EDUCATION AND HEALTH STANDING COMMITTEE

HEALTHY CHILD – HEALTHY STATE:
IMPROVING WESTERN AUSTRALIA'S CHILD HEALTH SCREENING PROGRAMS

Report No. 2
in the 38th Parliament

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Healthy Child – Healthy State: Improving WA's Child Health Screening Programs

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Report No. 2

Presented by:
Dr J.M. Woollard, MLA
Laid on the Table of the Legislative Assembly
on 21 May 2009

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COMMITTEE'S FUNCTIONS AND POWERS

The functions of the Committee are to review and report to the Assembly on:

(a) the outcomes and administration of the departments within the Committee's portfolio responsibilities;

(b) annual reports of government departments laid on the Table of the House;

(c) the adequacy of legislation and regulations within its jurisdiction; and

(d) any matters referred to it by the assembly including a bill, motion, petition, vote or expenditure, other financial matter, report or paper.

At the commencement of each Parliament and as often thereafter as the Speaker considers necessary, the Speaker will determine and table a schedule showing the portfolio responsibilities for each committee. The annual report of government departments and authorities tabled in the Assembly will stand referred to the relevant committee for any inquiry the committee may make.

Whenever a committee receives or determines for itself fresh or amended terms of reference, the committee will forward them to each standing and select committee of the Assembly and Joint Committee of the Assembly and Council. The Speaker will announce them to the Assembly at the next opportunity and arrange for them to be placed on the notice boards of the Assembly.

INQUIRY TERMS OF REFERENCE

That the Committee examine, report and make recommendations into the general health screening of children at pre-primary and primary school level, and specifically to:

(a) Appraise the adequacy and availability of screening processes for hearing, vision, speech, motor skill difficulties and general health; and

(b) Assess access to appropriate services that address issues identified by an appropriate screening process.

The Committee will report its recommendations to the Legislative Assembly by the 18th June 2009.

CHAIRMAN'S FOREWARD

As parents, and as politicians, one of our core daily concerns is the health of our children. This Inquiry into *Child Health Screening at Pre-Primary And Primary School Level* was driven by a similar concern of Committee members to that expressed by Noble prize-winning poet Gabriela Mistral:

> *Many of the things we need can wait. The child cannot. Right now is the time their bones are being formed, their blood is being made and their senses are being developed. To them we cannot answer 'tomorrow'. Their name is 'today'.*[1]

If a child's development falls behind because of health issues that could be detected and rectified, their development will be delayed and the process of resolving the problem will become progressively more costly the later it is attempted in a child's life.

Western Australia's child health screening programs service approximately 35,000 pre-primary and 119,000 primary school students. These programs are staffed by hard working and committed people across the State who have regularly suggested ways in which the system could be improved.

This Inquiry was conducted to assess the adequacy and availability of screening programs and the access to appropriate services that address issues identified by the screening process.

Recommendations have been made by the Committee that address funding for child health services including: additional staffing, particularly school and child health nurses; funding to ensure the standard of screening is consistent with other States and with national guidelines; and funding to ensure that services are delivered in a timely manner whenever a general health, hearing, vision, speech or motor skill problem has been identified.

Specifically the recommendations suggest the Government address:

- **Staffing shortages**: the Inquiry reinforced early research findings dating back to 1999 that child development services are inadequately staffed. This is currently more noticeable in metropolitan primary schools. In 2008 the Department of Health prepared a business case for the previous government seeking an additional 126 full-time equivalent (FTE) in the Child Development Service, 105 FTE Community Child Health Nurses and 135 FTE for School Nurses.

The urgent need for more staff has been made worse over the past five years by a large increase in demand for child health services due to the growing numbers of births in Western Australia (an additional 4,000 births a year) and an escalation in migration to the State by young families as a

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1 Gabriela Mistral (1889-1957) is the pseudonym for Lucila Godoy y Alcayaga, who was born in Vicuña, Chile. Gabriela won the Nobel prize for literature in 1945 and this quotation is from her acceptance speech on 10th December, 1945. Nobel Prize, "Biography", (2008). Available at: http://nobelprize.org/nobel_prizes/literature/laureates/1945/mistral-bio.html. Accessed on 8 July 2008.

result of the mining boom. The regions under most pressure from the recent population growth include the Pilbara and Perth's outer metropolitan suburbs.

While the WA school population has increased substantially over the past 15 years, NO additional school nurses have been employed by State governments from either side of politics. The average age of community nurses is increasing and in 2006 was 54 years, with 91% over the age of 40. The Department of Health confirmed that there will be a 10% shortfall of general nurses and midwives by 2015-16.

- **Waiting times**: The primary issue identified by submissions was the initial long waitlists to obtain an assessment. Following the assessment and identification of a health care problem there are also long waiting lists for children to be referred for treatment.

School staff confirmed waiting lists for some conditions of up to 18 months, saying "it takes nine months to get an initial assessment and then, when a course of therapy is recommended, it takes another six months for something to happen." It was reported that in some cases, an 18 month wait for treatment would mean that a child then becomes ineligible for a service, as they are deemed outside the targeted age group.

We were told that waiting lists and access to treatment were higher in regional areas and have a particularly critical impact on children living in Aboriginal communities.

- **Early screening**: Other States and Countries have adopted new ways of undertaking health screening activities. As over 90% of WA's four-year-olds attend child-care or pre-school, staff in these areas could be trained to carry out some of the screening tests, such as sight, hearing, speech and language, or work with the community health nurses to complete the testing.

- **Full participation in State-Federal funding initiatives**: An example of the new opportunities in Federally funded initiatives is the $2.6 billion five-year commitment to enhance the integration of early childhood development services the Minister for Education, Hon Julia Gillard, announced in May 2008. Another is the $872 million dedicated towards preventative health strategies countering the harms attributable to obesity, alcohol and tobacco under the COAG National Partnership Agreement on Preventive Health 2008.

- **Hearing, Vision, Speech and Motor Skills**: Additional funding is required for screening in each of these areas. In particular, the committee recommended the adoption of the universal neonatal hearing screening test that is undertaken in ALL other Australian jurisdictions, and which is regarded as a long term cost-effective measure. Additionally, the Committee recommended the adoption of the three-year-old vision screening test and the collaboration between multidisciplinary, government and non-government initiatives to service the vision needs of children in rural and remote areas.

- **Mandatory inclusion of phonics in teaching English**: The Committee felt that a renewed focus on early exposure to the tradition of phonemic awareness (i.e. during kindergarten) could have a profound impact on the school-readiness and development of a child.

- **Additional Funding for the necessary staff and services for children in particular areas of need**: This includes funding for community migrant health nurses for refugees, incorporating torture and trauma counselling for children. Additional funding is also needed for screening for Foetal Alcohol Spectrum Disorder (FASD), which is widely recognised as the most common preventable cause of significant developmental delay in children, and which occurs in Indigenous mothers at a rate 1,000 times that of non-Indigenous mothers.

I would like to thank those 33 individuals and groups who made a submission to the Inquiry, as well as the 40 witnesses who attended the public hearings. It has been a long while since a review of WA's child health screening system has been undertaken and this expert evidence has assisted the Committee frame its findings and recommendations.

I would also like to thank my fellow Committee Members who worked on this Inquiry, Mr Peter Abetz and Mr Ian Blayney, as well as the co-opted members from the Education and Health Standing Committee of the 37th Parliament – Hon Mr Tom Stephens, Mr Martin Whitely and Mr Paul Papalia, CSC. This Committee has worked hard over two parliaments in a collegiate manner to ensure a thorough report was completed.

The Committee was also very fortunate to have the experienced guidance and valuable assistance of Dr David Worth, Principal Research Officer, and Mr Tim Hughes and Mr Roy Tester, Research Officers. These three staff worked extremely hard to gather data, organise the hearings, help the Committee analyse the data and prepare this excellent Report. I hope that this effort has produced a report which will have a major impact on the government's approach to child health screening in Western Australia, and improve the health of future West Australians.

DR J.M. WOOLLARD, MLA
CHAIRMAN

ABBREVIATIONS AND ACRONYMS

ABS	Australian Bureau of Statistics
ADHD	Attention-Deficit Hyperactivity Disorder
AEDI	Australian Early Development Index
AIFS	Australian Institute of Family Studies
ARBD	Alcohol Related Birth Defects
ARND	Alcohol Related Neurodevelopment Disorders
ASD	Autistic Spectrum Disorder
ASeTT	Association for the Services of Torture and Trauma Survivors
ASQ	Ages and Stages Questionnaire
ASQ:SE	Ages and Stages Questionnaire: Social and Emotional
CACHP	Child and Adolescent Community Health Policy
CAHS	Child and Adolescent Health Service
CAMHS	Child and Adolescent Mental Health Service
CALD	Culturally and Linguistically Diverse
CAT	Computer Assisted Tomography
CCYP	Commissioner for Children and Young People
CDC	Child Development Centre
CDIS	CDS Reform Project - Child Development Information System
CDS	Child Development Services
CHN	Community Child Health Nurse (also known as Child Health Nurse)
COC	CDS Reform Project - Continuum of Care Framework
CPP	CDS Reform Project - Consumer Perspectives Project
DAO	Drug and Alcohol Office
DET	Department of Education and Training
DOH	Department of Health

DSC	Disability Services Commission
ECIA	Early Childhood Intervention Australia
EHSC	Education and Health Standing Committee
EPC	Medicare's Enhanced Primary Care Program
FaCSIA	Federal Department of Families, Community Services and Indigenous Affairs
FAE	Foetal Alcohol Effects
FAS	Foetal Alcohol Syndrome
FASD	Foetal Alcohol Spectrum Disorder
FTE	Full-Time Equivalent
HCM	Healthy Child Manitoba
HKC	Healthy Kids Check
HRCT	DSC's Health Resource and Consultancy Team
HRIT	Health Reform Implementation Taskforce
IEP	Individual Education Plans
IIOY	Investing in Our Youth Inc.
JCG	Joint Consultative Group
LDC	Language Development Centre
LEAF	Linking Education and Families program
LGA	Local Government Area
LSA	Local Service Agreements
MELS	Middleton Early Language Screening
MOU	Memorandum of Understanding
MRI	Magnetic Resonance Imaging
NWS	Neonatal Withdrawal Syndrome
NGO	Non-Government Organisation
NHMRC	National Health and Medical Research Council
NHS	Newborn hearing screening

Niftey	National Investment for the Early Years
OECD	Organisation for Economic Co-operation and Development
OME	Otitis Media with Effusion
P&C	Parents and Citizens group
PC	Productivity Commission
PDD-NS	Pervasive Development Disorder - Not Otherwise Specified
PEDS	Parent Evaluation of Developmental Status
pFAS	partial Foetal Alcohol Syndrome
PMH	Princess Margaret Hospital
PPP	Positive Parenting Program
RUCSN	Resource Unit for Children with Special Needs (now known as CHILD Australia)
SAC	School Age Children
SCDC	State Child Development Centre
SE	Static Encephalopathy (alcohol exposed)
SEHA	School Entry Health Assessment
SEI	Socio-Economic Index
SES	Socio-Economic Status
SHS	School Health Service
SOSL	DET Officers for Speech and Language
UCS	Birth to School Entry Universal Contact Schedule Policy
VES	DET's Vision Education Service
WHO	World Health Organization
WISH	WA Infant Screening for Hearing Program

EXECUTIVE SUMMARY

This Inquiry into child health screening at pre-primary and primary school level was referred to the Education and Health Standing Committee (EHSC) by the Parliament on the 27th November 2008. This allowed the completion of an Inquiry that had commenced in the 37th Parliament, with similar terms of reference, which was near completion when the State election was called in August 2008. This earlier Inquiry had been initiated due to concerns raised by the Committee's previous Inquiries during the 37th Parliament. The Committee was particularly influenced by data on child health gathered for *Report 13, Ways Forward - Beyond the Blame Game: Some Successful Initiatives in Remote Indigenous Communities in WA*, tabled in May 2008, and for *Report 2, Inquiry into Swimming Pool Program in Remote Communities*, tabled in June 2006.

More than 30 submissions were received for this Inquiry from members of the public, non-government organisations, professional associations, school staff and concerned health practitioners. Formal submissions were also sought from the Departments of Health, Education and Training and the Disability Services Commission. The Inquiry's terms of reference were to:

(a) Appraise the adequacy and availability of screening processes for hearing, vision, speech, motor skill difficulties and general health; and

(b) Assess access to appropriate services that address issues identified by an appropriate screening process.

Chapter One outlines the background to the Inquiry and the way in which it was conducted over the two parliaments. The Inquiry is important in the effort to improve the health outcomes for children at pre-primary and primary school level, who have problems in hearing, vision, speech, motor skill difficulties or general health that may hinder their social, cognitive or emotional development. In addition the future fiscal benefits derived from early intervention for such children are undeniable. As Dr John Wray advised the Committee:

> *The Government must come to understand that community health services are cheaper to run than tertiary health services, and furthermore, that community health services are preventative and will decrease reliance on tertiary health structures (such as hospitals).*

In a similar fashion, the Nobel Peace Prize-winning economist Professor James Heckman has argued that "every $1 spent in the early years of a child's life saves at least $17 in later service demands."

Chapter Two provides an overview of the current best practise framework that is advocated domestically and internationally for early child health intervention. This chapter identifies a range of components that are considered essential to delivering an optimal child health screening program. These components are drawn from recommendations offered by the World Health Organization (WHO) and contained in the Australian study prepared for the National Health and Medical Research Council (NHMRC)- *Child Health Screening and Surveillance: A Critical Review of the Evidence.*

WHO has a list of eight recommendations including the provision of "adequate facilities for diagnosis and appropriate treatment [and]…maintenance of program data to evaluate and monitor the program regularly." According to the NHMRC report, the early detection of child health conditions should encompass an approach where screening is undertaken for defined conditions within a program of 'surveillance', which encourages the ongoing participation of parents and carers in the assessment of a child's well being. As part of the surveillance program, preventative health activities should be actively promoted. This chapter summarises three programs, from the US, Canada and the UK, whose success can be attributed to the adoption of many of these best practise principles.

Chapter Three offers a broad introduction to the child health screening services for Western Australia's approximately 35,000 pre-primary and 119,000 primary school students in the context of the 2006 *Future Directions for Western Australian Child Development Services* (*Future Directions* report). The *Future Directions* report was conducted by the WA Health Reform Implementation Taskforce (HRIT). It found that child health services were delivered:

- in a variety of models according to available resources and staff;
- in a way that was described as a 'postcode lottery'; and
- with the adequacy of access to therapy services varying from service to service, and region to region.

The current system resulted in:

- poor integration of the provision of services between school and community health services; and
- waiting times for a range of remedial services ranging between two and 18 months.

The report confirmed that delayed interventions end up being more costly for government, as it extracts a greater demand on future health services to provide therapy and treatment requirements. In addition, many of these delays may exacerbate a child's behavioural conditions and social dysfunction, which ultimately places added pressures on other public agencies, such as the education and justice departments.

Chapter Four examines some widely-recognised ongoing challenges that hinder the provision of a truly universal and accessible screening, assessment and treatment service throughout the State. Factors that increase the demand for health services (and are common to many developed societies) include changes in family structure, marginalised populations, migration and local health concerns such as Foetal Alcohol Spectrum Disorder (FASD). Specifically:

- The modern family has undergone a variety of changes, including increased divorce rates, changed working hours, greater female participation in full-time employment and a higher incidence of casual labour, which have impaired the opportunity for raising healthy children.

- Poorer and marginalised populations, including Indigenous, Culturally and Linguistically Diverse (CALD), and refugee communities, are particularly susceptible to inferior health outcomes relative to other social groupings. Moreover, for cultural or other reasons, these marginalised groups are less-likely to access the screening and treatment services that are available to them.

- Local health services have also had to cater for the influx of new families to the State that occurred during the recent mining boom. This migration has led to a 16% increase in Western Australia's birth rates between 2001 and 2006. It is inevitable that such significant population growth will add further pressure to an already overstretched child health sector.

- There has been a large impact from conditions that are not currently targeted in screening assessments, such as Foetal Alcohol Spectrum Disorder (FASD). Data from the Telethon Institute for Child Research shows that there is a one thousand-fold increase in the prevalence of FASD in WA's Indigenous mothers relative to their non-Indigenous counterparts.

Chapter Five then provides an extensive summary of the current screening programs in Western Australia. This chapter looks at how services are currently administered across the Department of Health (DOH), the Department of Education and Training (DET), the Disability Services Commission and various non-government programs.

School entry health assessments are offered to all children in WA's public and private primary schools as soon as possible after school entry. There were over 27,500 Year 1 students enrolled in WA in mid-2008, and about 84% had received school entry health assessments. About 70% of Aboriginal children had received assessments.

In this chapter the magnitude of the current resource shortfall becomes apparent. For instance:

- The ratio of School Health Nurses to students in metropolitan primary schools is one-third of the government target that is required to provide appropriate services.

- The status of the Community Health Nursing sector is dire. The average age of the current Community Health Nurse is 54. Already under-resourced, this ageing workforce is becoming increasingly dispirited by the growing demands being placed upon its members.

- DOH future projections estimate that there will be a 10% shortfall of general nurses and midwives, based on current levels, by 2015-2016.

- DOH conceded to the Committee that, without redress, "there will remain a problem of demand for services exceeding capacity of the Child Development Service (CDS) to provide". A number of submissions confirmed the impact of these shortfalls, suggesting that waiting times of between nine and 12 months were 'commonplace' amongst the CDS.

- Speech and Language services provide a stark example of current inadequacies. For the 14,500 children in K-12 years suffering from an impairment or difficulty, only 1,000

places are available in the DET Language Development Centres, and all of these are located in the metropolitan area.

Permanent under-resourcing under previous governments has forced agencies into implementing 'waitlist management strategies'. These include:

- Prioritising services on the perceived urgency of individual cases;
- Offering group therapies instead of individual consultations; and
- Conveying written information to parents and carers.

In the case of children aged eight years and over, the situation can be particularly grim. The DOH originally acknowledged to the Committee that "as a result of resource restrictions, many sites have been unable to effectively manage children older than eight years of age". Dr John Wray lauded the work of the CDS staff, but described the services they were currently able to offer as 'inadequate' and 'watered down'. This has added ramifications for the quality of health care being provided. The situation is made worse for many children because there are often two waiting lists:

- The first to obtain a proper assessment and referral for treatment; and
- The second for the actual treatment of a condition.

Parents can become anxious and disaffected when treatment of their child is delayed. This stress undermines the engagement of families with their child's health, a centrepiece of the current holistic approach to child health care.

Chapter Five concludes by looking at some of the initiatives that the DOH is undertaking to improve the current service model, including improving services to children over eight years old. Foremost amongst these strategies is the CDS Reform Project, which emanated from the HRIT report's recommendations. A major aim of these reforms is to integrate the work of the various agencies to "ensure consistency across the state". While the Reform Project consists of a variety of strategies, DOH perceives that the most critical is the Child Development Information System (CDIS). The CDIS will replace the current paper records and centralise the record keeping process across the entirety of the metropolitan child health services, thereby enabling administrators to automate follow-up procedures with parents, to quickly identify areas where resource shortfalls are most acute and to share data between DOH and DET. This database is seen as "the linchpin of the single service" and has been funded from within the existing DOH budget. It should be operational by the end of 2009.

Having considered the overall status of Western Australia's child health services, Chapters Six through Nine evaluate the individual health domains under scrutiny against the Inquiry's terms of reference. Australian jurisdictions use different ages at which to screen children and undertake health checks before they enter school. All have at least six contacts, with some having as many as nine. Table ES.1 compares WA's new program with that used in other states (but doesn't include what checks and screening activities take place at these ages).

Table ES-1 Comparison between assessment age contacts in WA and other states

WA Contacts	QLD Contacts	SA Contacts	TAS Contacts	VIC Contacts	NSW Contacts
Birth – 10 days	Birth – 10 days	Birth	Birth	Birth	Birth and newborn
	1 – 4 weeks	1 – 4 weeks	1 – 2 weeks	1 – 4 weeks	1 – 4 weeks
				2 weeks	
				4 weeks	
6 – 8 weeks	6 – 8 weeks	6 – 8 weeks	6 – 8 weeks	6 – 8 weeks	6 – 8 weeks
3 – 4 months	4 months			4 months	
	6 months	6 – 8 months	6 months	6 – 8 months	6 months
8 months	12 months			12 months	12 months
18 months	18 months	18 months	18 months	18 months	18 months
				2 years	2 years
3 – 3.5 years	2.5 – 3.5 years	2.5 – 3.5 years	3.5 years	2.5 – 3.5 years	3 years
4 – 6 years	4 - 5 years	4 – 5 years			4 years

Pre-school and school-based programs are now part of a continuum of health checks and screening that begins with a child's birth. The revised screening program now used in Western Australia (see Table ES-2 below) was proposed in DOH's *Policy Rationale* and introduced in 2009. It includes new health contacts at birth and 3-4 months old, while removing the contact at 1-2 weeks.

