POLICY	
Vulnerable populations	
Scope (Staff):	Community health staff
Scope (Area):	CAHS-CH, WACHS

This document should be read in conjunction with this DISCLAIMER

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Aim

To provide community health staff with information to identify and support vulnerable children and their families through appropriate health care.

Risk

Vulnerable children and families will not receive the service they need and will be at increased likelihood of poorer health and/or developmental outcomes.

Background

WA Health provides universal child health services to children across Western Australia. It is recognised that some children require more assistance, support and intervention than others. In an effort to attain uniformity in health and other outcomes between children of differing demographics; programs and services need to be delivered to all children and their families with a scale and intensity proportionate to individual needs.[1]

The progressive universalism model incorporates a universal platform available for all children and parents, and targeted services for those with additional needs. Research evidence indicates that the progressive universalism approach can improve health outcomes across the whole population, including vulnerable groups.

Three levels of services are included within the WA child health services program:

- Universal services – providing services to all children
- Universal plus – providing targeted support for families with additional needs
- Partnerships – identifying and referring families with complex needs so they can receive the support they require.

WA Country Health Service offers an enhanced schedule of contacts plus a tertiary level service, Partnerships plus, for children and families with complex chronic or severe conditions.

Community health staff will utilise their clinical knowledge and judgement of clients to assess parenting skills and needs of families, together with their resilience and capacity to cope with adversity to determine the appropriate level of service required.[2] While there are a number of families who do not require further support beyond confirmation that their child's development and behaviour are on track, there are others who have considerable, complex additional needs. Some families classed as vulnerable may not need any additional help; therefore, clinical judgement will play a significant role in assessing and providing the appropriate level of service for all children and families.

The groups of children recognised as being vulnerable and therefore potentially in need of additional support, intervention, assistance and follow-up include:

- Aboriginal children
- Children of refugee and culturally and linguistically diverse(CaLD) families
- Children of teenage parents
- Children of parents/carers who are living with mental illness
- Children living with parents/carers affected by alcohol and drug use[1]
- Children with disabilities.

This is not an exhaustive list of vulnerable groups and staff must be mindful of families who are overwhelmed by their circumstances. These groups may overlap, increasing the vulnerability of children and families. Other groups to consider include:

- Children from socio-economically disadvantaged families
- Children living in rural, regional or remote areas
- Children of parents who have been/are incarcerated.[3]

Community health staff should refer to the following documents for support should other issues be noted;

- Children in Care – conducting an assessment
- Family and domestic violence protocol
- Neglect protocol.

Key Points

Community health staff:

- Provide a comprehensive approach to service delivery which includes prevention, early detection, early intervention and appropriate referral systems
- Monitor health and development of children and identify key early interventions for those children and families facing difficulty
- Assist children and families to overcome barriers to accessing health services
- Understand and demonstrate respect for individual and family needs and culture, as well as eliminating any form of prejudice and racism
- Provide children and families with culturally appropriate information materials
- Work in partnership with families acknowledging individual and family strengths
- Establish and maintain awareness of support systems in the community for vulnerable children
- Develop partnerships with relevant people, agencies and organisations so that children and their families can be linked to appropriate community services
- Advocate that services and care plans are reviewed regularly to acknowledge development and changing needs
- The risk of Sudden Unexpected Death in Infancy (SUDI) is increased within vulnerable populations. Red Nose guidelines and safe sleeping strategies should be discussed with parents with consideration being given to cultural values, parental preferences and child safety
- Refer to the WA Health Protection of Children Policy if a child is at risk of neglect, physical, sexual or emotional abuse and action accordingly.

Care planning

Community health staff will respond to identified client needs and discuss appropriate care planning by undertaking a holistic assessment of the client. Staff will use endorsed clinical practice guidelines and surveillance and screening tools; including the Indicators of Need, and professional judgement in partnership with the client, to determine the level of service required.

