate nutrition for infants by protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution'.

In New Zealand, the WHO Code is implemented under the Code of Practice for Health Workers (developed by the Ministry) and the Infant Nutrition Council Code of Practice for the Marketing of Infant Formula in New Zealand (developed by industry), both of which are voluntary and self-regulatory. The Ministry of Health manages a complaints procedure for breaches of both of these codes.

Health practitioners need to be aware of their responsibilities under the Code of Practice for Health Workers. For more information on the Code of Practice for Health Workers and on the complaints procedure, see Ministry of Health (2007a).

Breast-milk substitutes

For babies who are not breastfed or do not receive breast milk, an infant formula is the only appropriate breast-milk substitute in the first year of life (Ministry of Health 2007a).

The composition of infant formula is modelled on breast milk, although it cannot replicate breast milk completely because of the large numbers and complexity of the non-nutritional components in breast milk (see the *Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0–2): A background paper*, Ministry of Health 2008b, for further discussion).

⁴⁸ Prescribed as defined in the Medicines Act 1981.

While stressing the superior benefits of breastfeeding for both infants and mothers, where mothers and families decide to feed infant formula to their infants health practitioners must give objective, consistent and accurate advice on its safe and proper use. Information prepared by health practitioners on formula feeding should explain the costs and risks associated with the unnecessary or improper use of formula. Infant formula powder is not a sterile product and can become a medium for bugs to grow in if appropriate care is not taken when preparing and, if necessary, storing reconstituted formula. Promoting safe formula feeding includes education on sterilising feeding equipment, making up formula to the correct concentration and checking the temperature of the milk. Ideally formula is made up just prior to use but, if storage is required, safe storage methods are essential.

For information on safe formula feeding, see the *Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0–2): A background paper* (Ministry of Health 2008b) and the health education resource 'Feeding your baby infant formula' (see under Resources).

Health practitioners also need to be aware that some baby bottles sold in New Zealand have inaccurate volume markings. These bottles tend to be cheaper bottles sold in discount shops. Inaccurate markings on some of these bottles **over**estimate the volume of water added to make up the formula, which can have both short- and longer-term health consequences for babies.

The Ministry recommends that consumers, where possible, buy baby bottles marked with the EN14350 standard as these are accurate to within 5 mL of 100 mL fluid volume. If parents are not sure whether their baby bottles meet this standard and/or cannot buy new bottles with the EN14350 stamp, they should be advised to take their bottles to the pharmacy where pharmacy staff can check the bottle and mark the correct volume level on them if necessary. There may be a fee for this service. For more information on this issue, see the Ministry of Health website (www.health.govt.nz).

Age of child

Information and anticipatory guidance should be provided at all WCTO core contacts up until the age of one year and beyond where required.

Personnel

All providers delivering WCTO care, including the LMC and WCTO Provider team, can provide this component.

Procedure

Give a mother or family clear and unbiased information to help them with their feeding decision. Once they have made an informed decision, you should support them in that decision, and provide sound advice around how to best meet their infant's needs and protect their infant.

Carefully document breastfeeding status at six weeks, three months and six months according to the breastfeeding definitions.

Where applicable, provide practical breastfeeding management and support (eg, latching, positioning) and resources.

Refer where necessary.

Referral pathways

Where breastfeeding complications fall outside the problems that can be most appropriately dealt with in the community setting by the LMC or WCTO Provider team, you can refer them to:

- La Leche League for support, information and breastfeeding peer counsellors (www.lalecheleague.org.nz)
- other breastfeeding peer counsellors who have graduated from breastfeeding peer counselling programmes and who operate out of any number of groups or organisations – providers of WCTO services should become familiar with the counsellors in their area of practice who are available to take referrals
- International Board Certified lactation consultants (IBCLCs) for clinical assessments. There are free services in some centres now and some fee-for-service IBCLCs.

Referral may be considered for such issues as baby not latching, lactation concerns, poor milk transfer, poor infant weight gain and inadequate output. If a tongue tie, an abnormally short thin membrane under the baby's tongue, is interfering with feeding, referral can be made to a paediatrician or lactation consultant.

It is recommended that providers of WCTO care familiarise themselves with local services. For example, there may also be breastfeeding advocates, support groups and drop-in clinics in some centres within community organisations and maternity facilities in the local area of the LMC or WCTO Provider.

Resources

A host of Ministry of Health resources is available, online or for order, in multiple languages, and for health practitioners or as health education tools. Those available from www.health.govt.nz include:

- [Breastfeeding your baby](#) (HE2098) – a health education resource for mothers
- [Breastfeeding naturally](#) (HE2255) – a DVD developed for pregnant women as a guide to breastfeeding
- [Eating for healthy breastfeeding women](#) (HE1806) – healthy food information
- [Feeding your baby infant formula](#) (HE1306) – for use by health practitioners in advising parents who have decided to partially or completely formula feed
- [Folic acid and spina bifida/iodine and iodine deficiency](#) (HE4147) – a health education resource for pregnant or breastfeeding women or women planning a pregnancy.

The following resources are available from www.health.govt.nz:

- Ministry of Health. 2006b. *Food and Nutrition Guidelines for Healthy Pregnant and Breastfeeding Women: A background paper*. Wellington: Ministry of Health – guidelines for health practitioners, educators and caregivers.
- Ministry of Health. 2007a. *Implementing and Monitoring the International Code of Marketing of Breast-milk Substitutes in New Zealand: The Code in New Zealand*. Wellington: Ministry of Health.
- Ministry of Health. 2008b. *Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0–2): A background paper (4th ed) – Partially revised December 2012*. Wellington: Ministry of Health – for use by health practitioners (includes a comprehensive list of breastfeeding support organisations in Appendix 9 and health education resources in Appendix 10).

- National Breastfeeding Advisory Committee of New Zealand. 2009. *National Strategic Plan of Action for Breastfeeding 2008–2012: National Breastfeeding Advisory Committee of New Zealand's advice to the Director-General of Health*. Wellington. Ministry of Health – a strategic framework to support the establishment of a breastfeeding culture in New Zealand.
- [Breastfeeding in special situations](#) – information for families about breastfeeding in cases of, for example, adoption, when a baby is premature, or multiple births.

World Health Organization and related resources include the following.

- WHO. 1981. *International Code of Marketing of Breast-milk Substitutes*. Geneva: World Health Organization.
- WHO. 2008. *International Code of Marketing of Breast-milk Substitutes: Frequently asked questions*. URL: <http://apps.who.int/iris/handle/10665/43947> (accessed 14 March 2013).
- FTSE. [FTSE4Good Inclusion Criteria for the Marketing of Breast Milk Substitutes, FTSE4Good Index Series](#). URL: www.ftse.com/Indices/FTSE4Good_Index_Series/Downloads/FTSE4Good_Breast_Milk_Substitute_Criteria.pdf (accessed 14 March 2013).
- WHO. 2007. *Evidence on the Long-term Effects of Breastfeeding: Systematic reviews and meta-analysis*. Geneva: World Health Organization.
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- WHO/UNICEF. 1990. *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding. Policymakers meeting on breastfeeding in the 1990s: A global initiative*. Geneva: World Health Organization/UNICEF.
- WHO/UNICEF. 2011. *Baby-Friendly Hospital Initiative Documents for Aotearoa New Zealand*. New Zealand Breastfeeding Authority, Christchurch.
- WHO/UNICEF. 2003. *Global Strategy for Infant and Young Child Feeding*. Geneva: World Health Organization.
- WHO/UNICEF. 2005. *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding*. Geneva: World Health Organization/UNICEF.
- [Ten Steps to Successful Breastfeeding](#) and [Ten Facts on Breastfeeding](#).
- The WHO website also includes a review of the [Evidence for the Ten Steps to Successful Breastfeeding](#) and information about complementary feeding.

The New Zealand Breastfeeding Authority encourages and supports parents and health workers through a number of initiatives including the [Baby Friendly Community Initiative](#) and the associated [Seven Point Plan \(www.babyfriendly.org.nz\)](#). It also provides workshops and online sessions for health workers.

[Breastfeeding Talk Cards](#), for health practitioners to use as a teaching tool, are available from the Mama Aroha website (www.mamaaroha.co.nz).

In addition to providing practical support, La Leche League (www.lalecheleague.org.nz) also provides a number of booklets and brochures. See also the international La Leche League website (www.lalecheleague.org) for further information and resources.

The Raising Children in New Zealand website (www.raisingchildren.org.nz) contains information for parents about breastfeeding. Written material and supporting videos cover:

- [why breastfeed?](#)
- [getting baby on the breast](#)
- [establishing a breastfeeding partnership.](#)

Women's Health Action Group (www.womens-health.org.nz) is a charitable trust that aims to provide women with high-quality information and education services. They offers breastfeeding [resources](#) at a nominal charge.

The following are two reference books.

Riordan J, Wambach K. 2010. *Breastfeeding and Human Lactation* (4th ed). Southbank, MA: Jones & Bartlett.

Lawrence RA, Lawrence RM. 2011. *Breastfeeding: A guide for the medical profession* (7th ed). Maryland Heights, MO: Mosby/Elsevier.

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Ministry of Health. 2007a. *Implementing and Monitoring the International Code of Marketing of Breast-Milk Substitutes in New Zealand: The Code in New Zealand*. Wellington: Ministry of Health.

Ministry of Health. 2008b. *Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0–2): A background paper (4th ed) – Partially revised December 2012*. Wellington: Ministry of Health.

Nutrition

Component links

This component links to:

- breastfeeding
- oral health
- growth
- development
- child safety/injury prevention
- behaviour assessment (section 5)
- parenting skills and support.

Purpose

The purpose of this component is to:

- promote appropriate nutrition for the developmental stage and age of the child, including for premature infants
- reduce the incidence of food-related health disorders.

Key messages

Nutritional needs are high during pregnancy and meeting those needs has positive effects on the development of the foetus as well as on the mother. The influence of the in utero environment on health is discussed in the *Food and Nutrition Guidelines for Pregnant and Breastfeeding Women: A background paper* (Ministry of Health 2006b).

Food and nutrition for infants, toddlers and children

Breastfeeding is recognised as the best food for infants. Its positive effects (in the short and long term) are well documented (eg, refer to [Breastfeeding](#) and [Oral health](#)).

Infants and toddlers rely totally on their parents/caregivers for providing nourishment. In the first two years of life, as infants move from a diet consisting solely of milk (breast and/or infant formula) to a diet of a variety of foods, dietary changes are dramatic. Optimal nutrition, especially in infancy and early childhood, has a powerful effect on brain growth, development of the nervous system, overall growth and development, and future health (Ministry of Health 2008b). Establishing good nutrition (and activity patterns) in childhood sets up a foundation that plays a role in good health in later life.

Childhood is a time of rapid physical development, as well as cognitive and social change. Nutritional needs and dietary requirements for toddlers and children vary from those for adults, and change as the child develops. The Ministry of Health (2008b, 2012b) *Food and Nutrition Guidelines* refer to and describe each of the four major food groups in relation to the requirements of infants, toddlers and children and broadly indicate the main nutrients supplied by each group. Refer to [Appendix 12](#) and [Appendix 13](#) in the Handbook for summaries of this information.

Food-related choking in babies and young children

Parents/caregivers should be advised that under-fives are particularly vulnerable to choking due to their small air and food passages, and when they are still developing their biting, chewing and food-grinding skills.⁴⁹ Choking occurs when the airway becomes blocked and prevents breathing. One of the most important choking prevention measures is for caregivers to supervise young children while they are eating.

Gagging is sometimes confused with choking. The gagging reflex is a safety mechanism that babies use as they regulate the amount of solids or milk they can manage to chew and swallow. Babies may gag often when they are first introduced to solids. Parents can mistake gagging for choking and may unnecessarily restrict the child's progression to more challenging textures. When babies gag, it will be temporary and will resolve naturally and quickly.

Micronutrient deficiency

Micronutrient deficiency may be an issue for some children. Deficiencies in iron and vitamin A have been identified, most commonly among Māori and Pacific children and children from low-income families. Low income or poverty is a key mediator of poor child health outcomes, including nutrition (Ministry of Health 2010b).

⁴⁹ This relates to developmental readiness. For a comprehensive table on the developmental stages and complementary foods for the first and second years of life, see Table 4 in the *Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0–2): A background paper (4th ed) – Partially revised December 2012* (Ministry of Health 2008b).

Vitamin D deficiency in infants and children is also of some concern (see Ministry of Health 2013 for further discussion). The main source of vitamin D in New Zealand is exposure of skin to sunlight, specifically ultraviolet B radiation. However, infant skin is very sensitive so infants should not be left in direct sunlight. Incidental sun exposure is likely to enable sufficient vitamin D to be synthesised in infants with fair skin. Risk factors for vitamin D deficiency are infants who are breastfed and have one or more of the following: they have darker skin, mother is vitamin D deficient, or a sibling has had rickets. Babies who are breastfed over winter months may also be vitamin D deficient by late winter/spring (Ministry of Health 2013).

Procedure

Give clear and unbiased information to the mother or family to help them with their feeding decision. Once they have made an informed decision, support them in that decision and provide sound advice around how to best meet their infant's needs and protect their infant.

Use the Ministry of Health food and nutrition guidelines for healthy infants, toddlers, children and young people (see Resources below). These resources cover food and nutrition guideline statements, information about breastfeeding, complementary feeding, formula feeding, fluids, choking, considerations for Māori, Pacific, Asian and other population groups, growth, energy and nutrients, and physical activity.

Parents can assess their baby's eating readiness cues with the [Starting solids](#) resource (see Resources below). For premature babies (<37/40 weeks), the earliest time is the mid-point between four months from birth and four months from the expected due date, and the latest is seven months after birth. Also see Table 4: Developmental stages and complementary foods for the first and second years of life, in the *Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0–2): A background paper (4th ed) – Partially revised December 2012* (Ministry of Health 2008b).

Referral pathways

For children with feeding difficulties, initially direct families to behavioural strategies such as those outlined on the Raising Children in New Zealand website (www.raisingchildren.org.nz) (see also Resources below). If these approaches do not work and if the child has faltering growth, referral to a paediatrician or community dietician (where available) is appropriate.

Also see [Growth measurement and monitoring](#) and [Breastfeeding](#).

Resources

Refer to the list of related resources under [Breastfeeding](#) and [Oral health](#).

Ministry of Health resources for parents/caregivers available from www.healthed.govt.nz include:

- [Eating for healthy pregnant women](#) (HE1805)
- [Eating for healthy children aged 2 to 12](#) (HE1302)
- [Eating for healthy babies and toddlers](#) (HE1521)
- [Folic acid and spina bifida/iodine and iodine deficiency](#) (HE4147)
- [Starting solids](#) (HE6014)
- [Vitamin D and your pregnancy/your baby](#) (HP5639).

The following resources are available on www.health.govt.nz:

- Ministry of Health. 2008b. *Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0–2): A background paper (4th ed)* – Partially revised December 2012. Wellington: Ministry of Health – comprehensive guidelines for use by health practitioners.
- Ministry of Health. 2006b. *Food and Nutrition Guidelines for Healthy Pregnant and Breastfeeding Women: A background paper*. Wellington: Ministry of Health – guidelines for health practitioners, educators and caregivers.
- The **Your health** section contains nutrition-related topics such as:
 - [Baby-led weaning](#)
 - [Food and physical activity](#)
 - [Food-related choking in young children](#)
 - [Nutrition](#).

Refer to the TAHA: Well Pacific Mother and Infant Service website (www.taha.org.nz) for their [talk cards](#) about teen pregnancy. Messages include healthy eating, being smokefree, pregnancy checks, exercising and family support.

The Raising Children in New Zealand website (www.raisingchildren.org.nz) has a section on [eating](#) that covers developing baby’s taste buds. It also deals with how to set up a good relationship with food, which includes useful information for families coping with picky eaters.

Plunket (www.plunket.org.nz) presents information on food and nutrition by child’s age in the [You & your child](#) section.

Dietitians New Zealand (www.dietitians.org.nz) also provides information on food and nutrition. (See [Nutrition Resources/Children](#).)

References

Ministry of Health. 2006b. *Food and Nutrition Guidelines for Healthy Pregnant and Breastfeeding Women: A background paper*. Wellington: Ministry of Health.

Ministry of Health. 2008b. *Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0–2): A background paper (4th ed)* – Partially revised December 2012. Wellington: Ministry of Health.

Ministry of Health. 2012b. *Food and Nutrition Guidelines for Healthy Children and Young People (Aged 2–18 Years): A background paper*. Wellington: Ministry of Health.

Ministry of Health. 2010b. *Living Standards and Health: New Zealand 2006/07*. Wellington: Ministry of Health.

Ministry of Health. 2013. *Companion Statement on Vitamin D and Sun Exposure in Pregnancy and Infancy in New Zealand*. Wellington: Ministry of Health.

Suffocation prevention through safe sleep practices (an aspect of SUDI prevention)

This subsection includes information about sudden unexpected death in infancy (SUDI). While acknowledging other key modifiable risk factors for SUDI, it focuses on the prevention of unintentional suffocation that occurs through unsafe sleep practices.

The Child and Youth Mortality Review Committee (CYMRC) and the Ministry of Health have identified promoting safe sleep practices as a key approach to reducing SUDI that results from unintentional suffocation.

Component links

This component links to:

- smokefree environment
- breastfeeding
- alcohol and other drugs
- child safety/injury protection.

Purpose

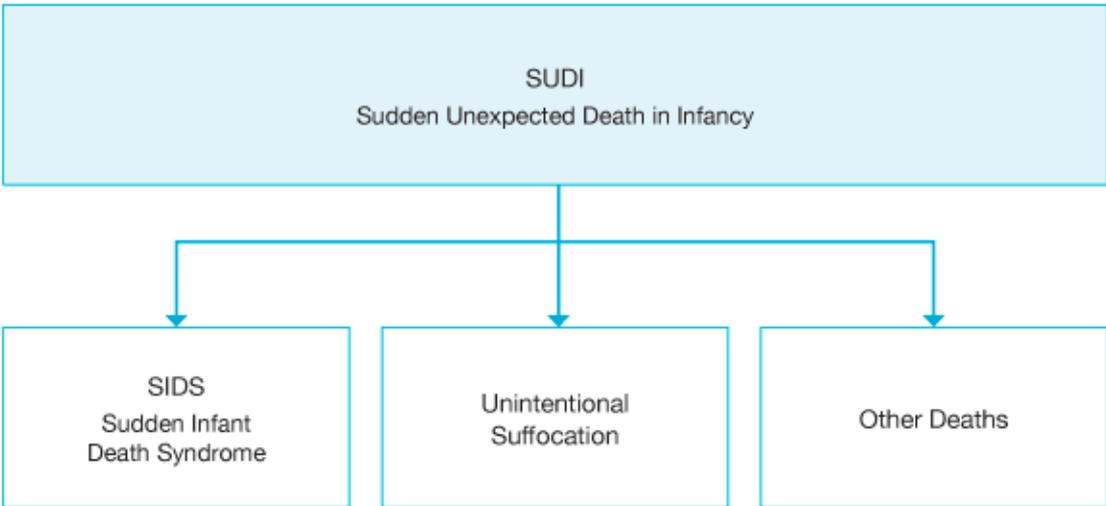
The purpose of this component is to:

- provide information and support to families about safe sleep practices for babies
- prevent the unintentional suffocation of babies.

Key messages

In New Zealand, SUDI rates for European babies have declined markedly over the last two decades. Declines for Māori babies have been much less marked. From 2003 to 2007, 328 infants (aged 4 weeks to 52 weeks) died as a result of SUDI. Of these, 61.6 percent were Māori infants, 24.4 percent were Other (including European) infants, 12.8 percent were Pacific and 1.2 percent were Asian.

Deaths attributed to SUDI can be broadly categorised into the following three groups.



Unintentional suffocation includes suffocation in the place of sleep, which is increasingly recognised as a significant contributing factor to SUDI in those aged less than one year. Suffocation in the place of sleep occurs when infants become wedged between bedding and a firm surface (eg, mattress and cot/bed) or is overlain by a co-sleeping partner (eg, sibling or parent) (CYMRC 2013).

Following a review of SUDI deaths, a key recommendation to further reduce the occurrence of SUDI was for communities, families and practitioners to place a greater importance on the safe sleeping of infants.

LMCs and WCTO Provider teams were identified as being critically placed to disseminate safe sleeping messages, and information about other SUDI factors to families and whānau who receive WCTO care (CYMRC 2009).

With the same aim, to reduce SUDI resulting from unintentional suffocation in the place of sleep, the Ministry of Health has developed the following safe sleep messages.

Safe sleeping for babies

Safe sleeping for babies entails:

- sleeping on their backs – to keep their airways clear
- sleeping in their own bassinet, cot or other baby bed – that is, free from other people who might overlay them
- having a parent who is alert to their baby's needs and free from alcohol and drugs
- having baby's bed in the parents' room at night for the first six months of life
- having a firm and flat mattress with no gaps between the frame and mattress, to keep baby's airways clear and avoid trapping or wedging baby
- having nothing in the bed that might cover baby's face, lift their head or put pressure on the chin – for example, no pillows, toys, loose bedding or bumper pads
- having a comfortable temperature at night – that is, not too hot.

A safe sleep space should be smokefree to allow baby to breathe air free of smoke.

Procedure

At the first home visit from the midwife and the first home visit from the WCTO nurse or nurse practitioner, a safe sleep needs assessment should be undertaken. The assessment should be based on the 'sleep position and environment' items in [Appendix 14](#) and the 'safe sleeping' messages above, as part of the care for the family or whānau and the support component of the Schedule. Wherever possible, look at the sleep space with the family or whānau and use this as a focus for checking through the practical items in [Appendix 12](#), identifying and modifying risks.

Provide information to the family or whānau as required on all key modifiable risk factors for SUDI.

Age of child

For parents/caregivers of children from birth to one year. Information and support should be provided in accordance with the Schedule and at other times in response to identified needs.

Personnel

All providers delivering WCTO care are responsible for delivering this component. This includes the LMCs, general practice team and WCTO Provider team.

Resources

Fully funded SUDI prevention workshops are available for health practitioners in locations nationally or as an online programme. For further information, links to research and resources, refer to the Whakawhetu National SUDI Prevention for Māori website (www.whakawhetu.co.nz).

TAHA: Well Pacific Mother and Infant Service (www.taha.org.nz) provides information for parents and health practitioners. TAHA's services include workshops to help health practitioners better understand the issue of SUDI and stillbirth within Pacific families. It also provides parent/caregiver [SUDI prevention information resources](#).

Similarly, Change for our Children (www.changeforourchildren.co.nz) offers information for parents and health practitioners. Change for our Children produces the [Baby Essentials Online](#) education tool, and downloadable summary versions in 20 languages.

Parents/caregivers can be directed to the [SUDI](#) pages of the Ministry of Health website (www.health.govt.nz).

Also see [Child safety/injury prevention](#) in the Handbook for information about accidental strangulation (eg, from blind and curtain cords).

References

CYMRC, Te Rōpū Arotake Auau Mate o te Hunga Tamariki, Taiohi. 2009. *Fifth Report to the Minister of Health: Reporting mortality 2002–2008*. Wellington: Child and Youth Mortality Review Committee.

CYMRC, Te Rōpū Arotake Auau Mate o te Hunga Tamariki, Taiohi. 2013. *Special Report: Unintentional suffocation, foreign body inhalation and strangulation*. Wellington: Child and Youth Mortality Review Committee.

Shaken baby syndrome prevention

Component links

This component links to:

- family violence assessment
- development
- parenting skills and support.

Purpose

The purpose of this component is to:

- provide information and support to families in order to prevent shaken baby syndrome.

Key messages

Shaken baby syndrome (SBS) is a term for babies with serious inflicted head injuries, usually caused by violent shaking or shaking combined with impact.

SBS is the single most common cause of serious head injury in babies under 1 year of age, but there is evidence that prevention is possible. All caregivers should be taught about infant crying, how to cope with a crying infant and the dangers of shaking a baby.

Many babies are admitted to hospital each year with such injuries; their median age is five months, and some are as young as four weeks. Many have been injured more than once by the time of diagnosis. International evidence suggests that many more babies are injured but never diagnosed.

It is important to note that most shaken babies have no external signs of injury such as bruising. The presenting symptoms are often non-specific (eg, vomiting, lethargy or irritability). A diagnosis of inflicted head injury is easily missed.

The trigger for shaking a baby is universal – the stress of caring for a newborn baby. Anyone, no matter how ‘normal’ they may seem, is potentially capable of losing their temper with a crying baby. All babies cry, and crying typically increases dramatically in the first few weeks of life, before decreasing. Caregivers who admit to shaking their baby almost always say that it was a response to their baby crying.

Six key messages

There are therefore six key messages to convey to parents/caregivers.

- **Crying is how babies communicate** and it is normal for caregivers to get frustrated when the crying doesn’t stop.
- **It’s okay to walk away.** First you should check if your baby is sick or needs feeding, changing and so forth, but if you can’t find a reason for the crying and you’re getting upset, it’s okay to walk away. Put baby in a safe place, close the door and take a break. Do not pick up the baby until you have calmed down.
- **Never, ever shake a baby.** A single moment when you lose control may damage your baby forever.
- **Never leave your baby** alone with anyone you think may lose control.
- **Share this information** with anyone who is looking after your baby.
- **If you ever think your baby has been hurt, call 111.** Don’t let fear or pride stand in your way. It could save your baby’s life.

Age of child

For parents/caregivers, families and whānau of all children from birth to six months. Information and anticipatory guidance should be provided in accordance with the Schedule and at other times in response to identified needs.

Personnel

All providers delivering WCTO care are responsible for delivering this component. This includes the LMC, general practice team and the WCTO Provider team.

Procedure

1. Some time in the first six weeks of the baby's life, make time to have at least one conversation with the parents or caregivers about infant crying and the dangers of shaking. Ideally the father or stepfather should be part of this conversation.

This conversation can be short and simple, taking no more than 10 minutes of your time, or up to 20 minutes of the caregivers' time if they choose to watch the DVD as well (which they can do in their own time).

Introduce the conversation with a framing statement. For example:

I would like to give you some information that will help you to keep your baby safe and healthy. This information is about coping with a crying baby and the dangers of shaking a baby, and I try to have this conversation with all parents. Is this a good time to talk?

Invite the caregiver(s) to read the 'Power to protect – Coping with a crying baby' pamphlet (see Resources below).

'Here is a pamphlet for you to read. Would you like me to go through it with you? I'll add some comments after we have had a look at the pamphlet.'

Be sensitive to caregiver(s) who may be unable to read.

2. Encourage the caregiver(s) to view the DVD *Power to Protect* (see Resources below). If you don't have time to watch it with them, offer to leave it with them.
'I'd also like to show you a short documentary on the topic. It is 10 minutes long.'
3. Reinforce the key messages and answer any questions. Ideally this part of the conversation would take place after they have watched the DVD.
4. Encourage caregivers to have a plan for what to do when feeling frustrated. The plan might include putting the baby in a safe place (such as a cot) and taking a break. A quick shower, a walk to the letterbox or listening to music might help the adult to calm down. They should check on the baby every 5–10 minutes, but should not pick the baby up until they are sure they have calmed down.
5. Ensure caregivers have someone they can call when they need to talk – a friend or relative, health practitioner or helpline. Everyone needs help at some stage.
6. Complete any documentation your organisation requires to track delivery of the programme.

Resources

An education programme for parents/caregivers was developed collaboratively in a two-year district health board pilot. For information about this programme along with associated materials (including the 'Power to protect' pamphlet in multiple languages and the DVD) about how to cope with a crying baby, visit www.powertoprotect.net.nz or email the national training coordinator at powertoprotect@adhb.govt.nz

Power to Protect is a 10-minute DVD funded by the Starship Foundation and produced by Eyeworks Touchdown. It shows true stories of New Zealand families whose lives have been affected by the shaken baby syndrome. It also contains an interview with a paediatrician and tips on how to cope with a crying baby. It can be ordered free from www.powertoprotect.net.nz/form/powertoprotect/net/nz/form.req?requestType=powertoprotect-net-nz-order-resources

Information for parents/caregivers about shaken baby syndrome is available on the Kidshealth website (www.kidshealth.org.nz).

The following are other resources for parents/caregivers.

- Power to Protect helpline: Freephone 0800 300 026 (24/7) to talk to a trained support person who can offer support and advice, or put you in touch with services.
- Plunket: Freephone 0800 933 922 or visit www.plunket.org.nz for parenting advice and support. Plunket knows about the challenges of raising a new baby and has lots of tips to help with sleeping, breastfeeding and child behaviour.
- Barnardos: Freephone 0800 472 7368 or visit www.barnardos.org.nz for family support and counselling.
- Healthline: Freephone 0800 611 116 or visit www.health.govt.nz for health advice for the whole family. The freephone service is staffed by registered nurses who can give information and advice to help decide on the best level of care.
- Youthline: Freephone 0800 376 633 – for young parents.
- Your midwife or doctor: They know you and are there to help.
- In an emergency, call 111 for immediate medical help for your baby.
- If you've got family problems and are worried, freephone a CYF social worker on 0508 FAMILY or 0508 326 459.
- The American-based National Center on Shaken Baby Syndrome (www.dontshake.org) has developed the Period of PURPLE Crying programme, an evidence-based prevention programme focusing on the normality of infant crying and the dangers of shaking a baby.

Child safety/injury prevention

Component links

This component links to:

- family violence assessment
- development
- parenting skills and support
- strengthening family relationships
- suffocation prevention through safe sleep practices
- perinatal mental health
- alcohol and other drugs.

Purpose

The purpose of this component is to:

- promote a safe environment and reduce the chance of injury at each of the stages of the growth and development.

Key messages

Injury is the main cause of mortality and hospitalisation of children aged 1 to 14 years. Injuries are preventable. By informing parents and caregivers on how to prevent key child injuries, WCTO practitioners can support a reduction in morbidity and mortality related to child injury. (See Kendrick et al 2013 for good evidence that injury prevention activity reduces unintentional injury in children and can improve home safety.)

Most injuries can be prevented by using appropriate equipment or modifying the environment. Families need to be made aware of these prevention activities, and be assisted in implementing these, well before the activities are actually required. Some injuries could be prevented by enhancing parental understanding or child supervision (see [Perinatal mental health](#) and [Alcohol and other drugs](#) as areas requiring particular support). While it is recognised that it is necessary to provide individual parents and children with educational safety resources, this action is not enough on its own to significantly lower the high rates of unintentional injury experienced by New Zealand children. Effective prevention requires a multifaceted approach such as that of Safekids New Zealand. The Safekids New Zealand approach involves a continuum of linked strategies that support communities to deliver safety messages, advocate for legislation and policies that are child-safety conscious, orient organisations towards safer practices and strengthen the awareness and skills of those who could be involved in prevention work.