Table ES-2 Screening programs in WA, from birth to six-years-old

Age	Carried Out By/Comments	Developmental Screening & Surveillance	Disease/Condition identified
Birth – 10days	Community Health Nurse	Observational assessment of baby	
6 – 8 weeks	Community Health Nurse -Observation of milestones for physical, social and emotional development Edinburgh postnatal Depression Scale is offered to the mother	Visual Appraisal - Observation of eyes, Red Reflex Test and vision behaviours Observation of Hearing Behaviours Screening examination of the Hips (Ortolani and Barlow manoeuvres) Physical Assessment: Observation of Early Motor Development Weight Measurement	Congenital eye conditions, e.g. cataracts, tumours, amblyopia Congenital Deafness Developmental Dysplasia of the Hips Abnormality or absence Developmental Delay Growth abnormality
3 – 4 months	Community Health Nurse -The parent completed Ages and Stages screening tool (ASQ:SE) if indicated. Edinburgh postnatal Depression Scale is offered to the mother	Visual Appraisal - Observation of eyes, Red Reflex Test and vision behaviours Weight Measurement In 2009, a parent-completed child developmental screening tool called the Parent Evaluation of Developmental Status (PEDS) will be offered	Cataracts, small angle strabismus and unequal refractive errors Growth abnormality Developmental Delay in various domains: Gross and fine motor Vision and hearing Speech and language personal and social behaviour
8 months	Community Health Nurse - ASQ &ASQ: SE if indicated Edinburgh postnatal Depression Scale is offered to the mother	Visual Appraisal - Eye movements, Corneal light reflex test and vision behaviours Physical Assessment: weight measurement PEDS	Examination for strabismus Growth abnormality Developmental Delay in various domains

18 months	Community Health Nurse - ASQ &ASQ: SE if indicated	Observation of milestones for physical, social and emotional development PEDS	Developmental Delay in various domains
3 – 3.5 years	Community Health Nurse - ASQ &ASQ: SE if indicated	Observation of milestones for physical, social and emotional development PEDS	Developmental Delay in various domains
4 – 6 years	School nurse - ASQ &ASQ: SE if indicated	Visual Appraisal - Eye movements, Lea Symbols Chart, Corneal light reflex, cover test and vision behaviours Hearing Screening: Otoscopy and Audiometry screening PEDS	Examination for strabismus Distance visual acuity and amblyopia Hearing Loss – congenital or acquired Developmental Delay in various domains

Hearing tests and treatments programs are assessed in Chapter Six against the Inquiry's two terms of reference. Universal neo-natal testing for hearing, in conjunction with a range of corrective technologies, allows the opportunity to obtain significant preventative health benefits. Deafness Forum Australia reinforced the value of neonatal screening, claiming that "children who enter early intervention before six months of age will have the greatest opportunity to achieve their fullest potential across all developmental domains."

The eminent ENT Surgeon, Associate Professor Harvey Coates, added that:

> *every child whose poor hearing was identified during a newborn hearing test will save the government $1.2 million in ongoing health and social costs.*

According to this estimate, the 80 children in WA already identified by these tests with hearing problems represent a $100 million saving in future government outlays.

Unfortunately, the benefits of such intervention are not fully realised in Western Australia. DOH offers a free, but limited, newborn hearing screening test. It is only available in six public hospitals, reaching just 49% of all babies The full cost for implementing a universal program would be relatively small, about $10 million over four years. DOH advised that it is planning on implementing a universal program in the next two years. In WA, current waiting times for treatments range between six and 12 months. Federal initiatives, including a program that supplies free cochlear implants, are seen to be significantly under-utilised in Western Australia.

Visual screening and treatment services are assessed in Chapter Seven. There is little contention over the method of vision testing, although concerns were raised regarding the fact that no standard test is currently offered between the post-natal period and a child's first year of schooling. Evidence was received suggesting that rural and remote populations, especially Indigenous children, were subject to inconsistent access to vision screening.

As with hearing, many vision conditions are inherently preventable. Yet, as the Association for the Blind of WA argue, under the current screening schedule "many children with low vision are not detected until poor school performance alerts parents and teachers."

In terms of access to remedial treatment, submissions noted the delay and lack of coordination for clinical services at Princess Margaret Hospital. A DET stakeholder group confirmed that services in this area lacked coordination and that delays "from diagnosis to treatment" could be reduced.

Speech, language and fine motor skills are assessed in Chapter Eight. DET advised that "there are currently no universal, standardised screening processes in place" for both speech and language and motor skills. Presently only 25% of children are tested for speech. While some basic screening processes are in place, they are quite limited in terms of their diagnostic rigour (often being exclusively reliant upon parent or teacher input) and the frequency with which they are offered.

The Inquiry was advised that the best time to screen for speech language and fine motor skills is by four years of age. Deficiencies in these health domains have usually become apparent by this time and the earliest possible diagnosis is required in order to expedite the remedial treatment that will improve a child's capacity for learning when they enter the formal school environment.

The Committee was advised that several local screening tools, *Middleton Early Language Screening (MELS)* and *Catch Them Before They Fall*, had shown early promise with their validity and reliability. Yet these programs have not yet progressed beyond the pilot project stage.

Problems identified for children with speech and language disorders include:

- access to appropriate services;
- a shortage of places available at the Language Development Centres; and
- a shortfall in the number of DET Support Officers for Speech and Language (SOSL) who help teachers develop Individual Education Plans for affected children.

Private treatment services are available, but are prohibitively expensive for many parents who often end up simply enrolling their ill-prepared child into a mainstream classroom. Speech WA correctly argued that "the inadequacy of access to appropriate services wastes the opportunity to prevent difficulties from jeopardising literacy and learning levels."

Problems identified for children with motor skill difficulties include:

- access to services;

- delays between six and nine months before children receive a post-screening assessment; and

- further delays before remedial treatment commences.

General health conditions are assessed in Chapter Nine. The Inquiry found that children in rural and remote populations were particularly disadvantaged in this domain. The DET Stakeholder Group expressed concern regarding "the lack of universal screening processes for key areas". There is no screening for conditions such as Foetal Alcohol Spectrum Disorder (FASD) and it can take up to 12 months for children to access mental health assessment and treatment processes.

With a view to improving the health prospects of the State's children, this chapter concludes with a look at several community-based projects that are enjoying some early success in improving early intervention processes in their local areas. Foremost amongst these is the Linking Education and Families (LEAF) Program, which has been trialled by the non-profit group Investing In Our Youth Inc (IIOY) in partnership with the DET. Using the pre-school environment, LEAF works with local families and communities to support their efforts to identify priorities and develop a plan to improve the wellbeing of their children. An evaluation of the program conducted by Curtin University cited a broad range of benefits that can be attributed to LEAF. These include:

- increasing families links to community services;

- facilitating access to early intervention;

- providing access to early childhood information and activities; and

- fostering school readiness.

This Inquiry recommends that these community programs need to be given serious consideration by government as a way of providing an environment where parental engagement in the early childhood model of care is actively encouraged. Equally important, these programs may provide the ideal location for conducting a wide range of health screening tests before children start formal schooling. Properly trained childcare workers could assist the under-resourced school and community nurse workforce in undertaking screening programs, as the earliest identification of health conditions is essential to ensuring the 'school readiness' of Western Australia's children.

WA's screening program suffers because a dedicated, but under-resourced, labour force works in a disjointed system that has responded too slowly to recent demographic changes and emerging health conditions. This is an unacceptable scenario when 20-25% of the State's children are commencing school with some form of health complaint that can impair their learning capabilities. These figures incorporate 10% of children with language delays and 10% with some form of physical disability.

Chapter Ten is the final chapter and provides some future strategies for government as current service delivery does not apply international best practise measures and does not satisfy the recommendations of the HRIT Report.

There are a range of strategies that can assist in targeting the deficiencies revealed in this report. These strategies will necessitate greater government expenditure, particularly for staff, across many areas of the child health services. Shortages are particularly acute in the school and community nursing sectors.

The Committee recommendations include the importance, and affordability, of fully rolling-out the universal newborn hearing screening test and investigating the viability of community-based initiatives to enable earlier screening for the full range of health conditions under review. The committee believes strategies should be designed to ensure that remedial services are better integrated and waiting times are reduced.

The Committee accepts the evidence suggesting that a renewed emphasis on phonemic awareness in early education will deliver substantial preventative health benefits. This is particularly pertinent for children suffering speech and language disorders. Speech pathologists and representatives from the DET advised the Committee that inclusive language pedagogies, with a subsequent lower reliance upon 'whole of language' teaching methodologies, may help reduce current waiting lists at the Language Development Centres. This could have a profoundly positive impact on the school-readiness of a broader range of children. The renewed emphasis on phonemic awareness in the curriculum is supported by landmark studies including the 2006 report by Western Australia's Numeracy and Literacy Review Taskforce and the 2005 *National Inquiry into the Teaching of Literacy*. The latter report found "strong evidence" supporting the view that the current reliance upon "a whole of language approach to the teaching of reading on its own is not in the best interests of children".

A 'whole-of-government' approach needs to be adopted between the various State government agencies to coordinate the provision of local services in a way that addresses the current length of waiting times. The Committee accepts the Department of Health's view that the successful introduction of the CDIS is pivotal to this outcome, providing this does not mean more resources are spent on building an administrative 'empire' rather than employing staff in the field to conduct assessments and provide treatment.

It is essential that the coordination of Federal and state services is improved. Currently, a lack of collaboration between jurisdictions has meant that a range of Commonwealth schemes, including *Australian Hearing, Healthy Kids Check* and *Medicare's Enhanced Primary Care Program,* are not being fully utilised in WA.

Strategies such as these discussed in Chapter Ten represent economical measures that, if adopted, stand to deliver the significantly improved outcomes that many Western Australian children desperately need and deserve.

FINDINGS

Page 24

Finding 1

Aboriginal children have a higher incidence of middle ear disease than other children in Western Australia and this has a severe impact on their health and education.

Page 24

Finding 2

The current policy of the Department of Health to limit speech and language referrals to children below five years of age places children from refugee and Culturally and Linguistically Diverse (CALD) communities in a 'Catch 22' situation that limits their ability to fully integrate with Western Australian society.

Page 46

Finding 3

There is an urgent priority for the Western Australian government to increase the number of school and child health nurses, especially for metropolitan primary schools.

Page 49

Finding 4

The current process of providing school health and community nurses to undertake child health screening programs is likely to continue to fail to meet the needs of Western Australia's children in light of the Department of Health's (DOH) modelling showing a 10% shortfall in nurse numbers by 2015-16, the recent high rate of population growth in Western Australia and the aging of the DOH workforce.

Page 58

Finding 5

Other Australian and overseas jurisdictions have developed new approaches that have cut the waiting times in their child health sector.

Page 64

Finding 6

The Australian Early Development Index is a population measure of children's developmental progress over the first five years of life and is not a screening tool for individual children. Its results should be used in conjunction with other data to ensure better health outcomes for children in regions and local government areas in Western Australia with greater child health needs.

Page 70

Finding 7

The benefits of introducing a universal neonatal hearing screening program in Western Australia would far outweigh the costs of such a program, as has been shown in other Australian jurisdictions.

Page 74

Finding 8

Children living in Western Australia's rural and regional areas have limited access to therapies to deal with vision conditions. Multi-disciplinary teams consisting of government and non-government organisations could service these needs and such a process would result in lower costs, improved sharing of resources and improved service delivery.

Page 79

Finding 9

The current screening methods for speech, language and motor skills are even less adequate than that provided for hearing and vision.

Page 81

Finding 10

Access to remedial treatments for children with speech and language difficulties is fragmented, inadequate and unacceptable in all regions of Western Australia.

Page 84

Finding 11

Developmental delays in speech and language can have a profoundly negative impact on a child's education and socialisation. There is promising evidence that tools such as *MELS* and *Catch Them Before They Fall* offer a reliable and valid tool for screening children's competency in early language skills.

Page 92

Finding 12

There is promising evidence that programs such as *LEAF* and *A Smart Start* assist pre-primary children prepare for school, while allowing carers and parents to identify health concerns well before a child enters the school system. These programs provide an ideal environment for conducting a range of health screening tests before children start formal schooling. They would benefit both the child in terms of school readiness, and reduce the current burden for school health nurses who have to deal with children suffering from a variety of disorders that could have been diagnosed earlier.

Page 99

Finding 13

There should be significant benefits flowing from having one State Minister with portfolio responsibility for early childhood education and development.

Page 104

Finding 14

The future success of Western Australia's child health screening system is contingent upon it being appropriately and adequately staffed.

Page 109

Finding 15

The move away from mandatory teaching of phonics has had a detrimental effect for a growing number of children who enter the formal schooling system without language and literacy foundations appropriate to their age.

RECOMMENDATIONS

Page 3

Recommendation 1

That the Department of Health and the Department of Education and Training improve the usefulness of their websites, in particular the ease of use for parents seeking information on child health screening issues and programs.

Page 8

Recommendation 2

That the Department of Health review and compare Western Australia's current child health programs to the outcomes gained from overseas initiatives such as *Sure Start, Bright Futures* and *Healthy Child Manitoba* with a view to adapting and adopting those programs that bring together government, family and community stakeholders in well-integrated health and education processes commencing at birth.

Page 16

Recommendation 3

That the Government provide additional funds for the Department of Health to fully meet its planned introduction of child developmental screening tools at the key developmental ages of 3-4 months, 8 months, 18 months, 3 years and school entry.

Page 22

Recommendation 4

That the Government provide additional funds to support the introduction of the foetal alcohol spectrum disorder (FASD) 4-Digit Diagnostic Code to Western Australia's child health screening program.

Page 24

Recommendation 5

The Department of Health should prepare a business case that would fund a six-monthly hearing test for all Aboriginal children in Western Australia.

Page 26

Recommendation 6

Additional community migrant health nurses and greater access to child development and language services should be provided in those Western Australian communities with high concentrations of refugees and Culturally and Linguistically Diverse (CALD) members.

Children who are suspected of having language difficulties in Year 1 should be able to access Department of Health speech and language services. Government services should also be available to address the needs of CALD children with language difficulties detected beyond Year 1.

Page 27

Recommendation 7

That the Government increase the funding for the torture and trauma counselling services for children and young people provided by the Association for the Services of Torture and Trauma Survivors (ASeTTs).

Page 36

Recommendation 8

That the Government review the operation of the Memorandum of Understanding between the Department of Health and Department of Education and Training to address the shortcomings of Western Australia's child health screening programs identified by this Inquiry.

Page 37

Recommendation 9

The evaluation of the School Entry Health Assessment Program undertaken by the Department of Health should focus on the effectiveness of identification, treatment and the evaluation of treatment programs, and compare these three components with similar programs undertaken in other jurisdictions.

Page 46

Recommendation 10

As an urgent priority, the Government should increase the number of school nurses employed in the school health system and approve the proposed business case for additional school and child health nurses to be employed within the Department of Health's Child Development Services.

Page 48

Recommendation 11

That the Department of Health ensure the new Child Development Information System (CDIS) provides a management tool to assist in monitoring the numbers, employment status of, and future demand for, the allied health professionals it employs.

Page 49

Recommendation 12

In light of WA's increasing birth rates and long-standing shortages of school and child health nurses, the Department of Health (DOH) should urgently find and adopt other options that might be used to carry out child health screening programs. In particular DOH should investigate moving some screening programs (such as speech and language) from pre-primary and primary school years to an earlier age and have simpler tests undertaken by appropriately trained childcare staff.

Page 56

Recommendation 13

That the Auditor General undertake a comprehensive review of the Department of Health, Child Development Service and School Health Services and table a report to Parliament. This report should detail figures and timeframes for all children awaiting services for early assessment and early intervention for health related issues and make recommendations on the numbers of additional personnel across the health professions that are required to tackle the current backlog and cater for the increased population in Western Australia.

Page 58

Recommendation 14

That the Department of Health review experiences in other jurisdictions with a view to adopting strategies aimed at reducing waiting lists and times for children requiring services in respect of early assessment and early intervention for health-related issues.

Page 60

Recommendation 15

Given the importance of improving data sharing within Western Australia's child health system, the Minister for Health should provide the Parliament with regular reports on the status of the roll-out of the Child Development Information System, advising of any major alteration to the completion date and need for additional funding.

Page 60

Recommendation 16

The Department of Health should publish the Child Development Information System (CDIS) data on waiting lists in a way that assists:

i) parents making decisions about their child's health; and

ii) the professional allied health staff providing child health services in Western Australia.

Page 61

Recommendation 17

That the Government ensure that WA's future health and privacy legislation allows for the sharing between government agencies of data gathered by the Child Development Information System (CDIS), when it has been fully implemented.

Page 61

Recommendation 18

That the Department of Health ensure that the final version of the presentation of the clinical pathways is prepared in a way that makes them readily comprehensible to parents.

Page 64

Recommendation 19

That the Department of Health ensure that data on child health outcomes and resource shortfalls in Western Australia produced from the Australian Early Development Index is integrated with other data it collects, such as that held within the Child Development Information System.

Page 71

Recommendation 20

That the Government provide additional funds of approximately $10 million for the Department of Health to implement a universal neonatal hearing screening program in Western Australia by 2013.

Page 71

Recommendation 21

That the Department of Health assess the ability of midwives, Child Health Nurses and maternity nurses to be trained to carry out the greater number of neonatal hearing screening tests that will be required under the new universal testing scheme being implemented in Western Australia.

Page 72

Recommendation 22

The Child Development Information System (CDIS) project should be urgently expanded so that data on the screening programs delivered to Indigenous children, especially hearing screening, can be gathered across the State.

Page 74

Recommendation 23

That the Department of Health review its decision to remove the vision screening test for three-year-olds, as such a test would give affected children a better chance of receiving remedial treatment prior to their commencing school.

Page 75

Recommendation 24

That the Department of Health and Department of Education and Training develop greater collaboration between service providers to review the possibility of multi-disciplinary teams, consisting of government and non-government organisations, to service the vision needs of children in rural and remote areas.

Page 81

Recommendation 25

That the Government give a high priority to provide additional staff and other resources to address the current inadequacies in Western Australia's speech and language services.

Page 84

Recommendation 26

That the Department of Health and Department of Education and Training develop a joint business case for government on the introduction of a standardised speech and language screening tool, such as *MELS* or *Catch Them Before They Fall*, to be used at pre-primary level throughout Western Australia.

Page 86

Recommendation 27

That the Department of Health undertake a review of dental health services offered in rural and remote regions of Western Australia and report to the Ministers for Health and Indigenous Affairs on the dental health of children in regional and remote regions.

Page 92

Recommendation 28

The Department of Health should develop a business case for government on a formal evaluation of programs to assist children entering school, such as *LEAF* and *A Smart Start*.

Page 95

Recommendation 29

That the Department of Health (DOH) and the Department of Education and Training (DET) ensure that resources from Federal health initiatives in the area of early child health be fully utilised and integrated into current services in Western Australia. DOH and DET should include information in their annual reports on what Federal funds were available, have been applied for, accessed, and how the funds were utilised.

Page 97

Recommendation 30

That the Department of Education and Training, the Department of Health and the Disability Services Commission formalise their work on improving the health of Western Australian children by establishing an across-government State-wide approach to a common child health and development strategy, including all screening programs.

Page 98

Recommendation 31

In her role promoting public awareness of matters relating to the wellbeing of children and young people, the Commissioner for Children and Young People should annually maintain a child health identification and treatment register which collects and reports data from the Department of Health on the number of children who have been identified as needing treatment for health problems, and those who have been unable to receive treatment.

Page 99

Recommendation 32

That the Government continue to pursue the benefits of having one Minister with portfolio responsibility for early childhood education and development.

Page 100

Recommendation 33

The Government should ensure that any new Public Health Act address the identification, prevention, treatment and evaluation of contemporary and emerging child health issues.

Page 104

Recommendation 34

The number of school health nurses, community child health nurses and allied health professionals employed within Western Australia's child health services should be urgently increased as per the business cases developed by the Department of Health. The new staff required are 126 full-time-equivalent (FTE) in the Child Development Services, 105 FTE Community Child Health Nurses and 135 FTE for school nurses.

Page 105

Recommendation 35

That the Government conduct a review to assess what early childhood services can be transferred to, and resourced within, the Department of Education and Training.

Page 105

Recommendation 36

That both the Department of Education and Training and the Department of Health report separately their allocations for school and early childhood health programs (including screening) in their annual budgets. This should show costs for screening, costs for treatment and waiting times for each program by age group.

Page 109

Recommendation 37

The Department of Education and Training should adopt evidence-based language and literacy teaching for use in Western Australian schools to mandate the increased use of phonemic awareness (phonics) in the pre-primary and primary curricula.

MINISTERIAL RESPONSE

In accordance with Standing Order 277 (1) of the Standing Orders of the Legislative Assembly, the Committee directs that the Minister for Health, the Minister for Mental Health and the Minister for Education report to the Assembly as to the action, if any, proposed to be taken by the Government with respect to the recommendations of the Committee.

CHAPTER 1 INTRODUCTION

1.1 Background

This Inquiry into child health screening at pre-primary and primary school level was referred to the Education and Health Standing Committee (EHSC) by the Parliament on the 27th November 2008. This allowed the completion of an Inquiry that had commenced in the 37th Parliament, with similar terms of reference, which was near completion when the State election was called in August 2008. This earlier Inquiry had been initiated due to concerns raised by the Committee's previous Inquiries during the 37th Parliament. The Committee was particularly affected by data on child health gathered for *Report 13, Ways Forward - Beyond the Blame Game: Some Successful Initiatives in Remote Indigenous Communities in WA* tabled in May 2008[2] and *Report 2, Inquiry into Swimming Pool Program in Remote Communities*, tabled in June 2006.[3]

Additionally, anecdotal information had been provided to Committee members that children at the pre-primary and primary school level were not receiving adequate screening for general health factors such as vision, speech, hearing and meeting developmental milestones. The Inquiry's terms of reference were to:

a) Appraise the adequacy and availability of screening processes for hearing, vision, speech, motor skill difficulties and general health.

b) Assess access to appropriate services that address issues identified by an appropriate screening process.

The 38th Parliament directed the Education and Health Standing Committee to complete the Inquiry and table its report by 19 June 2009. The Member for Warnbro, Mr Paul Papalia CSC; the Member for Pilbara, Hon Tom Stephens; and the Member for Bassendean, Mr Martin Whitely, were co-opted to the Committee for the purpose of the Inquiry. In particular, the Committee sought to consider:

- What screening is currently being undertaken in WA's schools?
- Are there gaps in screening procedures and who is not being screened?

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2 Legislative Assembly, "EHSC Report", (2008). Available at: www.parliament.wa.gov.au/Parliament/commit.nsf/(ReportsAndEvidence)/F8AD2B1768DC623CC825744A000E6F73?opendocument. Accessed on 27 November 2008.