The uptake of universal child health services within WA Health by families is voluntary; therefore community health staff can only provide services to consenting families. If there are concerns about children who have received child health services, or where families decline offered services, community health staff must act in accordance with the

appropriate policies, including the WA Department of Health Protection of Children Policy and document all actions taken.

Documentation

Community health staff will document relevant findings according to local processes.

References

1. Edmond KM. The Western Australian Metropolitan Birth to School Entry Universal Health Service Delivery Model. Review of evidence with recommendations for an improved service delivery model. Perth: Department of Health Western Australia, 2015.
2. Oberklaid F, Baird G, Blair M, Melhuish E, Hall D. Children's health and development: approaches to early identification and intervention. Archives of Disease in Childhood. 2013;98(12):1008-11.
3. COAG Health Council. National Framework for Child and Family Health Services – secondary and tertiary services. Queensland: Australian Health Minister's Advisory Council, 2016. Available from: http://www.coaghealthcouncil.gov.au/Portals/0/National%20Framework%20for%20Child%20and%20Family%20Health%20Services%20-%20updated.pdf

Related policies, procedures and guidelines
The following documents can be accessed in the Community Health Manual: Internet link or HealthPoint link
Aboriginal child health policy
Clients of concern management protocol
Enhanced Child Health Schedule Guideline (WACHS policies HealthPoint intranet)
Family and domestic violence protocol
Perinatal and infant mental health guideline
Refugee health service guideline

Related resources
Department for Child Protection and Family Support - provides a range of child safety and family support services to Western Australian individuals, children and their families, including a Child Health Passport. Phone: (08) 9222 2555 Crisis Care (after hours): (08) 9223 1111; 1800 199 008 (country free call)
External links and resources - resources produced by external organisations where there are no appropriate WA Health ones available

Indicators of Need
WACHS Enhanced Child Health Schedule Practice Guide
WA Health Language Services Policy
WA Health Protection of Children Policy

Appendix A - Aboriginal children and their families

Aboriginal[1] children and their families continue to be among the most socially and economically disadvantaged in WA and consequently are over-represented in many negative demographic social, emotional and wellbeing health indicators. Social disadvantage increases with remoteness.[2] Social determinants such as education, employment and income level of their parents will also have an effect on children's health.[3]

As childhood is an important period for establishing positive health and social behaviours, which are learnt through family and community; it is important to work with parents of Aboriginal children in culturally respectful ways to ensure the best possible health outcomes.

The health issues Aboriginal children typically face include:

- Low birth weight
- Prematurity
- Increased risk of mortality and morbidity compared to non-Aboriginal children
- Ear infections and hearing complications
- Chest infections and respiratory conditions
- Abnormal vision
- Speech difficulties
- Dental problems
- Nutritional deficiencies (Refer to the CAN Manual)
- Type 2 diabetes
- Overweight and obesity
- Clinically significant emotional or behavioural difficulties.[3, 4, 5]

Aboriginal children and families are exposed to significantly higher rates of major life stress events, such as family and domestic violence, which may increase children's risk of poor attachment, developmental and behavioural problems and sometimes even child neglect. These problems not only affect a child's health and wellbeing, but can also have adverse outcomes for school readiness, transition to school and school performance.

The early childhood years are critical for early identification, support and intervention strategies to be established which will influence health and social outcomes across the lifecourse.[6] Community health care may include assessment, early detection, brief intervention, health information, referral, monitoring and support. Community health staff

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[1] OD 0435/13 - Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.

[2] Australian Health Ministers' Advisory Council. Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report. Canberra: Australian Health Ministers Advisory Council, 2012.

[3] Edmond KM. The Western Australian Metropolitan Birth to School Entry Universal Health Service Delivery Model. Review of evidence with recommendations for an improved service delivery model. October 2015. Perth: Department of Health Western Australia, 2015.