The injury prevention component of the Schedule arises out of (and is firmly embedded within) such a preventative approach. This component ensures that parents and caregivers receive timely advice on child injury prevention.

Age of child

For parents/caregivers, families and whānau of children aged birth to five years. Information and anticipatory guidance should be provided in accordance with the Schedule and at other times in response to identified needs.

Personnel

All providers delivering WCTO care according to the Schedule can provide this education component. This includes the LMC, paediatrician, general practice and WCTO Provider teams.

Procedure

Scan the household environment and sleeping and play areas for safety hazards and opportunities for intervention to prevent injuries. Sitting on the floor at a small child's eye level is a good way to see the dangers that they may face.

Discuss preventing injuries. Provide information on the common causes of unintentional injury, and on how to prevent unintentional injury in the home, on the road and in community settings.

Practitioners should have a good knowledge of key injury issues and key injury prevention messages and resources (Tables 1 and 2).

Table 1: Key injury issues to discuss

Age	Injury issues	General/all ages
First 6 weeks	Appropriate car restraints, falls safety (changing nappies on floor), hot drinks and burns, suffocation prevention through safe sleep practices	<ul style="list-style-type: none"> • Suffocation, strangulation and choking prevention
3 months	Appropriate car restraints, falls safety (changing nappies on floor), hot drinks and burns, hazards of baby walkers and baby bath seats, suffocation prevention through safe sleep practices	<ul style="list-style-type: none"> • Burns prevention
5 months	Appropriate car restraints, choking (product and toy safety), hazards of baby walkers and baby bath seats, falls safety (changing nappies on floor), household safety, suffocation prevention through safe sleep practices, safety around dogs, driveway safety, pool fencing	<ul style="list-style-type: none"> • Cutting and piercing prevention • Cyclist, skateboard and scooter safety
8–10 months	Appropriate car restraint, falls safety (stair and door guards/gates, window latches, bunk beds, changing nappies on floor), household safety (eg, secure furniture to walls – TVs, bookcases, chest of drawers, shelving), suffocation prevention through safe sleep practices, safety around dogs, driveway safety, pool fencing	<ul style="list-style-type: none"> • Dog safety • Falls prevention
15 months	Appropriate car restraint, water safety (supervision, water confidence classes, life jackets, pool fencing), driveway safety, safe play area away from road (includes pedestrian safety), falls safety, household safety (eg, secure furniture to walls), safety around dogs	<ul style="list-style-type: none"> • Household safety (including securing furniture) • Passenger safety
21–24 months	Appropriate car restraint, water safety, driveway safety, safe play area away from road, falls safety, household safety (eg, secure furniture to walls), safety around dogs	<ul style="list-style-type: none"> • Pedestrian and driveway safety
3 years	Appropriate car restraint/booster seat, cycling, scooter and skateboard safety (helmets, protective gear, visibility, supervision), safe play area away from road (includes pedestrian safety), water safety, driveway safety, falls safety, household safety (eg, secure furniture to walls), safety around dogs	<ul style="list-style-type: none"> • Poisoning prevention • Product safety
5 years	Appropriate car restraint/booster seat, cycling, scooter and skateboard safety, pedestrian safety, water safety, driveway safety, falls safety, household safety (eg, secure furniture to walls), safety around dogs	<ul style="list-style-type: none"> • Water safety

Table 2: Key injury prevention messages and related resources

Injury issue	Prevention	Resources
Accidental threat to breathing (suffocation, strangulation, choking)	<p>Use cleats instead of curtain blinds with cords.</p> <p>Cut curtain blind cords, or fix to bottom of wall or floor (no slack), or tie high up (no loops).</p> <p>Position cot away from windows.</p> <p>Use a cot that meets the safety standard.</p> <p>Leave no gaps between cot and mattress; sleep baby on back, in their own bed/cot/bassinet/pēpi pod, without loose bedding or bumper pads that could cover their face or lift their head.</p> <p>Never put baby to bed in clothing with neck ties; remove bibs before putting to bed; keep plastic bags, including bags for nappy disposal, out of reach.</p> <p>Never have toys or toy parts smaller than the diameter of toilet roll.</p> <p>Secure furniture that can tip over (eg, chests of drawers, TV sets, stoves).</p>	<p>Safekids New Zealand</p> <p>Ministry of Business, Innovation and Employment (MBIE)</p> <p>Plunket</p> <p>See Suffocation prevention through safe sleep practices</p>
Burns	<p>Never drink hot liquids when holding a child.</p> <p>Set hot water temperature to 45°C at tap; cold water into bath first, then add hot.</p> <p>Avoid clothing burns – make sure children are always a metre from the heater; use close-fitting, low-flammability nightwear.</p> <p>Put guards around fires and heaters.</p> <p>Keep matches and lighters out of reach and sight.</p> <p>Working smoke alarms save lives.</p> <p>Don't use baby walkers.</p> <p>Know burn first aid – cool burn under cold running water for at least 20 minutes as soon as possible.</p>	<p>New Zealand Fire Service</p> <p>Burn Support Charitable Trust</p> <p>Safekids New Zealand</p> <p>Plunket</p>
Cutting and piercing injury	<p>Use safety glass in windows and doors.</p> <p>Remove sharp and pointed objects at home and in play areas.</p> <p>Ride-on mowers are dangerous and are not ride-on toys.</p> <p>Keep children out of kitchen – away from dishwashers.</p>	<p>Safekids New Zealand</p> <p>Plunket</p>
Cyclist, skateboard and scooter injuries	<p>Be smart – plan safe routes with an adult.</p> <p>Be safe – no helmet, no bike/skateboard/scooter.</p> <p>Be seen – wear bright colours and use reflective gear.</p> <p>Actively supervise children.</p>	<p>New Zealand Transport Agency</p> <p>Safekids New Zealand</p> <p>Plunket</p>
Dog safety	<p>Always ask the dog owner's permission before approaching or petting a dog.</p> <p>Supervise children at all times when a dog is nearby.</p>	<p>New Zealand Dog Safety</p> <p>Regional councils</p>
Drowning	<p>Ages 0–3 years: Always maintain hand contact with babies and stay within sight and reach (ie, continual supervision) of your child in the bath.</p> <p>Ages 1–5 years: Stay within sight and reach of your child when in, on and around water.</p> <p>Actively supervise children when they are in, on or around water.</p> <p>Use four-sided pool fencing with a self-closing, self-latching gate.</p> <p>Use a non-slip bath mat.</p> <p>Babies don't need baby bath seats.</p>	<p>Water Safety New Zealand</p> <p>WaterSafe Auckland</p> <p>Safekids New Zealand</p> <p>Plunket</p> <p>MBIE</p>
Falls	<p>Change nappies on the floor.</p> <p>Don't leave babies unsupervised on any high surface such as a change table, bed or couch.</p> <p>Supervise children at playgrounds.</p> <p>Use stair and door gates/guards.</p> <p>Use safety latches on windows children can reach, especially upper storey windows.</p> <p>Use helmets and other safety gear with wheeled toys like skateboards, skates and scooters.</p> <p>Don't use baby walkers.</p> <p>Bunk beds are for older children.</p>	<p>Accident Compensation Corporation</p> <p>Safekids New Zealand</p> <p>Plunket</p>

Injury issue	Prevention	Resources
Motor vehicle occupant injury	<p>Always use correct child restraint or booster seat for child's height and age.</p> <p>Follow manufacturer's instructions for your child restraint.</p> <p>All child car restraints used in New Zealand must meet the accepted safety standards.</p> <p>Make sure restraint or booster seat correctly fits your vehicle.</p> <p>Child restraint technicians can provide help with choosing and installing the right restraint for the child and vehicle.</p> <p>The back seat is safest for children.</p> <p>Adults lead by example and always wear a seat belt.</p>	<p>New Zealand Transport Agency</p> <p>Safekids New Zealand</p> <p>Plunket</p>
Pedestrian injury, driveway runover	<p>Know where the children are before getting in the car.</p> <p>Check for children before driving off.</p> <p>Supervise children around vehicles – always.</p> <p>Separate play areas from driveways and roads.</p> <p>Talk with children about how to use pedestrian crossings and controlled intersections safely.</p>	<p>Safekids New Zealand</p> <p>Plunket</p>
Poisoning	<p>Follow the SAFE procedure.</p> <p>Store all medicines, chemicals and cleaners in original packaging and out of children's reach and sight.</p> <p>Ask your pharmacist for safety caps on medicines.</p> <p>Follow the dose instructions from your doctor or pharmacist.</p> <p>Ensure you read and follow safety instructions on medicines, chemicals and cleaners.</p> <p>Use safety latches on cupboards.</p> <p>Keep the Poison Centre phone number beside your phone.</p> <p>Lock outdoor sheds containing poisons to prevent children gaining access.</p>	<p>Safekids New Zealand</p> <p>Plunket</p> <p>National Poisons Centre</p>

Resources

Resources available from the Ministry of Health include:

- [Poisons around the home](#) (HE1121) and [Child-resistant packaging](#) (HE1322) from www.health.govt.nz
- [Food-related choking in young children for parents/caregivers and for health practitioners](#), from www.health.govt.nz
- Ministry of Health. 2012b. *Food and Nutrition Guidelines for Healthy Children and Young People (Aged 2–18 Years): A background paper*. Wellington: Ministry of Health, from www.health.govt.nz; see the sections about choking
- the parent-held *Health Book* (pages 47–68), which contains information on CPR for babies and injury-related information.

Other resources are:

- Plunket (www.plunket.org.nz) fact sheets and checklists (age-specific), and its *Thriving Under Five* parenting book which is provided to all parents accessing the Plunket service (and on the website)
- Safekids New Zealand (www.safekids.org.nz, www.mysafekids.org.nz) for fact sheets, position papers, information and resource centre services
- Raising Children in New Zealand (www.raisingchildren.org.nz) – see the [Health and Wellbeing](#) section for 'Making your home safe', Parts 1 and 2
- [The Safety for your Child checklists](http://www.healthychildren.org/tips-tools/pages/safety-checklists) (<http://www.healthychildren.org/tips-tools/pages/safety-checklists>) created by the American Academy of Pediatrics, for age-related safety sheets and information.

Other key agencies dealing with specific issues related to safety and injury prevention include:

- Accident Compensation Corporation, www.acc.co.nz
- Department of Internal Affairs on dog safety, www.dogsafety.govt.nz
- Ministry of Business, Innovation and Employment www.mbie.govt.nz or www.consumeraffairs.govt.nz
- National Poisons Centre, freephone 0800 POISON, www.poisons.co.nz
- New Zealand Fire Service, www.fire.org.nz
- New Zealand Transport Agency, www.nzta.govt.nz
- Water Safety New Zealand (www.watersafety.org.nz) and WaterSafe Auckland (www.watersafe.org.nz) for fact sheets and information
- local community safety resources.

See CYMRC, Te Rōpū Arotake Auau Mate o te Hunga Tamariki, Taiohi. 2011. *Low Speed Run Over Mortality*. Wellington: Child and Youth Mortality Review Committee, for background reading on infant and child mortality caused by low-speed vehicles (available on the Committee's website, www.cymrc.health.govt.nz and on the Health Quality & Safety Commission website, www.hqsc.govt.nz).

Refer to [Resources](#) under 'Suffocation prevention through safe sleep practices' in the Handbook.

Reference

Kendrick, D, Mulvaney CA, Ye L, et al. 2013. Parenting interventions for the prevention of unintentional injuries in childhood (Review). *Cochrane Databases of Systematic Reviews* 3: Art No: CD006020. DOI: 10.1002/14651858.CD006020.pub3 (accessed 24 April 2013).

Recognition of childhood illnesses

Component links

This component links to:

- smokefree environment
- parenting skills and support
- behaviour assessment (section 5)
- immunisation.

Purpose

The purpose of this component is to:

- help families recognise childhood illness, treat symptoms (eg, fever) and access appropriate care in a timely way.

Key messages

Infants and young children can quickly become unwell. When families can recognise symptoms early, the prognosis may improve. If parents/caregivers are unsure about whether their child is sick, or how sick the child is, encourage them to take their child to the doctor or hospital.

When children are sick, they can rapidly worsen and they should, therefore, be checked often.

It's important to keep up fluid intake when children are unwell, even if they lose interest in eating.

Procedure

Provide resources and information about childhood diseases and illness. Refer parents/caregivers to the parent-held *Health Book*, pages 69–72.

Carry copies of the A4 card 'Infectious diseases' (see Resources below) to give to families.

Provide information on the appropriate use and safe storage of medications, side effects, dosages and length of treatment.

Resources

The following resources are available for parents/caregivers.

- The Ministry of Health's A4 card, [Infectious diseases](#) (HE1215) available from www.health.govt.nz, lists at-a-glance information about 21 childhood diseases, covering how each is spread, time between exposure and sickness, early signs, how long the child is infectious for, and how long the child should remain away from kindergarten or another early childhood education setting. The leaflet [Child sickness](#) (HE4240) focuses on a child's temperature, breathing, vomiting and diarrhoea.
- The [Your health](#) section on the Ministry of Health website (www.health.govt.nz) is an A–Z guide to information about health topics, services and where to go for help. Topics include a number of childhood illnesses.
- The Kidshealth website (www.kidshealth.org.nz) provides [brief answers to your questions about infectious diseases](#).
- The Plunket website (www.plunket.org.nz) describes a comprehensive number of child health conditions and diseases and, in the [You & your child](#) section, how to care for a sick child.
- The Raising Children in New Zealand website (www.raisingchildren.org.nz) includes a section on health and wellbeing. It also lists [danger signs for babies and young children](#).
- Information on the meningococcal B epidemic and the immunisation programme is available at www.health.govt.nz or freephone 0800 IMMUNE or 0800 466 863.
- PlunketLine: Freephone 0800 933 922 (24/7).
- Healthline: Freephone 0800 611 116 (24/7).
- In an emergency, guide families and whānau to phone 111.

Immunisation

This component is divided into two parts. Part 1 covers the role of the immunisation providers. Part 2 discusses the role of child health providers, for example, LMCs and WCTO Provider teams, who support and encourage parents/caregivers to get their children immunised in a timely manner.

Part 1: Immunisation providers

Purpose

The purpose of this part of the immunisation component is to:

- inform parents/caregivers about vaccine preventable diseases and the benefits and possible risks of immunisation
- protect children from illness and disability caused by vaccine preventable diseases
- improve community immunity against vaccine preventable diseases so that those who cannot be immunised are protected.

Key messages

Immunisation is the most effective way to actively protect infants and children from preventable diseases.

The National Immunisation Schedule is designed to provide safe and effective combination vaccines to provide protection as early as possible and encourage uptake.

Immunisation for infants and children in New Zealand is delivered through linked primary health care providers.

On-time immunisation is important. Delaying immunisations has implications for a baby's risk of disease during a key period of vulnerability (Litmus 2013).

The national immunisation target is that by July 2013, 85 percent of eight-month-olds will have had their primary course of immunisation at six weeks, three months and five months on time, and that the proportion will increase to 90 percent by July 2013 and 95 percent by December 2014 (see *Health Targets 2012/13: Increased immunisation*, Ministry of Health website, www.health.govt.nz).

When being immunised, infants may be breastfed to alleviate their discomfort, if the mother chooses to do this. This practice can be supported by the personnel undertaking the procedure.

Age of child

Immunisation should be provided in accordance with the National Immunisation Schedule (Table 3, adapted from the current Immunisation Handbook).

Table 3: National Immunisation Schedule

Child's age	DTaP-IPV- HepB/Hib	PCV	Hib	MMR	DTaP-IPV	Tdap	HPV
	Infanrix®-hexa	Synflorix®	Act-HIB™	M-M-R® II	Infanrix®-IPV	Boostrix®	Gardasil®
Birth*							
6 weeks	✓	✓					
3 months	✓	✓					
5 months	✓	✓					
15 months		✓	✓	✓			
4 years				✓	✓		
11 years (Year 7)						✓	
12 years (Year 8) (girls only)							✓

Additional immunisation programmes

Pertussis booster (Tdap) immunisation – for pregnant women from 28–38 weeks' gestation during a pertussis epidemic.

- * Infants born to hepatitis B surface antigen (HBsAg) positive mothers – need hepatitis B immunoglobulin (HBIG) and hepatitis B vaccine at birth. They then receive immunisations as per the Schedule at six weeks, and three and five months of age. These infants need a blood test to check for hepatitis B infection and vaccine-induced immunity at five months of age.
- * BCG immunisation – should be offered to infants at increased risk of tuberculosis (TB). The neonatal BCG eligibility criteria are available in the *Immunisation Handbook 2011* (Ministry of Health 2011b).

High-risk pneumococcal programme – for children at increased risk of pneumococcal disease. Eligibility criteria are available in the *Immunisation Handbook 2011* (Ministry of Health 2011b).

Pre- and post-splenectomy immunisation programme – for children at increased risk of Hib, pneumococcal and meningococcal disease. Eligibility criteria are available in the *Immunisation Handbook 2011* (Ministry of Health 2011b).

Key: DTaP = diphtheria, tetanus, acellular pertussis (child); HepB = hepatitis B; Hib = *Haemophilus influenzae* type b; HPV = human papillomavirus; IPV = inactivated polio vaccine; MMR = measles, mumps and rubella; PCV = pneumococcal; Tdap = diphtheria, tetanus, acellular pertussis (adolescent/adult).

Source: Ministry of Health 2011b.

Personnel

Personal with responsibility for this component are:

- midwives working independently or for a district health board
- the general practice team and authorised vaccinators providing immunisation services through general practice/medical centres
- authorised vaccinators providing outreach immunisation services in the wider community
- hospital-based doctors and registered nurses who opportunistically provide catch-up immunisations.

Procedure

Refer to 'Immunisation Standards for vaccinators' in the current *Immunisation Handbook* and the Guidelines for organisations offering immunisation.

It is important that vaccinators complete a Status Query at each immunisation visit to obtain the most up-to-date documented immunisation history. Do not rely on a parental immunisation history alone.

Update the National Immunisation Register (NIR) after immunisations are given. The vaccinator should also update the immunisation section of the parent-held *Health Book* (page 156).

Advise the NIR team if your service has immunisations recorded for a child that are not included in the earlier Status Query results.

National Immunisation Register

All providers and vaccinators are required to complete an Authorised User Agreement form and send this to the NIR before they access and message information to and from the NIR.

Authorisation of vaccinators

Non-authorised vaccinators require a doctor's order before administering the immunisations.

The *Immunisation Handbook* outlines the process for the authorisation of vaccinators in New Zealand.

Authorised vaccinators must participate in a vaccinator update and apply for re-authorisation every two years.

Part 2: Immunisation information providers

Purpose

The purpose of this part of the immunisation component is to:

- provide current information about vaccine preventable diseases and the benefits and possible risks of immunisation to parents/caregivers to enable them to make an informed choice about immunisation
- reduce the incidence of vaccine preventable diseases and residual disability.

Key messages

- Almost 90 percent of women make the decision of whether to immunise during the antenatal period (Wroe et al 2004).
- On-time immunisation is the most effective way to actively protect infants and children from preventable diseases.
- The National Immunisation Schedule is designed to deliver safe and effective combination vaccines that provide protection as early as possible and encourage uptake.

Personnel

All providers delivering WCTO care – including LMCs, paediatricians, general practice teams, outreach immunisation teams, WCTO Provider teams and hospital-based doctors and registered nurses – deliver this component.

Procedure

Provide current information about the benefits and potential risks, including possible side effects, of immunisation.

Referral pathways

Where necessary, refer to the child's general practice team or contact your local National Immunisation Register office.

Resources

The *Immunisation Handbook* is updated at regular intervals and provides information on vaccine preventable diseases, including New Zealand epidemiology, the immunisation schedule and current vaccines. The *Immunisation Handbook* can be ordered or downloaded from the Ministry of Health website (www.health.govt.nz).

The following are other Ministry of Health resources available on its website.

- Ministry of Health. 2012a. *Annual Cold Chain Management Guide and Record*. Wellington: Ministry of Health.
- Ministry of Health. 2012d. *Immunisation: Making a Choice for Your Children*. Wellington: Ministry of Health.
- Ministry of Health. 2012e. *National Guidelines for Vaccine Storage and Distribution*. Wellington: Ministry of Health.
- Ministry of Health. 2012f. *Newborn Pre-Enrolment Toolkit 2012*. Wellington: Ministry of Health.

A range of resources in English and other languages, for health practitioners and parents/caregivers, has been produced by the Ministry of Health. These are available from regional HealthEd offices and online (www.healthed.govt.nz). They include:

- [Childhood immunisation](#) (HE1323)
- [Immunise your children](#) (HE1327)
- [National immunisation register](#) (HE1502)
- [Does your child start school soon?](#) (HE1108).

The medical officer of health can be contacted through your local Regional Public Health Service.

The Immunisation Advisory Centre provides information for health practitioners and parents/caregivers through a freephone service (0800 IMMUNE or 0800 466 863) and a website (www.immune.org.nz). The website also includes contact details for [regional immunisation advisors and local coordinators](#).

References

Litmus. 2013. *Audience Research: Delayers of infant immunisation*. Wellington: Ministry of Health.

Ministry of Health. 2011b. *Immunisation Handbook 2011*. Wellington: Ministry of Health.

Wroe AL, Turner N, Salkovskis PM. 2004. Understanding and predicting parental decisions about early childhood immunizations. *Health Psychology* 23(1): 33–41.

Early childhood education

Key messages

The role of ECE

Many children in New Zealand spend at least some of their time away from their family, some from a very young age. There is a large variety of types of early childhood education (ECE) in New Zealand, including home-based care, playgroups, Playcentre, Pacific language nests, kōhanga reo, kindergartens, full-day education and care centres and different educational philosophies such as Montessori and Rudolf Steiner. This variety of service types caters for the needs of almost all families, providing for various language and cultural environments, variable levels of parent involvement, and a range of time commitments (from a few hours per week to full time, and from birth to six years of age).

All ECE services work towards educational goals because New Zealand's ECE policy and practice are based on the notion that education and care for very young children are inseparable.

Children who attend quality ECE receive long-lasting educational and developmental benefits (Mitchell et al 2008), which are greater for less advantaged children (eg, those from backgrounds of a lower socioeconomic status). However, **quality** is key to achieving these benefits, particularly for very young children (Dalli et al 2011).

ECE services may also provide parent support, both in terms of parent education and practical connection to social services such as housing, health and income support.

The Ministry of Education website (www.minedu.govt.nz) provides information about the **different kind of ECE services** and their **availability in different parts of the country**.

Subsidies for ECE are available through the Working for Families package (www.workingforfamilies.govt.nz).

Ministry of Education data⁵⁰ show that by about the age of three years, 90 percent of New Zealand children participate in ECE and a greater rate of subsidy is available for three- and four-year-olds (through the 20 Hours ECE funding programme). However, Māori and Pacific children, and children from lower socioeconomic areas tend to participate in ECE at substantially lower rates than other groups.⁵¹

The Ministry of Education has a substantial **work programme promoting participation in ECE** for Māori and Pacific children, and children from lower socioeconomic backgrounds. For more information, refer to the Ministry's ECE website (www.lead.ece.govt.nz).

The Ministry of Education's early intervention services

The Ministry of Education's early intervention services are available for children with developmental delays or disabilities. If you observe or are worried about a possible developmental delay or disability, you or the parents can contact this service by calling your local Ministry of Education office.

⁵⁰ See Figure 2 in the Annual ECE Census Summary Report 2012, p 4, available at www.educationcounts.govt.nz/statistics/ece2/annual-ece-summary-reports

⁵¹ www.educationcounts.govt.nz/statistics/ece2/participation

Early intervention services are tailored to the particular needs of the individual child and take into account their family circumstances. Staff come from a range of disciplines and work as a team with children at home or at their ECE service (if participating in ECE). Staff have an in-depth understanding of early childhood development and knowledge of special education in early childhood. Team members include:

- speech–language therapists
- early intervention teachers
- psychologists
- advisors on deaf children
- resource teachers: vision
- kaitakawaenga (Māori liaison advisors)
- education support workers.

Early intervention teams work closely with parents, families, whānau, caregivers and teachers because the knowledge and involvement of all these people are vital to the effectiveness of the services provided to the child. For children with complex disability needs, the coordination of services and support around the child and their family is another vital ingredient of the service. Early intervention teams also work collaboratively with specialists from other agencies to strengthen and extend children’s educational learning.

For some children, the services are ongoing until the child transitions successfully into school and school services. For other children, early intervention support is focused for a short time to address a specific development concern such as speech and language development.

Some children with developmental and behavioural issues also need referral to a paediatrician, as they have conditions that are treatable (eg, epilepsy) or that are untreatable but important to the family (eg, genetic conditions that may recur in subsequent children). Children with language delay should also be referred to an audiologist, as hearing problems commonly present with language delay and are often treatable. In many areas, the DHB Child Development Service will assess children who are younger or with specific problems, such as autism spectrum disorders, fetal alcohol spectrum disorders and cerebral palsy. If you have any questions about whether a referral is necessary, discuss this with your manager or clinical leader.

For more information about [early intervention services](#), visit the Parents section of the Ministry of Education website (www.minedu.govt.nz).

References

- Dalli CE, White J, Rockel J, et al. 2011. *Quality Early Childhood Education for Under-Two Year Olds: What should it look like? A literature review*. Wellington: Ministry of Education.
- Mitchell L, Wylie C, Carr M. 2008. *Outcomes of Early Childhood Education: Literature review*. Wellington: Ministry of Education/New Zealand Council of Educational Research.

Section 5:

B4 School Check

This section will guide practitioners through the standard protocols for each component of the B4 School Check. The protocols can be used for planning services, training nurses and VHTs, and improving quality. The section also describes the clinical pathways and referral processes for the screening and surveillance aspects of the B4 School Check.

Overview of the B4 School Check

Purpose of the B4 School Check

The purpose of the B4 School Check is to promote health and wellbeing in preschool children and identify behavioural, developmental or other health concerns that may adversely affect the child's ability to learn in the school environment.

Fulfilling this purpose will ensure that children start school able to participate to the best of their ability. Appropriate and timely referrals will be made when problems are identified.

Content of the B4 School Check

Several components of the B4 School Check are outlined elsewhere in the Handbook. Two others – the Child Health Questionnaire and the behavioural assessment (the Strengths and Difficulties Questionnaire) – are unique to the B4 School Check.

The B4 School Check is made up of the following.

Child health and development

Provide advice and support for parents about child health and development, covering:

- [Child Health Questionnaire](#)
- [hearing screening](#)
- [vision screening](#)
- [oral health](#)
- [height and weight measurement](#)
- [developmental assessment \(PEDS\)](#)
- [behaviour assessment](#) (completed by parents and teachers in discussion with health practitioners).

Refer the child to specialist services if the child appears to have problems that need further investigation.

The B4 School Check is not solely a physical health check, but also considers the child's community and environment. A child's ability to learn and communicate, their social development and the circumstances of their family and whānau are part of the check.

Family and whānau care and support

Focus on family health and wellbeing (as per [24–48 hours core visit](#)).

Discuss parental observation and interaction with their infant and parent mental health.

Relevant topics may include:

- [alcohol and other drugs](#)
- [parenting skills and support](#)
- [supporting families to access income and housing assistance](#)
- [strengthening family relationships](#)
- [building social connectedness and social capital](#)
- [family violence assessment](#)
- [smokefree environment](#).

Conduct a needs assessment and refer as appropriate.

Health education

Discuss:

- [nutrition](#) and physical activity
- [immunisation](#)
- [child safety/injury prevention](#)
- [recognition of childhood illnesses](#)
- parenting for child age and stage (see [General parenting information and support](#) under 'Referrals and resources' in 'Parenting skills and support')
- [development](#)
- [oral health](#)
- preparing for school – for information about [moving on to school](#), refer to the early years information in the Parents section of the Ministry of Education website (www.minedu.govt.nz).

Screening and surveillance in the B4 School Check

The B4 School Check incorporates three screening tests, surveillance of the child's growth, and questionnaires about a child's development and behaviour. This Handbook guides health practitioners through the tests and surveillance processes.

- **Hearing screening** involves sweep audiometry followed by tympanometry, if indicated.
- **Vision screening** involves distance visual acuity using a single optotype (Parr) 4 m letter-matching test.
- **Oral health screening** involves the 'Lift the Lip' oral health check and oral health promotion.
- **Growth surveillance** involves regularly measuring and recording a child's height and weight and routinely providing advice to parents about healthy eating and exercise within the framework of WCTO services.

- **Identifying behavioural problems** is achieved using the Strengths and Difficulties Questionnaire, which is a formal tool the parent and a teacher both complete.
- **Identifying developmental issues** is assisted through regularly using the Parents' Evaluation of Developmental Status tool, which ascertains parents' concerns about their child's development.

Eligibility for the B4 School Check

The B4 School Check will be offered to all families with 4-year-old children. Most children will be assessed at age 4, but if they miss out they will be offered the existing School New Entrant check (hearing and vision screening as a minimum).

Person undertaking the B4 School Check

Registered nurses or nurse practitioners with experience and training in child health will do the B4 School Check, usually with help from other health providers such as VHTs.

Location of the B4 School Check

Registered nurses or nurse practitioners will undertake the B4 School Check in different locations, for example, preschools, kōhanga reo, doctors' clinics and other community venues such as churches and marae, depending on the needs of the community. In some cases, they carry out some parts of the B4 School Check in the child's home.

Time needed for the B4 School Check

The B4 School Check usually takes 45–60 minutes.

Informed consent

Refer to [Informed consent](#) for an introduction to this concept.

Consent in the B4 School Check

A parent information pamphlet and consent form have been developed for use in the B4 School Check ([Appendix 15](#)). The pamphlet describes the B4 School Check and what will happen to information collected, including who it will be shared with, where it will be stored and who will have access to it. This information will be provided to parents before the check so that they understand what is involved.

While a parent/caregiver may sign this consent form before the B4 School Check, full informed consent requires a discussion between the provider and parents/caregivers at the time of the check to ensure they understand what is involved. An informed consent standard has been developed to support providers in ensuring that parents/caregivers have given informed consent to their child having a B4 School Check ([Appendix 16](#)).

The B4 School Check Information System

The B4 School Check Information System (B4SC IS) captures and stores data relating to the child, permission, checks (height, weight, hearing, vision, development and behaviour assessments), and any issues identified and referrals made.