3 Legislative Assembly, "EHSC Report", (2008). Available at www.parliament.wa.gov.au/Parliament/commit.nsf/(ReportsAndEvidence)/2B062EFED0A5328548257195000E57F0?opendocument. Accessed on 27 November 2008.

1.2 Inquiry conduct

An advertisement calling for submissions was placed in *The West Australian* and *The Australian* on 26 March 2008 and was accompanied by a press release. Written invitations were sent to key stakeholder organisations. Formal submissions were also sought from the Departments of Health (DOH), Education and Training (DET) and the Disability Services Commission (DSC). A full listing of the Inquiry's submissions is contained in Appendix One and all submissions have been posted to the Committee's web site.

Public hearings were held with the Department of Health, Department of Education and Training and the Disability Services Commission, as well as with witnesses from non-government and professional organisations. A full listing of those who gave evidence is contained in Appendix Two and transcripts of evidence and replies to questions on notice have been posted to the Committee's web site.

The Western Australian public has a general understanding that child health screening is conducted throughout the State. However, despite decades of screening in schools, there is a dearth of easily obtainable information about its history, development and health outcomes. Similar flaws have been reported in the health systems of other developed nations, including the United Kingdom.

A search of the DOH website revealed that reports were frequently compiled by various departmental committees or taskforces. However, as there was no clear authorship or contact person, it was difficult to follow up information contained in these reports and to inquire further about matters of interest.[4] The website has been revamped since this Inquiry commenced but it is still very difficult to access material about the State's child health and screening programs.

The DET website provides a clearer overview of its School Health Service Delivery program, with links to the relevant departmental policy on student health care. On 13 January 2009, the Premier announced that an Early Childhood Development portfolio would be created and incorporated into the Minister for Education's responsibilities.[5] A new Early Childhood Education section has been added to the DET website[6], however, it contains minimal information for concerned parents in relation to Western Australia's child health screening programs and doesn't seem to be accessible from the DET website's home page.

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4 For example, the July 2006 report *Future Directions for Western Australian Child Development Services* claims that "There is no single system for managing waiting lists for these services throughout the health regions" and that "Waiting lists vary between 2-18 months". Yet the report provides no authorship details.

5 Department for Communities, "Early Childhood Portfolio Changes", (2009). Available at: www.community.wa.gov.au/DFC/Resources/Early+Childhood+Portfolio+changes.htm. Accessed on 14 April 2009.

6 Department of Education and Training, "Early Childhood Education", (2009). Available at: www.det.wa.edu.au/education/ece/index.html. Accessed on 14 April 2009.

Recommendation 1

That the Department of Health and the Department of Education and Training improve the usefulness of their websites, in particular the ease of use for parents seeking information on child health screening issues and programs.

CHAPTER 2 INTERNATIONAL AND NATIONAL APPROACHES TO CHILD HEALTH SCREENING

2.1 World Health Organization's screening processes

The child health programs in Western Australia draw heavily from similar programs in other OECD nations, as well as from the World Health Organization (WHO). WHO has a long history of establishing recommended principles to guide health care practice, such as the 1986 Ottawa Charter for health promotion. This Charter was the first to recognise the importance of a 'whole of government' approach to health issues by putting "health on the agenda of policy makers in all sectors and at all levels."[7]

In terms of a health screening program, WHO recommends that the required components include:

a. *Clear objectives of the program and its predicted health benefits*

b. *Identification of the individuals who will benefit from the screening*

c. *Measures to ensure high coverage and attendance*

d. *Resources to record health information for evaluation and monitoring of the program-appropriate facilities available for testing and interpreting results*

e. *Organized quality control for the screening tests and their interpretation*

f. *Adequate facilities for diagnosis and appropriate treatment*

g. *A referral system for management of any abnormalities found and for provision of information on normal screening tests*

h. *Maintenance of program data to evaluate and monitor the program regularly.*[8]

These WHO principles have been used in Australia to guide the development of significant population-based screening programs, including the National Cervical Cancer Screening Program.[9] These broad principles can also be seen in the Western Australian Department of Health's definition of child health surveillance, as:

> *the systematic and ongoing collection, analysis and interpretation of indices of child health, growth and development in order to identify, investigate and, where appropriate,*

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7 WHO, "Ottawa Charter for Health Promotion", (1986). Available at: www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf, page 2. Accessed on 25 August 2008.

8 Submission No. 16, Telethon Speech and Hearing, 9 May 2008, p 5.

9 Submission No. 16, Telethon Speech and Hearing, 9 May 2008, p 5.

> *correct deviations from predetermined norms aims to optimise the health of children through the ongoing overview of the physical, social and emotional health and development of all children. Child health surveillance is initiated by health professionals but involves partnerships with parents.*[10]

While Western Australia's child health system aspires to emulate these WHO principles, this Inquiry has found that it is inadequately funded to systematically collect and analyse data on child health conditions, and to offer treatments in a timely fashion to all Western Australian children.

2.2 International child health programs

Governments in other western jurisdictions have implemented WHO's principles in child health programs. Three programs from Canada, USA and England all contain the key elements of incorporating school health screening into a comprehensive program that involves other non-health stakeholders, such as parents and teachers.

(a) England's *Sure Start* program

England's *Sure Start* program:

> *covers children from conception through to age 14, and up to age 16 for those with special educational needs and disabilities. It also aims to help parents and communities across the country. Sure Start contributes to children's health and to reducing health inequalities by making health services more accessible to the most disadvantaged children and families.*[11]

An innovative aspect of *Sure Start* has been its encouragement of the delivery of childcare alongside early education and other health and family services through *Sure Start* children's centres. These centres aim to bring high-quality integrated early years services to "the heart of communities." The 2010 target for the number of children's centres is 3,500. As at June 2008 2,907 children's centres had been established, offering services to over 2.2 million young children and their families.[12] The program's effectiveness is presently being evaluated.[13]

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10 Submission No. 30 (Appendix 1), Department of Health, 16 May 2008, p 28.

11 SureStart, "About us", (2008). Available at: www.surestart.gov.uk/aboutsurestart/. Accessed on 24 July 2008.

12 SureStart, "What we do", (2008). Available at: www.surestart.gov.uk/aboutsurestart/about/thesurestartprogramme2/. Accessed on 24 July 2008.

13 Birkbeck University of London, "BBK NESS Site", (2008). Available at: www.ness.bbk.ac.uk/. Accessed on 29 July 2008. An initial cost-effectiveness report on *Sure Start's* local programs was published in 2006, but this report is more a summary of the different cost structures of the different sized programs. Birkbeck University of London, "Measuring the Cost-Effectiveness of Sure Start", (2008). Available at: www.ness.bbk.ac.uk/cost-effectiveness/documents/1.pdf. Accessed on 29 July 2008.

(b) US' *Bright Futures* program

The American Academy of Paediatrics sponsors the *Bright Futures* program, which is "a national health promotion and disease prevention initiative that addresses children's health needs in the context of family and community."[14] This initiative was launched in 1990 by the Maternal and Child Health Bureau of the US Federal Health Resources and Services Administration.

The core of *Bright Futures* is a comprehensive set of health supervision guidelines developed by child health experts that provide a framework for 'well-child' care, from birth to age 21. These guidelines were developed to present a single standard of care based on a model of health promotion and disease prevention. Educational material is available in hard copy, a pocket guide, a multimedia PDA and health promotion material aimed at parents. The printed material is based on 31 recommended health visits and screening activities, from infancy through to late adolescence. According to its web site, each visit:

- *Starts with a context that captures the child at that age.*
- *Contains handy lists and tables that summarize interval history questions, parent-child and developmental observation, physical exam, medical screening, and immunizations.*
- *Lists five priorities that help you focus your discussions with parents and children on the most important issues for that visit.*
- *Provides anticipatory guidance for each priority sample questions and discussion points help you talk to children and families.*[15]

This program tries to place health promotion and screening within the community, and in particular, within families. This reinforces the general move in developed countries from 'screening' programs to models based on 'surveillance'. Surveillance programs actively elicit the concerns of other stakeholders, such as parents and families, who know children more intimately than official health staff. A surveillance approach encourages an earlier detection of a medical condition, and hopefully, an earlier start to any treatment. Appendix Three provides more information on the difference between a 'screening' and 'surveillance' approach to child health.

The *Bright Futures* program was evaluated between 2000-05 by Health Systems Research, Inc. who reported that:

> *Bright Futures is well-received and serves as a gold standard for well-child preventive care, packaged in a practical and well-designed fashion. Respondents appreciate the fact*

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14 American Academy of Pediatrics, "Home", (2008). Available at: http://brightfutures.aap.org/index.html. Accessed on 24 July 2008.

15 American Academy of Pediatrics, "3rd Edition Guidelines, Pocket Guide and PDA", (2008). Available at: http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html. Accessed on 24 July 2008.

that the guidelines and materials include a broad range of child and adolescent health topics and are accessible to many types of practitioners.[16]

(c) Healthy Child Manitoba

The government of the Canadian province of Manitoba, with its community partners, has developed a well-respected continuum of programs for children, youth and families called *Healthy Child Manitoba* (HCM).[17] Like *Bright Futures*, HCM operates from birth to adulthood and involves a range of government agencies in a seemingly well-researched evidence-based approach to child development and education. It offers parenting programs such as *Triple P* (Positive Parenting Program)[18], as well as foetal alcohol syndrome (FAS) programs, especially for its Indigenous First Nation people. HCM claims that:

Led by the Healthy Child Committee of Cabinet, HCM bridges departments and governments and, together with the community, works to improve the well-being of Manitoba's children and youth. HCM focuses on child-centred public policy through the integration of financial and community-based family supports. HCM researches best practices and models and adapts these to Manitoba's unique situation. It strengthens provincial policies and programs for healthy child and adolescent development, from the prenatal period to adulthood. HCM then evaluates programs and services to find the most effective ways to achieve the best possible outcomes for Manitoba children, families, and communities.[19]

Recommendation 2

That the Department of Health review and compare Western Australia's current child health programs to the outcomes gained from overseas initiatives such as *Sure Start, Bright Futures* and *Healthy Child Manitoba* with a view to adapting and adopting those programs that bring together government, family and community stakeholders in well-integrated health and education processes commencing at birth.

16 Altarum Institute, "Assessing the Bright Futures for Infants, Children and Adolescents Initiative: Findings from a National Process Evaluation", (2008). Available at: www.altarum.org/files/pub_resources/05_project_report_hsr_assessing_bright_futures.pdf, page x. Accessed on 29 July 2008.

17 Healthy Child Manitoba, "Home", (2008). Available at: www.gov.mb.ca/healthychild/. Accessed on 5 August 2008.

18 Triple P, "Home", (2008). Available at: www.triplep.net/. Accessed 5 on August 2008.

19 Healthy Child Manitoba, "About Healthy Child Manitoba", (2008). Available at: www.gov.mb.ca/healthychild/about/index.html. Accessed on 5 August 2008.

2.3 National guidelines on child health screening

The National Health and Medical Research Council report on child health screening

The National Health and Medical Research Council (NHMRC) is Australia's peak body for supporting health and medical research; for developing health advice for the Australian community, health professionals and governments; and for providing advice on the conduct of health and medical research. Its report, *Child Health Screening and Surveillance: A Critical Review of the Evidence,* was prepared by the Centre for Community Child Health at the Royal Children's Hospital in Melbourne and states:

> *In the last 75 years, we have weighed and measured children, watched them draw circles and crosses, hop and skip, and physically examined them over and over again – and only recently have we realised that this may be futile.*[20]

The NHMRC report admitted that "the early detection of health and other problems in children is a worthy goal" and that "at first glance the benefits [of screening] appear to be self-evident" but noted:

- There is little evidence for the effectiveness of screening programs for many conditions.
- There are major issues of screening program quality, monitoring of compliance with referrals for assessment and whether the appropriate community facilities exist for follow up.
- Much attention is paid to the test or procedure and little to the main elements of a community-wide program.
- In some matters, there is little evidence that recommended therapy alters outcomes.
- Relatively few conditions could be recommended for formal screening programs.[21]

The common problem identified by the NHMRC is that many screening tools and programs lack sensitivity and specificity (i.e. they identify too many 'false positives' and/or 'false negatives'). Australian government health departments appear to have adopted many of the report's findings to support their policy decisions to reduce or modify population-wide screening processes in favour

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20 National Health and Medical Research Council. (2002) *Child Health Screening and Surveillance: A Critical Review of the Evidence*, NHMRC, Canberra, p 18.

21 National Health and Medical Research Council. (2002) *Child Health Screening and Surveillance: A Critical Review of the Evidence*, NHMRC, Canberra, pp 4-5.

of a 'community based approach'.[22] This new approach places a greater reliance upon community health nurses, families and other professionals (e.g. pre-primary teachers) to be alert to child health issues and instigate more detailed assessment and intervention before they enter the formal education system.

The report suggests in relation to early detection and health promotion activities that:

> *For defined conditions there is strong evidence for screening. For a few conditions, the absence of such evidence should not be construed as being equivalent to there being evidence of the lack of benefit to such an approach.*
>
> *…the most pressing need is for further research and critical thinking around prevention of problems and promotion of health…… An active research program into efficacy and effectiveness of various approaches to detection, intervention and health promotion should be strongly encouraged, and evaluation be considered an integral part of program development.*[23]

In summary, the NHMRC report recommends a three-tier approach to the early detection of child health conditions:

- screening for defined conditions;
- health surveillance; and
- the promotion of healthy activities.

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22 An example in WA was the Minister for Health's decision in 2003 to cut $300,000 from the budget for WA's universal newborn hearing screening program. The Minister explained his decision as being based on expert opinion and "They believe that universal screening for such a very small return is a waste of resources. We have accepted the view of those people." Hansard (2003), "Universal Newborn Hearing Screening Program", *Questions Without Notice*, 25 September, pp 11778d - 11778d/4.

23 National Health and Medical Research Council. (2002) *Child Health Screening and Surveillance: A Critical Review of the Evidence*, National Health and Medical Research Council, Canberra, p 17.

CHAPTER 3 CHILD HEALTH RESEARCH IN WESTERN AUSTRALIA

Much of the demand for hospital services is for conditions that are clearly preventable with appropriate health promotion and prevention strategies. Substantial investment in these strategies is warranted and necessary. 'Reid Report'[24]

3.1 Previous research

Submissions and evidence confirmed that many stakeholders in Western Australia's child health system have significant experience and a thorough understanding of its major weaknesses but argue that little has changed over the past 10-15 years. For example, many of these stakeholders were also involved in 1999 in the *Interagency Committee on Children's Futures* that prepared a thorough report on issues surrounding child behaviour problems. Recommendations made by these stakeholders to the Committee included:

- **Staffing** – The provision of additional child health and school health nurses to meet demand flowing from increasing population and to make up for an historic lack of resources.

- **Timing** – An emphasis on earlier intervention, with a focus on collaborative approaches and 'joined up' solutions across all government and non-government sectors.

- **Consistency** – A set of common principles and technical standards which guide collaborative and high quality services.

- **Siting** – The provision of Early Childhood Centres located to encourage greater use by families, particularly targeted to areas of disadvantage and high need but with an ultimate aim for universal provision.

- **Engagement** – Local communities and families involved in the design, delivery and governance of programs after being provided with evidence-based information, such as from the results of the Australian Early Development Index.

- **Leadership** – A dedicated department or office which has the responsibility for early childhood, including the possible creation of a Ministerial portfolio for children or early childhood.[25]

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24 Department of Health. (2004) *A Healthy Future for Western Australians: Report of the Health Reform Committee*, WA: Department of Health, Perth, p v. This report is publicly described as the Reid Report.

25 Submission No. 28, Commissioner for Children and Young People, 12 May 2008, p 13.

3.2 Health Reform Implementation Taskforce (HRIT) report

In July 2006 the HRIT released its report *Future Directions for Western Australian Child Development Services.* The report originated out of concerns raised by paediatricians within the State Child Development Centres (CDCs) that services had become fragmented due to an absence of central leadership over many years, and that the issue of child health had been overlooked by the earlier Reid Report.[26]

The HRIT report highlighted that, in the absence of timely, age appropriate and early intervention services, there are substantial negative effects for the child, its family and the State's health services. It found that child development services were delivered in a variety of models according to available resources and staff numbers. Access to therapy differed, from service to service and region to region, in a 'postcode lottery'.[27]

This report highlighted deficiencies with the access and equity of WA services, including:

- Intake and discharge criteria (including age, diagnosis and severity) is applied differently;
- Availability of programs and levels of full-time equivalent (FTE) staff to provide services varies across sites;
- Lengthy waitlists for most therapeutic disciplines, with no single management system, waiting times vary from two –18 months with some children not obtaining any services; and
- Some services implementing home or school-based services as a means for managing waiting lists and demand.

Staff-related issues identified affecting service delivery included:

- High workloads with increasing numbers of complex cases;
- Resource constraints impact upon providing efficient and effective services;
- Inequity of distribution of professional staff across service areas;
- Integration required between school health services, community health services and social services; and
- Need for professional supervision and support.[28]

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26 Department of Health. (2006) *Future Directions of Western Australian Child Development Services*, Health Reform Implementation Task Force, Department of Health, Perth. Available at: www.health.wa.gov.au/hrit/childdevelopment/docs/CD_Framework_Outline.pdf, p 3. Accessed on 8 September 2008.

27 Department of Health. (2006) *Future Directions of Western Australian Child Development Services*, Health Reform Implementation Task Force, Department of Health, Perth, p 3.

28 Department of Health. (2006) *Future Directions of Western Australian Child Development Services*, Health Reform Implementation Task Force, Department of Health, Perth, p 7.

The HRIT noted the lack of statistical data regarding demand for services, as it was either unreliable or too variable to provide any meaningful information. Its findings can be summarised as:

- Models of care across Western Australian child development services differ substantially with different intake and management approaches and no uniform progression through the complexity of care;
- Coordination is also variable and to a large extent dependent on the personal networks of child development professionals;
- Data is incomplete and unreliable making it impossible to estimate demand or plan service demands accurately;
- Lack of mandated leadership in this area has fragmented roles and responsibilities, which has frustrated effective governance of this critical function;
- As a result, while it is universally accepted that early intervention is critical, the current environment prevents the delivery of services in a timely and most effective way. Many children receive insufficient intervention, too late for it to be truly 'early' with a commensurate increase in the need for ongoing therapy; and
- Comprehensive governance of these services is the critical development required in overcoming their fragmentation and independent approaches to service delivery.[29]

The report confirmed that the early detection of health issues and subsequent early medical intervention produces the maximum benefit for a child. It added that delayed intervention ends up being more costly, as it extracts a greater demand on health services to provide longer-term therapy requirements, while placing concurrent pressure on other governmental services, such as education and justice. The report included some useful data from 2005 on the use of WA's metropolitan CDCs which has been in included in Appendix Five and made a number of recommendations to reform WA's child development services which are included in Appendix Six.

The Department of Health advised that it has applied the NHMRC report's findings on child health screening implementing the HRIT recommendations, as summarised in Table 3.1 below.

[29] Department of Health. (2006) *Future Directions of Western Australian Child Development Services*, Health Reform Implementation Task Force, Department of Health, Perth, p 8.

Table 3.1 Comparison of WA health screening practise to NHMRC recommendation[30]

NHMRC Report Recommendations	DOH Response
Vision	
Continuation of specific examination of the eye at the newborn check, provided it is in the context of an adequate early detection program; Without further evidence, screening for risk factors for amblyopia should be reviewed and are not recommended; Programs of preschool or school entry visual acuity should not be instituted. Where current programs exist, further research into visual acuity screening is required.	The universal child health contacts include examinations of the eye and assessment of the red reflex and/or the corneal light reflex test at birth, 6-8 weeks, 3-4 months and 8 months. The universal school entry assessment includes a visual acuity assessment. Colour vision screening is not offered as part of the universal school entry assessment. Information on colour vision is distributed to all parents of children in year 7 or year 8.
Hearing	
Hearing screening before discharge for all NICU neonates and preferably all neonates admitted to special care nursery; The evidence supports some form of neonatal screening for hearing impairment – pilot projects should consider various models i.e. hospital based or community based universal screening programs, with or without genetic screening, processes, acceptability and costs. Universal screening programs for programs to detect otitis media are not recommended.	Newborn hearing screening has been introduced into the neonatal units; babies need to be at least 34 weeks gestation before the test is undertaken. Babies who pass the newborn hearing screen, but have risk factors will be followed up by the Child Development Service at 8 months of age. Research provided evidence to justify continuation of the hearing screening program as it was found to be effective in identifying (previously undetected) hearing loss. Screening programs to detect otitis media with effusion (OME) are not offered universally in WA. Assessments are offered to target populations i.e. Aboriginal children in rural and remote areas of WA.
Scoliosis	
Implementation of new scoliosis screening programs is not recommended, where there are existing programs, these should be reassessed.	Screening programs to detect scoliosis are not offered as part of the universal school entry assessment. Information on scoliosis is distributed to all parents of children in year 7 or year 8.
Dental Health	
Screening programs for dental caries in the	WA offers the most comprehensive child dental care service in Australia.[31] Children up to 17 years

30 Department of Health, Response to Questions on Notice, 4 August 2008, pp 15-19.

deciduous teeth are not recommended; Regular surveys to document prevalence and severity of caries in preschool and school aged populations; Focus on preventive dental health in preschool and school aged populations.	of age are contacted and offered routine preventive and operative dental care subject to parental consent. Child health nurses offer health promotion messages to parents about care of their child's teeth at the 8 month, 18 month and 3 year contacts.
Development	
For developmental screening to be effective, children with subtle delay or at risk of delay needed further assessment. Developmental delay did not meet criteria for screening programs, however there was evidence that early identification and subsequent intervention improved developmental outcomes. If developmental screening tools are used, they should have adequate psychometric properties greater than 70% sensitivity and specificity.	Early detection is not based solely on screening tools but is a continual developmental surveillance program. In 2009, parent-completed child developmental screening tools (PEDS) will be offered at the key developmental ages of 3-4 months, 8 months, 18 months, 3 years and school entry.
Language	
Implementation of formal screening programs for language delay is not recommended; Further research is urgently needed to better quantify early predictors of later language delay.	Screening programs to detect language delay are not offered as part of the universal child health or school entry assessment. In 2009, parent completed child developmental screening tools are being introduced. The Parent Evaluation of Developmental Status (PEDS) has two specific questions relating to speech and language. If a parent or nurse is concerned about the child's speech and language, then brief interventions/support and referral processes are put in place.
Height	
New growth screening programs outside the research context are not recommended.	Screening for height is not included in the universal contact schedules, however height is assessed in at risk populations or where there is professional or parental concern.
Weight	
Routine weight monitoring at birth, 6-8 weeks and at 8-12 months is recommended as part of routine clinical care. This does not however constitute a	Routine weight assessments are offered at birth, 6-8 weeks, 3-4 months and at 8-12 months. Further assessments are offered if there are concerns indicated from history, or expressed

[31] The Committee was not provided with other evidence to corroborate this claim by the Department of Health.

screening program.	parental/professional concern. Targeted assessment for school age children with body weight issues has commenced in 2008.