[4] Australian Indigenous HealthInfoNet. Overview of the health of Indigenous people in Western Australia 2013. Retrieved [March 2 2017] from http://www.healthinfonet.ecu.edu.au/states-territories-home/wa/reviews/our-review

[5] Zubrick S.R., Lawrence D.M., Silburn S.R., Blair E., Milroy H., Wilkes T., Eades S., D'Antoine H., Read A., Ishigushi P. and Doyle S. Western Australian Aboriginal Child Health Survey, Summary Booklet – Strengthening the Capacity of Aboriginal Children, Families and Communities. Perth: Telethon Institute for Child Health Research, 2004.

[6] Irwin L.G., Siddiqi A., and Hertzman C. Early Child Development: A Powerful Equaliser. Final report. World Health Organization's Commission on the Social Determinants of Health, 2007.

may also provide primary health care services and health counselling for adolescents, which may address a wide range of health issues.

Useful resources
For Health Professionals
Australian Indigenous Health*InfoNet* – internet resource making Aboriginal research and health information readily available
Kimberley Interpreting Service – provides accredited interpreters for more than 18 Kimberley and central desert Aboriginal languages to clients anywhere in Australia
CAHS Patient care and cultural learning guidelines 2016
Aboriginal Cultural Learning and Aboriginal Cultural Awareness training (mandatory)
For Clients
The Aboriginal Medical Service (AMS) in your area; the Aboriginal Health Council of WA lists all AMS's.

Appendix B – Refugee and Culturally and Linguistically Diverse children and their families

Children of refugee and culturally and linguistically diverse (CaLD) parents include refugees, migrants and asylum seekers. Each of these groups is different and definitions of each provided below.

Asylum-seeker - an individual who is seeking international protection. In countries with individualised procedures, an asylum-seeker is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it. Not every asylum-seeker will ultimately be recognised as a refugee, but every refugee is initially an asylum-seeker.[7]

CaLD - a broad and inclusive descriptor for communities with diverse language, ethnic background, nationality, dress, traditions, food, societal structures, art and religion characteristics. CaLD is the preferred term for many government and community agencies as a contemporary descriptor for ethnic communities. CaLD people are generally defined as those people born overseas, in countries other than those classified by the Australian Bureau of Statistics (ABS) as “main English speaking countries”.[8]

Migrant - a person who makes a conscious, voluntary choice to leave their country to make a new life in another country.[7]

Refugee - any person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable, or owing to such fear, is unwilling to avail himself/herself of the protection of that country.[7]

The background of refugee and CaLD children and families is likely to be significantly different to most Western Australians. Families who now reside in Australia may have had long and difficult journeys, where they faced deprivation and uncertainty, which contributed and increased their vulnerability to disease and chronic health conditions. They are at greater risk of poor physical and mental health outcomes.

Western Australia provides a Humanitarian Entrant Health Service (HEHS) for those children and families newly arrived to Australia. Community Health staff providing child health services to this cohort should be mindful to follow up on any HEHS Care Plan directives.

The health issues refugee and CaLD children typically face include:

- Infectious diseases
- Growth and nutrition problems – such as iron deficiency, Vitamin A, D and C deficiency, poor appetite and food insecurity[9]

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[7] Refugee Council of Australia. Definitions. Surry Hills: Refugee Council of Australia; 2016 [retrieved April 11 2017] Available from: http://www.refugeecouncil.org.au/getfacts/international/definitions/

[8] Ethnic Communities' Council of Victoria Inc. Glossary of Terms. Victoria: Ethnic Communities' Council of Victoria Inc; 2012 October 23 [Retrieved April 11 2017] Available from: http://www.eccv.org.au/library/file/document/ECCV_Glossary_of_Terms_23_October.docx

[9] Child and Adolescent Community Health. Community and Antenatal Nutrition Manual – Multicultural Nutrition. Perth: Child and Adolescent Community Health, 2014.

- Incomplete immunisations (refer to immunisation schedule)
- Poor dental health
- Unrecognised developmental delay or disability[10]
- Female genital mutilation
- Mental health issues – Parents and children may be at increased risk of mental health issues due to traumatic events pre-arrival which may lead to post-traumatic stress disorder (PTSD). Therefore it is important to monitor the emotional health and well-being of parents and children.