The **overall purpose** of the B4SC IS is to track improved health outcomes from the B4 School Check. The system records any:

- identified health, developmental or behavioural issues that may limit the child's ability to learn in the school environment
- referrals or follow-up required to improve child health and education outcomes and reduce inequalities.

The system's capture and storage of data relating to the child and the B4 School Check is a lawful purpose connected with Ministry of Health, district health boards and their agents' functions of improving individual and population health. The creation of a reliable source of B4 School Check information history for each child at a local and regional level across New Zealand, available to authorised health practitioners, will assist in tracking improved health outcomes and reduced inequalities.

The **objectives** of the B4SC IS are to:

- provide a secure information system that can only be accessed by authorised health practitioners
- accurately record all B4 School Check results and retain this information throughout the lifespan of that child (this information must be available to the parent/guardian through their health provider)
- provide B4 School Check information to assist with the recall and follow-up of individuals by health providers at local and district levels
- provide information to providers that an individual has declined a B4 School Check and that follow-up is not required
- provide a readily available, accurate history for each child to approved health providers
- provide accurate local, district and national B4 School Check coverage data by age and ethnicity
- identify populations that are not accessing the B4 School Check so that services and resources can be targeted to assist those people to access the B4 School Check, and thus improve coverage
- provide accurate information so providers may evaluate and audit their services
- provide an information base to improve programme policy and the delivery of services.

The benefit of the B4SC IS for a parent/guardian is that the information is portable. Providers they consult about their child's health throughout New Zealand can access that child's information if required.

Because services will be provided by a range of providers working together, the benefit of the B4SC IS to a provider is that they will be able to access the data that their colleagues have generated and be able to track frequent movements of the child and respond if necessary.

Each district health board and its agents will have authorised access to the information for their population. The district health board and its agents will use, analyse and monitor the data about their own population to inform their planning and delivery of the B4 School Check service.

Health information privacy obligations for users of the B4SC IS

The collection, exchange and management of health information about identifiable individuals held on the B4SC IS fall within the provisions of the Health Act 1956, the Privacy Act 1993 and the Health Information Privacy Code 1994 (HIPC). The HIPC and Privacy Act 1993 can be accessed from the Office of the Privacy Commissioner's website (www.privacy.org.nz).

The HIPC provides a broad framework of controls for the management of information about identifiable individuals. That framework is briefly summarised here as a guide to users' information privacy obligations when delivering the B4 School Check.

B4 School Check providers must ensure that the child and their parents/guardians are informed about the B4SC IS, the information being collected and what that information may be used for ([Appendix 16](#)). The overall purpose and objectives behind collecting and storing the information are described above.

Those collecting information will collect it in a professional, considerate and respectful manner, sensitive to cultural differences. Users of the B4SC IS must take all reasonable steps to provide accurate information to the system and to check the accuracy of the information with the child and parent/guardian before relaying the information. An individual will also be able to access their (or their child's) information on the B4SC IS and to update and correct their individual details.

The Ministry of Health will ensure that storage and security safeguards will prevent unauthorised access to and use of the information contained on the B4SC IS. All employees of the Ministry of Health, district health boards and their agents who have access to the system will be required to show that they understand and will adhere to all privacy requirements.

The *Access, Use and Disclosure Policy* provides further details about information collected as part of the B4 School Check (Ministry of Health 2010a).

Reference

Ministry of Health. 2010a. *Access, Use and Disclosure Policy for B4 School Check Information System Users*. Wellington: Ministry of Health.

Child Health Questionnaire

Information obtained from the Child Health Questionnaire

The B4 School Check includes the two-page Child Health Questionnaire (CHeQ). The CHeQ seeks general information about the child, their family and whānau, including information about existing health conditions and access to services.

The CHeQ was developed specifically for the B4 School Check and is reproduced in [Appendix 17](#).

If any concerns arise from the CHeQ results, the child is likely to be referred to their GP or a child health specialist.

Immunisation

The CHeQ asks about the immunisations the child has received. The B4 School Check is an opportunity to arrange any of the scheduled immunisations that the child has missed.

If unsure of the child's immunisation history, look up their routine childhood vaccine schedule records on the National Immunisation Register before undertaking the B4 School Check.

Screening tests may not be necessary

The CHeQ asks about medical treatment the child is receiving for pre-existing eye or ear conditions.

It is not necessary to carry out audiometry or tympanometry if the child:

- is under the care of an otorhinolaryngologist (ORL, otherwise known as an ear, nose and throat specialist) or an audiologist
- is wearing a hearing aid
- has a cochlear implant
- currently has grommets inserted.

Note the reasons for not undertaking the audiometry or tympanometry screen in the child's B4 School Check record.

If the child is already under the care of an ophthalmic practitioner (an ophthalmologist or optometrist), a vision screening test is not necessary, whether the child is wearing glasses or not. However, ask the parent whether the child has had a recent check-up.

If either hearing or vision screening was not undertaken, inform the child's primary health care provider that it was not and state the reason/s for this.

Hearing screening

The hearing screen of four-year-olds is part of an overall framework of hearing screening and WCTO hearing surveillance. This screen follows the newborn hearing screening as part of the Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP) shortly after birth and subsequent surveillance at core Well Child checks.

Screening audiometry and tympanometry (if required) are the screening tests to be administered.

Overview of hearing screening

Purpose

The purpose of this component is to:

- detect the presence of hearing impairment and/or otitis media effusion
- refer to appropriate agencies.

Key messages

The screening protocol is designed to identify hearing loss that is likely to interfere with normal speech, language development and learning, and to find children with persistent middle-ear disorder as this also causes a significant hearing loss. This screen is also designed to target, detect and refer children where there are hearing-related developmental or learning difficulties (referred to as risk factors), so that appropriate intervention can be provided prior to or early in a child's primary education.

B4 School Check hearing screening is part of the National Vision and Hearing Screening Programme. Best practice requirements for vision and hearing technicians (VHTs) are described in the key document *National Vision and Hearing Screening Protocols* (Ministry of Health 2014).

Funding for services

Parents of children under 18 years who are eligible for health services and who have hearing problems are not asked to pay for audiological services, rehabilitation services or assistive devices. These costs are funded by the Ministry of Health and the Ministry of Education.

Age of child

This screening is conducted as soon as possible after the child turns four years old.

If a child has missed this component of the B4 School Check before starting school, then they will be checked at school (following consent process).

Repeat screening will also be provided to those children who need a follow-up test as a result of earlier screening.

Personnel

This screening is normally carried out by a VHT, but sometimes by other competent health practitioners.

Protocols

Frequency of visits

Venues should be visited regularly to ensure that all children are screened and that rescreens can be done in a timely fashion. Several visits may not always be possible in very small, remote rural areas. In these cases, serial testing could be carried out in a scheduled clinic setting.

Venue organisation

Before visiting an early childhood centre or school for screening, you should:

- notify the venue of your intended visit and ask that quiet activities are planned for when hearing screening is being carried out
- obtain the list of children requiring screening (eg, ENROL, preschool attendance lists)
- ensure the consent process with parents has been completed.

Consent

Although VHTs are still covered by section 125 of the Health Act 1956, all DHBs should now have implemented a consent process to encourage parents to make informed choices about their child's health. In addition, the recording of results in the national B4 School Check database requires the informed consent of parents. Therefore, all services delivering vision and hearing screening should implement an opt-off consent process. Section 125 should only be used in exceptional circumstances where the school, early childhood centre, or health services have concerns for a child's welfare.

The consent process should include providing parents with information about what their child is being screened for and asking about whether the child is already under the care of an audiologist or ORL and/or has grommets or a hearing aid.

Setting for hearing screening

Preschool hearing screening is generally carried out in community-based early childhood education centres or in clinic settings. Screening of school-age children is generally carried out in schools.

It is important that the VHT obtains a suitable room for hearing screening. Inappropriate conditions may compromise the validity of screening. A range of settings may be used for hearing screening, according to local availability. The conditions discussed below apply to community settings, as well as clinic settings.

Type of room. The room in which the hearing screening (and tympanometry if required) takes place must:

- be quiet and free of distractions
- have soft furnishings and floor coverings to absorb noise.

In a school or preschool, the most suitable room is usually the school library or an office.

Minimise ambient noise. The degree of ambient noise in the room in which the hearing screening will take place must be less than 40 dBA. Check the ambient noise with a sound level meter at the beginning of the screening session and at any other time you consider it necessary, when ambient noise levels increase.

If the noise level exceeds 40 dBA, speak to the staff and ask for noise levels to be reduced. Use approved noise-attenuating headset cups in noisier environments to offset the noise to the required level. If appropriate levels of background noise cannot be obtained, do not continue with the testing as the results are likely to be invalid.

Equipment needed for hearing screening

To conduct a hearing screening, you will need:

- an audiometer, tympanometer and ancillary equipment
- an appropriate chair and a table or desk on which to set up the audiometer and paperwork
- a set of record sheets
- a sound-level meter
- headphones
- pebbles and a container

- a chair for the child being screened.

Audiometers and tympanometers need to be calibrated regularly. An independently audited laboratory must conduct a basic calibration annually with full traceability to National Standards (International Accreditation New Zealand). Headphones are calibrated to a particular audiometer and so are not interchangeable.

Hygiene protocols for hearing screening

Audiometry

Hearing screening involves the placement of headphones over a child's ears. (**Note:** Audiometry should not be performed on children with discharging ears, or where the ear or surrounding skin is inflamed or broken. These children need referral to the GP or ear nurse and should be offered a rescreen when the issue is resolved).

Procedures

Back at base – Check headphones regularly. If cleaning is required, carefully remove rubber cushions from headphones and wipe with warm soapy water. Ensure cushions are totally dry before replacing. (**Note:** If headphone cushions become cracked or porous they must be replaced to maintain hygiene).

Tympanometry

Middle-ear screens involve the placement of a rubber tip at the opening of ear canal. (**Note:** Tympanometry is not performed on children with discharging ears, or where the skin is broken or inflamed).

Procedures

During screening – Change to a clean and unused rubber tip between each child screened.

Back at base – Ensure all used tips are wiped clean and any debris (eg, ear wax) removed, and placed in the dish of Milton solution. The tips should be totally submerged in the solution so that all surfaces are covered. After the required soaking period, (manufacturer's recommendation) the tips should be left to drain onto clean absorbent tissue. When dry, they should be stored in their covered containers.

Personnel

Where VHTs have cuts or abrasions of the skin that may be susceptible to infection (ie, to the hands), it is advisable to wear disposable plastic gloves. Regular hand washing during screening is recommended. Where there is no access to a hand-basin, a topical antibacterial solution handrub or similar is suitable.

Suggested cleaning products are:

- alcohol swabs: two-ply – medium grade (saturated with 70 percent isopropyl alcohol) in sterile individual packages
- handrub: Microshield Handrub (containing chlorhexidine gluconate 0.5 percent w/v in 70 percent v/v ethanol) or similar.

Pathway 1: Initial screening audiometry (sweep test) or rescreen

The procedure for initial screening (also known as the sweep test) is based on the American Speech–Language–Hearing Association screening guidelines (ASHA 1997). The technique relies on a conditioned response to sound. The screen is difficult for children under three years of age

or children with developmental or behavioural problems – note that these children should be referred for audiological assessment. The success of the screening test depends on achieving a conditioned response.

Preparing the child for Initial screening audiometry (conditioning)

Bring the child close to the audiometer (child must be no more than 30 cm from the headphones) and explain that you will be playing a simple game. Tell the child that you will be making some sounds or beeps with the machine.

Leave the headphones on the desk with headphones facing toward the child.

Demonstrate with a 1000 Hz tone at 100 dB.

Explain to the child that, to play the game, each time they hear a beep they must drop a pebble into the container.

Repeat presentation of tone 1000 Hz, at 100 dB and drop another pebble into the container at the sound of the tone. Repeat this a few times, and vary the presentation time between each beep so that the child understands that they must wait for the sound.

The child should then be able to demonstrate that they are able to drop a pebble at the sound of the tone. The child must repeat this a few times to show they thoroughly understand the task.

If the child is unable to sit still and participate, then they are not ready to be screened and will need to be put on a rescreen schedule. If the VHT has concerns about their hearing, they should be referred to an audiologist for an audiometric assessment, using techniques that are more appropriate for the child's developmental age.

When the child is fully conditioned and ready to begin the test, follow the procedure set out below.

Procedure for Initial screening audiometry

The flowchart for this pathway is shown in Figure 13.

IMPORTANT! Reduce the intensity level of the tone from 100 dB to 40 dB. Failure to reduce the sound level may cause pain or discomfort to the child.

Place the headphones on the child, and present a 1000 Hz tone at 40 dB in the right ear. If the child responds, present a 1000 Hz tone at 40 dB in the left ear.

If the child responds, switch back to right ear and test the following tones.

- Reduce the intensity to 20 dB at 1000 Hz tone and present it.
- If the child responds, present a 2000 Hz tone at 20 dB.
- If the child responds, present a 4000 Hz tone at 20 dB.
- If the child responds, present a 500 Hz tone at **30 dB**. (Note increased level.)

If the child responds to all these tones, then test the left ear in the same way, starting with the 500 Hz tone at 30 dB.

Possible outcomes for the screen

Formal hearing screening as part of the WCTO Schedule is undertaken at four years of age as part of the B4 School Check. This screen has four possible outcomes:

- **Not tested** because unable/unwilling to participate. If the child is unable to participate, note the result as 'not tested', record the result as a rescreen, and rescreen the child in three months' time.
- **Pass.** If the child hears audiometry screening levels of 20 dB at 1000, 2000 and 4000 Hz and 30 dB at 500 Hz bilaterally, record the child's hearing test as a 'pass'.
- **Rescreen.** If the child hears 40 dB bilaterally at 1000 Hz, but does not respond to the next or any other tone, record the result as a 'rescreen'.
- **Refer.** If the child does not respond to 40 dB in either the right or the left ear at 1000 Hz, the result is a 'refer'. (Document this as '40dB not achieved' in referral or record as >40dB.)

Procedure for each outcome

1. **The child is unable to participate.** If the child is unable to participate the result is **not tested** (record the result as a rescreen). Arrange a repeat of initial test in three months' time. If the child is unable to participate on the second attempt, they should be referred to an audiologist for an audiometric assessment, using techniques that are more appropriate for the child's developmental age
2. **The child passes all tones bilaterally.** If the child responds to all tones presented to both ears, the result is a **pass** and no further action is required. Record the result of the screening test in the B4 School Check database. If the child is over five years, one week of age then the result should be recorded in the ENROL database only.
3. **The child responds at 40 dB bilaterally but fails lower-intensity tones.** If the child responds at 40 dB bilaterally, and then does not respond to the next or any of the following tones, the screen result is a **rescreen**.

Stop the test and record the result as a **rescreen** and undertake tympanometry. The child should be rescreened within three months using Pathway 1 Initial screening audiometry (sweep test) or rescreen, or Pathway 2 Screening audiometry (hearing concerns) at the discretion of the VHT.

Note: If there are concerns about speech/language, development or behaviour or any risk factors (see Table 4), the child should be **referred** (see below). The preschool and parents/caregivers of children who require a rescreen should be notified when a rescreen is scheduled.

4. **The child does not respond to 40 dB in either ear.** If the child does not initially respond at 40 dB in either the right or the left ear, the screen result is **refer**.
 - Record the result as **refer** and undertake tympanometry.
 - If they pass tympanometry, refer to an audiologist.
 - If they fail tympanometry, refer to a GP or ear nurse.
 - The child's hearing must be tested following treatment by GP or ear nurse to rule out an underlying sensorineural hearing loss. It is the responsibility of the GP or ear nurse to arrange this test with an audiologist.

Table 4: Risk factors for hearing-related developmental and learning difficulties

- Permanent hearing loss independent of otitis media with effusion. Provided these children have already been identified and are being cared for, they should not be part of the screening programme but should be entered in the statistics
- Suspected or diagnosed speech and language delay
- Autism spectrum disorder or other pervasive developmental disorders
- Syndromes (eg, Down syndrome) or craniofacial disorders that include cognitive, speech and language delays
- Blindness or uncorrectable visual impairment
- Cleft palate with or without an associated syndrome
- Developmental delay
- Significant socioeconomic disadvantage

Recording of results

The results and outcomes (ie, not tested, pass, rescreen or refer) for B4 School Check audiometry must be recorded in the B4 School Check database and/or ENROL database, depending on the age of the child. The Ministry of Education ENROL database is now getting regular updates from the B4 School Check database. However, where children are unmatched or start school without having had a B4 School Check, their results will need to be manually entered on ENROL.

Pathway 2: Screening audiometry (hearing concerns)

A child's parent/caregiver or teacher may occasionally have concerns about the child's health, development, behaviour or learning and wonder whether a hearing problem is causing these symptoms or difficulties. Sometimes an older child will complain of hearing difficulties or hearing-related symptoms such as tinnitus or balance problems.

Those requesting a hearing test should be informed that screening is not a full diagnostic hearing assessment, and a child should be referred to an audiologist if there are ongoing concerns. The results and outcomes must be recorded in the ENROL database.

This is the appropriate screening test to be undertaken if a child is referred with concerns about a possible hearing loss. However, if the child has poor concentration skills, it may be necessary to offer Pathway 1 **Initial screening audiometry (sweep test)**.

The flowchart for Pathway 2 Screening audiometry (hearing concerns) is shown in Figure 14.

This test protocol may also be used by the VHT who is undertaking a rescreen following a 'Refer' at an Initial screen.

Note: All children on initial screen should be tested with initial screening (sweep) audiometry (Figure 13) unless the test is a hearing concern.

Screening audiometry may assist GPs, ear nurses and audiology clinics to triage waiting lists for those children awaiting further assessment.

Procedure for Pathway 2 Screening audiometry (hearing concerns)

The screen has two steps. The first step is to familiarise the child with the screening tones. Once that is achieved, the VHT should begin the test and record the child's responses.

Familiarisation is undertaken to make sure that the child is able to reliably perform the response task. The child must be presented with a signal loud enough to evoke a clear response. [Prepare the child](#) for screening in the same way as in the Initial screening (sweep test) audiometry, then proceed as follows.

Screening determination

The level of hearing is defined as the lowest decibel hearing level at which a response reliably occurs. The tones to be used are 1–2 second duration pure-tone stimuli at 500, 1000, 2000 and 4000 Hz.

Note that the minimum levels to be tested to are: 25 dB at all test frequencies except 500 Hz at 30 dB.

Screening procedure

1. Place the headphones on child.
2. Start at 1000 Hz at 40 dB and reduce intensity in 5 dB steps until the child passes at 25 dB, or record last response.
3. Present next tone at 2000 Hz at 40 dB, and continue test sequence. That is, reduce intensity in 5 dB steps until the child passes at 25 dB, or record last response.
4. Repeat steps at 4000 Hz and 500 Hz (minimum 30 dB).
5. Switch to left ear and repeat test, beginning at 500, 1000, 2000 and 4000 Hz at 40 dB.
5. If the child does not respond at 40 dB, record this result (>40 dB) and present tone at next frequency (Hz). The practitioner is required to complete the test. This result is **refer** (see [Referral pathways](#)).
6. Proceed to tympanometry screening and enter the results onto the Ministry of Health's B4 School Check database or the Ministry of Education's ENROL database. Refer these children as per the clinical pathway and referral criteria in for Screening audiometry shown in Figure 14.

Screening audiometry (hearing concerns) – pass result

If the child responds at passing level, as shown in Table 5, enter the results onto the Ministry of Health's B4 School Check database or the Ministry of Education's ENROL database. No further action is required.

Table 5: Sequence of screening frequencies and pass levels

Ear	Frequency (Hz)	Amplitude (dB)
Right ear	1000	25
	2000	25
	4000	25
	500	30
Left ear	500	30
	1000	25
	2000	25
	4000	25

Referral pathways

The VHT will need to provide a copy of the results of the audiometry test as shown in Table 5, tympanometry (if required), and any relevant observations of the child back to the person who requested the audiometric assessment.

Referral pathways can vary according to local requirements, but in general referral for suspected sensorineural losses should be made to audiology, and for suspected conductive loss to a GP or ear nurse where they are available. However, it is important to recognise that a sensorineural hearing loss may be masked by a conductive loss, and the conductive loss must be treated and the child retested once this has resolved.

Note: The child's hearing must be screened again to rule out an underlying sensorineural loss. This is the responsibility of the GP or ear nurse to arrange this test with an audiologist.

Key to flowchart symbols

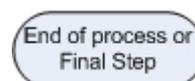
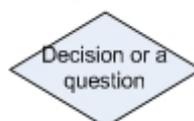
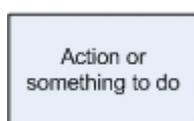
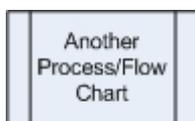


Figure 13: Pathway 1 Initial screening (sweep) or rescreen clinical pathway

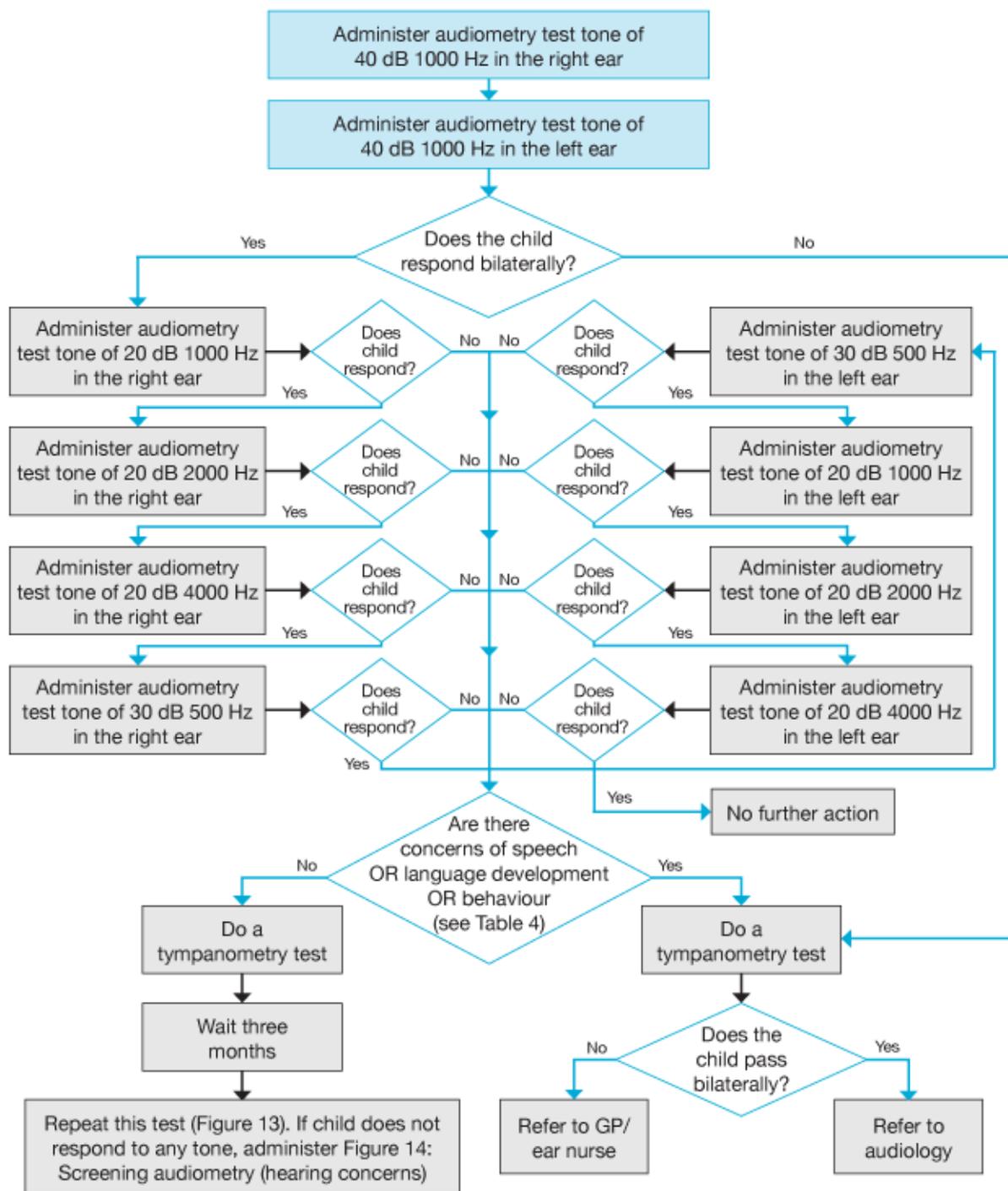
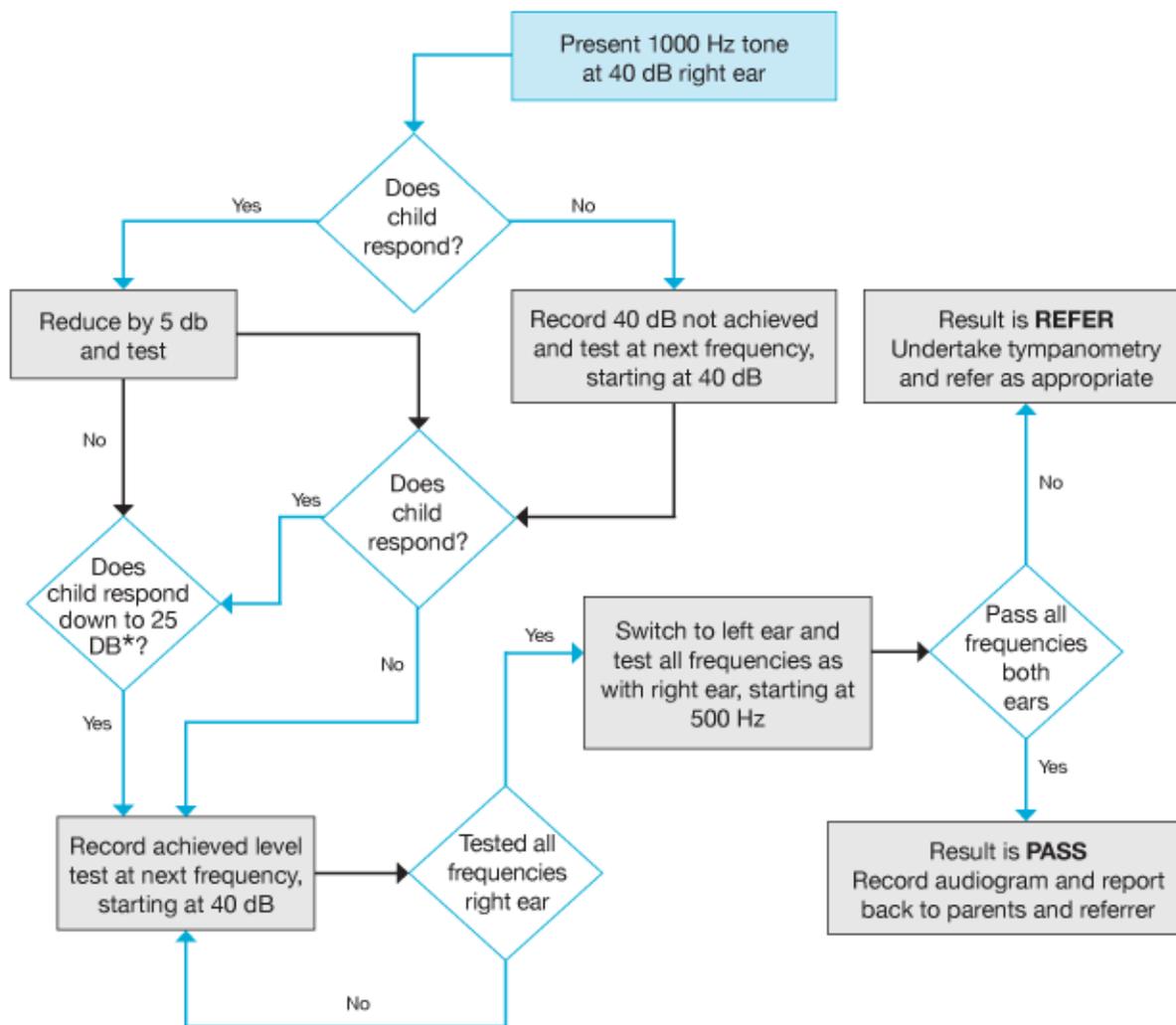


Figure 14: Pathway 2: Screening audiometry (hearing concerns) – clinical pathway



* Down to 30 dB at 500 Hz.

Screening technique: tympanometry

Children who are having tympanometry must have first had audiometry screening. Normal audiometry (ie, bilateral pass responses) means no further screening needs to be done. The tympanometry procedures below all follow an abnormal screening test, with the following exception: in some district health boards, targeted tympanometry screening of groups at high risk of harm from glue ear is undertaken.

Tympanometry screens for middle-ear function and involves the placement of rubber tip at the opening of ear canal.

Note: Tympanometry should not be performed on children with discharging ears, or where the skin is broken or inflamed. These children should be referred for treatment and rescreened when their condition is treated.

Tympanometry is not required for children with grommets

Children with patent grommets are likely to have an abnormal tympanogram. Before the tympanometry screen, parents should be asked as part of the consent process whether the child has grommets. If the child has grommets, no further action is required. If the VHT is unsure

whether grommets are in place they should undertake tympanometry. The result is likely to show a flat (type B) tympanogram with a high middle ear volume (above 1.5 ml).

Preparing the child for tympanometry

Follow these steps to prepare the child for the tympanometry screen.

1. Ask the child in to stand front of you, and explain that you will be using your 'special camera' to take a measurement/picture of their ears.
2. Show the child the tympanometer screen to reassure them; liken it to a small TV.
3. Tell the child they will need to stand still for just a minute while you take the picture.
4. When you feel the child understands and is ready, begin the procedure.

Procedure for tympanometry

Change to a clean, unused rubber tip between each child screened.

Follow these steps to undertake the tympanometry screen.

1. Turn the child so that their right ear is facing you.
2. Place the tympanometer probe at the opening of the child's ear canal and run a screen.
 - If the screen result is pass, record the result. Go to step 4.
 - If the screen is abnormal, go to step 3.
3. Repeat the test.
 - If the result is a pass, record the result. Go to step 4.
 - If the result is abnormal, record the result, including the physical volume measure. Go to step 4.
4. Turn the child so their left ear is facing you.
5. Place the tympanometer probe at the opening of the child's ear canal and run a screen.
 - If the screen result is a pass, record the result. This is the end of the procedure.
 - If the screen is abnormal, go to step 6.
6. Repeat the screen.
 - If the result is pass, record the result. This is the end of the procedure.
 - If the result is abnormal, record the result, including the physical volume measure. Rescreen in three months' time or refer using the appropriate pathway.