Recommendation 3

That the Government provide additional funds for the Department of Health to fully meet its planned introduction of child developmental screening tools at the key developmental ages of 3-4 months, 8 months, 18 months, 3 years and school entry.

CHAPTER 4 FACTORS INFLUENCING ACCESS TO SCREENING SERVICES

4.1 Demographic shifts

Western Australia's child health screening program faces some widely-recognised ongoing challenges and deficiencies that hinder the provision of a truly universal and accessible screening, assessment and treatment service throughout the State. Recent increases in divorce rates, changes to working hours, greater female participation in full-time employment, and the higher incidence of casual labour have all been detrimental to the health of children across most social groupings:

> *In single-parent and skipped-generation households* [where the grandparent has assumed parental responsibilities], *carers have less psychological and social capital to raise optimally developed children due to poverty, stress and social exclusion. Working parents without support have reduced parenting capacity because of less time available for children and reduced psychological capital as a result of work related stress or depression.*[32]

Recent trends directly challenge the ability of parents to engage in several areas that are critical to a child's developmental potential, including general bonding activities like reading (which has been shown to increase the speech, language, and mental health prospects of a child).[33] The extended periods of parental observation generated by such interactions are seen as a vital way of accurately predicting later developmental problems in children.[34]

Li, McMurray and Stanley argue that poverty of time and income are negatively correlated with "child health, behavioural, emotional and cognitive outcomes".[35] It is a paradox of societies such as WA that such adverse consequences have occurred during an era of unprecedented prosperity. DOH confirmed that similar social issues are prompting WA's health system to "reorient and redesign [its] services for families and children."[36]

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32 Li, J., McMurray, A. and Stanley, F. (2008) "Modernity's Paradox and the Structural Determinants of Child Health and Well-Being", *Health Sociology Review*, Vol. 17, p. xx-xx. Li, McMurray and Stanley further argue (p 71) that the modern neo-liberal, or capitalist, economic model "has contributed to a weakening of the resources needed by parents and families to raise optimally healthy and well-developed children". These authors identified (p 66) "income, time and human, psychological, and social capital" as essential resources for parents.

33 Mrs Rosemarie Candler, Speech Pathologist, Private Speech Pathologists' Association of WA, *Transcript of Evidence*, 30 July 2008, p11.

34 Submission No. 22, Early Childhood Intervention Australia, WA, 9 May 2008, p 2.

35 Li, J., McMurray, A. and Stanley, F. (2008) "Modernity's Paradox and the Structural Determinants of Child Health and Well-Being", *Health Sociology Review*, Vol. 17, p 66.

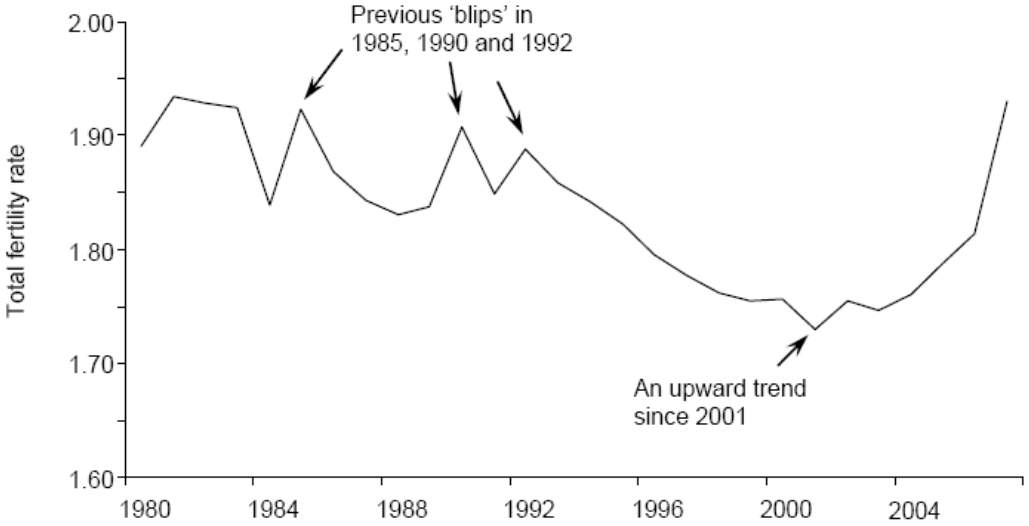
36 Submission No. 30 (attachment 2), Department of Health, 16 May 2008, p 11.

Other demographic factors particular to Western Australia that impact on the child health sector, include:

(a) an influx of new families to WA from other states as a result of the increased employment opportunities that the mining boom has afforded. This has led to an increase in the numbers of "vulnerable families with complex health and social problems."[37] Adding to the pressures these families face is the greater use of fly-in/fly-out workers by mining companies.

(b) a significant increase in annual birth rates from 24,782 in 2002 to 30,066 in 2007.[38] The Productivity Commission (PC)[39] recently reported "Australia's total fertility rate lies at the upper end of the distribution of developed countries. Its rate is much higher than those of the former Eastern European bloc, Southern Europe or the rich countries of Asia." The PC believes that this increase in Australia's fertility rate since 2001 is a significant change in the trends since the 1980s, and not just a statistical 'blip' (see Figure 4.1 below).[40]

Figure 4.1 Australia's Fertility Rate- 1980-2007



Significantly, Western Australia's recent population growth has not been uniform. The regions under most pressure from a rapid increase in population include the Pilbara and Perth's outer metropolitan suburbs. Finally, WA has a growing immigrant workforce from Culturally and

37 Submission No. 30, Department of Health, 16 May 2008, p 13.

38 Submission No. 30, Department of Health, 16 May 2008, p 8.

39 Lattimore, R. & Pobke, C. (2008) *Recent Trends in Australian Fertility*, Staff working paper. Productivity Commission, Canberra. Available at: www.pc.gov.au/__data/assets/pdf_file/0007/82375/04-chapter2.pdf, p 7. Accessed on 27 August 2008.

40 Lattimore, R. & Pobke, C. (2008) *Recent Trends in Australian Fertility*, Staff working paper. Productivity Commission, Canberra, p 14.

Linguistically Diverse (CALD) backgrounds and a high proportion of Indigenous people living in very remote areas, compared to other Australian jurisdictions.[41]

4.2 Foetal alcohol spectrum disorder (FASD)

Foetal alcohol spectrum disorder (FASD) is an umbrella term[42] describing a range of disorders including Foetal Alcohol Syndrome (FAS), Foetal Alcohol Effects (FAE), Partial Foetal Alcohol Syndrome (pFAS), Alcohol Related Neurodevelopment Disorders (ARND), Static Encephalopathy (alcohol exposed) (SE) and Alcohol Related Birth Defects (ARBD).[43] The irreversible foetal injury associated with alcohol consumption was first described in the late 1960s, and termed as FASD in 1973.[44] FASD is not a clinical diagnosis in itself, but describes a range of disabilities and a continuum of effects that may arise with prenatal alcohol exposure by pregnant women.

Researchers have not been able to determine a safe level of alcohol consumption for pregnant women. However, they have found that damage to the foetus varies depending on the volume of alcohol ingested, the stage of the pregnancy during which the alcohol was consumed, peak blood alcohol levels, and other genetic and environmental factors. Alcohol can damage the foetus throughout the pregnancy because it crosses the placenta freely, and produces concentrations of alcohol in the foetus equivalent to that in the mother's circulation. Studies have concluded that the child's developing brain can be injured even at low exposure levels to alcohol. Subsequently, there are varying degrees of foetal alcohol damage to a child.[45]

FASD is widely recognised as the most common preventable cause of significant developmental delay in children, especially in Indigenous communities. A US research project found a large majority of people with FASD suffered mental health conditions, disrupted school experiences and had problems with employment and involvement with the justice system.[46]

The Department of Health reported that:

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41 Submission No. 30, Department of Health, 16 May 2008, pp 3, 8, 13; Submission No. 28, Commissioner for Children and Young People, 12 May 2008, p 5.

42 Nofasard, "What is Fetal Alcohol Spectrum Disorder (FASD)?", (2008). Available at: www.nofasard.org.au/overview/what-is-fetal-alcohol-spectrum-disorder-fasd.html. Accessed on 31 July 2008.

43 This Report doesn't include information about a similar condition, Neonatal Withdrawal Syndrome, which impacts newborns suffering serious drug withdrawal symptoms. A new article by Professor Fiona Stanley claims that rates of NWS are now more than 40 times higher than those seen in 1980 and are increasing at an annual rate of over 16%. (2009). Telethon Institute for Child Health Research, "Alarming increase in drug affected newborns", (2009). Available at: www.ichr.uwa.edu.au/media/929. Accessed on 23 April 2009.

44 Russell, E. (2007) *Alcohol and Pregnancy: No Blame- No Shame!*, Zeus Publications, Burleigh QLD., p 17.

45 Hon Shelley Archer, Legislative Council- *Statement*, 20 June 2006, 3905b - 3908a/1.

46 Russell, E. (2005) *Alcohol and Pregnancy: A Mother's Responsible Disturbance*, Zeus Publications, Burleigh QLD, p 19.

> *The Telethon Institute for Child Health Research has been undertaking collaborative research on FASD since 2000. Results to date indicate that FASD is not fully recognised, diagnosed or reported by health professionals throughout Australia. … This has led to inadequate treatment outcomes and difficulty in evaluating current prevention strategies. In recognition of this, the Western Australia Child and Youth Health Network, and the Office of Aboriginal Health have recently moved to convene a working party to develop a Model of Care for FASD across the Department of Health (DOH). This will provide a state-wide framework for prevention, detection, diagnosis, intervention and education. It is anticipated this will be achieved in approximately six months.*[47]

While FASD is not fully recognised by some health professionals, Hon. Sue Ellery, the then-Minister for Child Protection representing the Minister for Health, recently reported to Parliament "One hundred and twenty-eight cases of foetal alcohol spectrum disorder in Western Australia were notified to the Birth Defects Registry from 1980 to 2005. These are for cases aged up to six years [old]. Data is not held on adult numbers."[48]

The Telethon Institute for Child Health Research highlights the dire impact of FASD on Western Australian Indigenous mothers. Their research quotes data from the WA Birth Defects Registry suggesting the overall incidence of FASD is 0.18 per 1,000 live births, but with very large differential rates for Indigenous and non-Indigenous mothers[49]:

- 0.02 per 1,000 non-Indigenous live births.
- 27.6 per 1,000 Indigenous live births.[50]

In the *2001–02 WA Aboriginal Child Health Survey*, the mothers of an estimated 23% of Aboriginal children reported that they had consumed alcohol during pregnancy[51], while a more recent press report suggested 80-90% of pregnant Aboriginal mothers in Halls Creek had drunk

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47 Department of Health, Response to Questions on Notice, 11 June 2008, p 11.

48 Legislative Council- *Questions Without Notice*, 29 November 2007, pp8011c - 8012a / 1.

49 Telethon Institute for Child Health Research, "Fetal alcohol syndrome", (2008). Available at: www.ichr.uwa.edu.au/research/highlights/disability/fas. Accessed on 1 August 2008.

50 According to ABS data from 2004-05, Indigenous adults were more likely than non-Indigenous people to **abstain** from drinking alcohol. However, rates of binge drinking were higher for Indigenous than non-Indigenous Australians, in every age group. Of Indigenous adults who consumed alcohol in the week prior to the ABS survey, one in six (16%) reported long-term (or chronic) risky/high risk alcohol consumption, up from 13% in 2001. While rates of risky/high risk drinking were similar for Indigenous people in remote and non-remote areas, Indigenous people in remote areas were nearly three times as likely as those in non-remote (or suburban) areas to report never having consumed alcohol (18% compared with 6%). ABS, "The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples", (2009). Available at: www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/51B575E133A75C6DCA2574390014EDFE/$File/47040_2008.pdf, pp 140-143. Accessed on 31 March 2009.

51 Zubrick *et al.* (2004) cited in ABS. (2008) *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, Catalogue No. 4704.0, Australian Bureau of Statistics, Canberra, p 81.

during their pregnancy.[52] Researchers at the Telethon Institute provide comparative rates of children with FASD for other jurisdictions:[53]

- USA – 5–20 per 10,000 live births.
- Canadian First nation mothers – 72 per 10,000 live births.
- NT Indigenous mothers – 17 per 10,000 live births.

In light of the more than 1,000-fold impact on Indigenous mothers in WA compared to non-Indigenous mothers, the Department of Health reported to the Committee that the Drug and Alcohol Office (DAO) is developing a number of education programs which specifically target alcohol consumption by mothers. DOH said that these initiatives include:

> *The Re-think Drink campaign* [which] *aims to change drinking culture awareness and reduce alcohol related harm. An Aboriginal specific Rethink Drink message is being developed for the Kimberley;*
>
> *Community Alcohol Management Plans* [which] *are being developed in regional areas to support prevention and the creation of safer, more responsible drinking environments;*
>
> *The Strong Spirit Strong Mind - Western Australian Aboriginal and Other Drugs Plan 2005-2009 – includes prevention and early intervention, support, treatment and harm reduction activities that address alcohol and pregnancy. Culturally secure resources that address alcohol and pregnancy have been developed for Indigenous clients, including:*
>
> ** a DVD (What our people need to know about alcohol);*
> ** brochures (What our women need to know about alcohol and Strong Babies);*
> ** Strong Spirit Strong Mind culturally secure DAO resources that address alcohol and pregnancy have been developed for the workforce, including:*
> ** The Aboriginal Alcohol and other Drugs Worker Resource: A guide to working with our people, families and communities;*
> ** Story Telling and Counselling Cards;*
>
> *Offer a skills-based training session: Raising the issue of alcohol use before and during pregnancy to a range of agencies;*
>
> *Deliver the Aboriginal Alcohol and other Drug Worker Training Program, Certificate III in Community Services Work, which includes a module concerning alcohol and pregnancy.*[54]

Currently, the DOH does not screen children for FASD. However, the Department reported that its FASD working party developing a model of care for FASD had its first round of consultations in

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52 Smith, S. (2009) "Kids drowning in a sea of grog", *The Weekend Australian*, 28-29 March, p 20.

53 Telethon Institute for Child Health Research, "Health Professionals Making a Difference", (2008). Available at: www.ichr.uwa.edu.au/files/user22/C_Bower_1.pdf, slide 16. Accessed on 1 August 2008.

54 Department of Health, Response to Questions on Notice, 11 June 2008, p 12.

April 2009. This model of care will provide a state-wide framework for prevention, detection, diagnosis, intervention, education and support for families affected by FASD. DOH is introducing the FASD 4-Digit Diagnostic Code, an internationally accredited system of recognition developed by the University of Washington, in order to improve recognition of this disorder in Western Australia.[55] It has purchased a copy of the diagnostic manual and "anticipates that all CDS paediatricians will be trained by the end of June 2009."[56] It is important for Indigenous children that WA increases its efforts in screening for FASD and in educating mothers about the danger of drinking while pregnant, as there is no medication or treatment that will reverse the symptoms of FASD and alcohol-related birth defects. Additionally, there is no treatment to reverse the physical features or brain damage associated with maternal alcohol use during the pregnancy.[57]

Recommendation 4

That the Government provide additional funds to support the introduction of the foetal alcohol spectrum disorder (FASD) 4-Digit Diagnostic Code to Western Australia's child health screening program.

4.3 Children on the margins

Children from Indigenous, CALD and refugee communities face a range of distinct health issues. These result from their often marginalised position within the WA community. Mr John Brigg, Acting Director, Inclusive Education Standards, Department of Education and Training, agreed that the Department saw gaps and challenges in terms of "Indigenous students and children in some parts of the state and some students from culturally and linguistically diverse backgrounds".[58]

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55 Department of Health, Response to Questions on Notice, 4 August 2008, p 11. The four digits reflect the expression of four key diagnostic features of FASD: (1) growth deficiency, (2) the FAS facial phenotype, (3) CNS abnormalities, and (4) prenatal alcohol exposure. The magnitude of expression of each feature is ranked on a 4-point scale, with 1 reflecting complete absence of the FAS feature and 4 reflecting a strong presence of the feature. Thus, the code 4444 reflects the most severe expression of FAS (significant growth deficiency, all three FAS facial features, structural/neurological evidence of CNS damage, and confirmed prenatal exposure to high levels of alcohol) while the code 1111 reflects normal health. See Astley, S. (2004) *Diagnostic Guide for Fetal Alcohol Spectrum Disorders: The 4-Digit Diagnostic Code*, School of Public Health and Community Medicine, University of Washington, Seattle, p 4.

56 Submission No. 30 (C), Department of Health, Response to Questions on Notice, 8 April 2009, p 4.

57 (2008). Available at: http://alcoholism.about.com/od/fas/a/fas_treatment.htm. Accessed on 17 March 2009.

58 Mr John Brigg, Acting Director, Inclusive Education Standards, Department of Education and Training, *Transcript of Evidence*, 11 June 2008, p2.

(a) Indigenous communities

The Department of Health established the Office of Aboriginal Health (OAH) in 1996, and it has a key role in ensuring the accessibility of health services for Indigenous Western Australians.[59] Indigenous communities and their children in rural and remote Western Australia have been subject to much recent research and commentary regarding their health issues. In other jurisdictions, the poor health and safety of Indigenous children has been used to justify major new policy initiatives. Within Western Australia, these communities receive inferior health screening for their children due to an inadequate response to the self-evident size of the challenge and logistical issues, such as their remoteness from major health services and the small size of many of their communities. Negative health impacts also flow from critically important social and economic issues, in particular a strong sense of alienation and powerlessness, that emanates from the original removal of Indigenous people from their land. These issues often manifest in the high level of Indigenous alcohol consumption that is currently a major focus of government in WA.

However, Aboriginal communities close to Perth also suffer health issues that **can** be more easily addressed through screening programs. Dr Harvey Coates, a senior ENT Surgeon at Princess Margaret Hospital, referred to his experience with several clinics he attends in Perth providing hearing services to Aboriginal children:

> *Indigenous children are reviewed on referral from Aboriginal health workers, school nurses or concerned parents. These children have a much higher incidence of middle ear disease than in the normal population…it is well known that Indigenous children may have up to 32 months of their childhood spent with hearing loss as opposed to 3 months to the average non-Aboriginal child. This severely impacts on their potential speech and language acquisition and education as well as social interaction.*[60]

Dr Coates supports Australian guidelines for Indigenous children which indicate that hearing testing should be undertaken on at least a six monthly basis. This is an important need given that recent research with Indigenous children in Perth primary schools found middle ear disease (otitis media) in 42% of children, and mild or moderate hearing loss in 19%.[61] Similar research with children in remote communities in the Northern Territory showed that 91% of Indigenous children had middle ear disease, and 25% had a perforated tympanic membrane.[62]

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59 Department of Health, "Aboriginal Health, Office of", (2009). Available at: www.health.wa.gov.au/services/detail.cfm?Unit_ID=487. Accessed on 14 April 2009.

60 Submission No. 3, Associate Professor Harvey Coates, 28 April 2008, pp 1-2.

61 Williams, C. *et al.* (2009) "Middle Ear Disease in Aboriginal Children in Perth: Analysis of Hearing Screening Data, 1998–2004", *Medical Journal of Australia*, Vol. 190, No. 10, pp 598-600.

62 Morris, P. *et al.* (2005) "Otitis Media in Young Aboriginal Children from Remote Communities in Northern and Central Australia: A Cross-sectional Survey", *BMC Pediatrics*, 5: 27. Available at: www.biomedcentral.com/1471-2431/5/27. Accessed on 28 August 2008.

Finding 1

Aboriginal children have a higher incidence of middle ear disease than other children in Western Australia and this has a severe impact on their health and education.

Recommendation 5

The Department of Health should prepare a business case that would fund a six-monthly hearing test for all Aboriginal children in Western Australia.

(b) Culturally and Linguistically Diverse (CALD) and refugee communities

CALD communities face a range of difficulties in accessing early childhood screening. Some of these barriers are related to difficulties with the English language. Despite the Department of Health providing interpreter services and descriptions of programs in a range of languages, these communities still suffer institutional barriers to health screening programs. The School Psychologists Association highlighted timeliness as a key deficiency in terms of the language abilities of children from refugee communities:

> *Children from refugee backgrounds, arriving in Western Australia through the Offshore Humanitarian Programme, are eligible to attend Intensive English Centres for a prescribed period of time. However, the only entry point for these centres is at Year 1 and beyond. As similar formal educational provisions are not available at the kindergarten and pre-primary levels, refugee students with speech and first language disorders are not identified sufficiently early or in a timely manner. The Department of Health generally will not accept speech and language referrals from students in Year 1 and beyond as the mandate is for service provision to students below five years of age. Additionally, many refugee students enter schools at different year levels with significant language disorders, and for which therapeutic services are not available.*[63]

Finding 2

The current policy of the Department of Health to limit speech and language referrals to children below five years of age places children from refugee and Culturally and Linguistically Diverse (CALD) communities in a 'Catch 22' situation that limits their ability to fully integrate with Western Australian society.