Community health staff need to be mindful that refugee and CALD parents and children may not be proficient in English, or English may be a second language to them. Therefore, the use of an interpreter may be necessary to facilitate meaningful communication. Interpreting services are available in most languages and Auslan (Australian Sign Language for the deaf community). Refer to the WA Health Language Services Policy.

Useful resources
For Health Professionals
Immunisation schedule
Refugee Health Team (Metrowide Staff Directory List)
WA Health Guidelines for Protecting Children (Female Genital Mutilation section)
For Clients
Association for Services to Torture and Trauma Survivors (ASeTTS) - Provides services to people who are humanitarian entrants or are from a refugee type background and who have experienced torture or trauma in their country of origin, during their flight to Australia, or while in detention.
Centre for Asylum Seekers, Refugees and Detainees (CARAD) – provides specialised welfare and advocacy assistance to asylum seekers, refugees and detainees in WA, through case management and volunteer programs.

[10] Edmond KM. The Western Australian Metropolitan Birth to School Entry Universal Health Service Delivery Model. Review of evidence with recommendations for an improved service delivery model. Perth: Department of Health Western Australia, 2015.

Appendix C - Children of teenage parents

Teenage mothers are at greater risk of medical or obstetric complications during pregnancy and childbirth due to a lack of healthcare knowledge which may lead to delay in confirming their pregnancy and/or seeking antenatal care.[11] Postnatal depression is a genuine risk for teenage mothers.[12]

In the long term, teenage pregnancy and parenthood make this group particularly vulnerable to poor maternal and child health outcomes due to:

- Reduced education and employment opportunities because of difficulties in completing their education
- Poverty and/or dependence on government income support[13]
- Increased exposure to mental health risk factors because of lack of support, isolation from peers and/or family, financial pressures and societal attitudes
- Relationship difficulties with father of the child, friends and family
- Increased risk of child abuse and neglect
- Inadequate guidance of child due to parental life experience predisposing child to developmental delay, academic difficulties and behavioural disorders
- Substance abuse.

The teenage birth rate has declined in the last eight years; however the Aboriginal teenage birth rate is still higher as compared to non-Aboriginal teens.[14]

Most teenage parents want to be seen to be coping well and believe they can and should do everything themselves. With much stigma around being a teenage parent, there is often a fear of being judged if they seek assistance. Community health staff need to be clear that all mothers, regardless of their age, need information and support from others.

Encouraging young mothers to join a play group or young parents' group can help in making new friends, allowing problems to be shared and talked through, while allowing children to socialise with other children and helping them to develop their social skills.

Community health staff; through building rapport, helping to build their self-esteem and working in partnership, can also encourage teenage parents they encounter to continue with their education, by providing opportunities for them to consider.

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[11] McCarthy FP, O'Brien U, Kenny LC. The management of teenage pregnancy. BMJ : British Medical Journal. 2014;349.

[12] Siegel RS and Brandon AR. Adolescents, pregnancy and mental health. J Pdiatr Adolesc Gynecol. 2014: 27(3):138-50.

[13] AIHW (Australian Institute of Health and Welfare) Health and wellbeing of young Australians: indicator framework and key national indicators. 2010: Bulletin no. 77. Cat. no. AUS 123. Canberra: AIHW.

[14] Australian Institute of Health and Welfare. AIHW National Perinatal Data Collection, 2016.

Useful resources
For Health Professionals
Playgroup WA (Inc) – supports, services and establishes playgroups throughout WA.
School of Isolated and Distance Education (SIDE) - Western Australia's leading K–12 distance education provider.
Young Parents Program, Balga Senior High School - encourages teen parents to complete their secondary education by catering for their individual needs. It is unique in that it has an accredited child care centre on the school campus.
Groups for Parents Guideline
For Clients
Beyond Blue – supports emotional health and wellbeing over the life course
HIPPY - two-year, home-based, early learning and parenting program for families with young children
Raising Children Network (Parenting as a teenager article)