The results and outcomes (ie, pass, rescreen or refer) for tympanometry screening must be recorded in the B4 School Check database and ENROL database.

After the screening

Notification to parents

Parents will be notified of results following a screening test.

Pass and refer brochures are available online from www.health.govt.nz/b4schoolcheck.

Preschool and school recording systems

The results and outcomes (ie, pass, rescreen or refer) for B4 School Check audiometry must be recorded in the B4 School Check database and/or ENROL database.

There are two national databases for recording hearing results:

- Ministry of Education's ENROL database
- Ministry of Health's B4 School Check Information System.

Hearing screening results must be entered to meet the national reporting requirements for hearing screening. The default system for entering the hearing screening results is the B4 School Check database. Results will be transferred centrally to the ENROL system.

Follow-up

Ear nurses, GPs and audiologists are asked to inform the referrer of their findings and proposed treatments. This information is recorded for future reference.

If no feedback information has been received from the referral, a follow-up letter or phone call to the family should be made to see if any action has been taken. If there is no response to this contact, then the case should be referred to the Public Health Nurse Services or Community Health Team. The information provided must be recorded for future reference.

Where a child has already been assessed and determined as needing hearing aids or another assistive device (eg, cochlear implants, FM systems) but is not wearing them, or where a child failed to attend a hospital audiology clinic appointment, the school's nurse or public health nurse should be informed. No further screening is warranted.

Cleaning equipment back at base

Check audiometer headphones regularly. If cleaning is required, carefully remove rubber cushions from headphones and wipe with warm soapy water. Ensure cushions are totally dry before placing them back in the headphones.

Note: If headphone cushions become cracked or porous, they must be replaced to maintain hygiene.

Ensure all used tympanometer tips are wiped clean of any debris (eg, ear wax), then place in the dish of Milton solution. Milton solution tablets (or similar antiseptic solution) are acceptable for cleaning tympanometer tips. The tips should be totally submerged in the solution so that all surfaces are covered. The solution must be mixed according to the manufacturer's recommendations and must be changed daily.

After soaking for the required period (manufacturer's recommendation), leave the tips to drain onto clean absorbent tissue. When dry, store them in their covered containers.

Referral pathways for tympanometry

Tympanogram is normal

If audiometry screening test is abnormal and the tympanogram is normal, the child may have a sensorineural hearing loss. In this situation, refer the child to audiology for further assessment.

Tympanogram result cannot be obtained

If you are unable to gain a seal (ie, there is an air leak) when trying to run a tympanogram, then:

- record 'no seal' on the child's notes
- refer the child to a GP or ear nurse for further assessment (note as 'refer').

Tympanogram is abnormal

- If the tympanogram shows no peak and the physical volume measure is under 0.3 ml or over 1.5 ml, refer the child immediately to a GP/ear nurse.
- If the tympanometry result shows no peak (ie, it is a flat graph), and the physical volume measure is 0.3–1.5 ml, rescreen the child in three months' time.
- If a rescreen tympanometry result shows no peak, refer the child to a GP or ear nurse.
- Children with the conditions listed in Table 4 are at high risk for developmental and learning difficulties, which otitis media with effusion is likely to exacerbate. If they fail their hearing test and have an abnormal tympanogram in either ear or both ears, refer them straight away.

Note: The child's hearing must be screened again to rule out an underlying sensorineural loss. This is the responsibility of the GP or ear nurse to arrange this test with an audiologist.

References

ASHA. 1997. *Guidelines for Audiologic Screening* [Guidelines]. URL: www.asha.org/policy/GL1997-00199.htm (accessed 10 June 2013).

Ministry of Health. 2014. *National Vision and Hearing Screening Protocols*. Wellington: Ministry of Health. URL: www.health.govt.nz/publication/national-vision-and-hearing-screening-protocols (accessed 28 March 2013).

Vision screening

Overview of vision screening

Purpose

The purpose of this screening test is twofold:

- Identify children who may have amblyopia (lazy eye) at an age when it may still be treatable.
- Measure visual acuity and refer children who are unable to complete this screen for further assessment.

Key messages

The prevalence of visual deficits in the preschool population is estimated to be 10–15 percent. Treatment for amblyopia, the primary focus of preschool screening, is most beneficial if started before the child starts school. Around 1–3 percent of preschool children have amblyopia which can lead to permanent vision loss in one eye if not treated early.

If the child is currently under the care of an ophthalmic/optometric practitioner, a screening test is unnecessary, whether the child wears glasses or not.

B4 School Check vision screening is part of the National Vision and Hearing Screening Programme. Best practice requirements for vision and hearing technicians (VHTs) are described in the key document, the *National Vision and Hearing Screening Protocols* (Ministry of Health 2014).

Age of child

This screening is conducted as soon as possible after the child turns four years old.

If a child has missed this component of the B4 School Check before starting school, then they will be screened at school (following consent process). The screening will also capture those who need a follow-up test as a result of earlier screening.

Personnel

This screening is normally carried out by a VHT, but sometimes by other competent health practitioners.

Protocol

Frequency of visits

Venues should be visited regularly to ensure rescreens can be achieved. It is acknowledged that several visits may not always be possible in very small, remote rural areas. In these cases, rescreening could be carried out in a scheduled clinic setting.

Venue organisation

Before visiting an early childhood centre or school, you should:

- notify the venue of your intended visit and ask that quiet activities be planned for when vision screening is being carried out
- obtain the list of children requiring screening (eg, ENROL, preschool attendance lists)
- ensure the informed consent of parents has been completed.

Consent

Although VHTs are still covered by section 125 of the Health Act 1956, all DHBs should now have implemented a consent process to encourage parents to make informed choices about their child's health. In addition, the recording of results in the national B4 School Check database requires the informed consent of parents. Therefore, all services delivering vision and hearing screening should implement an opt-off consent process. Section 125 should only be used in exceptional circumstances where the school, early childhood centre, or health services have concerns for a child's welfare.

The consent process should include providing parents with information about what their child is being screened for and asking about whether the child is already under the care of a vision specialist and/or has glasses.

Setting for vision screening

Preschool vision screening is generally carried out in early childhood education centres or clinic settings. Screening of school-age children is generally carried out in schools.

Vision screening requires a room that is free of distractions and more than 4 m long. The room should be uniformly and brightly illuminated. It should have a light level of at least 300 lux in the room with about 500 lux to illuminate the test chart. If you are unsure as to whether the lighting is sufficient, carry out a formal light meter test.

Equipment needed for vision screening

To conduct a vision screening, you will need:

- 4 m Parr letter-matching vision book with and without confusion bars with key card (or equivalent Sheridan Gardner charts)
- rigid plastic eye patch
- Snellen eye chart
- Hand-held eye occlude (Denver model or similar)
- retractable 5 m tape measure
- masking tape
- light meter.

Hygiene protocols for vision screening

Screening involves the placement of a rigid plastic eye patch over the child's eye.

Note: Vision screening is not performed on children with inflamed eyes, stye, or where the surrounding skin is broken or inflamed. These children should be referred for treatment (with parental consent) and booked for a rescreen at a later date.

Procedures

During screening – wipe rigid eye patch with alcohol swab after each screen. Allow to dry completely before using on a child.

Back at base – wipe eye patch thoroughly with alcohol swab and store it in a clean container.

Note: Where VHTs have cuts or abrasions of the skin, and may be susceptible to infection (ie, to the hands), it is advisable to wear disposable plastic gloves. Regular hand washing during screening is recommended. Where there is no access to a hand basin, a topical antibacterial solution handrub or similar is suitable.

Suggested cleaning products

Suggested cleaning products are:

- alcohol swabs: two-ply – medium grade (saturated with 70 percent isopropyl alcohol) in sterile individual packages
- handrub: Microshield Handrub (containing chlorhexidine gluconate 0.5 percent w/v in 70 percent v/v ethanol) or similar.

Screening technique: Parr letter-matching vision charts or Sheridan Gardner charts

The screening is conducted exactly 4 m from the child and at the same level as the child's eyes. Measure 4 m from the child with the tape measure, and mark the floor at both ends with a piece of masking tape.

Ensure that the chart (book) and the key card:

- match (ie, both have confusion bars)
- have a matte finish so that the child cannot see reflections
- do not show marks such as fingerprints or pen ink.

Also make sure the child is not facing a window or another bright light source that could make the chart difficult for them to see.

Remember that although the screen is done at 4 m, the results (eg, 6/6 or 6/12) are written as though the test was undertaken at 6 m. (Do not record the results as 4/4 etc.)

Preparing the child for Parr letter-matching or Sheridan Gardner charts

1. Ask the child to sit so that the masking tape on the mat/floor and their eyes are level (approximately 60 cm distance).
2. Explain to the child that you will be playing a simple game.
3. Show the child a large letter (shape) from your book and point to the letter that is the same on their card.
4. Show the child another large letter and explain that they have to find the same shape. Assist the child if needed.
5. Change the letter and ask the child to find the same shape.
6. When you feel the child understands the task, show the child the eye patch and suggest they need to be a 'pirate' to play the game.

Procedure for Parr letter-matching or Sheridan Gardner charts

1. Place the eye patch over the child's left eye.
2. Move to the 4 m point. Ensure no other children are sitting between you and the child being screened.
3. Beginning with the largest letter, show the child progressively smaller letters from each level. Encourage the child as much as possible. Continue until the child has difficulty identifying the letters.

4. Record the smallest letter size at which the child correctly matches two out of three letter shapes at any level. Use the conversion table on the back cover of the book (ie, 6/30,6/18,6/12,6/9,6/6).
5. Place the eye patch over the child's right eye.
6. Move to the 4 m point.
7. Beginning with the largest letter, show the child progressively smaller letters from each level. Show the letters in a different order from that which you showed the child in step 3. Encourage the child as much as possible. Continue until the child has difficulty identifying the letters.
8. Record the smallest letter size at which the child correctly matches two out of three letter shapes at any level. Use the conversion table on the back cover of the book.
Note: Record 6/6 6/6 when you show all three 6/6 letters and the child can achieve two.
9. Parr letter-matching vision test (with confusion bars) is the recommended screening test for all children younger than seven years old. If the child has difficulty understanding the test, consider using the Parr letter-matching vision test **without** confusion bars.
Note: If this test is used, the child must achieve a result of 6/6 in both eyes at the B4 School Check (four years)..
Children not achieving this should be rescreened (ie, result is 6/9 both eyes) or referred (worse than 6/9 either eye) with a note to the referrer that the Parr chart **without** confusion bars was used.
Five to seven year olds screened **without** confusion bars who achieve a 6/6 result in both eyes, should be rescreened within 12 months. If their visual acuity is worse than 6/9 in either or both eyes, they should be referred with a note, that Parr letter-matching vision test **without** confusion bars was used.

Screening outcome

This screen has three possible outcomes: a **pass**, **rescreen** or **refer**. Rescreens should be notified to the preschool and the parents and done as scheduled.

Pass, rescreen and refer criteria for vision screening

Vision is 6/9 or better in both eyes at the B4 School Check

- The child's vision screening is considered a pass.
- Note the measurements of vision on the child's records.
- Take no further action.

Vision is 6/9 in one eye and 6/6 in the other at the B4 School Check and New Entrant Check (5–7 years)

Children aged four, five and six years who have a visual acuity of 6/6 in one eye and 6/9 in the other should be rescreened within six months. This is because one eye may be improving or one eye getting worse. A rescreen will distinguish the two possible options.

- Note the measurements of vision on the child's record.
- Arrange a rescreen for within three to six months' time.

Vision is 6/12 or worse in either or both eyes at the B4 School Check or New Entrant test (5–7 years)

- Refer the child for further assessment according to the Ministry of Health's referral guidelines.

Vision is 6/9 in both eyes at New Entrant Check

- Arrange a rescreen for within 12 months.

On rescreen

If the child's vision is 6/6 in both eyes, the rescreen is considered a pass and no further action is required. If there is no change in the child's vision (ie, they are 6/9 in one eye and 6/6 in the other) or their vision has become worse in either eye (ie, they are 6/9 in both eyes, or 6/12 or worse in either eye), refer the child for further assessment according to the Ministry of Health referral guidelines (see [Referral pathways](#) below).

After the screening

Notification to parents

Parents will be notified of results following a screening test. Pass and refer brochures for use with all four and five-year-olds screened are available online: www.moh.govt.nz/b4schoolcheck.

Children who are identified as requiring a referral should be given an Enable Spectacle Subsidy brochure.

Copies of the Spectacle Subsidy brochure can be ordered through Enable New Zealand (freephone 0800 17 1981). Copies of the [subsidy for glasses and vision test brochures](#) in a number of languages can be printed from the Ministry of Health's website (www.health.govt.nz).

Subsidies for glasses/spectacles and eye exams

Children with vision problems, aged 15 years and under, from low-income families may be able to get funding assistance for examinations, frames, lenses, eye patches and repairs. The child will need to have an assessment by a vision assessor who is registered as an assessor for this subsidy. The accredited vision assessor will assess a child's vision needs and may recommend glasses or other vision equipment. An accredited assessor is usually an optometrist, eye specialist, or a service coordinator for the Royal New Zealand Foundation of the Blind. Not all optometrists and eye specialists are accredited vision assessors. The screener should have an up-to-date list of accredited assessors in their area.

There are brochures available for families to explain who is eligible for the subsidy. You can view this brochure and read [further information](#) at the Ministry of Health website (www.health.govt.nz).

If the child requires a referral and their parent has a Community Services Card, advise the parent to contact Enable New Zealand to find a vision assessor in their area (freephone 0800 17 1981).

Follow-up

Local records must be kept of all children who have been screened including those who have passed, those requiring a rescreen, and those who have been referred. Parents, ophthalmologists, optometrists and orthoptists are asked to inform the referrer of the findings and proposed treatment. This information is recorded for future reference.

If feedback information has not been received from the referral, a follow-up letter or phone call to the family should be made to see if any action has been taken. If there is no response to this contact, then the case should be referred to the Public Health Nurse Services or Community Health Team. This information must be recorded for future reference.

Where a child has already been assessed and determined as needing glasses but is not wearing them, or where a child failed to attend an appointment with a hospital eye clinic, ophthalmologist or optometrist, the school's nurse or the public health nurse should be informed. No further screening is required.

Preschool and school recording systems

There is one main national database for recording vision results: the Ministry of Health's B4 School Check Information System. Vision screening results must be entered to meet the national reporting requirements for vision screening, including the B4 School Check. The Ministry of Health and the Ministry of Education have developed a process for transferring vision screening data into the ENROL database. Results for Year 7 are recorded directly into ENROL.

Referral pathways

Figure 15: Vision screening clinical pathway and referral at four years old

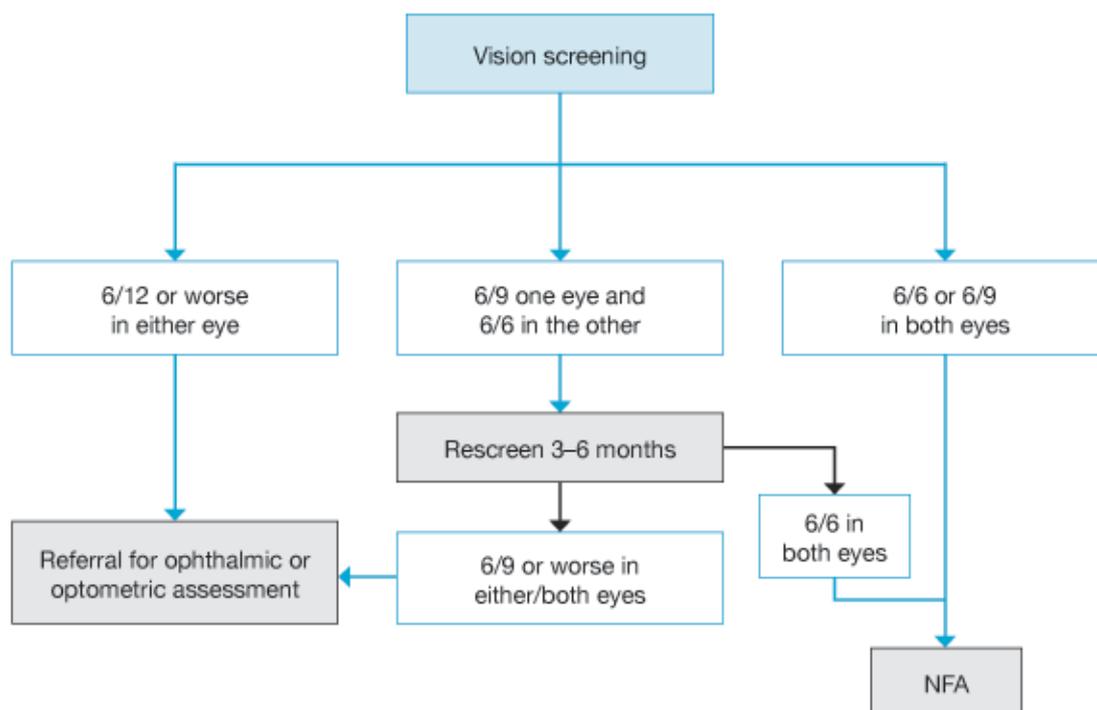
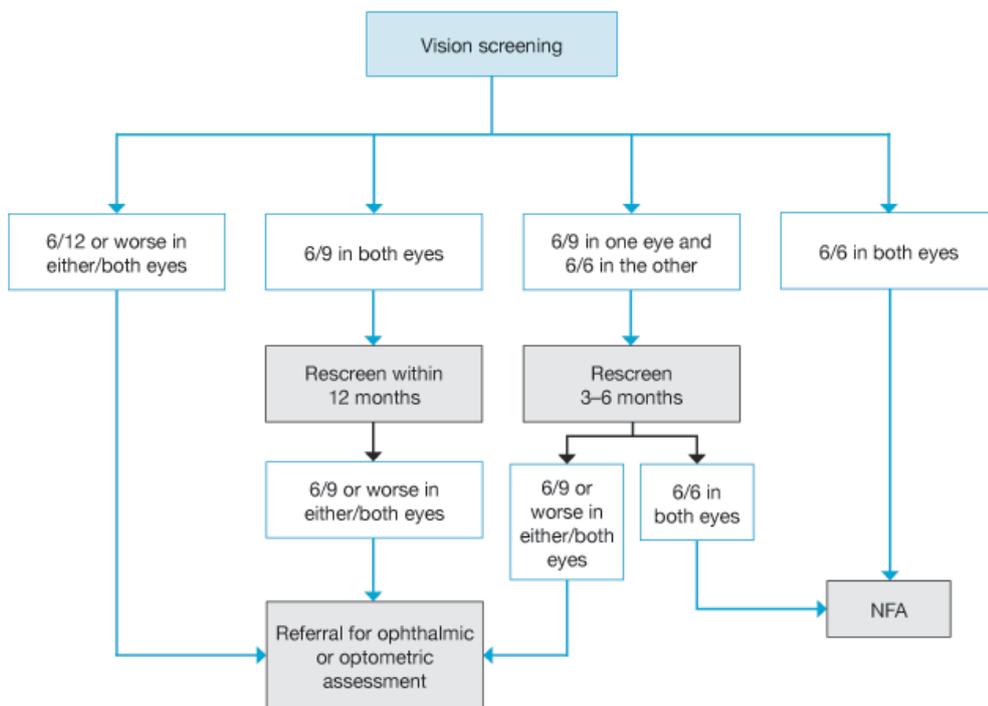


Figure 16: Vision screening clinical pathway and referral at five to seven years



Children failing a formal visual acuity screening

A four-year-old or new entrant child who is referred from the vision screen with unequal visual acuity or has a result of 6/12 or worse should receive further professional investigation. There are three possible referral scenarios.

1. A four-year-old or new entrant child who has distance vision that is equally reduced in each eye or with two or more lines difference in the vision between the eyes should be referred to either an ophthalmologist or an optometrist, depending on practitioner availability and parental preference.
 N.B: (If a four-year-old or new entrant child with greater than two lines difference between the visual acuity in each eye is referred to an optometrist, referrers should consult with the New Zealand Association of Optometrists about optometrists available in their area who have appropriate training, experience and interest in seeing younger children.)
2. A new entrant child who has a 6/9 6/9 distance vision result should be rescreened within 12 months. If at rescreening the result is worse than a 6/6 6/6, the child should be referred to an ophthalmologist or optometrist, depending on parental preference and practitioner availability.
3. A new entrant child with unequal vision of less than two lines difference should be rescreened at next visit.

The ophthalmologist at the hospital eye clinic or the optometrist to whom the child is referred should acknowledge receipt of the referral, and inform both the referrer and the child’s GP of the outcome of the referral.

Offer referral if concerns about child’s vision

A child’s caregiver or teacher may occasionally have concerns about a child’s health, development, behaviour or learning and wonder whether a vision problem is causing these symptoms or difficulties.

Those requesting a vision test should be informed that screening is not a full diagnostic visual assessment, and a child should be referred to an Optometrist or eye specialist if there are concerns. The results and outcomes must be recorded in the ENROL database.

It may be necessary to offer a referral of a comprehensive vision assessment for the child, as the screen does not cover some aspects of vision.

Following a parent-initiated, teacher-initiated or self-referral, the health practitioner consulted must work within their scope of practice to ensure that the family receives a timely, high-quality service that addresses their concerns.

Resources

[Keeping an eye on your child's vision](#) (B4 school vision screening) (HE2278) is a Ministry of Health resource for parents/caregivers, available from its HealthEd website (www.healthed.govt.nz) in multiple languages.

References

Ministry of Health. 2014. *National Vision and Hearing Screening Protocols*. Wellington: Ministry of Health. URL: www.health.govt.nz/publication/national-vision-and-hearing-screening-protocols (accessed 28 March 2013).

Behaviour assessment: The Strengths and Difficulties Questionnaire

This topic includes information about assessing and managing behavioural and emotional difficulties that children may have. It provides guidance and the procedure for administering, scoring and interpreting results for the Strength and Difficulties Questionnaire (SDQ). The SDQ is routinely administered as part of the B4 School Check to screen for behavioural and emotional problems.

In the original *Well Child/Tamariki Ora Handbook* (Ministry of Health 2002d), the behaviour topic focused on managing child behaviour. In this Handbook, [Parenting skills and support](#) covers the role of parenting in child development and its impact on child behaviour.

Overview of behaviour assessment

Component links

This component links to the following section 4 components:

- development
- parenting skills and support
- family violence assessment
- Infant and preschool mental health and attachment.

Purpose

The purpose of this component is to:

- assess behaviour in children before they begin school.

Key messages

Children often reach primary school with undetected or untreated developmental or behaviour problems. Surveillance before school is often incomplete and the highest-need families may least use health care services (Hall and Elliman 2003). Children with mild to moderate developmental difficulties or behavioural or mental health problems may not be identified even if they are receiving regular health care. There is evidence that early identification and intervention improve developmental and social outcomes for the child, family and whānau and that the earlier the intervention, the greater those improvements are (Centre for Community Child Health 2002).

When individuals observe the child in different settings using validated tools, they can record more typical behaviour.

Tools to identify child development and behaviour should be simple to administer and score (Tsiantis et al 2000). They should have sensitivity and specificity above 70 percent. Most tools are in the form of questionnaires.

Interventions

Functional assessment is the preferred method for identifying the factors that need to be changed during any intervention in a child's life (Church 2003). Functional assessment attempts to identify environmental conditions (including other people's behaviour) that influence a child's antisocial behaviour.

Any intervention in a child's life should aim to change the circular processes of behaviour problems – the child affects the adult who affects the child who affects the adult – by altering communication, roles, perceptions and beliefs (Tsiantis et al 2000).

The most effective intervention for managing a child's social behaviour is **contingency management**. It involves setting specific behavioural change goals, teaching the child the skills necessary to achieve these goals, offering the child rewards for good behaviour and penalties (such as time out but not physical punishment) for antisocial behaviour, and monitoring the intervention and its effects (Church 2003).

Contingency management (which uses rewards and penalties) is more effective than an intervention that uses only rewards. It is more likely to succeed if instituted both in the classroom and at home, rather than in just one environment.

Successful parenting programmes

Parenting programmes are important interventions. Several programmes are well documented for their effectiveness in assisting parents to manage their child's behaviour. Examples include the Triple P programme and the Incredible Years parenting programme, which are commonly used in New Zealand (Church 2003).

The SKIP resources have been informed by research and developed with funding from the Ministry of Social Development. They are aimed at parents and community groups and are well accepted.

Behavioural screening

Effectiveness of management decreases as child ages

It becomes more difficult to influence the development of a child's behaviour problems as a child gets older. Behavioural problems may be effectively managed in 75–80 percent of preschool children with antisocial behaviour. Once children are aged 5–7 years, management is effective in 65–70 percent of cases, but among those aged 8–12 years this rate decreases to 45–50 percent. It is very difficult to change antisocial behaviour in adolescents (Church 2003).

Parents are best at identifying socio-emotional and mental health problems

Evidence shows that parents can accurately identify children with socio-emotional and mental health problems. Asking parents about their child's behaviour has two advantages: it involves family and whānau members in the identification and management processes and is cheaper than involving health practitioners (Tsiantis et al 2000).

Teachers can also check children. Some tools have versions for both a parent and a teacher, including the Strengths and Difficulties Questionnaire (SDQ), which is the behavioural questionnaire for the B4 School Check.

Strengths and Difficulties Questionnaire⁵²

The evaluation of children's emotional and behavioural development is a central component of a child health assessment. Children's emotional and behavioural problems are not always evident in all situations. When they are evident, the problem is usually more severe.

Who the questionnaire is for

The SDQ is designed to assess those aged 3–16 years. It has different versions, which vary according to the age of the children being assessed and whether a parent or teacher is to complete the questionnaire. Older children can complete a self-assessment questionnaire.

What the questionnaire assesses

The SDQ asks about the child's psychosocial attributes (positive and negative behaviours): emotional attributes, conduct, hyperactivity, peer relations and prosocial behaviour. It also asks about how the child's behavioural difficulties affect their life (Youth in Mind 2001).

Why the questionnaire was selected

The SDQ was selected over other tools for identifying child behavioural issues because it is:

- widely used and accepted by people working in child health, development and education
- quick to use and easy to score
- valid, sensitive and specific
- free to download from the Youth in Mind website (www.sdqinfo.com).

⁵² Providers should have received formal training in the use of this tool (eg, via B4SC training), including how to discuss the purposes of the tool with parents, administer the tool and communicate findings and need for referral.

The version of the SDQ for three- and four-year-olds was selected for the B4 School Check as its language is more appropriate to describe preschool children's behaviour than is the language of the version for children aged 4–10 years.

Robustness of the questionnaire score

The SDQ score is significantly more sensitive (ie, it will be better at identifying strengths and difficulties) if both a parent and a teacher complete the questionnaire (versions SDQ–P and SDQ–T respectively) (Goodman et al 2000). Therefore, if the child is participating in early childhood education, their teacher should be encouraged to complete the teacher version of the questionnaire and be prepared to discuss their findings with the child's parents (SDQ–T3/4).

The SDQ is based on the Child Behaviour Checklist and Rutter questionnaires, which have long been used in clinical and educational practice, but it puts more emphasis on the child's strengths rather than just their difficulties (Goodman 1997).

The SDQ's focus is whether a child has difficulty with emotions, concentration, behaviour or getting along with others. It is currently being evaluated in the New Zealand setting for predictive validity, reliability, sensitivity and specificity. However, the evidence so far indicates that it is a robust tool. It is used by several countries and is available in many languages.

The SDQ, while behavioural in focus, contains good principles for considering a child's strengths as well as many areas of difficulty. It reflects current academic thought about risk and resilience and about the impact both these factors have on a child's development and learning (Allen and Clarke 2005).

Content of the questionnaire

The SDQ comprises five scales of five items each that refer to different emotions or behaviours. The parent and/or teacher complete their respective questionnaire by marking each item as 'Not true', 'Somewhat true' or 'Certainly true'.

The scales are scored to produce an overall score that indicates whether the child is likely to have a significant problem.

Selected items can also be used to form subscales for prosocial behaviour, hyperactivity, emotional symptoms, conduct and peer problems (Goodman 1997). It is usually easiest to score all five scales first before working out the total difficulties score. The answers are given on the basis of the child's behaviour over the last six months.

On the back of each questionnaire are questions that aim to assess the severity of the child's problems by scoring the duration of the difficulties and their impact on the child or others.

Evaluation of the questionnaire

An evaluation found that nurses should offer to read and complete the questionnaire with the parent. In this way, they can mitigate any literacy or language barriers the parent might have and answer the parent's questions (CBG Health Research 2007).

Guidance for administering the questionnaire

Further guidance for scoring and administering the SDQ is available in the toolkit provided as part of the B4 School Check train-the-trainer programme. However, note the following points.

Copyright

The SDQ (including content and form) are copyright documents and must not be modified or reproduced in any way, shape or form. The questionnaires when used must be downloaded and printed from <http://www.sdqinfo.org/> (once downloaded they may then be photocopied). Further information about copyright can be found at <http://www.sdqinfo.org/>.

Time required to complete the questionnaire

The questionnaire takes 5–10 minutes to complete.

Do not reword questionnaire and answers

Do not change the wording of the questions or answers, because this will change the validity of the tool.

Working with parents and teachers

Early childhood teachers play an important role in identifying children with behavioural difficulties. If a child undergoing a B4 School Check attends an early childhood centre, the teacher who knows them best should be asked and supported to fill out an SDQ–T.

Explain to the respondent – whether a parent or teacher – where and how the questionnaire fits into the overall B4 School Check assessment. As part of the B4 School Check, parents and teachers complete the SDQ to help us understand a child’s behaviour and emotional development.

Emphasise to parents and teachers that the SDQ’s purpose in relation to the B4 School Check is not to judge or label children. Rather, it is used to make sure the child has no problems that might hinder them from learning and to get appropriate support and help for the child, their family and whānau if any problems are identified.

Parents may be intimidated by the SDQ or it may raise anxieties about their child. Introduce and discuss the SDQ in a way that minimises parental anxiety and reassures parents about the purpose of the questionnaire.

Avoid saying things like, ‘I need your permission to administer the SDQ’ or ‘Sorry for having to put you through this’ or ‘You don’t have to do this if you don’t want to’. Such statements may prompt parents to react negatively or fearfully.