63 Submission No. 15, School Psychologists Association, 9 May 2008, p 2.

A large proportion of Western Australia's recent migrant intake has come from African countries where people have suffered great physical and mental trauma from lengthy and large-scale military conflicts. The refugee families, and in particular their children, have often suffered extreme personal hardship in refugee camps. Children have often had severely disrupted schooling before arriving in Western Australia. Other Australian jurisdictions which have accepted African refugees have instituted new resources directed toward their children, especially language programs.[64]

In Western Australia, a report for the Minister for Multicultural Interests by the Department of Communities highlighted the rapid increase in refugees to WA from Africa.[65] Humanitarian arrivals from Africa represented 73% of entrants in 2004-05, up from just 25% three years earlier. WA receives about 13% of Australia's humanitarian arrivals and in 2004-05 there were 1,760 arrivals from African nations affected by conflict[66], such as Sudan, Liberia, Sierra Leone and Ethiopia. ABS data indicate that the majority of these African refugees live in the Perth metropolitan area, with high concentrations in the Stirling (30%), Gosnells (14%) and Bayswater (10%) local government areas (LGAs).

Child health screening programs need to be adaptable to the community's needs, especially in those LGAs with high concentrations of refugees. Yet, the Department of Communities report states that "mainstream health services are struggling to cope with the high level of demand and complex health needs of humanitarian entrants." The report notes that the Department of Health's Migrant Health Unit has a permanent lengthy waitlist. To overcome this situation, the report recommends that:

> *Increased resources be provided for health services, and partnerships established with other service providers to allow better access to services, in particular the provision of increased community migrant health nurses, increased access into specialist outpatient clinics, and child development services.*[67]

The reason for the paramount importance of diagnosing and treating speech and language problems in young children is because of the oral to literacy continuum. A child who is having speech and language problems is at high risk of failing to develop literacy skills. A child's educational pathway is blocked without these skills, which are fundamental to a child's success both at school and later in life.

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64 Media Release (2008), *More Help for Growing Number of Refugee Students,* Victorian Minister for Education, 20 March. Available at: www.legislation.vic.gov.au/domino/Web_Notes/newmedia.nsf/bc348d5912436a9cca256cfc0082d800/bea2021df50a15deca25741600769169!OpenDocument. Accessed on 26 March 2008.

65 Department of Communities. (2007), *Across-Government Working Party on Settlement issues for African Humanitarian Entrants- Final Report,* Department of Communities, Perth.

66 Department of Communities (2007 3) reports that one in four African refugees have been tortured and 70% have had traumatic experiences, such as losing a loved one in violent circumstances.

67 Department of Communities. (2007), *Across-Government Working Party on Settlement issues for African Humanitarian Entrants- Final Report,* Department of Communities, Perth, pp 15-16.

For children, the optimal time for speech and language intervention is during early childhood or younger. Those who have not been able to access these services (e.g. refugee children who have arrived past the cut-off age) clearly have some very significant needs that should be addressed by DOH and DET. There is great value in the current departmental policy that targets children in early childhood; nonetheless, there is a case for some exceptions to be made by responding to the needs of CALD and refugee children who have arrived in Western Australia after the cut-off age for the provision of language services.

Recommendation 6

Additional community migrant health nurses and greater access to child development and language services should be provided in those Western Australian communities with high concentrations of refugees and Culturally and Linguistically Diverse (CALD) members.

Children who are suspected of having language difficulties in Year 1 should be able to access Department of Health speech and language services. Government services should also be available to address the needs of CALD children with language difficulties detected beyond Year 1.

A particular concern of the Department of Communities report was the lack of services to provide torture and trauma counselling for children aged five–12 years. Given the horrific experiences endured by many of these children fleeing their homelands, this gap in service provision seems to be a glaring oversight, contradicting a status report offered by a previous Education Minister:

> *Children and youth from culturally and linguistically diverse backgrounds attending government preprimary, primary or secondary schools and who are survivors of torture and trauma have access to student support services according to need. These services include Welfare Officers, School Psychologists, School Nurses and Youth Education Officers. The Education Department, through referral processes, utilises the services of the Association for the Services of Torture and Trauma Survivors (ASeTTs) to support students deemed to be seriously at risk of not fulfilling their educational potential because of past experiences of torture and/or trauma.*[68]

[68] Hon. Colin Barnett, Legislative Assembly- *Questions on Notice*, 20 August 1997, pp 5226/1.

Recommendation 7

That the Government increase the funding for the torture and trauma counselling services for children and young people provided by the Association for the Services of Torture and Trauma Survivors (ASeTTs).

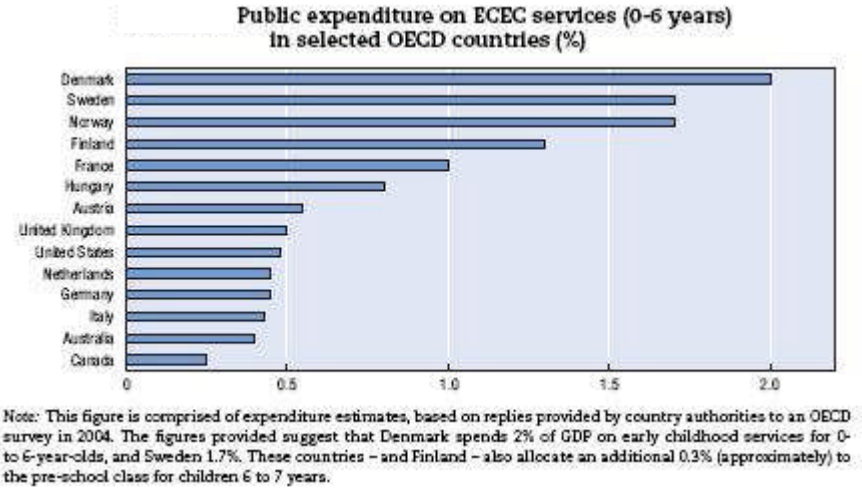
CHAPTER 5 WESTERN AUSTRALIA'S SCREENING PROGRAMS

5.1 Introduction

This chapter provides an overview of screening programs currently being undertaken in Western Australia. It describes the level of cooperation between the Department of Education and Training (DET) and the Department of Health (DOH) in the provision of these services, and how these screening processes are meant to form part of a continuum of health care from birth to teenage years.

Data from the Organisation for Economic Co-operation and Development (OECD) shows that Australia's funding for early childhood services is one of the lowest in the Western world, and nearly four-times less than that provided by Scandinavian countries (see Figure 5.1 below).[69]

Figure 5.1 OECD expenditure on childhood services (2004)



Note: This figure is comprised of expenditure estimates, based on replies provided by country authorities to an OECD survey in 2004. The figures provided suggest that Denmark spends 2% of GDP on early childhood services for 0- to 6-year-olds, and Sweden 1.7%. These countries – and Finland – also allocate an additional 0.3% (approximately) to the pre-school class for children 6 to 7 years.

This comparative lack of funding is reflected locally in WA, with nearly every submission, including those from the DOH and the DET, reporting that there are serious deficiencies with the current approach to health screening at primary and pre-primary levels. However, DOH stated:

> *Prevention and early intervention in childhood has become a priority for Australian governments and non-government organisations. In Western Australia, the Department of Health has a central role in the provision of services and responses for the prevention,*

69 OECD, "Starting Strong II: Early Childhood Education and Care", (2008). Available at: www.oecd.org/document/63/0,3343,en_2649_39263231_37416703_1_1_1_1,00.html. Accessed on 7 August 2008.

early detection, early intervention and treatment of child health and developmental problems.[70]

5.2 Community-based support programs

Beyond the child health programs coordinated by DOH described below, there are many examples of community-based support programs that have been developed in different parts of WA on small budgets that are producing remarkable results.

(a) Indigenous- East Kimberley Warmun Early Learning Centre

The Commissioner for Children and Young People (CCYP) reported on the evaluation of the Warmun Early Learning Centre in the East Kimberley that has employed local Indigenous Early Childhood workers to link schools and families. The evaluation stated that:

> *The children have made marked observable improvements in their general health and wellbeing as well as overall development. During the May visit the majority of children were not toilet trained, spoke only in Aboriginal English, were shy and reticent to take part in challenging activities. During the December visit children were much more confident, competent in self care and routines, engaged in challenging activities and were able to converse in Standard English as well as Aboriginal English. The appointment of a full time local Indigenous Early Childhood Worker is a very exciting development. This person is mature, capable and willing to take over the running of the program, when the current coordinator leaves in approximately eighteen months. This is an excellent outcome with regard to the sustainability of the program.*[71]

The CCYP commented further:

> *The evaluation identified strengths of the program including that it is highly valued by families (evidenced by regular attendance of children); it is holistic - combining children's health, nutrition and early learning; there are good relationships and evidence of collaboration with other service providers (allied health team, women's centre and primary school); and, importantly, that there are marked improvements in children's wellbeing and development.*[72]

(b) Metropolitan *Play Cafes*

Play Cafes are based at some suburban Perth schools and bring together teachers and other guest community members (e.g. community health nurses and local service providers). Enjoyable activities are provided for children, such as painting, songs, play dough, listening to a story, and

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70 Submission No. 30, Department of Health, 16 May 2008, p 3.

71 Hutchins, T. (2007) *Local Evaluation of East Kimberley initiatives for children and families - Phase 3 Formative evaluation February - December 2007*. Centre for Social Research, Unpublished report, Edith Cowan University, Perth.

72 Submission No. 28, Commissioner for Children and Young People, 12 May 2008, p 12.

cooperating in a group. These are activities that children will need to be able to do once they enter kindergarten the following year. Teachers attending the *Play Cafes,* in collaboration with the visiting nurse, are able to recommend early referrals for speech therapy, for a child to have their eyesight checked, and to act on glue ear or food allergies. They can also facilitate a parenting group such as the Positive Parenting Program (PPP).

(c) Rural programs

The Director General of the Disability Services Commission, Dr Ron Chalmers, gave evidence about a new Indigenous program funded by DCS and supported by the WA Country Health Service:

> *About five or six years ago we set out quite deliberately to look at some of the models that the health department was using in regional areas of the state. … In the more remote areas of the state, where you are not going to have a therapist in situ, it could well be that you could identify and train up local Aboriginal people to take on the role of therapy assistants to actually deliver programs that are developed by therapists. That has been rolled out in some areas. In fact, a new initiative using Aboriginal allied health assistants is just about to start in the Fitzroy Valley.*[73]

(d) General community-based programs

Given the increased responsibility parents and other non-health stakeholders have assumed within the clinical pathway of a child, it is pivotal that appropriate support structures are in place. Without this backing, parental engagement with health service providers is difficult to maintain. Community-based family support groups have been tested in pilot projects in an attempt to address these issues and early results have been encouraging. Normally free of charge, these programs are mainly conducted in child-care centres or in the pre-primary school environment. The Warmun Early Language Centre is a successful example of this concept. Other successful programs, which are explored later in the Report, include Resource Unit for Children with Special Needs (RUCSN) Play Groups, LEAF Play Café and Home Visitation Programs, and Smart Start.

The four-year-old cohort of children derives the greatest benefit from screening programs for speech and language difficulties. This group would also gain from additional testing for sight and hearing disorders before commencing formal schooling. Moreover, with over 96% of four-year olds in Australia now attending either childcare or pre-school[74], the application of community screening programs in these sites would provide as near a universal reach as the school population. Ms Shirley McInnes, from RUCSN, claimed that approximately 35,000 children attend either full-time or part-time child care in WA:

> *If that sort of screening can happen in schools, we suggest it might be able to happen in some form in child care. We have caregivers in child care who have some knowledge of*

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73 Dr Ron Chalmers, Director General, Disability Services Commission, *Transcript of Evidence*, 30 July 2008, p7.

74 For these figures, see Submission No. 28, Commissioner for Children and Young People, 12 May 2008, p 6.

child development or, ideally, you would have the health nurses come in and do some sort of screening.[75]

Such an approach provides an environment where parental interaction with community health professionals is encouraged. RUCSN confirmed that there has been a trend in recent years away from parents seeking assistance from the community nursing services. This seems to be attributable to the frustration felt by parents because of delays in the referral and treatment process for their children. It could also be a function of the time and financial pressures of modern lifestyles, especially where both parents are working. Some parents may feel there is a stigma attached to approaching the community health nurse for assistance, a feeling that didn't exist among earlier generations of parents.[76]

Speech pathologist Ms Rosie Candler, who conducts pre-school reading programs, said "I found that when we put things on for the community that provided enjoyment for the children, we never had any problems getting the numbers."[77] The formal assessment of the LEAF program made similar observations that "The program was highly successful in increasing parent access to, and comfort with, a range of early intervention services and ensured non-invasive early identification of learning and developmental delays in pre-school children engaged with the program."[78]

Finally, such community programs provide a forum in which parents can obtain information about identifying and acting upon developmental delays in their child. This can be done via consultation with child care workers, visiting specialists or through informal interaction with other parents. While the parents' knowledge is augmented by these programs, the child also benefits from the ability to interact with their peers in an enjoyable environment. This enhances the child's emotional preparedness for the more formal school environment, which consequently facilitates easier learning and lessens the likelihood of behavioural problems emerging.[79]

Lower Socio-Economic Status (SES) family groups may be less likely to participate in such community-based programs because of time pressures for families, financial stress and, possibly, a general suspicion of government education and health authorities.[80] A persistent emphasis on the complimentary and non-threatening aspect of these services would improve their underlying appeal across all families.[81] A recent Federal initiative may assist in this process. As part of a $2.6

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75 Ms Shirley McInnes, Resource Coordinator, RUCSN, *Transcript of Evidence*, 30 July 2008, p3.

76 Mrs Shirley McInnes, Occupational Therapist/Resource Coordinator and Ms Cathy Hewick, Inclusion, Disability and Community Services Manager, RUCSN, *Transcript of Evidence*, 30 July 2008, pp 3-8.

77 Mrs Rosemarie Candler, Speech Pathologist, Private Speech Pathologists' Association of WA, *Transcript of Evidence*, 30 July 2008, p3.

78 Submission No. 17 (attachment No. 2), Investing in Our Youth, 9 May 2008, p 73.

79 Submission No. 17 (attachment No. 2), Investing in Our Youth, 9 May 2008, p 41.

80 Submission No. 17 (attachment No. 2), Investing in Our Youth, 9 May 2008, p 70; Mrs Rosemarie Candler, Speech Pathologist, Private Speech Pathologists' Association of WA, *Transcript of Evidence*, 30 July 2008, pp 2-3.

81 Mrs Rosemarie Candler, Speech Pathologist, Private Speech Pathologists' Association of WA, *Transcript of Evidence*, 30 July 2008, pp 2-3; and Submission No. 17 (attachment No. 2), Investing in Our Youth, 9 May 2008, p 26.

billion five-year commitment to enhancing the integration of early childhood development services, the Minister for Education, Hon Ms Julia Gillard, announced in May 2008 that the Rudd Government plans to:

> *provide all Australian children…with access to affordable early learning programs delivered by a qualified teacher. All children will have access to 15 hours a week of early learning programs for 40 weeks a year in the year before formal schooling.*[82]

Ensuring equitable access to such programs across Western Australia's regional and remote areas would be a challenge. However, several of these type of initiatives are already offered by non-government organisations that specialise in servicing hard to reach populations. The Warmun Early Language Centre caters for families at the Warmun Community in the East Kimberley region, while RUCSN Play Groups cover areas of the Midwest Gascoyne, Murchison and the Pilbara.[83] The Rudd Government's proposal is targeted to include "Indigenous children living in remote communities."[84] An expansion of existing mobile health services to work in conjunction with these regional initiatives is another strategy that needs to be considered by DOH. The precedent of mobile clinics has been established with the School Dental Service and, in the non-government sector, the Variety Club's Ear Bus. The majority of these community-based services are 'pilot-projects' funded either directly from school resources, such as P&C groups, or from periodic Commonwealth and State funding.

In summary, the key components for successful community-based programs are:

- **Accessibility** - parents, extended family members and their children have been able to readily access the program in their local community.
- **Engagement** - of both children and caregivers, the former via appropriate play and learning activities and the latter by the informal nature of meeting and speaking with teachers and health professionals.
- **Holistic** - encompassing aspects of child development inclusive of social, economic, cultural and environmental factors.
- **Collaboration** - both government and non-government agencies working in partnership with the local community and or service providers in order to coordinate appropriate service provision and provide flexibility.

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82 Minister for Education, "Media Release", (2008). Available at: http://mediacentre.dewr.gov.au/mediacentre/Gillard/Releases/Earlychildhoodinitiativestobenefitindividualsthecommunityandtheeconomy.htm. Accessed on 28 August 2008.

83 Submission No. 7, Mrs Shirley McInnes, RUCSN, 9 May 2008, p 4.

84 Minister for Education, "Media Release", (2008). Available at: http://mediacentre.dewr.gov.au/mediacentre/Gillard/Releases/Earlychildhoodinitiativestobenefitindividualsthecommunityandtheeconomy.htm. Accessed on 28 August 2008.

- **Training** - to facilitate implementation of the program and engage with the professionals who are to deliver the service.
- **Outcomes** - are readily observable and supported by both qualitative and quantitative data.
- **Resources** - must be adequate to sustain the program over time.

5.3 School-based screening programs

(a) DET and DOH Memorandum of Understanding

The partnership between the Departments of Health and Education and Training for the operation of the School Health Service (SHS) in Western Australia was formalised in 2004 by a *Memorandum of Understanding* (MOU) *For the Provision of School Health Services for School Students Attending Public Schools*[85]. Under this agreement, both departments fund the operation of the SHS while the management responsibilities lie with DOH, including the employment of school and community health nurses. These nurses conduct the health screening services provided to approximately 35,000 pre-primary and 119,000 primary school students throughout WA.[86]

School entry health assessments are offered to all children in WA's public and private primary schools as early as possible after school entry. There were over 27,500 Year 1 students enrolled in WA in mid-2008, and about 84% had received school entry health assessments by November 2008. About 70% of Aboriginal children had received assessments. An evaluation of the *School Entry Health Assessment Program* found that, of the children known to have received assessments, approximately half (53%) were assessed during Pre-primary, 38% in Kindergarten and 8% during Year 1. The timing of assessment varied considerably across the State and the majority of students were assessed for vision (98%) and hearing (98%). Tests for speech and language were the third most common assessments, but limited to about 25% of students.

Of the children known to have received an assessment in 2008, 17% (about 4,700) were referred for further assessment and/or intervention. Most commonly referrals were made for speech and language (27%), vision (26%) and hearing (23%). For 23% (about 1,100) of these children referred, the intervention was completed with good outcomes, for 17% the intervention was in progress, and for 9% further assessment identified no need for intervention. The parents of 280

85 This MOU is one of three that DET has with the Department of Health and the Disability Services Commission to provide health services in WA's schools. For more information on these memoranda, see: Department of Education and Training, "2005 School Health Policy", (2008). Available at: http://policies.det.wa.edu.au/Members/e4002033/policy.2006-06-20.0422054705/Orig_2008-06-19.6439574557.pdf, p 7. Accessed on 18 August 2008.

86 Western Australia had 258,132 students enrolled in public schools, 72,349 in private primary schools and 58,891 in private secondary schools in first semester 2009. Hansard (2009), "Public Schools- Student Enrolment" & "Private Schools- Student Enrolment", *Questions On Notice*, 5 May, pp 3373-3374.

(6%) of the children did not pursue an intervention, and another 140 (3%) of parents did not support the intervention provided. The outcome was not yet known for 29% of referrals.[87]

The Memorandum of Understanding (MOU) between DOH and DET is managed by a Joint Consultative Group (JCG), which "meets approximately four times a year. However, senior policy officers from each of the Departments meet more frequently as required."[88] The MOU is reviewed annually by the JCG and the current three-year agreement was ratified in July 2007.[89] The funds provided by DET for the School Health Service (SHS) over the past five years are shown in Table 5.1 below.[90]

Table 5.1 Funds provided by DET for the School Health Service

Financial Year	Funds Provided (excluding GST)
2004/05	$4,656,000
2005/06	$4,772,000
2006/07	$4,892,000
2007/08	$5,315,000
2008/09	$5,528,000

The MOU endorses a 'Health Promoting Schools Framework' that sees the SHS provide not only screening procedures, but broader immunisation programs, health promotion strategies and specialist health expertise services.[91] The MOU also provides for Local Service Agreements (LSAs) between regional District Education Offices, schools and local health services.[92]

87 Submission No. 30 (C), Department of Health, Response to Questions on Notice, *School Entry Health Assessment Program- Statewide Evaluation 2008*, 8 April 2009, p 1.

88 Department of Education and Training, Response to Questions on Notice, July 2008, p 3.

89 The MOU includes an annual indexation rate of 3% applied to the level of funds provided by DET, and then varied in line with an agreed indexation rate. The revised indexation rates are- 5.5% for 2007/2008, 4% for 2008/2009 and 4% for 2009/2010.

90 Department of Education and Training, Response to Questions on Notice, July 2008, p 3.

91 DET and DOH, *MOU for the Provision of School Health Services 2007-2010*, p 4.

92 DET and DOH, *MOU for the Provision of School Health Services 2007-2010*, p 12.

Recommendation 8

That the Government review the operation of the Memorandum of Understanding between the Department of Health and Department of Education and Training to address the shortcomings of Western Australia's child health screening programs identified by this Inquiry.

(b) Western Australian legislation governing school screening

The modern international paradigm for child health screening places school programs into a continuum of health screening tests starting at birth, and involving other non-health participants in the community, such as parents and teachers. This process is currently followed in Western Australia and is a change from the earlier school-based programs common in the 1950s and 1960s. The government-funded child screening program, though, is still governed by legislation from the early 20th Century. The *WA Health Act 1911*[93] reflects past health practices. Part XIII of this legislation governing health service provision in this State refers to child health and preventive medicine:

- **s337**. Examination of school children.
- **s337A**. School dental service.
- **s338.** Authorises the Executive Director, Personal Health to authorise any medical officer or nurse to examine medically and physically any child attending any school or child care centre.