Appendix D - Children of parents with mental illness

Children of parents with a mental illness (COPMI) may not experience optimum emotional nurturing and sensitive parenting to support their health and emotional, cognitive and social development. They are also at an increased risk of facing major life stress events which can lead to poor health and wellbeing outcomes. These events may include;

- Relocation/out of home placement
- Disruption to routines
- Parental neglect
- Lack of emotional support[17]
- Violence or conflict in the home[15]

COPMI are also at an increased risk of developing a mental health problem of their own.[16] The stigma of having a parent with a mental illness can also have a negative impact on a child's social environment.[16]

Approximately one in five Australians will experience a mental illness,[17] yet it is still hard to measure the number of COPMI, as this is not usually recorded when a parent accesses mental health services.[18]

Child health services have an important role in assessing parental mental health status, and supporting parents to implement strategies to promote and maintain good mental health where mental illness is known. Nurses should identify what mental health services are in place and encourage regular access and review. Parental mental health should be assessed by clinical observation and enquiry, at every visit, as well as assessing attachment and emotional development of the child.

Supportive strategies such as enhancing social connections, providing parenting education, encouraging parents to take care of their physical health and to remain engaged with their mental health services will support both parent and child outcomes.

Identifying COPMI can be challenging in a school environment when this information has not been shared.

Children may present with a number of issues that may help to identify their status, such as:

- Low self-esteem
- Quietness
- Social isolation
- Trouble making friends
- Behavioural problems
- Tiredness and disrupted sleep patterns
- Clinginess
- Anger and/or anxiety

[15] Australian Infant, Child, Adolescent and Family Mental Health Association. Principles and Actions for Services and People Working with Children of Parents with Mental Illness. Stepney: Australian Infant, Child, Adolescent and Family Mental Health Association, 2004.
[16] Fudge E, Mason P. Consulting with young people about service guidelines relating to parental mental illness. AeJAMH. 2004; 3(2):1-9
[17] ABS. National Survey of Mental Health and Wellbeing: Summary of results. 4326.0. 2007 Canberra
[18] Maybery D, Ling L, Szakacs E, and Reupert A. Children of a parent with a mental illness: perspectives on need. AeJAMH. 2005; 4(2):1-11

- Unexplained school absences
- Unpreparedness for school (eg. no lunch)
- Signs of abuse or neglect[16]

Once a child of a parent with a mental illness has been identified, community health staff can assist in monitoring the child's health and wellbeing and ensure they are well supported. If necessary, records of primary school aged high-risk children, should be transferred to secondary school health services.

COPMI may take on 'adult' responsibilities, caring for younger siblings or parents, cooking and cleaning; as a result may be at higher risk of leaving school early.[16] A psychosocial assessment such as HEADSS, can help to identify and monitor adolescent mental health and wellbeing. Ensuring children have a well-developed support system can aid in reducing the negative impact associated with having a parent with a mental illness.[16] It is important that children are given age-appropriate information about their parents' mental illness and support to learn and practice effective coping strategies.[19]

Useful resources
For Health Professionals
Beyond Blue
COPMI – promoting better outcomes for children and families where a parent has a mental illness
HEADSS Assessment Guideline
Mental Health Commission - General facts, causes, and personal stories on mental health issues
For Clients
Beyond Blue
COPMI – promoting better outcomes for children and families where a parent has a mental illness
Lifeline - provides access to crisis support, suicide prevention, and mental health support services. 24 Hour Telephone Crisis Support: 13 11 14

[19] Reupert A, Mayberry D. Families affected by parental mental illness: A multiperspective account of issues and interventions. American Journal of Orthopsychiatry. 2007; 77(3):362-369

Appendix E - Children of parents affected by drugs and alcohol

There is overwhelming evidence that the misuse of drugs and/or alcohol may adversely affect the ability of parents to meet the physical, emotional and developmental needs of their children in both the short and long term.[20] Substance misuse during pregnancy may have significant adverse effects on the health and wellbeing of babies and children resulting in long term developmental problems and delays in emotional, physical, cognitive and language development.[20]