Completing the questionnaire

Offer the parent help and support with filling out the SDQ. If they appear uncomfortable working with you, they may prefer help from someone else (perhaps a member of their own community). Support that wish and do not make assumptions about their literacy or ability to complete the form on their own.

Discussing and communicating results

Try to keep any discussion to after the parent or teacher has finished the questionnaire, although sometimes you will need to acknowledge what the parent or teacher is saying immediately.

When communicating the results of the questionnaire to the parent or teacher, avoid using terms such as 'borderline' and 'abnormal' in relation to the child. These terms are unhelpful outside a clinical context, and are likely to make a parent anxious or react negatively. It is better to use the term 'concerning' if the child has a high score which will require referral.

It is vital to fully discuss the results of the questionnaire with parents for three reasons.

- It is important to establish the level and nature of any difficulties clearly. (Information from other sources is also relevant for this purpose.)
- Even if the child's overall score is below the cut-off point indicative of significant difficulties, some issues may still be important to the respondent.
- It is crucial you understand how the child, parent and other family or whānau members are responding to how the child is and what the child is doing and saying.

More information

For more information about issues and questions that may arise during the administration of the SDQ, see the toolkit provided for B4 School Check practitioners.

Procedure for administering the questionnaire

Follow this procedure to administer the SDQ.

Have the correct form ready, for example, the:

- SDQ-P3/4 for a parent (or other caregiver)
- SDQ-T3/4 for a teacher.

1. Briefly explain the SDQ to the parent and answer their questions.

Remember that the SDQ-P3/4 asks about behaviour in the **past six months**.

2. Ask the parent whether they would like you to go through the SDQ with them or whether they would prefer to fill it in on their own.

If the parent wants to fill out the SDQ on their own, provide clear instruction about the process for completing the questionnaire (as above). Provide them with a stamped addressed envelope to encourage them to return it. If the parent wants you to go through the SDQ with them, work through the 25 questions on page 1 plus the impact questions on page 2. However, if the parent answers 'no' to the first 'overall' impact question, do not continue with the rest of the impact questions.

Remember to ask, 'Do you have any other comments or concerns?', which is at the bottom of page 1.

3. Fill in the parent's answers by ticking the relevant 'Not true', 'Somewhat true' or 'Certainly true' box.
4. Score the questionnaire (see below).
5. Discuss the results with the parents.

Guidance for scoring and interpreting the questionnaire

Further guidance for scoring and administering the SDQ is available in the toolkit provided as part of the B4 School Check train-the-trainer programme. However, note the following points.

Guidance for scoring the questionnaire

Scoring is explained on the scoring sheet that accompanies the SDQ (refer <http://www.sdqinfo.org/py/sdqinfo/c0.py>).

Each item is scored 0, 1 or 2. 'Somewhat true' always scores 1. 'Not true' and 'Certainly true' are scored 0 or 2, depending on whether the item is framed as a strength or difficulty. The 20 difficulty items are scored to make up a 'total difficulties score'.

The impact questions are also scored. This score can be used to help interpret the 'total difficulties score' because it indicates how much impact the difficulties are having on the child's life at home or at school.

The scoring sheet explains which item contributes to which subscale.

The prosocial scale is scored so that an absence of prosocial behaviour scores low. A child may still have difficulties, but if they have a high prosocial score, the outlook for intervention is better than if they have a low score. Also, in taking a strengths-based approach to interventions, it will be possible to build on the child's acknowledged areas of strength.

The scoring sheet has a chart that indicates which total scores are low, average or high in the general population. High scores overall or for any subscale point to the likelihood of a significant disorder and/or a disorder of a particular type. The instrument has been proven useful for screening, but high scores do not guarantee that a disorder will be found after a more thorough assessment and low scores do not guarantee the absence of problems.

Procedure for scoring (for parent or teacher version)

Follow this procedure to score the SDQ-P or SDQ-T.

Have ready:

- the completed SDQ
- five scoring transparencies (the [scoring sheets](#) can be downloaded for free from the Youth in Mind website, www.sdqinfo.com, and copied onto transparencies)
- the SDQ record sheet.

If you score:

- using the scoring transparencies, go to step 1 below
 - by hand (although this method is not recommended as it is more time-consuming than using the scoring transparencies), go to step 4
1. Place one scoring transparency over the completed questionnaire.
 2. Count only the numbers that show at the 0, 1 or 2 areas if any ticks are present.
 3. Repeat steps 1 and 2 for each of the remaining four transparencies, then go to step 4.
 4. Use the scoring sheet that accompanies the SDQ (refer www.sdqinfo.org/py/sdqinfo/c0.py). Find each question then score the result.
 5. On the SDQ record sheet, fill in the number counted for the child for each of the five attributes: emotional, conduct, hyperactivity, peer problems and prosocial behaviour.
Make sure that you record the score on the correct informant line (ie, parent or teacher).

6. Add the score for the first four attributes (emotional, conduct, hyperactivity, peer problems). Scores will show as 'normal', 'borderline' or 'abnormal' for each attribute and for the 'total difficulties' score.

Important: Do not use the words 'borderline' or 'abnormal' when communicating the results back to the parent. Use the term 'concerning' to acknowledge parents' concern.

7. Score the impact questions if the parent or teacher answered 'yes' to the first 'overall' impact question and answered the subsequent impact questions.
8. For the questions on distress to the child and impact on the child's life (home life, friendships, learning and leisure activities), the following scores apply.
 - 'Not at all' and 'Only a little' are scored 0.
 - 'Quite a lot' is scored 1.
 - 'A great deal' is scored 2.

The responses to questions on chronicity ('How long have these difficulties been present?') and burden ('Do the difficulties put a burden on you or the family?') are **not** included in the impact score. However, these can be taken into account when considering referral for children who have a high 'total difficulties score'.

A total impact score of:

- 2 or more is considered 'concerning'
- 1 is 'some concern'
- 0 is 'no concern'.

9. Record the impact score on the SDQ record sheet, making sure that you score on the correct informant line (ie, parent or teacher).

Guidance for interpreting scores

If the child's total difficulties score is between 17 and 40 for a parent-completed SDQ or between 16 and 40 for a teacher-completed SDQ), **refer** the child for further assessment. See 'Secondary assessments and referrals' below.

Use the impact score to inform decisions about referrals, as it indicates the distress caused to the child by the problem and the degree of impact of the problem on various areas of the child's life.

If child's total difficulties score indicates 'some concern' (ie, 14–16 for a parent-completed SDQ or 12–15 for a teacher-completed SDQ), consider non-referral interventions. See 'Secondary assessments and referrals' below.

If the child's total difficulties score is 'no concern' (ie, 0–13 for a parent-completed SDQ or 0–11 for a teacher-completed SDQ), no further action is required.

Discuss the results of the questionnaire with the parent and any concerns that they raise.

Secondary assessment and referrals

Refer to the clinical referral pathway (Figures 17 and 18). The SDQ is a screening tool; it is not diagnostic. Therefore, it is only an initial indication of whether a child, their family and whānau may need support and/or intervention.

Total difficulties score between 17 and 40

A 'concerning' (prev. abnormal) total difficulties score on either of the SDQ-P or SDQ-T identifies possible mental health difficulties, socio-emotional issues or other developmental disorders affecting the child, their family and whānau. The SDQ is significantly more sensitive when both the SDQ-P and SDQ-T have been completed than when only one has been completed.

Refer a child with 'concerning' scores to a paediatrician, a child mental health specialist or the Child and Adolescent Mental Health Services, or Ministry of Education: Special Education, depending on the type of further evaluation and management the child needs. A multidisciplinary team is the ideal referral pathway. The subscores may assist in defining the best referral pathway. This is best defined locally based on the experience and availability of expertise.

Review of 'concerning' total difficulties score

The cut-off for referral and New Zealand norms will be reviewed once the results of the current validation study become available. If problems are identified, refer children for diagnostic evaluation to determine their eligibility for services. Diagnostic evaluation involves an in-depth assessment with help from the family or whānau. It has three possible outcomes – that is, the diagnosis may be:

- of a mental health disorder, so formal intervention is needed
- behavioural issues that suggest some form of informal intervention may be helpful such as reading material or a play group
- normal behaviour (Tsiantis et al 2000).

'Some concern' (borderline) total difficulties score

If a child has a 'some concern' total difficulties score, discuss the child's strengths and difficulties with their parent and teacher. Consider recommending targeted parenting programmes to support the child, their family and whānau.

Age of child

The SDQ is administered as part of the B4 School Check when the child is four years old.

Personnel

Registered nurses or nurse practitioners with experience in child health will undertake the SDQ.

Resources

Resources for administering and scoring the SDQ behavioural assessment tool are provided at www.sdqinfo.com.

For [Information for professionals about the SDQ](#), visit the Youth in Mind website (www.sdqinfo.com).

For resources about child behaviour more generally, refer to [Referrals and resources](#) under 'Parenting skills and support'.

Figure 17: Strengths and Difficulties Questionnaire–Parent (SDQ–P) clinical referral pathway

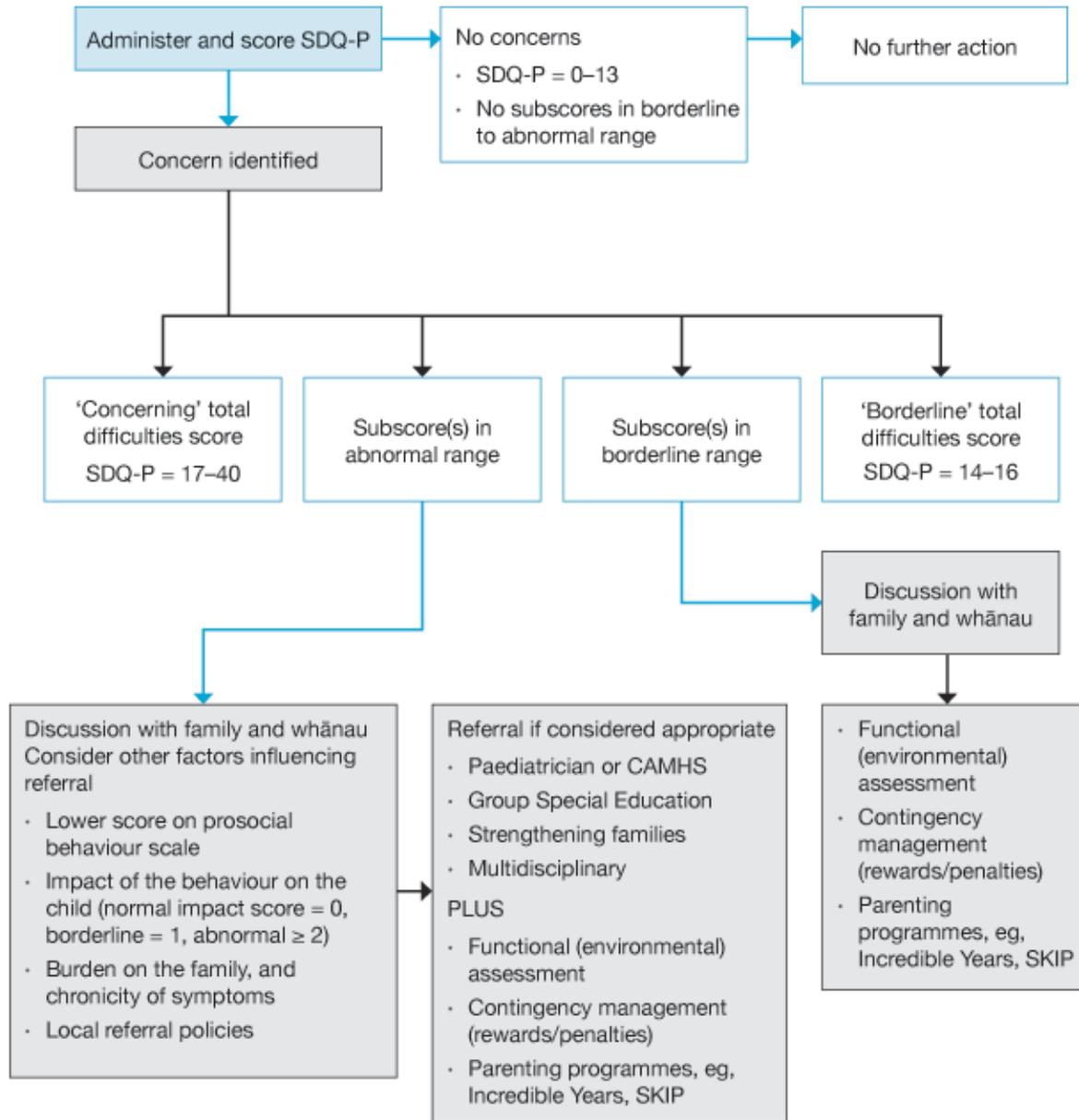
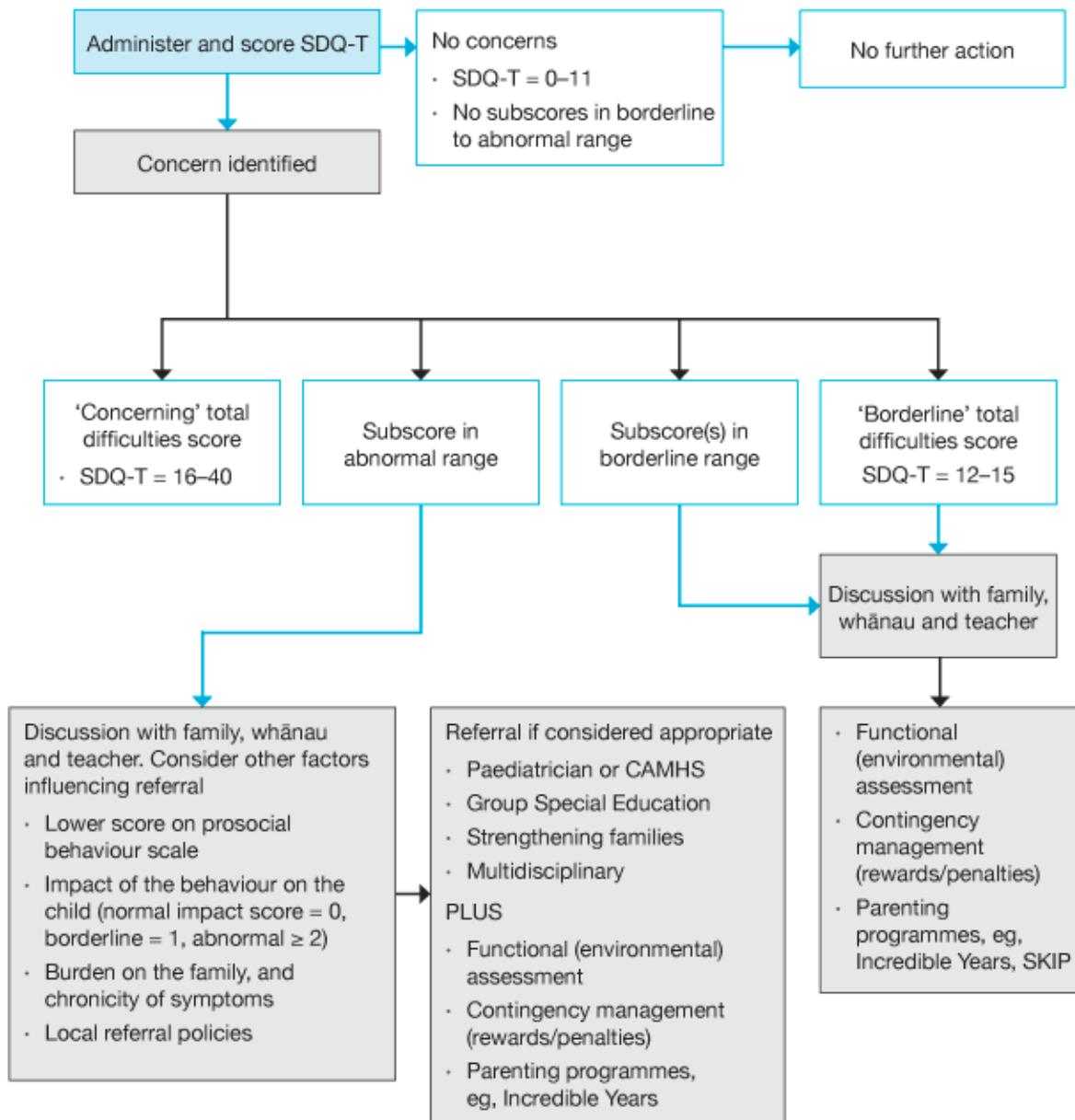


Figure 18: Strengths and Difficulties Questionnaire–Teacher (SDQ–T) clinical referral pathway



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Section 6:

Supporting vulnerable parents with specific needs

Overview of this section

Section links

This section links to the following components in section 4:

- development (and behaviour assessment in section 5)
- Whānau Ora
- Strengthening Families
- parenting skills and support
- supporting families to access income and housing assistance
- strengthening family relationships
- building social connectedness and social capital
- perinatal mental health
- infant and preschool mental health and attachment
- family violence assessment
- alcohol and other drugs.

Purpose

The foundation for optimal child development is primarily dependent on the quality of a child's relationships with parents, grandparents and other carers in the family and whānau. A child's growth and developmental progress rely on those relationships being safe, nurturing, stimulating and consistent.

Most parents can provide their children with an environment to grow up in that is safe, predictable and nurturing most of the time. Other parents find themselves dealing with multiple challenges that can impact on their capacity to parent and build and/or maintain safe, predictable and nurturing relationships.

This section is not about blaming parents. All parents, especially when they first become parents, want to do the best for their children. However, some parents face particular difficulties and challenges that will make it hard for them to provide good-enough parenting.

Providing parents with the support and services they need to meet their responsibilities of protecting and supporting their child's development is a key goal of WCTO services. WCTO services can contribute to identifying and addressing risk factors that impact on the early relationship between a parent and child. WCTO services can also support protective factors, which may prevent or reduce poor developmental outcomes for children and may exist alongside these complex and enduring challenges.

The wellbeing of the family and caregivers will be influenced by their cultural connections and the characteristics of the communities they live in. These influences include the quality of early childhood services and schools, safety and resources in the community, and the availability of adequate health and social services.

Vulnerable families are generally affected by a range of challenges that can have a direct impact on children and the parent–child relationship. It is common for multiple, interacting factors, such as family violence, prematurity, poverty and mental illness and/or an alcohol or drug disorder in a parent, to coexist in families alongside protective factors such as supportive friends, family and whānau.

Māori children in particular tend to experience higher rates of exposure to multiple risk factors. To start with, they are more likely to have parents who are younger, leave school early with fewer qualifications, and have limited engagement with antenatal services. These parents have higher levels of depression, and they are more likely to have infants with low birthweight and/or prematurity and higher rates of admission to neonatal care. Additionally they may live in poverty and in communities with limited resources.

These challenges may have less impact by strengthening protective factors. Some of these factors are specific to Māori, including having predictable, safe and close relationships with whānau (extended family), having knowledge of and access to tikanga and traditional practices – especially parenting practices of Tikanga Whakatipu Ririki⁵³ – and being connected to their marae and whakapapa.

Families with significant, long-term needs require high-intensity services and involvement with different multiple resources and/or agencies. Parents who are preoccupied by their life circumstances and environment may find it difficult to respond to and benefit from professional expertise and advice. A coordinated team approach to supporting such families is required. These vulnerable families, who are the focus of this section, can include:

- parents with little family support
- teen parents
- parents with a mental illness and/or problematic substance use or addiction
- parental disabilities
- parents with intellectual disability
- families with complex social needs including poverty and repeated or multiple crises
- families involved with CYF, the criminal justice system and/or the Family Court
- parents with criminal activities or gang associations
- highly mobile families
- families affected by changes in structure such as separation of parents and new partners
- new migrants and refugees, especially where the parents' comprehension of English is limited.

⁵³ Helen Mountain Harte, Tikanga Whakatipu Ririki – A Way of Raising Children. See www.ririki.org.nz

Key messages

Focus on what is in the best interest of the child

Safeguarding, promoting and enhancing the child's wellbeing are the main considerations when working with families. Family and whānau must be protected and supported as they are vital in a child's life and usually provide the best environment to support a child's development. However, assessments, planning and decision-making must always focus on what is in the best interests of the child. Where a child's safety, health or wellbeing is at significant risk of harm from their family or whānau, clear and appropriate referral pathways must be used to protect the child from harm. Providers of WCTO care must be skilled at balancing support for parents to build capacity and strengths with their focus on what is in the best interests of the child.

No one size fits all when engaging vulnerable families

Innovative and diverse methods are required to engage with families who are experiencing a number of issues and therefore may be wary of or not prioritise WCTO services. It is important that providers of WCTO care maintain good links with other community groups who may already be engaged with these families and be able to introduce or open the door to these families. Flexibility in timing and location of visits may be required, as well as additional resources such as disability supports, interpreters and transport.

Establish positive relationships with families

The initial contact that families have with services is critical in establishing positive relationships and identifying urgent need. Every person – adult and child – has the right to respect and dignity. The views, beliefs and values of the child, and of the parents in relation to the child's care, must be sought and understood at all times. Non-judgemental, supportive and effective communication is required with parents, families, whānau and other professionals involved with the families.

Take a family-centred approach

With a family-centred approach that makes the parents, family and whānau partners in assessment, treatment and evaluation, parents need not feel helpless and angry and positive outcomes are more likely. Involve parents fully in planning the timing and content of each contact so that care is flexible and tailored to meet their child's needs. Parents must be given the opportunity to make informed decisions about their own and their child's care and any interventions needed.

Balance risk factors with resilience and protective factors

As risk factors increase in their number, frequency and length of exposure, the immediate, medium-term and long-term risks for the child accumulate. It is important to identify protective factors and build on those with the family as well as making appropriate referrals for additional support. This priority highlights the need for comprehensive and thorough assessment in partnership with these families using information gained from many different sources and agencies to plan the frequency and type of additional support needed. A focus on risk factors alone can leave families feeling judged or to blame for their circumstances and misses an opportunity to support the family to build capacity based on their strengths.

Focus on the parent–infant relationship

Assessments with families need to consider the impact of parental difficulties on caregiving and the developing infant–parent relationship. Again, be thoughtful as parents' intentions are to do the best for their infants. Taking a family-centred, collaborative approach, discuss concerns parents may have about their relationship with their baby, the baby's communication and responsiveness, and whether the parents' difficulties are having an impact on how they want to parent.

Consider referrals for interventions that address the parental and/or family issues and the developing parent–child relationship.

Coordinate assessment and services

Multidisciplinary, collaborative and intersectoral virtual teams⁵⁴ are necessary to support families with highly complex needs. No single intervention is likely to be effective and different forms of support and services will be required from providers. There is a need to coordinate the assessments and services these providers offer for vulnerable families to reduce the number of times a family has to repeat information, ensure families don't fall through gaps between services and reduce the burden on vulnerable families having to navigate multiple services and appointments.

Provide useful and practical information for parents

Parents need useful and practical information about child development to support them in their parenting role. All information will be accurate and up to date, tailored to meet the needs of the individual parents and provided in a form that is accessible to the parents. For vulnerable parents in particular, information must be provided within the context of an open discussion between the provider and parents rather than just in written form.

Provide up-to-date information on local services and referral pathways

It is essential that providers of WCTO services have a comprehensive and up-to-date understanding of local services and referral pathways to effectively support families. Availability of community support organisations and services, social networks, mutual aid and peer groups will be crucial to supporting the family to enhance their child's development. Compile and maintain a list of locally available support organisations and the services or interventions they provide, to refer families to for assistance. As areas may differ in agreed referral pathways for support, collaborate with local child health and social service networks to determine the appropriate referral paths in their area.

Age of child

For parents/caregivers, family and whānau of children from birth to 5 years, information and anticipatory guidance should be provided in accordance with the WCTO Schedule and at other times in response to identified needs.

⁵⁴ In a virtual team, the members are likely to come from different organisations, not be co-located and probably not work under the same contract or services. However, they work together 'virtually' by email, phone and possibly some physical meetings to collaborate and coordinate their services around high-need populations so that the parents receive more joined-up, coordinated services.

It is especially important to identify and provide support (where realistic) or referral to appropriate services for any issues parents experience that impact on caregiving and/or the bond with their infant in the first year. Refer to [Infant and preschool mental health and attachment](#) (section 4) for information on problematic parent–child relationships and referral for assessment and intervention.

Personnel

All providers of WCTO services – including LMCs (obstetricians, midwives or general practitioners), paediatricians, general practice and WCTO Provider teams – deliver this component.

General guidance for supporting vulnerable families

Engagement and relationship building

While most parents will make full use of the services on offer, the circumstances of some vulnerable families makes accessing WCTO services difficult. Engagement difficulties may be due to pragmatic issues such as lack of phone or transport, frequent changes in address or chaotic family functioning; or perceived barriers such as negative perceptions of mental health, disability or medical status, involvement with CYF and/or police or reluctance to talk about family business.

Providers of WCTO services working in partnership with other agencies must ensure that the services are available and accessible to all families in their boundaries, especially vulnerable groups. Consider the following when planning services to engage vulnerable families:

- be flexible in the timing, location and nature of each WCTO visit
- coordinate with and deliver WCTO services from alternative settings where vulnerable families may already be engaged
- consider any support the family may require to improve their access to WCTO services such as disability supports, interpreters and transport.

Establishing both initial contact and ongoing engagement and continuity of care can be a challenge with vulnerable families who may be wary of or not prioritise WCTO services. However, it is a crucial first step to providing these families with support as many will be reluctant to disclose their problems and concerns, especially if they worry the outcome may be that child protection services become involved. Research has shown the following factors are important in developing and maintaining a trusting relationship with families.

- When initiating the relationship, engage in conversation, not a set of questions.
- Be open and listen to what parents and family want to discuss and achieve. What does the family want help with?
- Be responsive to the different cultural needs of families.
- Value parents as partners in assessing the child’s wellbeing and in the contribution they can make.
- Be genuine and honest.
- Show empathy in attempting to understand the world from the viewpoint of the parents.
- Be predictable and consistent.

It is well documented that some families are reluctant to participate in programmes that identify them as at risk. A key to supporting these families is acknowledging strengths and protective factors that they can build on to address any risks to the safety and wellbeing of the child.

All practitioners need to be aware of and resist the tendency to judge and act on the perceived social worth of parents. Worthiness in this sense can be either a perception based on social status or a judgement of whether the family's needs are a legitimate call on the practitioner's time and/or whether they deserve help.

Assessment

The Paramountcy principle (Mahony 2002) makes it clear that the welfare and interests of the infant or child shall be the main consideration for WCTO Providers. Emphasise the needs of the child in discussions with parents and always consider the child's safety.

The circumstances of children and their families will constantly change. Assessment provides the opportunity to evaluate the changing strengths and needs of the family and to ensure the WCTO practitioner has an opportunity to consciously stop and reflect on the child's wellbeing and the family's circumstances.

Assessment should be comprehensive, covering all aspects of the child's life, including the circumstances of the parents, wider family and whānau. At every core contact, the provider of WCTO care will:

- discuss any parental concerns
- where appropriate, enquire about the parents' health and wellbeing
- provide information about local support networks and contacts for additional advice
- facilitate referrals as appropriate and agreed with the family
- make a plan with the family for ongoing support and contact.

Assessing the impact of parents' behaviour or the circumstances of the family or whānau on the infant's wellbeing requires information gathered from a number of sources, including observation of the infant's developmental progress and the infant–parent relationship. Refer to [Infant and preschool mental health and attachment](#) (section 4) for information to support you in assessing and supporting these relationships. Because a warm, predictable, responsive relationship with a parent/caregiver is central to the optimal development and resilience of the infant or young child, intervention is directed to the relationship and caregiving.

Assessment is a collaborative process between the provider of WCTO services, the parent and the child and takes into consideration other professionals' views of the child where available. Providers of WCTO care must combine these views to gain a multidimensional view of a child's strengths and the risks to their wellbeing.

A number of assessment tools, frameworks and screens to assess where the family is at are discussed in sections 2 to 5. They are intended as a guide to inform professional judgement and discussion with the family and to draw attention to the factors that are likely to contribute to health, wellbeing and resilience.

Consider factors that may enhance a family's capacity to cope with stressors or problems, such as the availability of extended family support, good relationships with friends or neighbours or factors promoting personal resilience. The objective is to plan the right course of action to achieve positive outcomes for the child.

Use professional judgement to consider the nature and frequency of further contacts with the family according to their concerns and needs. Negotiate and agree these contacts with each family, and document the outcome of these discussions. In addition to the agreed programme of contacts, opportunistic reviews may be undertaken as and when the family makes contact with the service. The need for support may also be identified through other professionals in contact with the child and/or family. Encourage these professionals to make referrals for additional support to providers of WCTO services.

Referrals and support services

If the family or whānau has not already been referred to Family Start, discuss with them the benefits of Family Start and, with their consent, make a referral for support. Visit the Family and Community Services website (www.familyservices.govt.nz) for referral information.

Attending quality ECE has been shown to be beneficial for a child's development while providing additional benefits to parents. This is especially true for children, families and whānau facing adverse circumstances. Encourage the family or whānau to register the child with a licensed ECE facility before the child is 18 months of age and, where necessary, facilitate enrolment (see [Early childhood education](#) in section 4).

Individuals turn first for support to people they trust, typically family and friends, and subsequently to a range of people encountered in their everyday lives. Social networks reduce the stress of disadvantage. They can also strengthen a parent's motivation to care for themselves and others as well as their belief in their ability to be a good parent. Reconstituted families, alienation between parents and children, frequent moves of home, and poor transport are believed to weaken social networks and reduce the extent to which child care knowledge is transmitted between generations. Those parents with the most to gain from social support networks are often the least accessible and least amenable to receiving help unless someone, usually a practitioner, leads them to participate. Enquire about the family's social support networks, discuss local support services and opportunities to increase their support networks and, where necessary, facilitate access to these support networks. Refer to [Building social connectedness and social capital](#) (section 4) for more details on the types of services available.

Vulnerable families may also benefit from referrals to Whānau Ora provider collectives or the Strengthening Families process. These services are discussed further in [Care and support for families and whānau](#) (section 4).

Hoki Ki Te Rito Group Parenting Programme (www.ohomairangi.org.nz) has success in engaging families with multiple adversities. The website has information on the programme and a short film for parents.

Resources and additional reading

Atwool N. 2010. *Children in Care: A report into the quality of services provided to children in care*. Wellington: Office of the Children's Commissioner. URL: www.occ.org.nz/__data/assets/pdf_file/0008/7694/CC_ChildreninCareReport_09.09.2010.pdf (accessed 13 March 2013).