See Appendix Four for the full text of these sections of the Act.

(c) Departmental collaboration

DOH summarises the history of the century-old partnership between the State education and health sectors to provide the school health screening program:

> *In Western Australia, the affiliation between Health and Education began with the establishment of School Medical Services in 1910. The mandate of the School Medical Services was to improve the health of the State's school-aged children. This service continued until the 1970's.*
>
> *In the 1970's some additional school health nurses were appointed to deliver services to some senior high schools as part of the Commonwealth Government's Priority School strategy. During this period, the services were also extended in Education Support Units.*

93 Austlii, "Health Act 1911", (2008). Available at: www.austlii.edu.au/au/legis/wa/consol_act/ha191169/. Accessed on 18 August 2008.

> *The School Medical Services, Community Health Services and Child Health Services were merged in 1984, under the banner of Community and Child Health Services.*
>
> *Since 1998, there has been a broad agreement in place between the Department of Health and Department of Education and Training, which underpins the delivery of School Health Services. The services are jointly funded, with staff employed by Area Health Services.*[94]

Only now are efforts being made to formally evaluate WA's school screening program, its impact on general child health outcomes, and the efficacy of post-screening referrals for further medical attention and intervention. DOH reported that a statewide evaluation of the School Entry Health Assessment Program is now being conducted.[95] The only prior evaluations undertaken by DOH have been of a particular program (e.g. *A Smart Start* by the WA Country Health Service in 2008), or parts of an overall program (e.g. hearing screening (Department of Health 2005)). DOH reported that it has recently been involved in further research by the Child and Adolescent Community Health Policy (CACHP), following on from the NHMRC Report, in the areas of:

- *introducing a validated parent reported child developmental screening tool into the current universal developmental assessment process.*
- *consider*[ing] *the evidence on childhood overweight* [sic] *and obesity. As a result … adaptations have been included into the early detection policy to incorporate targeted assessment for children with body weight issues.*
- *working with the Telethon Institute of Child Health Research on a project called 'Development of a Schedule of Child Health Services for Aboriginal Children and their Families'. This project will involve reviewing the evidence and identifying the need for specific services for Aboriginal communities.*[96]

Recommendation 9

The evaluation of the School Entry Health Assessment Program undertaken by the Department of Health should focus on the effectiveness of identification, treatment and the evaluation of treatment programs, and compare these three components with similar programs undertaken in other jurisdictions.

94 Department of Health, Child and Adolescent Health Service, School Health Service Policies, *Policy Rationale School Health Service 2007-2009*, p 3.

95 Submission No. 30, Department of Health, 16 May 2008, p 15.

96 Department of Health, Response to Questions on Notice, 4 August 2008, p 20.

(d) School health nurses

It is difficult to accurately assess the school health nurse staffing numbers at primary and secondary level, as many Western Australian schools in rural and remote regions encompass classes from Kindergarten through to Year 10. However, the business case prepared by the Department of Health in November 2007 for an additional 135 FTE of school health nurses (112 FTE for primary schools) has not been accepted by government.[97]

Primary schools

The Department of Health reported that in Western Australia's primary schools:

> *nurses have a lesser presence, often visiting schools on a fortnightly or monthly basis only. Nurses visit all schools in the public, Independent and Catholic Education sectors. There are overall school health nursing staffing shortfalls in primary schools in both metropolitan and country primary schools. It should be noted that primary schools have been under-serviced by school health services for many years. It appears that staffing levels have not been increased to accommodate increases in population, and there are historical staffing inequities between primary and secondary schools.*[98]

Table 5.2 School nurses in public primary schools

Region	Ratio of nurses to students	Ratio of nurses to schools
Recommended[99]	**1:1,160**	**N/a**
Country WA	1:1,717	1:12.6
Metropolitan	1:3,459	1:11.3

The Department offered no justification for there being only one-third of the recommended number of school nurses in metropolitan primary schools, nor for the perennially recognised "inequities between primary and secondary schools."[100]

97 Submission No. 30 (D), Department of Health, Response to Questions on Notice, 11 May 2009, p 1.

98 Submission No. 30 (B), Department of Health, Response to Questions on Notice, 31 July 2008, p 22.

99 DOH reported in Submission 30 (B), page 22, that "These calculations are based on the number of hours required to complete the various components of school health service provision in primary schools. Time required per 100 primary school students was established to be 93 hours, or 0.93 hours per student, each year. All calculations were based on an average primary school with 300 students including 35 pre-primary students. The calculations include government and non-government schools since the screening and assessment is done for all primary schools."

100 Submission No. 30 (B), Department of Health, Response to Questions on Notice, 31 July 2008, p 22.

Secondary schools

School health nurses have a strong presence in public secondary schools and staff resources in these schools in the metropolitan area appear to be adequate. However, in country areas staffing is less than the recommended level.[101]

Table 5.3 School nurses in public secondary schools

Region	Ratio of nurses to students	Ratio of nurses to schools
Recommended[102]	**1:1,020**	**N/a**
Country WA	1:1,394	1:1.75
Metropolitan	1:1,091	1:1.3

The figures provided by DOH are averages across the State and some schools are likely to fare far worse than others. The Department acknowledged this regional variation, especially in accessing appropriate Child Development Services (CDS), by confirming that "access to CDS's across the State is not consistent and dependant on availability of appropriate staff."[103]

Evidence from many submissions claim there has been a 10 to 15 year stagnation in the size of the school health nurse workforce that has coincided with, and been unacceptably strained by, the State's recent rapid population growth.[104] Stuart McKenzie, President of the School Psychologists' Association of Western Australia, corroborated this view when he argued that the School Health Service:

> *has not been resourced to accommodate new schools or increasing student numbers. As a result, some schools do not receive any School Health Service or are grossly under-resourced as the existing service is further stretched.*[105]

DOH itself acknowledged the dire situation in staffing child health services[106], including the school screening program:

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101 Submission No. 30 (B), Department of Health, Response to Questions on Notice, July 2008, p 22.

102 DOH reported "These calculations are based on the number of hours required to complete the various components of school health service provision in secondary schools. Calculations were based on an average secondary school with 800 students. School Health Nurse time required per 100 secondary school students was established to be 108.125 hours, or 1.08 hours per student, each year."

103 Submission No. 30, Department of Health, July 2008, p 25.

104 Submission No. 10, Dr John Wray, 8 May 2008, p 2; Submission No. 20, Ms Judy Walsh, OT Australia WA, 8 May 2008, p 3; Submission No. 28, Ms Michelle Scott, Commissioner for Children and Young People, 12 May 2008, p 5.

105 Submission No. 15, Mr Stuart McKenzie, School Psychologists Association (WA) Inc, 9 May 2008, p 3.

> *Keeping staff in some parts of the State is also a problem due to the resources boom. The ability to deliver universal health services and respond to high needs groups is being compromised.*[107]

DOH cites a number of demand-side factors contributing to the stress on school health services:

> *Demand for community child health services has increased in the past five years due to growing numbers of births in the Western Australian community, an escalation in migration to WA by young families as a result of the mining boom and increasing numbers of vulnerable families with complex health and social problems. The increase in births and migration was unforseen and is affecting both maternity and child health services.*[108]

The Department's claim that the recent large increase in birth rates was 'unforseen' strains credibility, given the wide publicity since 2004 surrounding the Federal Government's $3,000 (and then $5,000) 'baby bonus' and its acknowledgement to the Committee's *Review of WA's Current and Future Hospital and Community Health Care Services* that it has an annual planning process that reviews demand and capacity modelling and "one of the reasons we do it every year is to try to keep abreast of changes in things like demographic changes, population projections."[109] DOH acknowledged that child heath services had faced growing demands, particularly as a result of the escalating birth rates that had resulted in longer waiting times for the one to three year-old cohort.[110] According to the Australian Bureau of Statistics, Western Australia had the highest increase in fertility rate of any Australian jurisdiction between 2001 and 2006.[111]

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106 A recent report for the Cancer Council of WA highlights that in their sector of health too, the Department of Health is facing similar workforce shortages and "a lack of implementation of plans for the increased demand [for services]" See Barton, M. *et al.* (2008) *2001 Overview of Cancer Treatment Services in Western Australia*, Cancer Council of WA, Perth, p 58.

107 Submission No. 30, Department of Health, 16 May 2008, p 14.

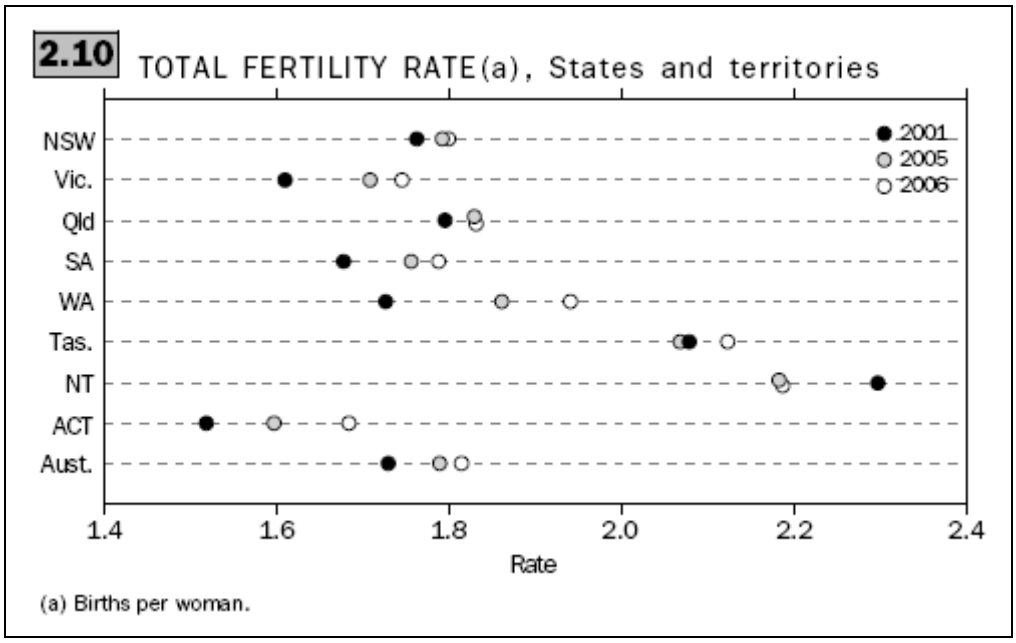
108 Submission No. 30, Department of Health, 16 May 2008, p 13.

109 Ms Jodie South, Senior Project Manager – Infrastructure, Department of Health, *Transcript of Evidence*, 18 March 2009, p 13.

110 Submission No. 30, Department of Health, 16 May 2008, p 13.

111 ABS, "Births 3301.0", (2006). Available at: www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/0C4C341C51104DC4CA2573800015C2DC/$File/33010_2006.pdf, p 18. Accessed on 2 September 2008.

Figure 5.2 Fertility rates by Australian jurisdiction, 2001-06



(e) Community Child Health Nurses

There are 196 FTE of Community Child Health Nurses (CHN) who work in Western Australian with children of all ages in their local communities, with a primary focus on preventive and promotional activities.[112] National Investment for the Early Years (Niftey) and RUCSN both argued that the quality and availability of services from Community Child Health Nurses had suffered as a result of staff numbers not matching the recent population surge.[113] CHILD Australia reported that most CHNs are too busy carrying out the basic screening of babies and providing support to new mothers to have the time to check the development of toddlers and pre-schoolers. They suggested it is necessary for a mother to have a concern regarding her child's development before an appointment can be made to visit the CHN.[114] DOH and DET both reported that the

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112 For a fuller description of the role of Community Health Nurses in WA: Community Health Nurses WA, "what is a community health nurse", (2009). Available at: www.chnwa.org.au/index.php?option=com_content&task=view&id=13&Itemid=27. Accessed on 2 April 2009.

113 Submission No. 27 National Investment for the Early Years, 8 May 2008; Mrs Shirley McInnes, Resource Coordinator, RUCSN, *Transcript of Evidence*, 30 July 2008, pp 2-3.

114 Submission from CHILD Australia to the Community Development and Justice Standing Committee's *Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children*, 27 February 2009, p 8.

CHN staffing shortage of 105 FTE was particularly significant for its rural and regional clientele.[115]

Another factor that exacerbates this shortfall in nurses is the growing burden that is placed on staff to cater for, what Niftey termed, the 'changing complexity of developmental concerns'.[116] Conditions such as autism, obesity, and social dysfunction have become increasingly prevalent, and onerous, for child health workers who also have to monitor the health of the broader school-age population. The lack of government support for proposals for additional staff and resources is having a noticeable impact on the spirit of the current CDS workforce. Several submissions referred to a mood of disaffection amongst CDS workers. This was supported by Occupational Therapists Australia, WA:

> *Staff morale within these services is low amongst highly skilled and experienced therapists and staff retention occurs out of a commitment to the children. We cannot 'expect' this of younger therapists entering the DOH services and they will not stay under such pressures.*[117]

The significance of staff retention and recruitment difficulties across all sections of the child health system is augmented by the ageing demographic profile of the workforce. DOH confirmed that there is likely to be a 9.7% shortfall of general nurses and midwives (based on current levels) by 2015-16. DOH reported that the Community Health Nurses are "an ageing workforce - the average age of community nurses is increasing and in 2006 the average age was 54 years. 91% of the community health nursing workforce is over the age of 40."[118]

Even with the current staff levels, lengthy delays for assessment and remedial services are common across all child health programs. A number of submissions said waiting times of between nine and 12 months were commonplace.[119] The HRIT report found that waiting times across all regions varied "between two-18 months."[120] These delays are being compounded by 'wait-list management' strategies that have been adopted in an attempt to meet growing demands for already-stretched services. These strategies include:

- Prioritising children according to the perceived urgency of their condition;

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115 Submission No. 30 (D), Department of Health, Response to Questions on Notice, 9 May 2009, p 1; Submission No. 29, Department of Education and Training, 21 May 2008, pp 5-16; Submission No. 30, Department of Health, 16 May 2008, p 26.

116 Submission No. 27, National Investment for the Early Years, 8 May 2008.

117 Submission No. 20, Ms Judy Walsh, OT Australia WA, 8 May 2008, p 4.

118 Submission No. 30 (A), Department of Health, Response to Questions on Notice, 24 July 2008, p 8.

119 Submission No. 7, Mrs Shirley McInnes, RUCSN, 9 May 2008, p 6; Submission No. 27, National Investment for the Early Years, 8 May 2008; Submission No. 21, Speech Pathology Australia, 9 May 2008, p 4.

120 Department of Health. (2006) *Future Directions of Western Australian Child Development Services*, Health Reform Implementation Task Force, Department of Health, Perth, p 7.

- Offering group educational and treatment programs instead of individual consultations; and

- Distributing greater quantities of handout material to educate parents on their child's developmental requirements.

In the case of the metropolitan CDS centres, evidence was given that services are no longer provided for children over eight years of age. The Willandra Primary School in Armadale said that under these circumstances "when the child is discharged, they are given no further help or support and most of the time the problem still exists."[121] Notwithstanding the issue of affordability, parents are encouraged to pursue further assessment and treatment in the private sector.[122] However, rebates from health funds for services by allied health staff, such as occupational and speech therapists, are limited to about $600 per annum.[123]

Resource restraints have resulted in CDS centres offering, what Dr John Wray has called, "inadequate 'watered down' services in many developmental areas."[124] This can undermine parental engagement in the clinical pathways of their child, which is a key tenet of the holistic model of child health care that is now advocated as best practise. Parents who are engaged with their child's condition can become anxious when referrals are delayed, or disaffected to the extent that they do not follow through with appointments.[125] The HRIT report notes an 'alarming' 10% of cases where a client didn't attend their appointment, or weren't at home for a scheduled visit.[126] This was also confirmed by Ms Sharon Rimmer, Pastoral Care Coordinator from Warnbro Primary School:

> *It is pretty cut and dried really. There is a lengthy wait. Sometimes when the appointment comes through, the parents say, "I'm over it." So there goes that waiting time, and then that child is not progressing.*[127]

Conversely, there are some parents who are not engaged with attempts to treat their child's health condition identified through screening tests, such as the School Entry Health Assessment (SEHA) program. An evaluation of SEHA found that about 6% (or 280) of children referred for treatment

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121 Submission No. 6, Year One Teachers, Willandra Primary School, 2 May 2008. The Committee questioned the Department of Health to ascertain the rigidity with which this process was applied to children of this age group. The response is cited below in Chapter 5.4 (a).

122 Submission No. 10, Dr John Wray, 8 May 2008, pp 2-3; Submission No. 22, Early Childhood Intervention Australia, WA, 9 May 2008, p 3.

123 Submission No. 20, Occupational Therapists Australia (WA), 8 May 2008, p 3.

124 Submission No. 10, Dr John Wray, 8 May 2008, p 3.

125 Submission No. 7, Mrs Shirley McInnes, RUCSN, 9 May 2008, p 10; Submission No. 16, Telethon Speech and Hearing, 9 May 2008.

126 Department of Health, "Future Directions for Western Australian Child Development Services", (2006). www.health.wa.gov.au/hrit/childdevelopment/docs/CD_Framework_Outline.pdf, p 11. Accessed on 1 August 2008.

127 Ms Sharon Rimmer, Pastoral Care Coordinator, Warnbro Primary School, *Transcript of Evidence*, 18 June 2008, p 8.

did not obtain it because their parents did not follow-up the referral and another 3% of children had parents who did not support the intervention provided.[128] Under the current shortages, child health workers may not be able to dedicate the time they ordinarily would to pursuing these parents to encourage follow-up treatments. Children most vulnerable to falling through the gaps created by the current resource constraints are those from poorer, CALD, refugee or Indigenous families. Private treatment options, offered as an alternative to government services, are prohibitively expensive for these families. In addition, there is a general tendency for service shortfalls to be more evident in areas or suburbs dominated by lower socio-economic households.[129]

DOH has been aware of the problems regarding staff shortages in this area and reported that three business cases were presented to the then-Minister for Health, Hon Jim McGinty, to increase the number of school, child health nurses and community nurse managers.[130] Similar business cases are before the new WA Government, including one to add another 91 child health nurses to the existing cohort of 196 FTE.[131] DOH's submission to the Inquiry acknowledged the extent of these supply-side problems:

> *There are currently 146 Full Time Equivalent (FTE) of school health nurse positions across WA, 99 FTE in the metropolitan area and 47 FTE in the WA Country Health Service. The number of school health nurses has remained static since 2002.*[132]

This concern with the number of available school health nurses goes back more than a decade and several governments. For example, the Hon. Mark McGowan questioned the then-Minister for Education and presented a petition for a full-time school nurse at the East Waikiki Primary School in 1999.[133] Mrs Shirley McInnes, a Resource Coordinator at RUCSN, confirmed:

> *we think it was about 1996 or 1997 when we realised that the child health nurses were not so easily accessible in child care. I think, perhaps, their numbers did not increase at the same rate as the population increased and so they had to cut what they could do.*[134]

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128 Submission No. 30 (C), Department of Health, Response to Questions on Notice, 8 April 2009, p 1.

129 Submission No. 10, Dr John Wray, 8 May 2008, p 2; Department of Health. (2006) *Future Directions of Western Australian Child Development Services*, Health Reform Implementation Task Force, Department of Health, Perth, p 13.

130 Mr Mark Morrissey, Executive Director, Child and Adolescent Community Health, Department of Health, *Transcript of Evidence*, 6 August 2008, p 6.

131 Mrs Margaret Abernethy, Senior Policy and Portfolio Officer, Department of Health, *Transcript of Evidence*, 8 April 2009, p13.

132 Submission No. 30 (B), Department of Health, Response to Questions on Notice, 31 July 2008, p 21. DOH also noted "Child health nurse FTE and school health nurse FTE are two separate resources in the area health services. There are currently 196 Full Time Equivalent (FTE) of child health positions across WA, 129 FTE in the metropolitan area, and 67 FTE in Country Health Services."

133 Legislative Assembly, *Questions on Notice*, 14 September 1999, pp1136/3 and Legislative Assembly, *Petition*, 19 October 1999, pp 2227/2.

134 Mrs Shirley McInnes, Resource Coordinator, RUCSN, *Transcript of Evidence*, 30 July 2008, p 3.

The Court Government's Minister for Education reported in 1999 that "The Education Department has established the School Health Services Working Party to examine the best ways of meeting schools' health needs."[135] Despite this project, school nurse numbers stayed at a similar level. Not only has the number of school nurses not kept pace with the population growth in WA, but their role seems to have changed as well, with more tasks needing to be completed. Ms Sharon Rimmer, the Pastoral Care Coordinator at Warnbro Primary School, said that school nurses are involved:

> *with a lot more health promotion in schools than ever before. Including PPP, Rainbows, nutrition information sessions with parents and children, Crunch and Sip Implementation and they work collaboratively with the Local Drug Action Group and other organisations to provide education to year 7's at a conference annually.*
>
> *There are also new things in the pipeline such as the introduction of a developmental parent questionnaire to be introduced in 2009 and assessment of BMI and addressing obesity issues to be introduced over the next 12 months.*[136]

The role of school nurse seems to be highly appreciated by those who work with them. St Cecilia's Catholic Primary School reported they have:

> *a very close working relationship with the School Nurse. This is a relationship that is to be valued and fostered. … Open lines of communication, which currently exist, allow for information to be transmitted to all interested parties quickly, professionally and honestly. The current screening practices utilised by the School Nurse are thorough and informative.*[137]

The main issue of staff levels in the school health nursing system seems to be with the total number of FTE employed rather than problems with high levels of vacancies. The DOH advised the Committee that "As of July 2008, there appears to be no vacant positions in school health services in WA, however a small number of positions are filled by temporary employment arrangements (i.e. in the North Coastal Metropolitan area, and the Pilbara region)."[138] DOH reported that the business case to increase the number of child health nurses by 91 FTE is unlikely to be supported in the 2009-10 State budget.[139]

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135 Legislative Assembly, *Questions on Notice*, 14 September 1999, pp 1136/3.