Substance misuse will impact on the parent's capacity to interact positively and consistently with their child and may result in an authoritative parenting style. During episodes of intoxication the child may be at risk of harm as a result of parental incapacity to monitor and intervene in risky situations.[21] Other outcomes for children include;

- Child neglect and/or abuse
- Family and domestic violence
- Separation of children and parents due to breakdown of parental/family relationships or incarceration.[22]

Parental substance misuse commonly co-occurs with mental health disorders, poverty or other complex social issues such as;

- Social isolation
- Poor housing
- Unemployment
- Low educational achievement
- High levels of hopelessness and despair
- Severe psychological and family stress.[22]

Children of parents affected by drug and alcohol misuse may develop behavioural, physical, educational and emotional or psychiatric problems, including communication disorders or aggressive behaviour.[21]

Community health services have an important role in supporting parents to promote optimal health and developmental outcomes for their child, through a child-centred approach. Where nurses identify concerns for the wellbeing of a child they must consider a referral to the Department for Child Protection and Family Support in accordance with the WA Department of Health Protection of Children Policy.

Extended family members are increasingly assuming care for children in response to concerns for the welfare of these children.[21] These carers may require help and support in caring for the children, but there is currently no Australian best-practice model for providing this support.

[20] Drug and Alcohol Office. Policy Framework for reducing the impact of parental drug and alcohol use on pregnancy, newborns and infants. 2008. Perth: Drug and Alcohol Office
[21] Social Care Institute for Excellence (SCIE). SCIE research briefing 6: Parenting capacity and substance misuse. 2005. http://www.scie.org.uk/publications/briefings/files/briefing06.pdf
[22] Ministerial Council on Drug Strategy. National Drug Strategy 2010-2015: A framework for action on alcohol, tobacco and other drugs. 2011. Perth: Commonwealth of Australia

Useful resources
For Health Professionals
Mental Health Commission – has information regarding drugs and alcohol and a state-wide service directory
For Clients
Alcohol and Drug Support line - a telephone counselling, information and referral service for people struggling with alcohol and other drug use, families and friends of users, and health and welfare professionals. 24 hour telephone support: (08) 9442 5000 or 1800 198 024 (outside metropolitan area)
Parent and Family Drug Support Line 24 hour telephone support: (08) 9442 5050 or 1800 653 203 (outside metropolitan area)

Appendix F - Children with disabilities

The overwhelming majority of Western Australia children are healthy. However there is a sub-population of children with disabilities who are at higher risk of poor health and developmental outcomes.

Disabilities range from minor impairments to significant functional and intellectual limitations. Disabilities may be accompanied by multi-medical and/or mental health co-morbidities and include;[23]

- Developmental delay or disability
- Intellectual/cognitive
- Physical
- Psychosocial
- Self-regulation issues
- Sensory
- Social
- Speech and language

The nature of the disability will determine the needs of the child and their families, and the appropriate services that will support them. Child health services have an important role in supporting parents to implement strategies to promote optimal health and developmental outcomes for their child. Nurses should identify the medical or disability services are in place and encourage regular access and review.

There are many children with disabilities enrolled in mainstream schools in Western Australia. Many of these children require health care plans to ensure optimal care is provided in school. The Department of Education group disabilities into four broad categories;

- Cognitive – Down syndrome, Foetal Alcohol Spectrum Disorder, language disorder
- Physical – cerebral palsy, multiple sclerosis, spina bifida
- Sensory – hearing impairment/chronic otitis media, vision impairment
- Social/Emotional – Autism Spectrum Disorder, anxiety disorder, eating disorder

The Department of Education implement an inclusive schooling approach enabling parents to choose whether their child attends an education support or mainstream school.[24] While children with disabilities will be receiving regular, comprehensive health checks from specialist health staff, this will usually be focussed on a particular disability. It is important that a child's mental and physical health and wellbeing are monitored so that problems or issues are identified early.