Charter on the Rights of Tamariki Children & Rangatahi Young People in Healthcare Services in Aotearoa New Zealand. Children's Hospitals Australasia, Paediatric Society of New Zealand. URL: <http://children.wcha.asn.au/children-and-young-peoples-rights-healthcare-services-charter> (accessed 25 March 2013).

Early childhood education information for parents, family and whānau, www.minedu.govt.nz/Parents/EarlyYears.aspx

Family Services Directory, www.familyservices.govt.nz/directory

Hall D, Elliman D. 2006. *Health for All Children* (revised 4th ed). Oxford: Royal College of Paediatrics and Health.

Mahony PD. 2002. *New Zealand Initiatives in Decision Making Around Child Protection Issues*. URL: <http://www.justice.govt.nz/courts/family-court/publications/speeches-and-papers/archived-speeches/new-zealand-initiatives-in-decision-making-around-child-protection-issues>

Mares S, Newman L, Warren B. 2011. Families with multiple adversities. In *Clinical Skills in Infant Mental Health: The first three years* (2nd ed). Melbourne: ACER Press.

Ministry of Social Development's Family and Community Services website, www.familyservices.govt.nz

National Scientific Council on the Developing Child. 2005. *Excessive Stress Disrupts the Architecture of the Developing Brain*. Working Paper No. 3. URL: http://developingchild.harvard.edu/index.php/resources/reports_and_working_papers/working_papers/wp3/ (accessed 15 January 2013).

National Scientific Council on the Developing Child. 2012. The Science of Neglect: The persistent absence of responsive care disrupts the developing brain. Working Paper No. 12. URL: http://developingchild.harvard.edu/index.php/resources/reports_and_working_papers/working_papers/wp12 (accessed 31 March 2013).

The White Paper for Vulnerable Children, www.childrensactionplan.govt.nz

Specific guidance for supporting vulnerable families

Teen parents

Children born to unsupported teen parents and the teen parents themselves are particularly vulnerable groups. This statement does not mean that all young parents have high support needs solely because of their age, but acknowledges that younger parents as a group tend to experience multiple disadvantages that impact on outcomes for their children. Teen parents are at higher risk of:

- leaving school early with no qualifications, limiting their earning potential and social contact with peers
- living off limited income and/or benefits
- mental illness and/or substance abuse
- being a sole parent
- experiencing family violence and child maltreatment.

In addition to being vulnerable, teen parents have a different range of health needs themselves. Young people also tend to prioritise different aspects of life and health compared with practitioners – for example, in relation to housing and personal relationships – and therefore may not respond to traditional methods of health education (ie, given as directions or as written information only). Access to continuing education can have positive outcomes for the emotional wellbeing of the parents and the long-term financial security of the family.

It may be difficult for WCTO services to engage with teen parents on an ongoing basis because these parents may have competing priorities and many other agencies may be involved in their lives. Maintaining good relationships with other health, education and social services that provide dedicated youth services may facilitate access to WCTO services for young parents, by either making introductions or providing a neutral site for delivery of services.

Considerations with teen parents

- Enquire whether a teen parent is currently receiving services from a dedicated youth health service and, if so, seek consent to share information with that service as necessary.
- If they are not involved with a youth health service, consider undertaking a HEADSS⁵⁵ assessment with the young person or making a referral to a dedicated youth health service where available.
- Discuss with the parent any plans or desires to continue their education and provide information on locally available opportunities for education and training, including child care provisions.
- Discuss the availability and benefits of social, parenting and other support groups and services specifically for young parents.
- With the parent's consent, make and facilitate referrals.

Resources and additional reading

Families Commission reports on teen pregnancy and parenting:

- *Teenage Pregnancy and Parenting: An overview.* (nd). URL: www.familiescommission.org.nz/publications/research-reports/teenage-pregnancy-and-parenting (accessed 22 March 2013).
- Pihama L. (nd). *Overview of Māori Teen Pregnancy.* URL: www.familiescommission.org.nz/publications/research-reports/overview-of-m%C4%81ori-teen-pregnancy (accessed 22 March 2013).
- Kaipuke Consultants. 2012. *Regional Trends in Teenage Parenthood.* URL: www.familiescommission.org.nz/publications/research-reports/regional-trends-in-teenage-parenthood (accessed 22 March 2013).

HealthEd resources on teen health, www.healthed.govt.nz (choose 'Teen health' from the dropdown menu).

Ministry of Health publications on youth health, www.health.govt.nz/search/results/Youth%20Health

Ministry of Social Development Youth Service website, www.youthservice.govt.nz – for information and resources for young people looking for education, employment or work-based training.

Youth development resources, www.arataiohi.org.nz/YouthDevelopmentResources

Winnard D, Denny S, Fleming T. 2005. *Successful School Health Services for Adolescents: Best practice review.* Auckland: Kidz First Community Health – Centre for Youth Health. URL: www.schoolnurse.org.nz/best_practice.html (accessed 13 March 2013).

⁵⁵ The HEADSS Assessment Framework includes questions on home (H), education/employment (E), eating and exercise (E), activities (A), drugs/alcohol (D), sexual health/sexuality (S) and suicidality/mood (S).

Parents with intellectual disabilities

Disabled parents' needs for support vary widely, and any support required is likely to change over time. At various points in their life, disabled parents may require support with parenting. Support must be flexible and responsive to changes in individual and family circumstances, non-judgemental and easy to access.

It is conservatively estimated that approximately 2.5 families per 1000 in New Zealand include at least one parent with an intellectual disability. Research cautions that a parent's competence should never be predicted on a simple measure or label of intellectual disability. The majority of people with intellectual disability who become parents are those with milder degrees of disability. Because of the stigma associated with a label of intellectual disability, parents may hide their learning difficulties and may not identify as a person with a disability or use disability-related services.

Children of parents with an intellectual or learning disability may have a number of problems, depending on the severity and cause of the disability. The child may have similar difficulties and need investigation to identify the cause. The parent may experience difficulty with general care of themselves. Parenting may be compromised especially where the infant or young child has additional needs (eg, prematurity, feeding problems, is irritable and/or unsettled), and there are limited or no supports and protective factors. Neglect may be an unintended consequence of parenting difficulties.

Disabled parents may also view the fact that they share a disability with their child as a positive factor, allowing them to better understand and support their child when they face challenges related to their disability.

Influences on the wellbeing of disabled parents, their families and whānau may include poverty, low incomes, social isolation and inadequate professional support. When families are well resourced, financially and socially, they are better able to meet day-to-day challenges posed by the disability. Disabled parents, their families and whānau, and support providers need to be well informed about the available support and resources, and where and how to access them.

Disabled parents continue to face attitudinal barriers, including discrimination and misunderstandings about their abilities, and their right to parent may be questioned. Parents with intellectual disabilities are particularly vulnerable. Not all disabled parents will need, seek or welcome support. Some may perceive offers of assistance as unnecessary and intrusive. Some disabled parents are reluctant to approach health and social services in case this is seen as a sign that they are having difficulties.

When engaging with families, keep their abilities and strengths at the forefront because these assist them in coping with challenges. Protective factors identified with positive parenting outcomes include being prepared to ask for help and support, having a strong partner who is not (intellectually) disabled, and in particular the presence of a strong and supportive social network, and adequate professional support.

Considerations with parents with intellectual disabilities

- Use conversational and observation skills and professional judgement to identify any impact the parent's disability is having on the child's wellbeing and development. Be alert to neglect and the degree to which the parent's disability is well supported by disability support agencies.
- If appropriate, facilitate referrals and/or access to local Needs Assessment and Service Coordination (NASC) and/or Disability Information and Advisory Services (DIAS).
- Discuss with the family any basic support needs such as housing, income and budgeting and, if appropriate, make a referral to the relevant agency with the family's consent.
- Enquire about and note the presence of any protective factors or strengths and discuss with the family how these strengths may help in planning their support needs.
- Consider the parent's need for information and the form in which they will find it most accessible. Information will usually be best received via conversation and within the context of a trusting relationship with the provider.

Resources and additional reading

Families Commission. October 2012. *Disabled Parents: Diversity, experiences and support needs*. Wellington: Families Commission. URL: www.familiescommission.org.nz/publications/research-reports/disabled-parents (accessed 13 March 2013).

Ministry of Health website (www.health.govt.nz):

- Your health, [Disability services](#) section
- contact details for [DIAS organisations](#) and for [NASC organisations](#).

Ministry of Social Development, www.msd.govt.nz, for information on [support for people with disabilities](#).

Raffensperger M, Morton M, Gage J, et al. 2012. *From Our Perspective: Exploring the strengths and resilience of families that include a parent with a disability*. Research Report 7/12. Wellington: Families Commission. URL: www.familiescommission.org.nz/publications/research-reports/from-our-perspective (accessed 13 March 2013).

Parents experiencing significant financial difficulties or poverty

Parents experiencing significant financial difficulties or poverty are seriously stressed. They experience more adverse life events, including higher levels of depression, anxiety, alcohol and drug use, and poor physical health including ischaemic heart disease.

The infants and young children of these parents have a higher incidence of prematurity, intrauterine growth restriction, SUDI, neglect and/or abuse, injuries and exposure to family violence. These children are more likely to experience learning, social, emotional, behavioural and physical health problems, including more hospital admissions, dental decay, injuries, oppositional and conduct disorders and educational problems. In adolescence, compared with their peers who are not experiencing these cumulative adverse events, this group has a higher rate of unplanned pregnancies, substance abuse, delinquent/criminal behaviour and involvement with the justice system, mental health problems including depression, anxiety, self-harm, suicide, and leaving school early with lower educational achievement.

Families experiencing poverty tend to live in deprived communities characterised by higher levels of unemployment and benefit dependency, unemployment, low incomes, family breakdowns, and social dysfunction including crime, violence, alcohol and drug abuse, low educational attainment and poor health outcomes. These environments are unpredictable and stressful, affecting safety and wellbeing of both the child and parents.

Poverty and deprivation are complex issues. In countries like New Zealand, relative poverty is more closely related to negative health outcomes than absolute poverty. Poverty includes not only material poverty but also poverty of information, choice and access to essential services.

Providers of WCTO services cannot increase a family's income, but practitioners can work with a family to support them in promoting the wellbeing of the parents and their children. Where families have debts with their primary health organisation (PHO), they may have anxieties and/or a sense of shame that gets in the way of seeking timely medical help for their children. Providers of WCTO services can check the family is receiving all their income entitlements, through facilitating referrals to relevant agencies and if necessary advocating for the family (eg, with their PHO).

Families living in poverty may not seek help when it is needed. They may be focused on and/or overwhelmed by internal problems as well as external problems of money, housing or work so that WCTO checks for apparently healthy children have a lower priority. Lack of transport and a telephone can lead them to miss appointments, which practitioners may find irritating and misinterpret as indifference or neglect. Parents and children may be difficult to visit at home because the parents are out at work or seeking work, the family moves frequently and/or the child may be with a friend, child minder or extended family for most of the day. Providers of WCTO services may need to offer flexibility in timing and location of visits to assist these families to make appointments. Maintaining good relationships with local social support agencies and services may facilitate access to WCTO services for these families.

There are children with immediate needs whose parents do not have sufficient income to adequately feed, house and clothe them and keep them warm. In addition, many families have difficulty accessing benefits appropriately and/or struggle with budgeting for essential expenses on a limited income. For many parents, poor housing is a major preoccupation. Inadequate insulation, condensation, damp, inefficient heating systems and fuel costs contribute to the problem.

Socioeconomically deprived communities also have strengths that WCTO Providers need to be aware of. There may be community-led programmes funded to build on these strengths and address the above issues at a community level.

Considerations with parents experiencing significant financial difficulties or poverty

- Consider and discuss with the family their income, housing, transport, employment, budgeting and other basic needs. Offer assistance either directly or by referral to the relevant agency.
- Identify families who would benefit from government initiatives on improving housing and make referrals to the relevant departments. See [Supporting families to access income and housing assistance](#) (section 4) for more information.
- Providers of WCTO services can play a role in advocating on behalf of their communities for access to community development funds and projects.

Resources and additional reading

The Children's Social Health Monitor, www.nzchildren.co.nz

Couchman J. 2012. *One Step at a Time: Supporting families and whānau in financial hardship*. Research Report 3/12. Wellington: Families Commission. URL: www.familiescommission.org.nz/publications/research-reports/one-step-at-a-time (accessed 22 March 2013).

Expert Advisory Group on Solutions to Child Poverty. 2012. *Solutions to Child Poverty in New Zealand: Evidence for action*. Wellington: Office of the Children's Commissioner. URL: www.occ.org.nz/publications/child_poverty (accessed 22 March 2013).

Families Commission. 2009. *Escaping the Debt Trap: Experiences of New Zealand families accessing budgeting services*. Research Report 6/09. Wellington: Families Commission. URL: www.familiescommission.org.nz/publications/research-reports/escaping-the-debt-trap (accessed 22 March 2013).

Housing New Zealand, www.hnzc.co.nz, for [information and resources on renting a property](#).

Ministry of Social Development community initiatives and services, www.workandincome.govt.nz/community

Office of the Children's Commissioner, www.occ.org.nz, for a list of [Expert Advisory Group on Solutions to Child Poverty working papers](#).

Support and assistance available for families and children, www.workandincome.govt.nz/individuals/how-we-can-help-you/families-and-children.html
Warm Up New Zealand: Heat Smart initiative, information on the Energy Efficiency and Conservation Authority website, www.eeca.govt.nz

Parents involved in criminal activities or with gang associations

Parents who have gang associations or are involved in criminal activities, and their children, are among the most socially excluded groups in our society. Their children tend to have complex needs and are at higher risk of:

- growing up in violent and unstable home environments
- exposure to family violence, neglect, and alcohol and drug abuse
- repeated changes in or loss of primary caregivers
- mental health problems beginning in infancy, including post-traumatic stress disorder, oppositional and conduct disorder, depression, anxiety, self-harm
- physical health problems
- experiencing poverty and social disadvantage
- difficulties engaging with early childhood education
- being fostered (within family or out-of-home foster care) and having multiple foster placements.

Parents who are criminally active or gang associated are more likely than the general population to:

- be unemployed
- live in socioeconomically deprived areas
- have low education attainment and skills
- have multiple mental health problems, including drug and alcohol abuse
- experience involvement in the criminal justice system and/or imprisonment
- have relationship difficulties
- have experience of abuse and neglect.

Parental imprisonment can exacerbate these issues through the stigma experienced by the children and other family members, the potential for financial and housing instability, unstable care arrangements for children, and distress in trying to maintain contact and relationships with the prisoner. Positive effects on wellbeing for the family can include relief from family violence and from exposure to drug and alcohol abuse.

While being among those in greatest need of health and other services, these parents tend to be highly service resistant. They are in general wary, distrustful and unwilling to engage with service providers. They may fear judgement and consequences, have chaotic lives, be overwhelmed by multiple and intractable difficulties, and struggle to develop trusting relationships with practitioners. The children and parents in these situations will often have missed out on many routine services.

The first interaction between the practitioner and the parents sets the tone for how the relationship will proceed and, in some cases, whether it will continue. The nature of the relationship the practitioner establishes will determine whether the parents are willing to meet a second time and, in time, to communicate their concerns and questions regarding their children's development, their parenting and the parent–child relationship.

Avoid making judgements and assumptions about parents' involvement in gangs and criminal groups. For many gang members and associates, gangs provide them with a sense of family and belonging that has frequently been absent from their own childhood, as well as a form of income, housing and protection. However, gangs can also expose families and children to drugs and alcohol, unpredictable stress and trauma, and various forms of criminal activity. The focus must remain on the infant or child: what is the quality of caregiving, and what is the impact on the child of, for example, violence, drugs and alcohol, and multiple changes of carer? Work in partnership with these families to identify what they want help with, and their strengths as well as difficulties in meeting the overall aim of protecting their child's wellbeing and promoting their development.

These parents may know little about the services to which they are entitled. However, receiving written information is often not helpful. They are more likely to be receptive to information that is conveyed directly, face-to-face rather than written information that they cannot find time in their often chaotic lifestyles to read, or they may not be able to read. A relationship-based approach puts more emphasis on the practitioner finding ways to work openly and non-judgementally with parents, trying to put them at ease.

Practitioner safety may be an anxiety or actually threatened during home visits, not necessarily from the parents themselves. Where the home is being used for gang- or drug-related crime, practitioners may face an increased risk of exposure to violence or other hazards. Providers of WCTO services must be alert to any potential threats to their safety in interactions with a child and their parents before or during a WCTO check and decide whether a home visit is suitable. WCTO organisations will have standards of practice for home visits. All practitioners must have access to competent and consistent risk management advice. It may be appropriate to take security measures, as well as to provide conflict resolution training for frontline staff.

Considerations with parents involved in criminal activities or with gang associations

- Consider and discuss with the family their income, housing, employment, budgeting and other basic needs. Offer assistance either directly or by referral to the relevant agency.
- Consider the parents' need for information and the form in which they will find it most accessible. Information will usually be best received via conversation and within the context of a discussion as to what the parents want to know.
- Ensure the family is enrolled with a PHO and able to access GP visits and immunisations for their child. Where appropriate and with the parents' consent, facilitate enrolment with a PHO and access to GP services.
- Discuss the availability and benefits of social, parenting and other community support groups and services. Make referrals to these services with the parents' consent.
- Practitioners must have an objective view about the child's safety and wellbeing. If you have concerns, discussed them with a supervisor.

Resources and additional reading

Dennehy G. 2000. *Troubled Journeys: An analysis of women's reality and experience within New Zealand gangs*. University of Canterbury. URL: <http://ir.canterbury.ac.nz/handle/10092/5629> (accessed 22 March 2013).

Gangs. *Te Ara Encyclopaedia of New Zealand*. URL: www.teara.govt.nz/en/gangs (accessed 22 March 2013).

Ministry of Health. 2006. *Results from the Prisoner Health Survey 2005*. Wellington: Ministry of Health. URL: www.health.govt.nz/publication/results-prisoner-health-survey-2005 (accessed 22 March 2013).

Wesley Community Action. 2009. *The Health of Prisoners' Families*. A report to the National Health Committee. URL: <http://nhc.health.govt.nz/publications/nhc-publications-pre-2011/health-prisoners-families> (accessed 22 March 2013).

Parents with moderate to severe or untreated mental illness and/or addiction

A focus on parental mental illness and addiction is not intended to imply that parents with a mental illness or addiction are negligent, uncaring or to blame for their children's difficulties. However, mental illness and/or addiction creates significant challenges for parents around the care of their children and, at times, these families require particular support and assistance.

Children of parents who have mental health or addiction problems are vulnerable to a range of poor outcomes. These impacts can include:

- exposure to alcohol in utero resulting in developmental problems – fetal alcohol spectrum disorder
- perinatal complications (eg, low birthweight, prematurity, withdrawal symptoms immediately following birth)
- exposure to problematic caregiving
- increased incidence of disorganised attachment in infants
- increased adverse experiences including neglect, abuse (physical, emotional and sexual) and exposure to family violence with effects on physical, cognitive and mental health⁵⁶
- emotional, social, behavioural and learning problems in childhood and adolescence
- developing mental health problems later in life.

A number of other risks associated with moderate to severe mental illness and/or addictions impact on children's experience of stress and relationship disruption. These risks include exposure to family conflict and violence, changes in or loss of attachment relationships (parental separation and new relationships), separations from attachment figures (hospitalisation of parent), poverty, poor housing, limited or no social supports, and social discrimination.

With social support, home visiting, and access to and engagement with appropriate intervention services, many parents with a mental illness and/or addiction problems manage these challenges adequately. Parenting and doing the best they can for their children is often a central motivation for looking after their own mental wellbeing and/or addressing their addiction problems. In the early years in particular, specific assessment and intervention need to be directed to the parent–child relationship and the wider relationships in the family and whānau to improve the health outcomes for these children. Where illness and/or addiction are moderate to severe, assessment and intervention should be informed by the discipline of infant mental health (IMH) – a home-visiting service with practitioners who have additional IMH training and/or IMH supervision, and/or a DHB Infant Mental Health Service.

Parents who have a mental illness or addiction problem may be wary of seeking help from specialist services, for fear of involvement with CYF and/or separation from their child if inpatient care is required. The nature of the relationship that the practitioner establishes with the parents will determine whether the parents come to trust the practitioner and are willing to communicate their concerns and seek help from the provider of WCTO care.

Considerations with parents with severe or untreated mental illness or addiction

- If neglect and/or abuse is suspected, the WCTO Provider must act immediately according to your organisation's child protection policies and protocols. Neglect or failure to respond to the needs of the child is the most likely issue and this is typically directly due to illness and/or addiction rather than deliberate abuse. However, the welfare of the child takes priority.
- Recognise the family's vulnerabilities as well as emphasising their strengths.

⁵⁶ See the Adverse Childhood Experiences (ACE) Study, Centers for Disease Control and Prevention website (www.cdc.gov/ace).

- Where there is no immediate concern or risk involving child protection, consider the needs of the whole family, taking into account factors such as the following.
 - What is the current health of the parent – how unwell/impaired are they?
 - Is there co-morbidity of substance abuse and mental illness?
 - What is the parental history of mental illness or addiction and what are other relevant or contributing factors?
 - Who is providing primary care for the children in the house?
 - Who is available to support the parent/s?
 - What is the general health of each child? Consider frequency of GP visits, and accidents and illnesses as a consequence of poor nutrition, lack of supervision and inadequate care.
 - How is each child developing? Are they achieving milestones appropriately?
 - Are there ongoing concerns around an infant’s exposure to drugs and/or alcohol if being breastfed?
 - What are your observations of caregiving interactions and the quality of the child–parent relationship? It is particularly useful to observe what happens when a child is upset, ill or distressed, whether they seek comfort or care from their parent and how effective that care is in soothing the child.
- Check the family has sufficient funds to provide adequately for their child’s physical needs – food, shelter, safety, heating, nappies.
- Check the child is not being left alone or in an unsafe care situation while the parent is procuring or consuming drugs and/or alcohol, or experiencing symptoms of their illness such as delusions, hallucinations or suicidal mood that impacts directly on caregiving.
- Consider the parent’s need for information and support related to safely storing alcohol and drugs away from children (in line with safe storage of other potentially poisonous household items) and the nutritional needs of everyone in the family.
- Ensure the family is enrolled with a PHO and able to access GP visits.
- With the parent’s consent (when issues are not care and protection concerns), maintain clear communication and liaison with GP and services involved.
- With the parent’s consent, make a referral to the GP to assess the parent’s mental health and/or substance use and the need for referral to specialist health services.
- Alternatively, discuss with the parent how to access local mental health and/or drug treatment services and, where appropriate, facilitate a referral to these services. If the parent is not motivated to address their illness or addiction, you may need to discuss the best approach with the mental health or drug treatment services.
- If the parent is already under the care of mental health and/or addiction services, with the parent’s consent contact their case manager or the specific service to discuss concerns. In this discussion, cover:
 - the need for review – assessment of current mental state, medication, additional supports
 - children in the home and concerns around parent–child relationships and development of the children. What supports/services exist for children of parents who have mental health or addiction problems?
- These families may have multiple services involved. It is important to attend interagency meetings including Strengthening Family meetings and Family Group Conferences.

- Assessment and intervention to improve the quality of caregiving and the parent–child relationship will be the key ways of improving health outcomes for children and resilience.
 - Take a sensitive, non-judgemental, culturally appropriate approach with parents. Ask them about how they manage parenting, what’s difficult, what they are concerned about and what help they would like.
 - Share information that every parent receives on parenting, child development, supporting the parent–child relationship, and community resources.
 - Explain that research has helped us learn more about how moderately severe mental illness and/or drug problems interfere with being able to parent optimally as every parent wants to do.
 - Explain that, as a consequence of that research knowledge, it is helpful to consider additional support and/or intervention including home visiting, referral to an IMHS and early childhood education experience to support socialisation and learning. For very young children, consider Playcentre Space programme.

Resources and additional reading

Children of Parents with a Mental Illness website, www.copmi.net.au/

Discrimination and Mental Illness: Parenting. URL:
<http://waikato.webhealth.co.nz/articles/view/article/207/> (accessed 22 March 2013).

HealthEd resources on mental health, www.healthed.govt.nz (choose ‘Mental health’ from the dropdown menu).

Ministry of Health. 2011a. *Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand*. Wellington: Ministry of Health. URL:
www.health.govt.nz/publication/healthy-beginnings-developing-perinatal-and-infant-mental-health-services-new-zealand (accessed 22 March 2013).

Ministry of Health website, www.health.govt.nz, ‘Our work’ section on [Mental health and addictions](#) contains publications and resources relating to mental health and addictions.

Ministry of Health website, www.health.govt.nz, ‘Your health’ section on [Alcohol and drugs](#) includes links to other websites and service directory.

Moriarty H, Stubbe M, Bradford S, et al. 2010. *Living with Addiction: Exploring the issues for families*. Research Report 35/10. Wellington: Families Commission. URL:
www.familiescommission.org.nz/publications/research-reports/living-with-addiction (accessed 22 March 2013).

Parents with a Mental Illness: Factsheet. URL:
www.mentalhealth.org.nz/file/downloads/pdf/file_221.pdf (accessed 22 March 2013).

Parents involved with Child, Youth and Family

Children who come to the attention of CYF are some of New Zealand’s most vulnerable children. They have the highest likelihood of negative outcomes such as poor physical and mental health, lack of educational achievement, unemployment, welfare dependency, offending and progression into prison.

As a result of their backgrounds, they are often disconnected from regular health and education services, and are more likely to have cognitive, physical, behavioural and emotional barriers to overcome. Many have a combination of health and education needs that have gone unidentified or untreated before they came into care. Twenty percent of children under the statutory care of CYF are aged between 0 and two years of age; a further 10 percent are aged between two and five years.

The parents of these children also tend to have multiple and complex needs, many of which are discussed elsewhere in this section and throughout the Handbook. Often the complexity of problems means that no single agency is able to provide the full package of care and services required. Providers of WCTO care will need to coordinate their checks with the services and activities parents may be receiving from CYF and other agencies.

These parents, their families and whānau may also be highly sensitive to interaction between WCTO services and CYF and further statutory intervention, which may make it difficult to engage with them. Whether there is ongoing contact with the family and whether they are willing to discuss concerns will depend on whether the provider of WCTO care builds an open, working relationship and communicates effectively with the parents.

The Gateway Assessment is an interagency project between CYF, the Ministry of Health and the Ministry of Education. Gateway Assessments aim to ensure every child or young person entering care, in care or being referred for a care and protection family group conference receives an assessment of their needs, and gets access to the right health and education services. It also provides the opportunity to ensure their health and education needs are considered in the wider context of their care and protection needs.

If asked by a Gateway Assessment coordinator, providers of WCTO care will need to provide information on the care and services they have provided to these children. For more information, guides and templates on providing information, refer to [Gateway health and education assessments](#) on the CYF website (www.cyf.govt.nz).

Considerations with parents involved with CYF

- Where possible and appropriate, explain to parents/caregivers anything that you wish to discuss with CYF and why it is important for them and their child. Be sure to highlight any strengths or progress you identify with the family, as well as any specific needs for services.
- Include all those involved in caring for the child. Where possible and appropriate, and in discussion with CYF, where the child is in the care of the Director-General include the child's birth parents.
- Ensure advocacy for the child's health when making referrals, particularly related to waiting list transfers and access to mental health services.
- Integrate your services with prior assessments. For example, if a Gateway Assessment has been completed, these findings should not be duplicated.
- Ensure that the GP keeps the child's lead health record and this record is tracked when the child moves areas.
- Secure consent for WCTO checks and referrals, and respect confidentiality.

Resources and additional reading

Atwool N. 2010. *Children in Care: A report into the quality of services provided to children in care*. Wellington: Office of the Children's Commissioner. URL: www.occ.org.nz/__data/assets/pdf_file/0008/7694/CC_ChildreninCareReport_09.09.2010.pdf (accessed 13 March 2013).
CYF website, www.cyf.govt.nz, for:

- actions related to [working with others](#) to keep children and young people safe
- guidance on [keeping kids safe](#), reporting concerns to CYF including forms and templates
- information for [parents with children in CYF care](#) or concerns about their child's safety
- information for [caregivers of children in CYF care](#)
- [working together](#) to keep children and young people safe.

Guy, D. 2011. Infant mental health and child protection. *Best Practice* 39: 4–9. URL: www.bpac.org.nz/magazine/2011/october/contents.asp (accessed 31 March 2013).
Ministry of Social Development and Child, Youth and Family. *Why You Should Care. Corporate Report*. URL: www.cyf.govt.nz/about-us/publications/corporate-reports-and-publications.html (accessed 31 March 2013).

Highly mobile families

Some of the reasons why families move into an unfamiliar area relate to unemployment, family break-up and domestic violence. In such cases, families may be reluctant to establish new social links and, as a result, the child may not benefit from the services available. Finding such families and supporting them can be difficult and time consuming but they are a vulnerable group and must be targeted.

However, moving may also be a positive change for families and may indicate upward social mobility.

When practitioners maintain good relationships with local agencies and services such as Work and Income, Housing New Zealand, and primary health and hospital services, these agencies are more likely to make referrals to WCTO services when families who are new to an area make contact with their services. Collaborative intersectoral working builds trust between services and between practitioners, which in turn facilitates further intersectoral collaboration to improve outcomes particularly for mobile children and families with complex needs.

Considerations with highly mobile families

- Discuss with the family the available services in the area. Where appropriate, make referrals with the family's consent.
- Ensure the family is aware of and connected to essential services. In particular, make sure the family is enrolled with a GP, the children are up to date with immunisations and on the Immunisation Register, and the mother has an LMC if pregnant.
- Consider the family's social support and discuss opportunities to increase their social networks to give them greater stability and a stronger sense of permanence.
- Consider the family's housing and employment needs and their unique circumstances – for example, seasonal workers.

Resources and additional reading

Housing New Zealand website, www.hnzc.co.nz, for information and resources on [renting a property](#).

Ministry of Health website, www.health.govt.nz, for information about [enrolling in a PHO](#).

Ministry of Social Development website, www.workandincome.govt.nz, for information on [community initiatives and services](#).

Migrant and refugee families

Migrant and refugee families are a unique and diverse group of families and the various ethnic communities they represent are growing. Some have chosen to emigrate from their home countries for lifestyle or family reasons, whereas others have been forcibly displaced due to threats of violence, warfare or extreme poverty in their home countries.

Regardless of the reason for their arrival in New Zealand, all migrant and refugee families will experience a period of resettlement and may require assistance in navigating access to the entitlements and services available to them. Health practitioners need to know about these entitlements and should be prepared to advocate on behalf of families if necessary.