136 Ms Sharon Rimmer, Pastoral Care Coordinator, Warnbro Primary School, *Transcript of Evidence*, 18 June 2008, p 6.

137 Submission No. 2, Ms Melissa Marquis, St Cecilia's Catholic Primary School, 6 April 2008, p 1.

138 Submission No. 30 (B), Department of Health, Response to Questions on Notice, July 2008, p 23.

139 Mr Mark Morrissey, Executive Director, Child and Adolescent Community Health, Department of Health, *Transcript of Evidence*, 8 April 2009, p 12.

Finding 3

There is an urgent priority for the Western Australian government to increase the number of school and child health nurses, especially for metropolitan primary schools.

Recommendation 10

As an urgent priority, the Government should increase the number of school nurses employed in the school health system and approve the proposed business case for additional school and child health nurses to be employed within the Department of Health's Child Development Services.

(f) Allied health staff shortages

Concerns about staff shortages weren't limited to school and community health nurses but were also raised in regard to administrative staff and allied health staff. Dr John Wray raised several points in respect of CDS staff resources:

> *I am sure that the Government does not wish to hear the plea for more resources for our children's needs. However, I can assure the Government that the public sector employees who work with children and the parents of children with developmental difficulties are mightily disheartened by the impoverishment of child development services in this state.*[140]

He further stated:

> *The Child Development Service has a highly motivated workforce. This sense of purpose has kept the clinicians and primary managers going over the years. The service however has inadequate infrastructure, crumbling buildings and inadequate staffing levels. Most of the Child Development Centres have had no or very little growth in the last 15 years, despite the growing population and growing evidence of the usefulness of early intervention services. I believe that the Child Development Service is at risk of losing its high calibre clinicians and managers.*[141]
>
> *The Child Development Service currently faces difficulties in achieving appropriate classification levels for the managers and clinicians. …This perpetuates the impression*

140 Submission No. 10, Dr John Wray, 8 May 2008, p 1.

141 Submission No. 10, Dr John Wray, 8 May 2008, p 2.

> *that community health work is a poor sister to acute services. These matters should be immediately addressed.* [142]

The concerns were not just about accessing sufficient DOH staff, but also about particular areas of allied health speciality, such as speech therapy:

> *In the Eastern Wheatbelt, … there were also years when screening was not carried out as we had no Therapists and were waiting in excess for 12 months for Therapists to be appointed, this was highly unsatisfactory from the school's perspective of early intervention.*[143]

The President of the School Psychologists Association in Western Australia presented similar concerns in respect of the availability of adequately trained psychologists:

> *In metropolitan and regional centres, where community and allied health services are located, it is usual for there to be at least a nine month delay before children and adolescents with acute or chronic health problems can be assessed and treated. In some locations, this timeline may be extended due to a lack of personnel trained to work with children and adolescents. In these circumstances, schools frequently attempt to support these children and families whilst still engaging in their core business of teaching and learning.*[144]

(g) Future staffing inadequacies

The recent surge in WA's birth rate will see the demand for school health nurses worsen in the very near term.[145] According to the Commissioner for Children and Young People:

> *The increase in demand currently experienced by Community Child Health Nurses and the childcare sector will continue through primary schools. The first cohort of children from 2004 the first year of* [birth rate] *increase will be coming into the four year old pre primary system in 2008/2009. This will increase demand for some schools, school health nurses and the need for intervention programs.*[146]

The Department of Health said that its own modelling had indicated there will be an imbalance between the supply and demand for nurses across the WA health system, due to issues such as an ageing workforce, less staff wanting to work full-time and the continuing resources boom. They estimate that by 2015-16, there will be a shortfall of nearly 10% in the number of nurses required

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142 Submission No. 10, Dr John Wray, 8 May 2008, p 3.

143 Submission No. 1, Ms Fiona Yeates, Bruce Rock District High School, 31 March 2008, p 1.

144 Submission No. 15, the School Psychologists' Association of WA (Inc), 9 May 2008, p 2.

145 Although in 2010 secondary schools will see a lessening of demand for school nurses due to a half-cohort enrolling in Year 8. Legislative Council- Estimates Committee, 28 May 2008, *Division 50: Education and Training, $3,326,235,000* - pp 583c - 599a/1.

146 Submission No. 28, Commissioner for Children and Young People, 12 May 2008, p 6.

by the State.[147] In terms of allied health staff, which make up nearly 10% of its workforce, DOH reported that until 2008 there was no centralised system of monitoring numbers and the employment status, and future demand of its own allied health professionals. This is an area that needs addressing in DOH plans to reform the State's child health screening program.

Recommendation 11

That the Department of Health ensure the new Child Development Information System (CDIS) provides a management tool to assist in monitoring the numbers, employment status of, and future demand for, the allied health professionals it employs.

The Department gave evidence that it had prepared for government three draft business cases for additional school and child nursing staff and "implemented an intensive recruitment and marketing campaign to target mature age entrants to join the nursing professions". Additionally, it has put in place a wide range of strategies to retain and recruit nursing and other health staff, including offering more flexible working hours and greater access to workplace child care.[148]

Professor Zubrick from Curtin University summarised the current state of the child health system as one where:

> *there has been a systematic erosion and neglect by government departments of the state maternal and child health service workforce, along with poor support for, and wide variability in, the provision of school nurse services. This is resulting in delays in some detection rates and wasteful burdens on families looking for assistance.*[149]

A staff member at the State Child Development Centre supported this assessment of long-standing neglect in child health services and said "SCDC has to rationalise services. Its staffing allocation has not changed in the last 16 years even though the primary school population (years 1 to 7) in WA has grown from 93,162 in the 1992 census to 169,870 in the 2006 census."[150]

Evidence from other witnesses suggest that the Department may not succeed with their efforts to increase staff levels by attracting new staff, and may need to make greater use of nurses and allied health staff from the private sector, or change its approach to how the school health screening program is undertaken. New approaches suggested in evidence included making greater use of community health nurses to assist school nurses in primary schools in the metropolitan area, or by

147 Submission No. 30 (B), Department of Health, Response to Questions on Notice, July 2008, p 8.

148 Submission No. 30 (B), Department of Health, Response to Questions on Notice, July 2008, p 9.

149 Prof Stephen Zubrick, Head, Division of Popular Sciences, Curtin University of Technology, Centre for Developmental Health, *Transcript of Evidence*, 30 July 2008, p 2.

150 Submission No. 18, Ms Gabi Levi, Audiologist State Child Development Centre, 9 May 2008, p 1.

moving the screening program to an earlier age where school, childcare and kindergarten staff could be trained to undertake some of the more basic screening tasks.[151]

In a similar fashion, WA Country Health Service has had difficulty recruiting full-time practitioners within a tight labour market. WACHS gave evidence that as a result, over the past four to seven years they have developed a TAFE-trained assistant program. An allied health specialist supervises the allied health assistant. WACHS is also working with the Combined Universities Centre for Rural Health in Geraldton to develop Aboriginal allied health assistants as part of this program.[152]

Data from the ABS *2002 Child Care Survey* provided an estimate of the proportion of 4-year old children attending preschool programs. This (and later data) found that approximately 59% of children aged 4 years attended preschool and an additional 25% of children attended long day care.[153] The Committee felt that if new approaches are not put in place, such as moving some screening programs to an earlier age, the existing long waiting times presently facing families who have children needing assessment and treatment will continue.

Finding 4

The current process of providing school health and community nurses to undertake child health screening programs is likely to continue to fail to meet the needs of Western Australia's children in light of the Department of Health's (DOH) modelling showing a 10% shortfall in nurse numbers by 2015-16, the recent high rate of population growth in Western Australia and the aging of the DOH workforce.

Recommendation 12

In light of WA's increasing birth rates and long-standing shortages of school and child health nurses, the Department of Health (DOH) should urgently find and adopt other options that might be used to carry out child health screening programs. In particular DOH should investigate moving some screening programs (such as speech and language) from pre-primary and primary school years to an earlier age and have simpler tests undertaken by appropriately trained childcare staff.

151 Hon. Colin Barnett, then Minister for Education, reflected similarly in 1998 when he said "However, I cannot help thinking a better way is available to organise and manage those [school health] services." Legislative Assembly, *Grievance*, 10 June 1998, pp 3662/2.

152 Mrs Kathryn Gatti, Senior Portfolio and Policy Officer, Department of Health, *Transcript of Evidence*, 8 April 2009, p 11.

153 AIHW, "A Picture of Australia's Children", (2005). Available at: www.aihw.gov.au/publications/phe/apoac/apoac.pdf, p 65. Accessed on 2 September 2008.

5.4 Lengthy waiting lists

The primary, issue of concern identified by the majority of submissions was that of the long waitlists and waiting times before children were provided with treatment, therapy or appropriate services. The situation is made worse for many children because there are often two waiting lists: the first to obtain a proper assessment and referral for treatment, and the second for the actual treatment of a condition. For example, Dr Ridden, a school principal, confirmed in his evidence that "it takes nine months to get an initial assessment and then, when a course of therapy is recommended, it takes another six months for something to happen. They are not fantastic figures; they are normal figures and they have been confirmed by parents."[154] Speech WA's submission also highlighted the long delay in getting children assessed by the CDCs:

> *Any child who raises concern in the screening process is referred to the state Child Development Centre (CDC) for an assessment. Families face long wait-lists and wait times for such a government service of up to12 months depending on the CDC. The CDC wait-lists exist for children of Pre-primary and Primary school levels and the actual wait time depends on the age of the child and their district of residence. … Speech WA would argue that the lengthy wait times for assessment needlessly waste the opportunities gained by an early screening process.*[155]

(a) Child Development Services waiting lists

More than half of the submissions received by the Inquiry referred to service provision by the DOH's Child Development Services. Key concerns of these submissions were waiting periods for appointments, waitlist management strategies, lack of staff and resources, as well as the timing and continuation of therapeutic intervention. Dr Wray commented that:

> *After the screening process, the professionals and parents will want to have their child further assessed and managed, if a problem has been identified. Around 20-25% of children have significant developmental or behavioural concerns.*[156] *It is at this stage that the state-funded Child Development Service, various NGOs, or the private sector become involved. In a nutshell, the 'free' Child Development Service tries hard but is unable to adequately meet the demand for services.*[157]

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154 Dr Phil Ridden, School Head, St Stephen's School, *Transcript of Evidence*, 30 July 2008, p 10.

155 Submission No. 23, Speech WA (Inc), 9 May 2008, p 2.

156 In an email of 23 March 2009, Dr Wray breaks-down the figure of 25% of children with development disabilities as: about 10% are language delays, 10% disabilities, 7% physical development issues and about 3% ADHD- but there is some overlap with children having various disabilities. These figures are based on Wood, N. & Daly, A. (2007) *Health and Wellbeing of Children in Western Australia, July 2006 to June 2007, Overview of Results*. Department of Health, Perth, pp 22-28.

157 Submission No. 10, Dr John Wray, 8 May 2008, p 2.

The ECIA submission confirmed Dr Wray's view:

> *that some children in WA have difficulty accessing early childhood intervention services in a timely manner. To this end, ECIA (WA) recommends* [sic] *review of the length of wait-times experienced by families for initial appointment at their Child Development Service and separately, review of the length of wait-times for the commencement of Early Intervention services within the Child Development Service.*[158]

Speech WA highlighted one of the waiting list management practises that seems to create more frustration for families and their children:

> *Once a child reaches the top of the wait-list he receives one block of 5 therapy sessions and then returns to the bottom of the wait list. Children in Kindergarten and Pre-primary are considered fortunate if they receive* ***2 blocks of 5 therapy sessions in a year.*** *School-aged children in Primary class levels are older than the designated age range of priority and thus face even longer wait times and even less frequent blocks of therapy.*
>
> *We at Speech WA feel that the large number of children waiting for such long periods of time for a minimal block of therapy is an intolerable situation. Pertinent to this concern is the broad recognition of the importance of early intervention to ensure literacy development for children with speech and language disorders. Even when such needs are identified early, we feel the inadequacy of access to appropriate services wastes the opportunity to prevent difficulties from jeopardising literacy levels and learning.*[159]

The DOH itself acknowledges that "there will remain a general problem of demand for services exceeding capacity of the CDS to provide."[160] DOH also admitted in questions on notice after public hearings that:

> *Throughout the State there is great variability in CDS waitlist data. The variability reflects resource issues, and also reflects the different ways that the CDS sites deal with waitlists. For example, some centres conduct the initial assessment quite quickly, or the child may be incorporated into a group information session or brief initial assessment. For some children, this superficial service may be all that is required. However, for some children there may then be a significant wait between initial assessment and subsequent individual therapy. In other sites there may be a significant wait for initial assessment, but individual therapy is then available immediately. Wait lists for CDS in country areas do not always provide a true indication of need. For example, the number of referrals for a service may be less because the position within the CDS has remained vacant for sometime because of difficulties in filling the position.*
>
> *Waitlists are sometimes cyclical within a year. For example, there are a large number of referrals at the beginning of each school year, and there is also a high demand for speech*

158 Submission No. 22, Early Childhood Intervention Australia (WA), 9 May 2008, p 2.

159 Submission No. 23, Speech WA (Inc), 9 May 2008, p 2.

160 Submission No. 30, Department of Health, 16 May 2008, p 18.

> *pathology services from July to September in order to assess children for the purposes of application to Department of Education and Training Language Development Centres.*[161]

While the focus of the evidence on waiting times was on the delay of a child obtaining treatment, and the long-term impact of such delays on a child's learning, Ms Cathy Hewick, RUCSN's Inclusion, Disability and Community Services Manager, highlighted the impact of delays on a child's parents. She said "The GP sends a letter to the child development team or wherever and then they get put on a waiting list. I just cannot imagine the stress that not knowing – the uncertainty and the waiting time – would cause parents."[162] Another teacher reported that the frustrations with the long waiting lists spread further than the child's parents:

> *One area that needs to be addressed is the long waiting lists for appointments to medical specialists that are currently present. Children are being referred to Speech Pathologists, Occupational Therapists etc, but are having to wait for long periods of time for an appointment. This defeats the purpose of aiming for early intervention and all of the benefits that go hand in hand with this when it occurs. Frustration levels rise in this situation, for parents, students, and school staff.*[163]

In some cases, an 18-month wait for treatment means that a child would then become ineligible for a service, as they now fell outside the qualifying age group. The DOH confirmed that, while children can access services from the CDS if they are aged 0-16 years and have a developmental delay or disorder, "As a result of resource restrictions, many CDS sites have been unable to effectively manage children older than eight years of age."[164] As part of the CDS reform process described in Chapter 5.5 below, an eligibility policy has been developed to ensure consistency across the metropolitan sites. Children who have been receiving services from the CDS may continue to receive services until the age of 18 years according to relative need, prioritisation and available resources. The new eligibility policy is being implemented in 2009. Currently all CDCs are providing services to children up to 12 years of age and there are 10 sites providing services to children over the age of 12. The remaining sites have recently commenced accepting referrals for children over 12 years of age.[165]

The submission from Early Childhood Intervention Australia was another that highlighted the delays for children moving between services offered by different departments:

> *It is also known that transition of children between health and disability service providers is affected by wait-lists in disability services, disrupting smooth transitions for the child and family from one service to another.*[166]

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161 Submission No. 30 (B), Department of Health, Response to Questions on Notice, July 2008, p 6.

162 Ms Cathy Hewick, Inclusion, Disability and Community Services Manager, RUCSN, *Transcript of Evidence*, 30 July 2008, p 2.

163 Submission No. 2, Ms Melissa Marquis, St Cecilia's Catholic Primary School, 6 April 2008, p 1.

164 Submission No. 30 (B), Department of Health, Response to Questions on Notice, July 2008, p 5.

165 Submission No. 30 (C), Department of Health, Response to Questions on Notice, 8 April 2009, p 2.

166 Submission No. 22, Early Childhood Intervention Australia (WA), 9 May 2008, p 3.

In a similar fashion to the delays at the CDS sites, DET confirmed that while there were about 14,500 children in the K-12 range who have a speech and language impairment or difficulty, the Department's five Language Development Centres cater only for 1,000 students in the K-1 years within the metropolitan area.[167] DET acknowledged that 'official' LDC waitlists were not kept, but provided data for the number of children who met the assessment criteria for admission to a LDC but were unable to be placed in the 2008 program.[168]

Table 5.4 LDC waiting lists

Language Development Centre	Students unable to be placed
West Coast Language Development Centre Ridgewood Boulevard, Ridgewood	21
North East Language Development Centre View Street, Dianella	0
Fremantle Language Development Centre Winnacott Street, Willagee	18
Peel Language Development School La Guardia Loop, Port Kennedy	0
South East Language Development Centre Epsom Avenue, Cloverdale	5

However, DET admitted that the waiting lists for their LDCs were 'artificial' and didn't include the other students in years 2-12 with speech and language needs:

> *in relation to LDC referral, community speech pathologists are advised of the limited number of places available each year at LDCs. This avoids the time consuming task of assessing large numbers of children who could not then be accommodated in an LDC. As a result, speech pathologists refer* ***only a small number of students with the most severe language difficulties for assessment*** [emphasis added]. *Applicants who do not receive a place are invited to reapply the following year.*

This management of the LDC waiting lists has a 'knock-on' effect into the private services. Mrs Candler, a Speech Pathologist, representing the Private Speech Pathologists' Association of WA, reported that:

> *we have over eight private speech pathologists in the area of Fremantle and Peel district and they are flat out, but they are working with crisis children. They are getting children who have LDCs down there that cannot cope, so they are dealing with children who have not been earlier identified in the major stream.*[169]

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167 Submission No. 29 (B), Department of Education and Training, July 2008, p 1.

168 Submission No. 29 (B), Department of Education and Training, July 2008, p 1.

169 Mrs Rosemarie Candler, Speech Pathologist, Private Speech Pathologists' Association of WA, *Transcript of Evidence*, 30 July 2008, p 6.

RUCSN in its submission supported this representation and suggested that "Some private speech pathologists in Perth's northern corridor are currently not accepting any new clients to their program, their waiting lists are closed."[170]

In other areas of the child health system, waiting lists are similarly managed by providing some children requiring longer-term treatment with an initial allocation of treatment sessions before reinstating them at the end of the waitlist, despite the need for the child's treatment to be ongoing. Such 'treatment churn' may be useful in managing waiting times and improving the statistics for service agencies, however the benefits are questionable in terms of a child's health outcome.

Unless the Department of Health's goal of providing an early detection and intervention policy is sustained with timely and effective follow up for ongoing treatment where appropriate, the benefits of undertaking early detection programs are lost. The waiting times also affect the private allied health professionals. Mrs McInnes, from RUCSN, gave evidence that "I have been involved in the OT profession for a long time and when I talk to other OTs nowadays there are many concerns about how long it is taking for children to access services, and I cannot remember that discussion being so common 15 years ago."[171] In reference to another allied health area, Hon Barbara Scott reported that in October 2005, 3,556 children were waiting for speech therapy across all health services in Western Australia.[172] Surprisingly, some regional areas seem to have faster access to some specialist health services for their children:

> *We have had a number of parents leave our school and move to the South West or metro areas. Many parents have rung us to complain that they have waited in excess of 6 months to see a therapist once a referral was activated and then waited at least another 6 months before a program was put into place. Hence, overall Eastern Wheatbelt access is very good – to date.*[173]

Hon Sue Ellery, the then-parliamentary secretary representing the Minister for Health, outlined the services provided in regional Western Australia:

> *There is no requirement in any of the regions of the WA Country Health Service for children to be assessed by a paediatrician prior to accessing therapeutic services. Referrals to the services are by a range of avenues – GP's, community nurses, other allied health professionals and directly by the general public i.e. parents and guardians. The only proviso is that parent/guardian consent needs to be gained prior to treatment.*
>
> *Kimberley - Paediatrician clinics operate on a 2-6 weekly basis. The elective waiting time to see the Paediatrician ranges between 0-6 weeks with an average of 2-3 weeks across the region.*

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170 Submission No. 7, RUCSN, 9 May 2008, p 8.

171 Ms Shirley McInnes, Resource Coordinator, RUCSN, *Transcript of Evidence*, 30 July 2008, p 3.

172 Legislative Council, *Questions Without Notice*, 22 June 2006, pp 4173d -4174a/1.

173 Submission No. 1, Bruce Rock District High School, 31 March 2008, p 1.

> *Pilbara Gascoyne – Paediatrician clinics operate on a 2-8 weekly basis. The elective waiting time to see the Paediatrician is up to 3 months.*
>
> *Midwest Murchison – The elective waiting time to access the visiting paediatric service is up to 10 weeks.*
>
> *Goldfields South East - There is a 5-6 week elective waiting time to see the Paediatrician.*
>
> *Wheatbelt – There is a monthly visiting paediatric service specifically provided for Aboriginal children in the Eastern Wheatbelt. All other children requiring referral to a Paediatrician are seen in the metropolitan area at the Women's and Children's Health Service or are seen privately.*
>
> *Great Southern – There is a 6-8 week elective waiting time to see the Paediatrician.*[174]

The WA Country Health Service provided evidence that "every town within the WA Country Health Service has access to child development services" but because of the widespread nature of the location of WA's population, many of those staff may be generalists in a multidisciplinary team, usually comprising a speech therapist, a physiotherapist and an occupational therapist (see Appendix Ten for a listing of services available in each region). The larger regional centres such as Albany, Geraldton and Bunbury do have specialised paediatric teams to provide child development assessment and management services but three of the seven WACHS regions, Goldfields, Pilbara and Midwest – all with high numbers of Indigenous children – don't. WACHS works closely with the CDS to provide tertiary services that can't be located in country towns.