Children with disabilities might be susceptible to other health problems or issues as a result of their condition. Research has shown that particular adolescent groups, especially those with learning and intellectual disabilities, are at increased risk of being sexually

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[23] COAG Health Council. National Framework for Child and Family Health Services – secondary and tertiary services. Queensland: Australian Health Minister's Advisory Council, 2016.

[24] Department of Education and Training. Pathways to the Future: a report of the review of educational services for students with disabilities in government schools. Perth: Government of Western Australia, 2004.

abused.[25] The key to helping this group is to identify issues early and to advocate for and help create a supportive school environment.

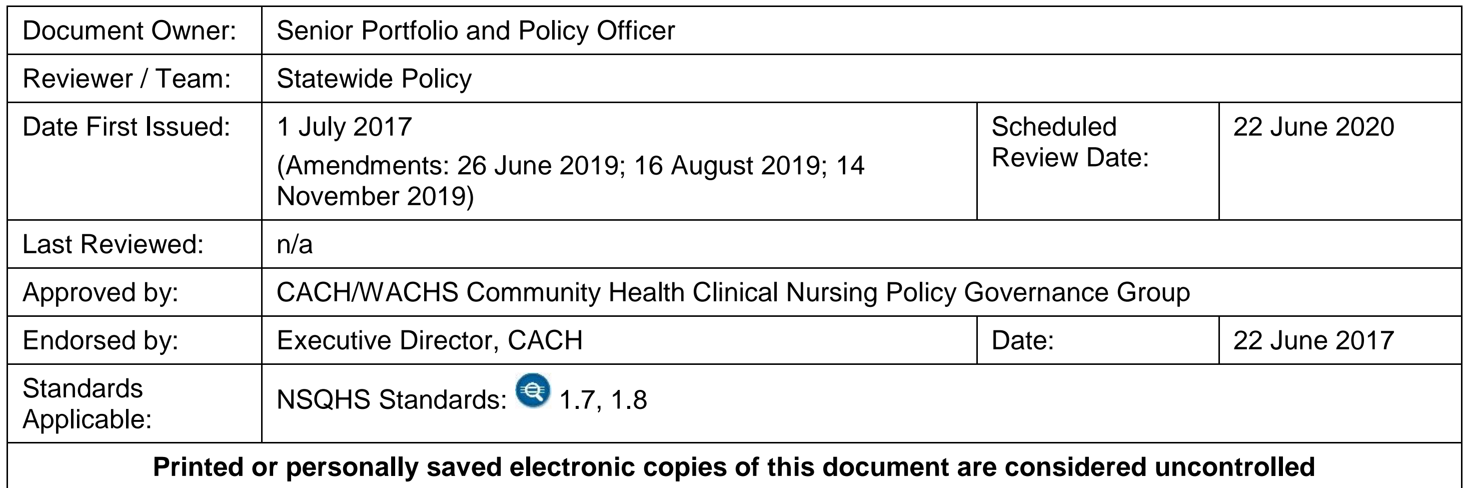
Children with disabilities have been shown to have a greater chance of developing a mental illness as compared to children without a disability.[26] The level of impairment and the attitudes and support by those around the child will be key factors of influence. As such, community health staff will have an important role in monitoring the mental health and wellbeing of children with disabilities.

Not all children with disabilities are at risk; many have supportive families and numerous protective factors in their lives. Use clinical judgement when working with children with disabilities.

Useful resources
For Health Professionals
Disability Services Commission – works in partnership with service providers and other government departments to provide information, supports and services to people with disability, their families and carers.
For Clients
Carers WA - work in active partnership with carers, persons with care and support needs, health professionals, service providers, government and the wider community to achieve an improved quality of life for carers.
Raising Children Network (Children with disability page)

[25] Briggs F, Hawkins R. Safety issues for children with learning difficulties. New Zealand Police and Ministry for Education, 2004.
[26] Dix, K.L., et al. KidsMatter for Students with a Disability: Evaluation Report Ministerial Advisory Committee: Students with Disabilities, 2010.

This document can be made available in alternative formats on request for a person with a disability.



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