The incidence of financial stress is higher in refugee and some migrant groups. For these families, the first and most important consideration is access to entitlements, services and employment. Migrants, quota refugees and family reunification members are generally eligible for the same benefits and entitlements as other New Zealanders. Asylum seekers are eligible for publicly available health, education and welfare services provided they have lodged a claim for refugee status and are awaiting a hearing. For information about Work and Income financial assistance, visit the Work and Income website (www.workandincome.govt.nz). Applicants can call the Work and Income Contact Centre (freephone 0800 559 009) or they can use the Language Line number (freephone 0800 000 196) to request language assistance.

Newly arrived children and their parents may speak little or no English and may have experienced traumatic events, grief and loss. Staff need training and support to understand the serious impact of trauma and loss on parents, parenting capacity, children and the parent–child relationship.

A good interpreting service is essential. It is not acceptable to rely on the use of older children as interpreters for the parents at appointments. Access to interpreters varies from region to region. District health boards provide interpreters for the community and secondary care services that they fund. In some regions, primary health providers have access to district health board interpreting services or to the Office of Ethnic Affairs' Language Line. The *Refugee Health Handbook* (Ministry of Health 2012h) contains further advice on working with a family and an interpreter.

Because families can be moved into alternative accommodation, it may be difficult to keep track of them. Good liaison with housing, and migrant and refugee community services can ensure that, as soon as a new family arrives in an area, these services inform a designated provider of WCTO care so they can make contact as soon as possible. Many families in temporary accommodation are unable to receive mail and have no direct telephone access. These families move frequently and therefore their children may never receive specialist or other referral services. Referrals should be managed with these constraints in mind.

Establishing rapport, engaging with the family and communicating clearly throughout the consultation are crucial factors in providing safe, effective and appropriate care.

Considerations with migrant and refugee families

- Ask parents if there are any special requirements or information that they would like you to consider when providing care. For example, there may be cultural differences in relation to who is involved in decision-making, and it may therefore be appropriate to include family members besides the mother or parents.
- Allow extra time for the appointment to accommodate the need for interpreting, establishing rapport, careful explanations and so on.
- Acknowledge that you understand that parents may have different perspectives and experiences of illness, health and disability.
- Encourage questions and respect the parent's knowledge and experience.
- Take opportunities to familiarise yourself with the cultural and religious beliefs and practices of the parents with whom you work.
- Avoid making generalisations and assumptions about ethnic groups. People from one group may 'look' similar, but differences in education, religion, culture and lifestyle can be vast.
- Beware of attributing too much to culture and ethnicity. Other factors, such as torture and trauma, grief, loss and resettlement issues, will influence the behaviour and engagement of parents and families.

Resources and additional reading

HealthEd resources on new migrant health, www.healthed.govt.nz (choose 'New migrant health' from the dropdown menu).

Ministry of Health. 2012h. *Refugee Health Care: A handbook for health professionals*. Wellington: Ministry of Health. URL: www.health.govt.nz/publication/refugee-health-care-handbook-health-professionals (accessed 25 March 2013).

Ministry of Health website, www.health.govt.nz, 'Our work' section on [refugee health](#) for publications this topic.

Refugee Health website, www.refugeehealth.govt.nz

Families affected by parental conflict, separation, divorce, remarriage and new partners

Children of all ages are adversely affected by conflict between parents that is frequent, intense and poorly resolved. Children will be less adversely affected by parental conflict when they have a secure attachment with at least one of their parents and when parents can think about the impact of their behaviours on their children and make changes to reduce the impact.

Where separated parents are unable to cooperate in decisions around care arrangements and maintain ongoing conflictual relationships, they have a harmful impact on their children's emotional and relationship development.

Parents may request advice, support and referral to services that would help with decision-making around 'separated parenting'. The New Zealand Family Courts has information for parents of older children. For infants and young children, see Resources below for guidelines developed by the Australian Association of Infant Mental Health Inc.

The introduction of new partners to children can strengthen or add risks to their wellbeing, depending on the circumstances. Risks tend to be associated with similar factors that are present in other parent relationships: financial strain, mental illness or addiction of parent or partner, and a parent or partner who is young, socially isolated and had poor parenting role models or suffered abuse as children themselves. Equally, the family may be strengthened if the new partner brings a higher income, good family and social support, and experience as a parent or experience of good parenting role models.

Considerations with families affected by changes in family structure

- As well as routine questioning as discussed under [Family violence assessment](#) (section 4), enquire about and, where possible, observe indicators of interparental conflict.
- Where appropriate and with the parent's consent, offer referrals to relationship or parenting services depending on the impact on the child and the causes of the conflict (see [Resources](#) under 'Strengthening family relationships').
- Consider any custody arrangements and privacy or safety concerns for the child and/or parent when contacting the family and making referrals.
- Be alert to the possible introduction of new partners or household members to the child. Assess the impact of these relationships on the parent's relationship with the child and the child's development and wellbeing.

Resources and additional reading

Families Commission. 2008. *Putting the Kids First: Caring for children after separation*. Research Report 2/08. Wellington: Families Commission. URL:

www.familiescommission.org.nz/publications/research-reports/putting-the-kids-first (accessed 22 March 2013).

Families Commission. 2009. *Separated Parenting*. Issues Paper 1. URL:

www.familiescommission.org.nz/publications/briefs-and-statistics/issues-paper-01-separated-parenting (accessed 22 March 2013).

Harold G. 2011. Families and children: a focus on parental separation, domestic violence and child maltreatment. In *Improving the Transition: Reducing social and psychological morbidity during adolescence*. URL: www.pmcsa.org.nz/wp-content/uploads/Improving-the-Transition-report.pdf (accessed 22 March 2013).

Mackay R. 2005. The impact of family structures and family change on child outcomes. *Social Policy Journal of New Zealand* 24. URL: www.msd.govt.nz/about-msd-and-our-work/publications-resources/journals-and-magazines/social-policy-journal/spj24/24-impact-of-family-structure-and-family-change-on-child-outcome-p111-133.html (accessed 22 March 2013).

McIntosh J. 2011. *Infants and overnight care – post separation and divorce: Guidelines for protecting the very young child’s sense of comfort and security*. Australian Association for Infant Mental Health Inc. Discussion paper. URL: www.aaimhi.org/inewsfiles/AAIMHI_Guideline_1_-_Infants_and_overnight_care_post_separation_and_divorce.pdf (accessed 31 March 2013).

Mitchell D, Chapman P. 2006. *Pathways through Parental Separation: The experiences of a group of non-resident fathers* 5/09. Wellington: Families Commission. URL: www.familiescommission.org.nz/publications/research-reports/pathways-through-parental-separation (accessed 22 March 2013).

New Zealand Family Courts, *Parents’ Guide to Caring for Children after Separation*, www.justice.govt.nz/courts/family-court/what-family-court-does/separation-and-dissolution/parents-guide-to-caring-for-children-after-separation (accessed 11 June 2013).

Glossary of abbreviations

AABR	Automated Auditory Brainstem Response
ACE Study	Adverse Childhood Experiences Study
ALAC	Alcohol Advisory Council of New Zealand
AOAE	Automated Otoacoustic Emissions
AOD	Alcohol and other drugs
ASQ	Ages and Stages Questionnaire
ASQ–SE	Ages and Stages Questionnaire: Social/Emotional
B4SC IS	B4 School Check Information System
BMI	Body mass index
BPAD	Bipolar affective disorder
CALD	Culturally and linguistically diverse
CHeQ	Child Health Questionnaire
CYF	Child, Youth and Family
CYMRC	Child and Youth Mortality Review Committee
DAS	Danger Assessment Scale
DDH	Developmental dysplasia of the hip
DDST	Denver Developmental Screening Tool
DHB	District health board
ECC	Early childhood caries
ECE	Early childhood education
EPPE project	Effective Pre-school and Primary Education project
ETS	Environmental tobacco smoke
FASD	Fetal alcohol spectrum disorder
FTT	Failure to thrive
FVIG	<i>Family Violence Intervention Guidelines</i>
GP	General practitioner
HIPC	Health Information Privacy Code
HIPPY	Home Interaction Programme for Parents and Youngsters
HPC Act	Health Practitioners Competence Assurance Act 2003
IBCLC	International Board Certified Lactation Consultant
IMH	Infant mental health
IMHS	Infant Mental Health Service
IPV	Intimate partner violence
LMC	Lead maternity carer
MBIE	Ministry of Business, Innovation and Employment
NGO	Non-governmental organisation
NHMRC	National Health and Medical Research Council

NIR	National Immunisation Register
NNS	Non-nutritive sucking
NSU	National Screening Unit
NZOHS	New Zealand Oral Health Survey
OECD	Organisation for Economic Cooperation and Development
ORL	Otorhinolaryngologist
PAFT	Parents As First Teachers
PEDS	Parents' Evaluation of Developmental Status
PHO	Primary health organisation
PHQ-3	Patient Health Questionnaire
PMS	Patient management system
PND	Postnatal depression
SBS	Shaken baby syndrome
SDQ	Strengths and Difficulties Questionnaire
SDQ-P	Strengths and Difficulties Questionnaire for parent of child
SDQ-T	Strengths and Difficulties Questionnaire for teacher of child
SKIP	Strategies with Kids/Information for Parents
SUDI	Sudden unexpected death in infancy
UNHSEIP	Universal Newborn Hearing Screening and Early Intervention Programme
VHT	Vision and hearing technician
VIP	Violence Intervention Programme
WCTO	Well Child/Tamariki Ora
WHO	World Health Organization

Appendices

Appendix 1: Parents' Evaluation of Developmental Status: Parent response form

PEDS RESPONSE FORM

Child's name: Parent's name:.....

Child's birthday: Child's age: Today's date:

1. Please list any concerns about your child's learning, development and behaviour.
2. Do you have any concerns about how your child talks and makes speech sounds?
Circle one: No Yes A little COMMENTS:
3. Do you have any concerns about how your child understands what you say?
Circle one: No Yes A little COMMENTS:
4. Do you have any concerns about how your child uses his or her hands and fingers to do things?
Circle one: No Yes A little COMMENTS:
5. Do you have any concerns about how your child uses his or her arms and legs?
Circle one: No Yes A little COMMENTS:
6. Do you have any concerns about how your child behaves?
Circle one: No Yes A little COMMENTS:
7. Do you have any concerns about how your child gets along with others?
Circle one: No Yes A little COMMENTS:
8. Do you have any concerns about how your child is learning to do things for himself/herself?
Circle one: No Yes A little COMMENTS:
9. Do you have any concerns about how your child is learning preschool or school skills?
Circle one: No Yes A little COMMENTS:
10. Please list any other concerns.

Appendix 2: Parents' Evaluation of Developmental Status: Score form

PEDS SCORE FORM – AUTHORISED AUSTRALIAN VERSION

Child's name: _____ Date of birth: _____ Date(s) of scoring: _____

Child's age: _____

Global/cognitive	<input type="checkbox"/>											
Expressive language and articulation	<input type="checkbox"/>											
Receptive language	<input type="checkbox"/>											
Fine motor	<input type="checkbox"/>											
Gross motor	<input type="checkbox"/>											
Behaviour	<input type="checkbox"/>											
Social-emotional	<input type="checkbox"/>											
Self-help	<input type="checkbox"/>											
School	<input type="checkbox"/>											
Other	<input type="checkbox"/>											

Count the number of ticks in the small shaded boxes and place the total in the large shaded box below.

If the number shown in the large shaded box is 2 or more, follow **Path A** on PEDS Interpretation Form. If the number shown is exactly 1, follow **Path B**. If the number shown is 0, count the number of ticks in the small unshaded boxes and place the total in the large unshaded box below.

If the number shown in the large unshaded box is 1 or more, follow **Path C**. If the number 0 is shown, consider **Path D** if relevant. Otherwise, follow **Path E**.

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Appendix 3: Parents' Evaluation of Developmental Status: Interpretation form

Child's name: _____ Date of birth: _____

Specific decisions

PEDS INTERPRETATION FORM			0–3 months _____
Path A: Two or more significant predictive concerns?	Yes? → Two or more concerns about self-help, social, school, or receptive language skills?	Yes? → Refer for audiological and speech-language testing. Use professional judgement to decide if referrals are also needed for social work, occupational/ physiotherapy, mental health services, etc.	4–5 months _____
		No? → Refer for intellectual and educational assessments. Use professional judgment to decide if speech-language, audiological, or other evaluations are also needed.	6–11 months _____
Path B: One significant predictive concern?	Yes? → Screen or refer for screening	If screen is passed, counsel in areas of concern and monitor carefully.	12–14 months _____
		If screen is failed, refer for testing in area(s) of difficulty.	15–17 months _____
Path C: No significant concerns?	Yes? → Counsel in areas of difficulty and follow up in several weeks	If unsuccessful, screen for emotional/behavioural problems and refer as indicated. Otherwise refer for parent training, behavioural intervention, etc.	18–23 months _____
			24–35 months _____
Path D: Parental difficulties communicating?	Yes? → Foreign language a barrier?	No? → Use a second screen that directly elicits children's skills or refer for screening elsewhere.	36–47 months _____
		Yes? → Send PEDS home in preparation for a second visit; seek an interpreter, or refer for screening elsewhere.	48–53 months _____
Path E: No concerns?	Yes? → Elicit any concerns at future time-point?	Use PEDS at future time-point.	54–71 months _____
			72–83 months _____
			84–96 months _____

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Appendix 4: High-risk indicators associated with child abuse⁵⁷

Child characteristics that may predispose them to be at risk

The child may:

- have a congenital abnormality, either mental or physical
- be a premature infant or ill newborn who is separated from the parents during the neonatal period
- be colicky or irritable
- be rigid or non-cuddly
- be unwanted
- not be the gender expected or desired by the parents
- be a foster child, adopted child or stepchild
- be intellectually impaired, highly intelligent or hyperactive
- be particularly difficult (or be seen as difficult).

Caregiver's perceptions of child that may predispose some children to be at risk

The parent/caregiver may see the child as:

- 'bad', 'naughty', or 'manipulative'
- 'difficult' and unrewarding to care for
- unloving or rejecting of the parents
- resembling a disliked person in appearance, behaviour or temperament
- a rival for attention or affection that parents themselves desire.

Family factors that may place children at higher risk of abuse

- Partner abuse is present.
- Parent was abused or seriously neglected as a child.
- Parent has serious mental health problems.
- Parent has had frequent trouble with the law.
- Parent has an alcohol or drug problem.
- Parent has rigid or unrealistic expectations of child.
- Parent has previously abused this or another child.
- Parent has violent temper or outburst towards things or people.
- Family is socially isolated.
- Parents have low self-esteem.

⁵⁷ See *Family Violence Intervention Guidelines: Child and partner abuse* (Ministry of Health 2002a).

- **Parent is a teenager.**
- **Family suffers from multiple crises.**
- **Parent administers harsh or unusual punishment.**

Source: Child and Adolescent Health Service, Taranaki Healthcare. 1993. Child Abuse Indicators: Information for General Practitioners and Community Workers (2nd ed).

Appendix 5: Signs and symptoms associated with child abuse and neglect

The signs, symptoms and history described below are not diagnostic of abuse. However, in certain situations, contexts and combinations they will raise the practitioner's suspicion of abuse. It is better to refer on suspicion. If you wait for proof, the child may be seriously harmed.

History

History inconsistent with the injury presented

Past abuse or family violence

Exposure to family violence, pornography, alcohol or drug abuse

Isolation and lack of support

Mental illness, including postnatal depression

Inappropriate or inconsistent discipline especially thrashings or any physical punishment of babies

Neglecting the child

Physically disabled – left home alone, food withdrawn as punishment

Physical signs

Multiple injuries, especially of different ages: bruises, welts, cuts, abrasions

Scalds and burns, especially in unusual distributions such as glove and sock patterns

Pregnancy

Genital injuries

Sexually transmitted diseases

Patterned bruising

Behavioural and developmental signs

Aggression

Anxiety and regression

Obsessions

Overly responsible behaviour

Frozen watchfulness

Sexualised behaviour

Fear

Sadness

Delay in seeking help

Disclosure by the child

Severe social stress

Parent/s abused as child/children

Unrealistic expectations of child

Terrorising, humiliating or oppressing

Promoting excessive dependency in the child

Actively avoiding seeking care or shopping around for care (frequent changes of address)

Abuse of animals

Unexplained failure to thrive (FTT)

Poor hygiene

Dehydration or malnutrition

Fractures, especially in infants or in specific patterns

Poisoning, especially if recurrent

Apnoeic spells, especially if recurrent

Defiance

Self-mutilation

Suicidal thoughts/plans

Withdrawal from family

Substance abuse

Overall developmental delay, especially if also FTT

Patchy or specific delay: motor, emotional, speech and language, social, cognitive, vision and hearing

Source: Ministry of Health, RNZCGPS, NZMA, CYF. 2000. *Recommended Referral Processes for GPs: Suspected child abuse and neglect.*

Appendix 6: Assessing for child neglect

The guide for prevention, assessment and intervention of child neglect identifies two primary questions that should be asked to identify whether child neglect has occurred:

- Do the conditions or circumstances indicate that a child's basic needs are unmet?
- What harm or threat of harm may have resulted?

To answer these questions, sufficient information is required to assess the degree to which neglect can or may result in significant harm or risk of significant harm. The decision often requires considering patterns of caregiving over time. The analysis should focus on examining how the child's basic needs are met and on identifying situations that may indicate specific omissions in care that have resulted in harm or the risk of harm to the child (DePanfilis 2006). While information on all these domains will not be accessible to all health care providers, the list in Appendix 5 provides some indications of issues that may require consideration.

Answers to the following questions may also indicate that a child's physical or medical needs and supervision may be unmet.

- Have the parents or caregivers failed to provide the child with needed care for a physical injury, acute illness, physical disability or chronic condition?
- Have the parents or caregivers failed to provide the child with regular and ample meals that meet basic nutritional requirements or have the parents or caregivers failed to provide the necessary rehabilitative diet to a child with particular health problems?
- Have the parents or caregivers failed to attend to the cleanliness of the child's hair, skin, teeth and clothes? Note: It can be difficult to determine the difference between marginal hygiene and neglect. WCTO Providers should consider the chronicity, extent and nature of the condition, as well as the impact on the child.
- Does the child have inappropriate clothing for the weather? WCTO Providers should consider the nature and extent of the conditions and the potential consequences to the child. They also must take into account diverse cultural values regarding clothing.
- Does the home have obviously hazardous physical conditions (exposed wiring or easily accessible toxic substances) or unsanitary conditions (faeces- or trash-covered flooring or furniture)?
- Does the child experience unstable living conditions (frequent changes of residence or evictions due to the caretaker's mental illness, substance abuse or extreme poverty)?
- Do the parents or caregivers fail to arrange for a safe substitute caregiver for the child?
- Have the parents or caregivers abandoned the child without arranging for reasonable care and supervision?

Appendix 7: Referral agency template

Note: This template could be printed on the inside front cover of any hard-copy resource regularly used by providers of WCTO services.

Local referral agency contact information

Contact details	Notes
Child abuse referral agencies	
Child, Youth and Family Service	
Local/regional interagency children's team	
Paediatrician	
Police	
Police Child Abuse Team	
Anger Change for Women	
Doctors for Sexual Abuse Care	
Barnardos	
Parentline	
Partner abuse referral agencies	
Women's Refuge	
Family Violence Interagency networks	
Women's Support Groups	
Stopping Violence Services	
Māori, Pacific and other social service agencies	
Māori health/social services	
Iwi	
Whānau Ora service provider	
Pacific health/social services	
Asian and refugee health/social service organisations	
Family Start	
Gateway	

Appendix 8: Signs and symptoms associated with partner abuse

The factors below may raise suspicion of abuse, but are not diagnostic.

Physical injuries

Injuries to the head, face, neck, chest, breast, abdomen or genitals

Bilateral distribution of injuries, or injuries to multiple sites

Contusions, lacerations, abrasions, ecchymoses, stab wounds, burns, human bites, fractures (particularly of the nose and orbits) and spiral wrist fractures

Complaints of acute or chronic pain, without evidence of tissue injury

Sexual assault (including unwanted sexual contact by a partner)

Injuries or vaginal bleeding during pregnancy, spontaneous or threatened miscarriage, low birthweight babies

Multiple injuries, such as bruises, burns, scars, in different stages of healing

Substantial delay between time of injury and presentation for treatment

Tufts of hair pulled out

Strangulation/choking

Parent's manner

Hesitant or evasive when describing injuries

Distress disproportionate to injuries (for example, extreme distress over minor injury, or apparent lack of concern about a serious injury)

Explanation does not account for injury (for example, 'I walked into a door')

Different explanation for same injury at different presentations

Illnesses

Headaches, migraines

Musculoskeletal complaints

Gynaecological problems

Sexually transmitted infections

Chronic pain/undiagnosed causes for pain

Malaise, fatigue

Depression

Insomnia

Anxiety

Chest pain, palpitations

Gastrointestinal disorders

Hyperventilation

Eating disorders

Serious psychosocial problems

Alcohol abuse or addiction

Severe depression

Drug abuse or addiction

Suicidal ideation or attempts

Continued alcohol, tobacco or substance abuse during pregnancy

Inappropriate attempts to lose weight, development of eating disorder during pregnancy

History

Record of or concerns about previous abuse (eg, injuries inconsistent with explanation)

Substantial delay between time of injury and presentation for treatment

Multiple presentations for unrelated injuries

Source: Injury Prevention Research Centre, 1996. *The Oasis Protocol: Guidelines for identifying, treating and referring abused women*. Auckland: Injury Prevention Research Centre.

Appendix 9: Risk assessment

This appendix describes procedures for undertaking further assessment of the risk associated with current violence. It outlines considerations for further assessment of physical and mental health concerns that may have resulted from the experience of intimate partner violence (IPV). Assessment of risk to others in the family is also discussed.

Assessing risk of homicide (danger assessment)

Violence in intimate relationships is one of the strongest risk factors for homicide against women. Almost all women homicide victims in New Zealand are killed by their partners or ex-partners who have histories of perpetrating IPV (Martin and Prichard 2010). Note that violence can occur after a relationship has finished (eg, violent ex-partners continue to harass, stalk and perpetrate violence against their former partners). Episodes of violence in intimate violence can occur repeatedly over the duration of an intimate relationship; in many reports, violence increases in frequency and severity over time. Single episodes of violence can also result in homicide or long-term physical disability.

While there are no absolute indicators of risk, a number of factors are associated with increased risk of homicide by intimate partners. These have been compiled into the Danger Assessment Scale (Appendix L in the revised draft *Family Violence Intervention Guidelines* (FVIG); www.dangerassessment.org). Note, however, that all of the validation studies for these factors have been done with male perpetrators of homicides to women (sometimes called 'femicides'), so the reliability and validity of the scale are less clear if used with male victims of IPV. Also be aware that risk prediction is not an absolute science, and there may be cases where no risk factors are evident, but the victim is deeply afraid or concerned that she might be killed by her partner. In this case, actively undertake safety and intervention planning. (See 'Safety planning' under [Summary of an enquiry about partner abuse](#) in 'Family violence assessment' (section 4) or refer to section 2.4 in the revised draft FVIG.)

Structured danger assessment is strongly encouraged because, while victims' perceptions of risk are important, it is also possible that they have not recognised the degree of risk they are facing, or they may be minimising or denying the extent of violence they have experienced. Structured risk assessments are also recommended because they can:

- indicate the level of risk of serious or fatal re-assault a woman is facing
- help you (and the victim of IPV) gain a more objective understanding of the frequency, severity and types of violence that the woman has experienced
- identify health and other concerns that require further assessment or intervention (eg, strangulation, suicidal ideation and suicide attempts, risk to children or others)
- reduce the opportunity of salient risk factors being missed
- send a message to the woman that the health care provider is taking the issue of IPV seriously
- assist with documentation.

Introducing the danger assessment

Remember that way you introduce the topic of danger assessment will be important in engaging the patient in the process. For example, you might say:

‘I am sorry that this has happened to you. No one deserves to be hurt in that way. There are options – people and places – that can help to make you safer. We can help you sort these out but, first, we need a little more information about what has been going on for you. We ask all women who have been hurt by their partners to do this. It will help us to provide you with the best care we can.’

Conduct of the danger assessment

The Danger Assessment Scale has been designed to be administered either with the health care provider working with the woman (Option 1); or with the health care provider explaining the instructions for completing the risk assessment, giving the woman time to self-complete the form, and then having the health care provider discuss the implications with the woman (Option 2). Option 1 is likely to give the health care provider a deeper understanding of the violence the woman has experienced because she is likely to provide more detail about it. However, time and resource constraints may make it more practical for the woman to self-complete the Danger Assessment Scale. Consult the policies and procedures for your organisation to determine the preferred option.

Note: If the woman self-completes the Danger Assessment Scale, the health care provider must **always** discuss the result with her, and must **always** provide information on support, intervention and referral pathways.

The Danger Assessment Scale: A calendar AND a checklist

Both parts of the Danger Assessment Scale (DAS) (Appendix L in the revised draft FVIG) need to be completed to ascertain the full picture of what has occurred. If the practitioner or the woman completes the checklist only, the practitioner will not be able to adequately assess whether the violence is increasing in frequency and severity.

Calendar: Provide the client with a blank calendar for the previous year, and ask her to mark each episode of violence she experienced, using the severity codes specified on the DAS. If she has difficulty remembering specific dates when violent episodes occurred, suggest she consider reference dates such as birthdays, anniversaries or public holidays. Use of the calendar is necessary in order to accurately answer the first question on the DAS checklist (has the violence increased in frequency and severity?).

Checklist: The DAS checklist consists of 20 yes or no questions about known risk factors associated with intimate partner violence. The scale has been validated in the USA, and weighted scoring options are available for use in that country. See www.dangerassessment.com for further details. For New Zealand, the recommendation is to use the simple cut-off scores based on a tally of ‘yes’ responses (< 10 moderate risk, ≥ 10, high risk) (Campbell, personal communication, 15 April 2011). Overall scores on the DAS can be used as the basis for discussion with the woman about the degree of risk they are facing, and can inform the types and intensity of safety planning that are required. (See ‘Safety planning’ under [Summary of an enquiry about partner abuse](#) in ‘Family violence assessment’ (section 4) or refer to section 2.4 in the revised FVIG.)

Health care provider follow-up required for ‘Yes’ responses to certain questions:

Use of the DAS can also alert practitioners to significant other risks that may require further assessment and response. In particular, ‘yes’ responses to the following items require further response from the health care provider.

- **Item 9 (forced sex)** can be a cue to follow-up on sexual or reproductive health consequences of IPV.

If the patient has recently been the victim of sexual violence, you should determine the last occasion on which this occurred, and consult with a doctor fully trained in the medical assessment of sexual assault (eg, Doctors for Sexual Abuse Care), before you decide whether it is appropriate for you to perform a medical examination. Consult your organisational policy and procedure, and follow the recommended path for referral to appropriate sexual health services if specialist services are necessary.

If you are not specifically trained in the forensic assessment of sexual assault, do not perform a medical examination for that purpose. If the woman does not wish to lay a Police complaint, it may be appropriate to perform a medical examination for the purpose of sexual and reproductive health, if that is within your expertise.

Prescription for the emergency contraceptive pill and STI prophylaxis (including hepatitis B immunisation) should be provided as appropriate.

If forced sex has occurred in the past, consider the implications of this history for other sexual/reproductive care. If you are providing routine sexual and/or reproductive health care to the woman, knowledge of past sexual abuse may influence the process by which you provide this care (eg, ask permission before touching, explain what you are going to do), and may influence the advice you give.

- **Item 10 (choking)** should cue practitioners to conduct further assessments around strangulation. (See revised draft FVIG, Appendix M: Draft Strangulation Guideline.)
- **Item 17 (does he threaten or harm your children)** needs to be followed up by further assessment of the risk to children (see [Summary of risk assessment for child abuse and neglect](#) under ‘Family violence assessment’ in section 4).
- **Item 20 (has the victim ever thought about killing herself)** should cue practitioners to undertake further assessment about suicide and self-harm (see ‘Mental health assessment’ below).

Further health assessment (history) and treatment

Given the extensive and long-lasting health consequences associated with IPV, victims need to be offered additional assessment and appropriate treatment.

These services should include the following.

Physical health assessment

A thorough physical examination, possibly including appropriate laboratory tests and X-rays, is indicated in all cases of intimate partner violence to identify all current and past injuries. This is important because victims of abuse frequently minimise or deny the extent of violence they have experienced, or their partner may have prevented them from receiving appropriate medical care. Documentation in the medical record of current and previous injuries can assist the woman in the future if she wishes to access legal help, such as protection orders. Let her know about this documentation so that she can make use of this resource if she needs it later.

Mental health assessment

A **mental state examination** needs to be undertaken to assess for depression, anxiety and post-traumatic stress disorder. Depression, extreme anxiety, agitation or enraged behaviour, excessive drug and/or alcohol use or abuse may also be the result of experiences of violence. If women present with these signs and symptoms, make direct enquiries about their experiences of violence. Their responses will provide opportunities to determine if improved safety might alleviate mental health problems.

Appropriate medical and/or psychological treatment needs to be offered to help women deal with mental health consequences arising from the violence, while working to improve their safety.

Risk of suicide or self-harm. There is a strong association between victimisation from partner abuse and self-harm or suicide. Psychological/emotional abuse in the context of intimate relationships can contribute to the victim's feelings of worthlessness, and perceived lack of options can leave victim's thinking that suicide is their only escape from the violence. Practitioners need to consider assessing possible suicide of identified victims (Fanslow and Robinson 2004). Signs associated with high risk of suicide include (Rives 1999):

- suicidal thoughts
- previous suicide attempts
- stated intent to die or attempt to kill oneself
- a well-developed, concrete suicide plan
- access to the method to implement their plan
- planning for suicide (eg, putting affairs in order).

Make direct enquiries to assess whether the abused person is thinking about committing suicide, or has attempted suicide in the past.

- 'You sound really depressed. Are you thinking about killing yourself?'
- 'Have you hurt yourself before?'
- 'What were you thinking about doing to hurt/kill yourself?'
- 'Do you have access to (a gun, poison, etc)?'

In extreme cases, referral to the appropriate adult or adolescent mental health service is required. Because of the abuse issues, however, joint referral to a specialist family violence agency is also warranted in these cases. The most helpful intervention to reduce suicide risk may be to assist the person to obtain safety from the abuse.

Note: Use caution when prescribing tranquillisers or anti-depressants to victims of partner abuse. While there is a need to properly identify and treat mental disorders (including depression), some studies have indicated that these drugs are overprescribed to women in abusive relationships, and that these drugs may place the woman at increased risk of more serious abuse. Proper treatment for any identified mental disorder for victims of partner abuse should include addressing the abuse as a central part of treatment.

Any treatment should also convey to the woman that abuse may be a causative factor in their mental health problems.

Guidelines are available for assessing and managing people at risk of suicide (refer to the revised draft FVIG, Appendix N).

If partner abuse is identified, assess the children's safety

As discussed in section 4, intimate partner violence and child abuse tend to co-occur within families. As a consequence, if IPV is identified or suspected, it is imperative for practitioners to conduct some assessment of risk to other members of the family. In all cases, the emphasis should be on keeping the child safe and enabling the abused partner to get real and appropriate help.

Questions and issues to consider when assessing risks the abusive partner may pose to children

- Does the abuser have access to the child/ren?
- Has the abuser ever hurt or threatened to hurt or kill the child/ren?
- Has the abuser ever removed or threatened to remove the child/ren from the abused partner's care?
- Has the child (or have the children) ever witnessed the partner abuse (physical or verbal)?
- Has the abuser hit the child/ren with belts, straps or other objects that have left marks, bruises, welts or other injuries?
- Has the abuser ever touched or spoken to the child/ren in a sexual way?
- Has the child (or have the children) tried to intervene to protect the abused partner from the abuser?
- Was the child (or were the children) injured as a result?

Questions that may assist assessment of risks the abused partner may pose to the children

- 'When women are experiencing the sort of abuse you have described to me, it can affect their ability to parent in the way they would if they were free from abuse. Is this true for you? In what ways has your parenting been affected?'
- 'Are you ever afraid that you might hurt your children?'
- 'Have you ever hurt your children?'
- 'Do you know what practical help there is to assist you?'

Note that asking these questions of the abused partner will provide you with some information about the child's safety, but will not necessarily provide a complete picture. Information from other sources (eg, grandparents, other family members or CYF) may be needed. In all cases, document what you have been told and consult with experienced colleagues if you have concerns about risks to children.

If partner abuse exists, and action is needed to protect the children, follow the procedures outlined under [Summary of risk assessment for child abuse and neglect](#) (section 4).

Remember that you should, if possible, discuss any concerns about the safety of the children with the abused person. If you have any doubts about discussing concerns about child abuse and/or neglect with the suspected victim's parents or caregivers, you should first consult with senior colleagues within your practice setting, and with the duty social worker at CYF. If available, consult with the social work department or specialist child protection team for your service.

Do not discuss concerns or child protective actions to be taken with a victim's parents or caregivers if:

- it will place either the child or you, the health practitioner, in danger
- the family may close ranks and make it more difficult to help a child
- the family may seek to avoid child protective agency staff.

Be aware that actions taken to protect the child may place the mother at risk. Always refer the mother to specialist family violence support services, and inform CYF about the presence of partner abuse as well as child abuse.

- Ask the abused partner how they think the abuser will respond.
- Ask if a child protection report has been made in the past and, if so, what the abuser's reaction was.
- If the perpetrator is present in the health care facility, ask the abused partner whom they would like to inform the abuser about the report. For example, would they like the health practitioner to do it? Does the abused partner want to be present when the abuser is told? Do they want to do it?
- Make sure the abused partner has information on how to contact support agencies (eg, the Police, Refuge, CYF) if problems arise.
- Plan and agree on follow-up.
- Reinforce the importance of keeping children safe, and not minimising the negative impact of witnessing violence. It may also be useful to consider to what extent violence is impacting on the woman's ability to parent her children.

References

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Appendix 10: Alcohol and other drugs procedure: AUDIT questionnaire

AUDIT is a 10-item questionnaire screening tool for alcohol use that has been validated for Maori, pacific peoples and Europeans.

AUDIT questionnaire: screen for alcohol misuse

Please circle the answer that is correct for you.

- 1 How often do you have a drink containing alcohol?
 - Never
 - Monthly or less
 - 2-4 times a month
 - 2-3 times a week
 - 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day when drinking?
 - 1 or 2
 - 3 or 4
 - 5 or 6
 - 7 to 9
 - 10 or more

3. How often do you have six or more drinks on one occasion?
 - Never
 - Less than monthly
 - Monthly
 - Weekly
 - Daily or almost daily

4. During the past year, how often have you found that you were not able to stop drinking once you had started?
 - Never
 - Less than monthly
 - Monthly
 - Weekly
 - Daily or almost daily

5. During the past year, how often have you failed to do what was normally expected of you because of drinking?
 - Never
 - Less than monthly
 - Monthly
 - Weekly
 - Daily or almost daily

6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?
 - Never
 - Less than monthly
 - Monthly
 - Weekly
 - Daily or almost daily
7. During the past year, how often have you had a feeling of guilt or remorse after drinking?
 - Never
 - Less than monthly
 - Monthly
 - Weekly
 - Daily or almost daily
8. During the past year, have you been unable to remember what happened the night before because you had been drinking?
 - Never
 - Less than monthly
 - Monthly
 - Weekly
 - Daily or almost daily
9. Have you or someone else been injured as a result of your drinking?
 - No
 - Yes, but not in the past year
 - Yes, during the past year
10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?
 - No
 - Yes, but not in the past year
 - Yes, during the past year

Scoring the audit

Scores for each question range from 0 to 4, with the first response for each question (eg never) scoring 0, the second (eg less than monthly) scoring 1, the third (eg monthly) scoring 2, the fourth (eg weekly) scoring 3, and the last response (eg. Daily or almost daily) scoring 4. For questions 9 and 10, which only have three responses, the scoring is 0, 2 and 4 (from left to right).

A score of 8 or more is associated with harmful or hazardous drinking, a score of 13 or more in women, and 15 or more in men, is likely to indicate alcohol dependence.

Appendix 11: Alcohol and other drugs procedure: CAGE questionnaire

CAGE is a four-item questionnaire screening tool for alcohol use.

CAGE questionnaire

- Have you ever felt you should **C**ut down on your drinking?
- Have people **A**nnoyed you by criticizing your drinking?
- Have you ever felt bad or **G**uilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)?

Scoring

Item responses on the CAGE are scored 0 or 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.

The CAGE questions can be used in the clinical setting using informal phrasing. It has been demonstrated that they are most effective when used as part of a general health history and should NOT be preceded by questions about how much or how frequently the patient drinks.

Appendix 12: Four major food groups: Examples of foods and the nutrients they provide for infants and toddlers

Food group	Examples	Nutrients provided
Vegetables and fruit (eg, fresh, frozen, canned and dried products)* (Remove stringy bits and skins for very young children)	Vegetables Potato, kūmara, pumpkin, taro, tapioca, cassava, manioke(a), carrot, kamokamo (marrow), parsnip, yam, green beans, pūhā, silverbeet, spinach, bok choy, Asian greens, broccoli, courgette (zucchini), cabbage, cauliflower, corn, parengo, peas, pele leaves, taro leaves (must be cooked), watercress, capsicum Salad vegetables Tomato Fruit Apple, apricot, avocado, banana, mango, melon, pawpaw, peach, pear, plum, persimmon, pineapple, orange, berry fruit, kiwifruit Fruit salad	Energy Carbohydrates Dietary fibre Vitamins: especially folate, vitamin A (yellow and green vegetables), vitamin C (dark green leafy vegetables and most fruit, potatoes) Minerals: magnesium, potassium
Breads and cereals (eg, breads, breakfast cereals, grains, rice and pasta)	Bread (eg, slice, roll, bun, pita, chapatti, rēwena) Baby muesli, cornflakes, infant cereal (eg, iron-fortified baby rice), porridge, wheat biscuits (iron-fortified) Plain rice, congee Pasta and noodles Steamed plain cake (mantou), steamed dumplings and buns Plain sweet biscuits, muffin, cake, rusks Crackers, puffed crispbread	Energy Carbohydrates Dietary fibre Vitamins: vitamins from the B group (except B12), vitamin E Minerals (particularly in wholegrain breads and cereals): magnesium, calcium, iron, zinc, selenium Protein
Milk and milk products (eg, milk, cheese, yoghurt) and suitable alternatives	Breast milk products (eg, milk) Whole (dark blue top) cows' milk Yoghurt Cheese Plant-based milk (calcium and vitamin B12-fortified) (eg, soy, rice) Soy yoghurt and cheese (calcium-fortified) Milk puddings (eg, custard, sago)	Protein Fats: higher proportion of saturated than poly- or monounsaturated fats especially in full-fat products Energy Vitamins: riboflavin, vitamin B12, vitamin A, vitamin D Minerals: especially calcium, phosphorus, zinc, iodine
Lean meat, poultry, seafood, eggs, legumes, nuts and seeds	Casserole, mince Chicken Fish, kina, pipi, kōura (crayfish), pūpū (periwinkles), parengo (seaweed), pāua, eel Egg Hummus, baked beans, dhal, nut butters, patties/loaves Soy meat alternatives (eg, tofu, tempeh)	Protein Fats: both visible and marbled in meat (mostly saturated fat, cholesterol); mostly unsaturated fats in seafood, nuts and seeds Carbohydrates: mainly legumes (dried peas and beans) Energy Vitamins: B12, niacin, thiamin Minerals: iron, zinc, magnesium, copper, potassium, phosphorus, selenium Iodine: particularly in seafood and eggs

* Dried fruit is high in sugar. It is also very sticky and can get stuck in teeth, contributing to dental decay.

Additional notes

Do not give:

- salty meat such as corned beef, povi/pulu masima (salted brisket), and tinned fish as first foods
- cows' milk before 12 months of age
- honey before 12 months of age
- whole nuts or large seeds before five years of age (because of the choking and inhaling risks)
- foods with added fat, salt and sugar
- alcohol, coffee, cordials, juice, soft drinks, tea (including herbal tea), and other drinks containing caffeine.

Appendix 13: Food groups, specific foods in each group, advice and serving size examples

Food group	Specific foods included	Recommendation (per day)	Serving size examples
Vegetables and fruit	All vegetables and fruit, including potatoes, kūmara and taro Vegetables and fruit – fresh, frozen or canned If consumed, only one serving of no-sugar-added fruit juice or dried fruit can count as contributing a serving to the recommended dietary intake [^]	Preschoolers: at least 2 servings of vegetables and at least 2 servings of fruit Children: at least 3 servings of vegetables and at least 2 servings of fruit Young people: at least 3 servings of vegetables and at least 2 servings of fruit	1 medium potato or kūmara (135 g) ½ cup cooked vegetables (eg, broccoli, peas, corn, spinach, pūhā) (50–80 g) 1 carrot (75 g) ½ cup salad (60 g) 1 tomato (80 g) ½ avocado (80 g) 1 apple, pear, banana or orange (130 g) 2 small apricots or plums (100 g) ½ cup fresh fruit salad (120 g) ½ cup stewed or tinned fruit (135 g) 1 cup no-added-sugar fruit juice (250 ml) [^]
Breads and cereals	All breads, cereals, rice and pasta (increasing wholegrain options as children age)	Preschoolers: at least 4 servings Children: at least 5 servings Young people: at least 6 servings	1 medium slice of bread (26 g) 1 roll (50 g) 1 pita pocket or tortilla (50–80 g) 2 breakfast wheat biscuits (34 g) ½ cup muesli (55 g) ½ cup porridge (130 g) 1 cup cornflakes (30 g) 1 cup cooked pasta or rice (150 g) 4 grainy crackers (40 g) 2 plain sweet biscuits (14 g) 1 cup plain popcorn
Milk and milk products	Milk (includes calcium-fortified milk alternatives), cheese and yoghurt (choose low-fat options)	Preschoolers and children: at least 2–3 servings Young people: at least 3 servings	Glass of milk or calcium-fortified milk alternative (250 ml) Pottle of yoghurt (150 g) 2 slices of cheese (40 g)
Lean meat, poultry, seafood, eggs, legumes, nuts and seeds*	Lean meat, poultry, seafood, eggs, legumes (eg, peas, beans, lentils), nuts and seeds* (Limit processed meats)	Preschoolers and children: at least 1–2 servings Young people: at least 2 servings Vegetarians: Preschoolers (2–5 years): at least 1–2 servings School children (5–12 years): at least 2 servings Young people (13–18 years): At least 3 servings	2 slices of cooked meat (100 g) ¾ cup of mince or casserole (195 g) 1 medium fish fillet (100 g) 1 chicken leg or 2 drumsticks (110 g) 1 medium pāua or kina (100–120 g) 1 egg (50 g) ½ can tuna or salmon (90 g) ¾ cup dried cooked beans, peas or lentils (135 g) 1/3 cup nuts or seeds* (50 g)

Notes:

[^] The Ministry of Health recommends choosing vegetables and fruit that are fresh, frozen or tinned. If vegetable/fruit juice or dried fruit is consumed, it contributes a maximum of only one serving of the total recommended number of servings for this food group. Servings of fresh, frozen and canned vegetables and fruit are still required to meet the recommendations.

* Do not give small, hard foods such as whole nuts and large seeds until children are at least five years old to reduce the risk of choking.

Appendix 14: Key modifiable risk factors for SUDI*

Focus	Risk factors	Wishes/beliefs of mother, family or whānau	Birth/immediate postnatal questions	Postnatal questions	Planned intervention
1. Sleep position	<p>Infant in a car seat</p> <p>Infant on a pillow</p> <p>Infant is too big for bassinet</p> <p>Sleeping on side or tummy</p> <p>Sleeping with the neck flexed due to an inappropriate sleep surface like a pillow or car seat or face buried⁵⁸</p>	<p>What are the mother's wishes/beliefs?</p> <p>What are the wishes/beliefs of the family or whānau?</p>	<p>Does your baby ever sleep on their front or side?</p> <p>Do you have a car seat?</p> <p>Do you use it all the time?</p> <p>Does your baby ever sleep for long periods in a car seat?</p> <p>Does your baby sleep on a pillow?</p>	<p>Does your baby ever sleep on their front or side?</p> <p>Does your baby ever sleep for long periods in a car seat?</p> <p>Does your baby sleep on a pillow?</p>	<p>Conduct regular safe sleep assessments</p>
2. Sleep environment	<p>Sleeping with parent or sibling in the same bed</p> <p>Parental duvets</p> <p>Anything that might make it hard for the baby to breathe; that covers the face, flexes the neck or applies pressure on the chest.</p> <p>Unsafe sleeping surface such as a sofa or parent's bed (not designed for babies)⁵⁹</p> <p>Saggy or unfirm mattress</p> <p>Inappropriately fitted mattress</p>	<p>What are the mother's wishes/beliefs?</p> <p>What are the wishes/beliefs of the family or whānau?</p>	<p>Where is your baby going to sleep?</p> <p>Do you have a cot?</p> <p>Which room is the cot in?</p> <p>Is the mattress firm?</p> <p>Does the mattress fit snugly within the cot base without any gaps?</p> <p>Is the cot broken?</p> <p>Does the cot have any pillows or loose blankets?</p> <p>Does your baby sleep anywhere other than their cot?</p>	<p>Where does your baby sleep?</p> <p>Do you have a car seat?</p> <p>Do you use it all the time?</p> <p>Does the cot have any pillows or loose blankets?</p> <p>Does your baby sleep anywhere other than their cot?</p> <p>Where does your baby sleep during the day?</p> <p>Where does your baby sleep if you are staying at someone else's house? Will your baby be placed to sleep on a sofa or adult bed?</p>	<p>Conduct regular safe sleep assessments</p> <p>Refer to Work and Income for access to funds to purchase basinet or cot</p> <p>Advance Payment of Benefit for beneficiaries and Recoverable Assistance Payment for non-beneficiaries provide assistance towards meeting the cost of an essential item or service. There is discretion to provide assistance having regard to the client's individual circumstances</p>

⁵⁸ Child Youth Mortality Review Committee – SUDI Statement (2012) 'Suffocation or strangulation in place of sleep is the commonest cause of death from unintentional injury in the first year of life in New Zealand. It is largely preventable and should be a substantial focus for all health and social service providers including those who specialise in injury prevention.' Infants under three months of age (and especially in the first month of life) are most vulnerable to suffocation or strangulation in place of sleep. Where interventions prevent circumstances that may compromise the airway or breathing of an infant, they will reduce the risks of suffocation or strangulation in place of sleep and will contribute significantly to reducing the incidence of SUDI in New Zealand. All places where infants sleep should be carefully assessed from first principles to minimise risks of suffocation or strangulation.

⁵⁹ Child Youth Mortality Review Committee – SUDI Statement (2012): Hazardous spaces would include couches, mattresses or beds not designed for infant sleep (even if nobody is sharing the space), bean bags, cushions or other makeshift arrangements.

Focus	Risk factors	Wishes/beliefs of mother, family or whānau	Birth/immediate postnatal questions	Postnatal questions	Planned intervention
2. Sleep environment (continued)	<p>Is your baby's sleeping space always safe? (eg, does not have any pillows, bumper pads, toys, loose bedding)</p> <p>Sleeping with unsafe objects such as pillows or loose blankets (eg, duvets, mink blankets, bumper pads for cots/bassinets)</p> <p>Sleeping with a parent or sibling in the same bed⁶⁰</p> <p>Baby sleeping in a separate room</p>		<p>Where does your baby go to sleep during the day?</p> <p>Will your baby be placed to sleep on a sofa or adult bed?</p> <p>If your baby is unsettled, how would you settle them?</p> <p>Are you planning to have your baby sleep with you or your partner?</p> <p>Is the person sharing the bed a smoker, obese, taking drugs/alcohol or excessively tired?</p> <p>Do you expect the baby to ever share your own bed or a bed with someone else (including siblings)?</p> <p>Where does your baby sleep if you are staying at someone else's house?</p>	<p>How are you settling baby at night?</p> <p>Does your baby sleep with you or your partner?</p> <p>Is the person sharing the bed a smoker, obese, taking drugs/alcohol or excessively tired?</p> <p>Do you expect the baby to ever share your own bed or a bed with someone else (including siblings)?</p>	<p>The Special Needs Grant Programme provides non-recoverable assistance to beneficiaries and non-beneficiaries who have an essential need or emergency need or require payment for specific circumstances and are not able to meet the need from their own resources or through other sources</p> <p>To qualify for financial assistance, a person must meet an income and asset test. For more information visit: www.workandincome.govt.nz/in-dividuals/how-we-can-help-you/dont-have-enough-income.html</p>
3. Smoking	<p>Smoke exposure in pregnancy</p> <p>Infant is exposed to tobacco smoke directly or indirectly when in contact with a smokers</p>	<p>What are the mother's wishes/beliefs?</p> <p>What are the wishes/beliefs of the family or whānau?</p>	<p>Did you smoke at all while you were pregnant?</p> <p>How can I help you to quit?</p> <p>Who in your household smokes?</p> <p>Can you get them to smoke outside even when the weather is bad?</p> <p>Is the baby exposed to smoke by anyone else involved with the upbringing of the baby (eg, the father, a grandparent, another family member or caregiver)?</p>	<p>Did you smoke at all while you were pregnant?</p> <p>Are you still smoking? Do you plan to quit?</p> <p>Who in your household smokes?</p> <p>Can you get them to smoke outside even when the weather is bad?</p> <p>Is your baby exposed to smoke by anyone involved with the upbringing of the baby?</p>	<p>Refer to smoking cessation services (Māori and Pacific services locally) www.aukatikaipaipa.co.nz</p> <p>Refer to Quitline: www.quit.org.nz or call 0800 778 778</p> <p>Refer to Smokefree environment and smoking cessation support in section 4</p>

⁶⁰ Child Youth and Mortality Review Committee – SUDI Statement (2012): Parents and caregivers have a right to know that a significant number of infants die every year because of overlaying in the situation of sharing a sleeping surface with an adult or child.

Focus	Risk factors	Wishes/beliefs of mother, family or whānau	Birth/immediate postnatal questions	Postnatal questions	Planned intervention
4. Breast-feeding	Not initiating breastfeeding Short-term breastfeeding (less than six months)	What are the mother's wishes/beliefs? What are the wishes/beliefs of the family or whānau?	How can I help you start breastfeeding? Are you breastfeeding exclusively? How long do you plan to breastfeed for?	How can I help you maintain breastfeeding? Are you breastfeeding – exclusively? How long do you plan to breastfeed for?	Refer to breastfeeding support services. Refer to local lactation consultant. La Leche League: www.lalecheleague.org.nz Lactation consultants: www.nzlca.org.nz Breastfeeding Talk Cards from Mama Aroha: www.mamaaroha.co.nz Refer to Breastfeeding in Section 4.

* Adapted from the full SUDI assessment checklist, part of the SUDI Toolkit, available at the end of June 2013 on the Whakawhetu website (www.whakawhetu.co.nz). For the safe sleep components, view the baby's sleep space with the family or whānau and use this as a focus for supportive discussion.

Appendix 15: B4 School Check information for parents and guardians pamphlet and consent form

The B4 School Check Information for Parents and Guardians pamphlet and consent form (HP 4632) can be downloaded from the Ministry of Health's website (www.health.govt.nz). The text is reproduced below for your information.

What is the B4 School Check?

The B4 School Check is a free check for four year olds. The Check helps to make sure your child is healthy and can learn well at school. It is a chance to discuss your child's health and development with a nurse.

The B4 School Check is the final Well Child check. It is not designed to pick up every health problem your child might have, so if you have any concerns about your child at any time, talk to your family doctor.

We want you to be involved. We need your help to fill out two questionnaires about your child's development and behaviour. An early childhood educator or teacher who knows your child well will also be asked to fill out the behavioural questionnaire. Your child will also have their vision and hearing tested.

How does my child get a B4 School Check?

Your local B4 School Check provider will invite you and your child to attend and will ask for your consent.

How does the B4 School Check happen?

The B4 School Check usually takes about 45–60 minutes. Most of it will be done by a nurse with you there because you know your child best. Your child's eyesight and hearing will usually be tested by vision and hearing technicians, and this test may happen separately.

If you or the nurse think your child has a possible problem or difficulty, the nurse will discuss this with you and offer to refer you to other services that may help. The nurse can also help if your child has missed out on any immunisations.

What happens after the B4 School Check?

After your child has had their B4 School Check the nurse will discuss the Check with you and you can get a copy of the results. If your child has a Well Child Tamariki Ora Health Book, bring it along to the B4 School Check and the nurse will fill out the details.

If your child needs anything more, the nurse will offer to refer them to another service. This could be to another nurse, a doctor, a specialist such as a paediatrician or speech–language therapist, the dental service, or someone who can help with behavioural problems. If a referral is needed you will be asked for your permission to pass on your child's information.

What happens to information collected as part of the B4 School Check?

At the B4 School Check the nurse will explain what happens to the information collected, who will have access to it, and what will be shared with your family doctor, early childhood centre or kōhanga reo, and the school your child is going to attend or attends.

For more information about the B4 School Check:

- talk to your family doctor or nurse, Well Child Tamariki Ora provider or public health nurse
- visit the Ministry of Health’s website (www.moh.govt.nz/b4schoolcheck)
- call the free 24-hour health advice service Healthline (0800 611 116), which includes a Well Child line that provides parenting advice and health education information.

B4 School Check consent form

Please discuss the information about consent with the person delivering the B4 School Check. If you do not consent we will keep only your contact details and a record of your non-consent so we do not contact you again. If you do not consent but still have concerns about your child, please see your GP.

Child’s details

Name of child

Date of birth

Name on birth certificate (if different from above)

Usual home address of child

Usual home phone number

Has your child had a B4 School Check? Yes No

If yes, do not fill out the rest of the form.

When your child has a B4 School Check:

- You will be involved by helping us complete the child health check and filling out two questionnaires about your child’s development and behaviour. An early childhood educator or teacher who knows your child well will also be asked to fill out the behavioural questionnaire. Your child will also have their vision and hearing tested.
- The results of your child’s B4 School Check will be given to your family doctor. Only the vision and hearing test results will be given to his/her early childhood education centre, kōhanga reo, and/or school. The sharing of further information will need your permission.
- Your child’s name, date of birth, ethnicity and National Health Index (NHI) number will be recorded by your B4 School Check provider and stored in the national information system along with the results of the Check.
- Any information stored can only be accessed by properly authorised people who are working with your child; and are co-ordinating the B4 School Check, or who are managing the information system.

I

Print full name of parent or legal guardian

understand what the B4 School Check involves and

- I give my consent to the B4 School Check
- I do not give my consent to the B4 School Check

Signature of parent or legal guardian:

Date:..... Checked by: (for office use only)

Appendix 16: B4 School Check informed consent standard

Standard

1. The child's parent(s)/legal guardian(s) is/are provided with full and accurate information in order for the parent/legal guardian to give their informed consent to the B4 School Check, which may include referrals to other services.⁶¹

Quality indicator

2. Each child's parent/legal guardian is sufficiently informed about the B4 School Check, how it operates, what it involves and its limitations (ie, it is a screening exercise rather than a diagnostic assessment, which may also be required) and given timely, accurate, sufficient and relevant information. The information must be communicated clearly, enabling an informed choice about participation of their child in the B4 School Check by the child's parent/legal guardian.

Criteria

3. B4 School Check providers must ensure that:
 - the requirements of the Health and Disability Code of Consumer Rights 5, 6 and 7 are fully met⁶²
 - the service clearly identifies and documents how and when consent for the B4 School Check is obtained and where this is to be recorded⁶³
 - the parent/legal guardian consents to the child's identified results, or a subset of the results, of the B4 School Check being sent to other parties. Those other parties may include, and limited to, the child's doctor and/or the Well Child/Tamariki Ora Nurse, Early Childhood Education Centre/Kohanga Reo and/or school (if relevant), the Ministry of Health, and Ministry of Education.
4. B4 School Check providers must provide the child's parent/legal guardian with:
 - sufficient and relevant information in an appropriate manner that s/he understands, and that enables her/him to give informed consent in relation to the criteria set out in paragraph 5 below
 - information that is appropriately conveyed in language, culture and manner
 - access to an appropriately qualified and/or authorised person to answer his/her questions about the Check
 - advice that she/he can decline the B4 School Check and/or referral services at any time and the consequences of that decision.

⁶¹ Standard complies with the requirements of the Code of Health and Disability Service Consumer Rights.

⁶² Code of Rights 5, 6 and 7 include the right to effective communication, the right to be fully informed, the right to make an informed choice, and the right to give informed consent.

⁶³ Consent may be obtained over the telephone if necessary provided the person is identifiable as the parent/legal guardian and the full explanation is given.

5. To ensure sufficient information has been provided, providers must discuss all of the following:
 - the purpose of the B4 School Check
 - the difference between the checks conducted as part of the B4 School Check and referral to diagnostic services (for hearing, vision, general health (including oral health), behavioural or developmental concerns), including an explanation that the various screens conducted are screens only and as such the inherent limitations in conducting such screens
 - the screens, procedures, equipment and health issues involved, in addition to other details that may be required by the parent/legal guardian
 - how and when the B4 School Checks will be provided
 - the objectives, benefits and limitations of participating in the B4 School Check
 - that the parent/legal guardian may decline the B4 School Check, if she/he wishes to do so
 - the parent/legal guardian is informed that information obtained during the B4 School check will be stored on the national B4 School Check information system
 - that the parent/legal guardian may withdraw consent for their child's
 - information to be stored on the B4 School Check information system at any point.
6. DHBs must provide written pamphlets to a child's parent/legal guardian, which detail the information discussed above.
7. B4 School Check providers should ensure that those parents/legal guardians who decline to consent to a B4 School Check are:
 - provided with information as to how they can monitor and promote their child's health (eg, hearing and vision) and development and who can assist them
 - advised that if they have concerns about their child's health or development at any time the child's parent/legal guardian should talk to the child's doctor or Well Child provider
 - asked to consent to the name, National Health Index number (NHI), date of birth and ethnicity being kept to monitor coverage and quality of the B4 School Check.

Appendix 17: Child Health Questionnaire for the B4 School Check



B4 SCHOOL CHECK CHILD HEALTH QUESTIONNAIRE



MINISTRY OF HEALTH
HAKOITŪ HAURŪA

To be filled out by parent/caregiver/guardian

Child's details

Family name: _____

First name/s: _____

Also known as: _____

Date of birth: ____/____/____ Boy Girl NHI number if known: _____

Home address: _____

Ethnicity: Tick all the boxes that apply.

<input type="checkbox"/> New Zealand European	<input type="checkbox"/> Cook Island Māori	<input type="checkbox"/> Chinese
<input type="checkbox"/> Māori	<input type="checkbox"/> Tongan	<input type="checkbox"/> Indian
<input type="checkbox"/> Samoan	<input type="checkbox"/> Niuean	<input type="checkbox"/> Other _____

Language/s spoken at home: _____

Details of one or more parents/caregivers/guardians

Name/s: _____ Relationship to child: _____

Address: _____

Phone: Home _____ Work _____ Mobile _____

Name/s: _____ Relationship to child: _____

Address: _____

Phone: Home _____ Work _____ Mobile _____

1/3



Do you have any other children in your care? Yes No

Name	Age	M/F	Name	Age	M/F

Who is your family doctor? _____

Medical centre: _____

Who is your Well Child provider? _____

Who is your Iwi provider (if any)? _____

Which preschool, if any, does your child attend? _____

Location of preschool: _____

Which school will your child attend when they start school? _____

Immunisation: Tick the box or boxes to show at which age or ages your child was immunised, and whether they have had any or all of the three Meningococcal B vaccinations:

6 weeks

5 months

4 year

3 months

15 months

Meningococcal B: 1 2 3

Has your child spent time in hospital? Yes No

If yes, details: _____

2/3

Does your child have any of the following?

Condition	Yes	No	Regular medication	Action plan
Asthma				
Food intolerance				
Eczema or other skin condition				
Heart condition				
Epilepsy or fits				
Chronic chesty cough				
Allergies				
• What is your child allergic to?				
• What was the child's allergic reaction?				

Medication

Is your child on any medication? Yes No

Please list: _____

Dental health

Do you have any concerns about your child's teeth? Yes No

Has your child been to a dental therapist in the past 1–2 years? Yes No

Eye health

Does your child wear glasses? Yes No

Ear health

Has your child had (or is planned to have) grommets or tubes inserted? Yes No

Does your child have any other conditions or disabilities? Yes No

If yes, please comment: _____

Services

Are you or your family getting help or support from any services? Yes No

If yes, which services? _____

Do you have any concerns about your child's health that you would like to talk about with the registered nurse or B4 School Check team?