> *Supporting that are the child development services in metropolitan Perth. We use a variety of intervention, either by phone or we may refer them down and fly them to more intensive specialist services in Perth. Video conferencing is increasingly being used. That is varied in its ability to be used appropriately. There are multidisciplinary teams throughout country WA.*[175]

The other concern in regard to waiting lists is how resource limitations have necessitated the practise of 'prioritising' children. The submission from Early Childhood Intervention Australia (WA) explained:

> *It is known that early childhood intervention service providers currently prioritise referred children for assessment and intervention differently. Hence, investigation into variations in prioritisation methods across service providers and potential impact of this for children with certain types of difficulties in the community* [is required].[176]

The DOH outlined their view on the prioritisation of services at CDCs:

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174 Legislative Council, *Questions On Notice*, 18 May 2005, pp 1805b-1809a/1.

175 Submission 30 (C), Department of Health, Response to Questions on Notice, 8 April 2009, p 4; Department of Health Officers, *Transcript of Evidence*, 8 April 2009, pp 6-8.

176 Submission No. 22, Early Childhood Intervention Australia (WA), 9 May 2008, p 3.

> *In terms of the way we are prioritising our service, clearly there is provision to target our services to children in the earliest years of their lives based on the significant body of evidence that says that is where you can have the most effective interventions.*
>
> *However, the prioritisation framework also allows for children of an older age group to be able to receive a priority 1 category due to the severity of their condition or if we are going to have a significant deterioration that would arise from delayed intervention. So, that will enable us to provide services more consistently, but within current resources it is a fairly limited capacity to meet the needs of that age group. There are other services that they can access, school services; if they are eligible for Disability Services Commission; if they are eligible for the child and mental health service; also I guess there is potential through the GPs to look for them to play more of an active role in terms of ongoing medical management, perhaps with some sort of consultative role from our paediatricians in supporting them in that.*[177]

The Department of Health described the current process underway to standardise the management of the 15 CDCs and four satellite services in the metropolitan area provided by the Child and Adolescent Health Service, including the prioritisation of children (see Appendix Eight) and the right of parents and schools to challenge a decision on a child's prioritisation:

> *We are currently in the process of developing a prioritisation framework for the child development service. That is in a final draft form, but we have not finished that yet. That will clearly set out the various priority categories for different children who are referred to our service and the reasons and the rationale for which they would receive a priority allocation in various categories. As part of the standardised processes that we are putting in place, we are also ensuring that we are providing consistent feedback to referrers; that would include providing feedback to families. And as part of the reform process, we are also starting to look at the issue of how people may be able to, if you like, appeal that decision and how we might respond, but we have not got to the detail of that yet.*[178]

Recommendation 13

That the Auditor General undertake a comprehensive review of the Department of Health, Child Development Service and School Health Services and table a report to Parliament. This report should detail figures and timeframes for all children awaiting services for early assessment and early intervention for health related issues and make recommendations on the numbers of additional personnel across the health professions that are required to tackle the current backlog and cater for the increased population in Western Australia.

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177 Ms Erin Gauntlett, Senior Portfolio and Policy Officer, Department of Health, *Transcript of Evidence*, 6 August 2008, p3.

178 Ms Erin Gauntlett, Senior Portfolio and Policy Officer, Department of Health, *Transcript of Evidence*, 6 August 2008, p 3.

The issue of constrained health budgets and waiting lists for access to health programs is a common one for patients of all ages, and in most jurisdictions. No witness provided evidence of what was being done in other jurisdictions to address similar issues. Clow *et al.* report that "There have been very few published studies reporting initiatives to reduce waiting times for child health services."[179] Lengthy waiting lists in most health systems have traditionally acted as a means for rationing care and capping budgets. However, Clow *et al.* report the results of an experiment in east London using a multi-disciplinary 'rapid response team' that slashed waiting times for children. A cooperative approach was adopted and operated within the hospital's existing resources and involved medical, nursing, managerial and administrative staff. The trial included:

- The identification of any bottlenecks, such as staffing and clinic space;
- The introduction of shorter consultation times (e.g. 30 minutes) where appropriate;
- Rationalisation and streamlining of time spent on documentation; and
- Undertaking a review of the accuracy of the existing waiting list.

Prior to the trial, the waiting times were similar to those here in WA, about 12 months on average. After their trial program, more than half of the children had been seen within two months.[180]The Committee has no additional information on this trial, and doesn't automatically support shorter consultations, but this trial does highlight the possibilities of dramatically shortening waiting lists if new approaches are taken.

The UK trial of using multi-discipline teams is similar to the 'trans-disciplinary' approach used by the Victorian Early Childhood Intervention Services. In this model "all team members (including the family) teach, learn and work together to accomplish a mutually agreed upon set of intervention outcomes. Individuals' roles are defined by the child and family needs rather than by the function of a specific discipline." The two key aims of this model are to prevent the fragmentation of services along disciplinary lines and any duplication of services. A key feature is its emphasis on the importance of the family as equal contributing members of the team.[181]

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179 Clow, D. *et al.* (2002) "Reducing waiting times associated with an integrated child health service", *The Journal of the Royal Society for the Promotion of Health*, Vol. 122, No. 4, p 249.

180 Clow, D. *et al.* (2002) "Reducing waiting times associated with an integrated child health service", *The Journal of the Royal Society for the Promotion of Health*, Vol. 122, No. 4, pp 245-250.

181 Department of Education and Early Childhood Development, "Early Childhood Intervention Services (ECIS) Program Framework", (2005). Available at: www.education.vic.gov.au/ocecd/docs/ecis_framework_2005.pdf, p 6. Accessed on 28 August 2008.

Finding 5

Other Australian and overseas jurisdictions have developed new approaches that have cut the waiting times in their child health sector.

Recommendation 14

That the Department of Health review experiences in other jurisdictions with a view to adopting strategies aimed at reducing waiting lists and times for children requiring services in respect of early assessment and early intervention for health-related issues.

5.5 Change initiatives already underway

(a) CDS Reform Project

The Child Development Services Reform Project was established by the Department of Health in November 2006 on the recommendation of the HRIT report and its primary goal is the "implementation of a single metropolitan Child Development Service (CDS)."[182] The reforms aim to improve working relationships with other agencies, including the WA Country Health Service, with whom a closer partnership is needed to "ensure consistency across the state".[183]

Some of the outcomes achieved to date include the establishment of a Consumer Perspectives Project (CPP) to obtain feedback from a wide variety of consumers and relevant professionals, and a Continuum of Care Framework (COC) to articulate CDS eligibility criteria for the full range of services they offer. Other achievements include the unification of the 19 Child Development Centres and the establishment of a memorandum of understanding between the CDS and the Disability Services Commission as well as a memorandum of understanding between the CDS and the Child and Adolescent Mental Health Service (CAMHS).[184] In addition, demographic profiling has been undertaken to identify areas of disadvantage and clinical pathways have been developed to define the screening procedures for a range of common conditions (see Appendix Nine for an example of such a pathway).

182 Submission No. 30 (A), Department of Health, Response to Questions on Notice, 24 July 2008, p 4.

183 Department of Health, "Child Development Services", (2008). Available at: www.health.wa.gov.au/hrit/childdevelopment/index.cfm, Accessed on 26 August 2008.

184 Ms Erin Gauntlett, Senior Portfolio and Policy Officer, Department of Health, *Transcript of Evidence*, 8 April 2009, p 8.

A new assessment and prioritisation system has been developed to address the problems with providing services to older children. This is described in Appendix Eight. Finally, from 2009 all parents are completing a Parent Evaluation of Developmental Status (PEDS) – a parent completed questionnaire covering five developmental domains that is already being used by 500 DOH staff. This form is based on one already used in NSW and planned to be used in other Australian jurisdictions. The PEDS has been written into the 2009 version of the school entry assessment form and similarly into the Personal Health Record ('purple book').[185]

The CDS Reform Project has addressed the critical issue of data management and has a centralised database system (CDIS) under development. Dr John Wray offered this alarming anecdote to highlight the importance of the new CDIS to improving the overall efficiency of the CDS:

> *I remind the committee that the majority of child development services in Perth have had no electronic database and have retained paper records. In the case of my centre, we have around 20,000 appointments per year, and all up the child development service in metropolitan Perth has 100,000 appointments a year, the majority of which we are unable to collate in any systematic fashion.*[186]

DOH concedes that "many of the ongoing CDS reforms will hinge upon the successful implementation of the Child Development Information System (CDIS), which will become the linchpin of the single service."[187] When asked by the Committee in August 2008 about the progress of the CDIS roll-out, Mr Mark Morrissey replied, "my vision and plan is we should have it ready to trial in 12 months [mid-2009]."[188] Mr Morrissey advised the Inquiry that the CDIS project used a web-based software from another jurisdiction, and he envisaged the project would be completed within the Department's current funding allocation.[189] Later evidence was provided to the Committee in April 2009 that the CDIS had been trialled at one CDS site and was due to be rolled out across all metropolitan CDCs by June 2009.[190]

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185 Ms Margaret Abernethy, Senior Portfolio and Policy Officer, Department of Health, *Transcript of Evidence*, 8 April 2009, pp 4-6.

186 Dr John Wray, Paediatrician, Special Interest Group of Physicians, *Transcript of Evidence*, 18 June 2008, p 8.

187 Submission No. 30 (A), Department of Health, Response to Questions on Notice, 24 July 2008, p 4 & p 26.

188 Mr Mark Morrissey, Executive Director, Child and Adolescent Community Health, Department of Health. *Transcript of Evidence*, 6 August 2008, p 2.

189 However, in a submission to the Community Development and Justice Standing Committee's *Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children* (27 February 2009, p 2), Dr John Wray suggests that the funds for the CDIS were provided by the PMH Foundation and not from the DOH budget.

190 Ms Erin Gauntlett, Senior Portfolio and Policy Officer, Department of Health, *Transcript of Evidence*, 8 April 2009, p 8.

Recommendation 15

Given the importance of improving data sharing within Western Australia's child health system, the Minister for Health should provide the Parliament with regular reports on the status of the roll-out of the Child Development Information System, advising of any major alteration to the completion date and need for additional funding.

The Reform Project seems to have engaged the opinions of many service providers and consumers to develop its strategic focus[191] and has begun to address the disjointed nature of the current system by bringing relevant state agencies together to develop the new streamlined clinical pathways. The new database could facilitate service planning and ensure that complementary Commonwealth schemes, such as *Australian Hearing*, are effectively utilised in WA (see Chapter Six for more detail on WA's child hearing screening programs). Productivity gains may also be possible through the centralised database's ability to identify areas of resource shortfalls. Child health services could be distributed more equitably across WA if the CDIS is used in conjunction with other strategic demographic information (such as that offered by the Australian Early Development Index (AEDI)). The AEDI will be examined in the following section.

Another likely outcome of the CDIS is that timely communication with parents should be improved via an automated booking and reminder service. Subsequent reductions in the current administrative burden could allow the relevant staff to dedicate greater time to personally contacting the families of 'at-risk' children that have been identified through the CDIS. DOH advised that "children and their families who need diagnostic assessment and specialist support will have the service provided by the right practitioner, in the right place and at the right time." [192]

Recommendation 16

The Department of Health should publish the Child Development Information System (CDIS) data on waiting lists in a way that assists:

i) parents making decisions about their child's health; and

ii) the professional allied health staff providing child health services in Western Australia.

Dr Wray cautiously endorsed the work of the Child Development Service (CDS) Reform Project. He said of the work completed thus far:

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191 The CPP survey obtained feedback from 662 current and former clients as well as 177 referring professionals. Submission No. 10 (B), Dr John Wray, 3 July 2008, p 10.

192 Submission No. 30, Department of Health, 16 May 2008, p 25.

> *The above elements of reform have not yet translated into measurable changes at a service level, however, each represents a significant body of work. Senior CDS staff have had considerable input into each element.*[193]

To ensure a better integration of future child health services, the recently established Memoranda of Understanding between the CDS and the Disability Services Commission, the CDS and the Child and Adolescent Mental Health Service and a draft MOU with the WA Country Health Service should urgently clarify legal issues around data sharing arrangements. In this way, a child's health record from birth through to the end of their schooling could be consistently and accurately maintained and shared between government stakeholders anywhere in WA. DOH reported that the *Commonwealth Privacy Act* does not allow data sharing between State agencies and the key issue was to have consent from parents to share information about their children. DOH said that it was working with DET on implementing a school enrolment form that required the signature of a child's parents to give the departments the legal status to share information.[194]

Recommendation 17

That the Government ensure that WA's future health and privacy legislation allows for the sharing between government agencies of data gathered by the Child Development Information System (CDIS), when it has been fully implemented.

DOH supplied diagrams that described the clinical pathways that the Reform Project team has established for some common conditions. While this work was urgently needed, the complex manner in which the pathways were presented suggested that the Continuum of Care Framework (COC) would need to be articulated in simpler terms to ensure that families and health workers could more easily understand them.

Recommendation 18

That the Department of Health ensure that the final version of the presentation of the clinical pathways is prepared in a way that makes them readily comprehensible to parents.

193 Submission No. 10 (B), Dr John Wray, 3 July 2008, pp 7-8.

194 Ms Sharon McBride, Senior Portfolio and Policy Officer, Child and Adolescent Community Health, *Transcript of Evidence*, 8 April 2009, pp 2-4.

(b) Australian Early Development Index (AEDI)

The Australian Early Development Index is an online tool that has been developed under the joint auspices of the Centre for Community Child Health at The Royal Children's Hospital Melbourne and the Telethon Institute for Child Health Research here in Perth. The AEDI is:

> *a population measure of children's developmental progress over the first five years of life. It is a measure of how children in their first year of schooling are doing in their:*
>
> *1. Language and cognitive skills,*
>
> *2. Physical health and well being,*
>
> *3. Communication skills and general knowledge,*
>
> *4. Emotional maturity,* [and]
>
> *5. Social competence.*[195]

The DOH *Policy Rationale* states that the most significant health problems of Western Australian school children relate to poor nutrition, unhealthy diet, lack of physical activity, alcohol, tobacco and other drug consumption, or unsafe sexual behaviour. Particular attention is drawn in the document to the trebling of child obesity rates over the past 20 years.[196] Demographic data from the Australian Bureau of Statistics (2003) and the Department of Health's publication *Population Data for WA Health Regions 2004* show that:

- 74% of school age children (SAC) live in the Perth metropolitan area.
- the local government areas (LGAs) with the highest proportion (16%-18%) of SAC are outer metropolitan areas of Wanneroo, Joondalup, Swan, Rockingham, Armadale and Kwinana.[197]
- LGAs with the lowest proportion of SAC are inner city areas such as Perth, Fremantle, Victoria Park, Vincent and Subiaco.
- regional areas with the highest proportion of SAC are the Kimberley (17.6%) and the Pilbara-Gascoyne (16.9%) regions.

Government schools are allocated a Socioeconomic Index (SEI) number based on ABS information and local school data such as parents' education and occupation, Aboriginality,

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195 Submission 31 (A), Centre for Developmental Health, 19 May 2008, p 3.

196 Injury is the highest cause of death of school-aged children, with falls in the home being the most common injury incurred.

197 More recent data from the ABS 2006 Census shows that the Canning Vale suburb within the Gosnells LGA has similar levels of SAC to these other LGAs.

household income and single parent families. Additional resources are allocated commensurate with a school's SEI rating.[198] The AEDI could be an important tool in providing timely data that allows DOH to better direct health interventions in regions and LGAs with greater child health needs.

The AEDI has been trialled in over 60 communities throughout Australia, including 22 LGAs within WA. The Federal Government has committed $20.2 million over five years towards a national roll-out of the AEDI.[199] This will allow the assessment of all five-year-olds in Australia during 2009. State governments are expected to provide the resources to support the establishment of program coordinators "to assist communities in making use of their AEDI findings."[200]

The AEDI is completed by a classroom teacher and results are anonymously compiled using a web-based interface. The AEDI doesn't report data on individual children but on the group of children living in a suburb or postcode area. This generates a community profile that allows communities, councils and state agencies to compare the relative school readiness of children living in that area. Communities are rated in terms of the proportion of children deemed to be 'developmentally vulnerable' in the five domains listed above. An additional indicator is provided to show the number of children either 'vulnerable' or 'performing well' in one or more domain.

CHILD Australia reported that the low scores in an early AEDI survey in some of the western suburbs of Perth resulted in a collaborative Early Years program involving schools, libraries, DOH and other early childhood services. The following AEDI survey in this area showed higher scores. This could indicate the effectiveness of the supported playgroups and other community activities provided for two and three-year-olds in the period before the later survey.[201] Appendix Twelve contains a sample AEDI report for the Rockingham LGA.

The AEDI offers the WA child health system several important benefits. Results can be used by communities to determine whether local approaches to child development are effective or in need of further modification. Secondly, it may give teachers an added opportunity to identify children who may require formal screening. Finally, AEDI community profiles allow policy makers to prioritise the localities where the provision of additional early intervention resources is most needed.

198 Department of Health. (2005) *Population Data for WA Health Regions 2004*, Department of Health, Perth.

199 Minister for Education, "Media Release", (2008). Available at: http://mediacentre.dewr.gov.au/mediacentre/Gillard/Releases/Earlychildhoodinitiativestobenefitindividualstheecommunityandtheeconomy.htm. Accessed on 24 September 2008.

200 Submission 31 (A), Centre for Developmental Health, 19 May 2008, p 2.

201 Submission from CHILD Australia to the Community Development and Justice Standing Committee's *Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children*, 27 February 2009, p 19.

Finding 6

The Australian Early Development Index is a population measure of children's developmental progress over the first five years of life and is not a screening tool for individual children. Its results should be used in conjunction with other data to ensure better health outcomes for children in regions and local government areas in Western Australia with greater child health needs.

Recommendation 19

That the Department of Health ensure that data on child health outcomes and resource shortfalls in Western Australia produced from the Australian Early Development Index is integrated with other data it collects, such as that held within the Child Development Information System.

5.6 Conclusion

The following chapters review the major domains of child health screening and assess them against the Inquiry's two terms of reference in light of the major challenges discussed in this chapter. The majority of submissions recommended that to promote best practice, child health screening should be conducted at an early age using standardised processes. The importance of early screening, and the scientific basis behind it, was well articulated by Ms Judy Walsh, from OT Australia:

> *Since the late 1990s Child Development Services around the world have responded to the Early Brain Development evidence, which requires that health, social and education services should identify children as young as possible in order to attain the most effective intervention outcomes.*[202]

Another submission supplied a *Sydney Morning Herald* article from a respected Australian economist, Mr Ross Gittins, who said that the best time for screening is "long before they get to school. Wait till kids turn eight and you've missed the bus."[203] While the ideal screening time varies according to the condition being tested, the general theme holds that the earliest intervention possible is critical to ensuring a positive outcome for a child's learning.

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202 Submission No. 20, Ms Judy Walsh, OT Australia WA, 8 May 2008, p 1.

203 Gittins, R. (2006) "Cast the Die Early and Reap the Rewards", *Sydney Morning Herald Online*, 22 March, www.smh.com.au/articles/2006/03/21/1142703349737.html received in Submission No. 7, Mrs Shirley McInnes, RUCSN, 9 May 2008.

The importance of standardised testing has been quantified by a US research project conducted by developmental paediatricians, Katherine TeKolste and Sam Zinner, whose findings suggest that:

> *Without use of standardized tools only 30% of children with developmental disabilities are identified. This rises to 70-80% of children identified when standardized tools are used.*[204]

Standardised testing plays a key role in reducing the level of subjectivity exercised during any diagnostic process, such as testing for speech and language delays.[205] Subjective assessments can lead to misdiagnosis and subsequent mistreatment of conditions, which can be costly to both a child and their family, as well as costly for the health system. Conditions such as Attention Deficit Hyperactivity Disorder (ADHD) are particularly susceptible to misdiagnosis.[206]

Like many other governments in the OECD, and consistent with the recommendations of the NHMRC report, Western Australia has adopted a screening program that has moved beyond a reliance upon general testing to one that places an increasing emphasis on health surveillance and promotion strategies incorporating greater input from, and interaction with, parents and caregivers. Advocates of the new approach argue that it can improve diagnostic accuracy by reducing the incidence of 'false positives' and 'false negatives' (see Appendix Three for more information on screening and surveillance). It is important to note that parental feedback is crucial to this process, as it is seen as a more reliable indicator of children's developmental problems.[207] Yet the concern here is that the children of parents who struggle to recognise developmental difficulties, often

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204 Washington State Medical Home, "Developmental Surveillance & Screening: Monitoring to Promote Optimal Development", (2006). Available at: www.medicalhome.org/physicians/dev_surveillance.cfm. Accessed on 1 August 2008.

205 However, it is important to note that this risk is not always negated, as the parameters used for standardised testing may not be objectively derived.

206 Education and Health Standing Committee. (2004) *Report No. 8: Attention Deficit Hyperactivity Disorder in Western Australia*, State Law Publisher, Perth. pp 36-39.

207 Submission No. 22, Early Childhood Intervention Australia, WA, 9 May 2008, p 2.

those from low socio-economic status families, are vulnerable to having their conditions remaining undiagnosed.[208]

The optimal age and processes used for assessing developmental delay vary markedly according to the sensory domain. Several submissions argued that evidence-based best practice (such as that provided in the NHMRC report) suggested it was better not to offer any screening process if it could not be appropriately serviced.[209] The Committee does not agree with this view and prefers to focus on strategies aimed at overcoming the system's current challenges. A number of strategies that are cost effective and can be implemented relatively quickly are examined in more detail in Chapter Ten.

208 This was the experience of several witnesses to the Inquiry. See for example: Submission No. 7, Mrs Shirley McInnes, RUCSN, 9 May 2008, p 7; Dr Phil Ridden, School Head, St Stephen's School, *Transcript of Evidence*, 30 July 2008, p 2.

209 Submission No. 20, Ms Judy Walsh, OT Australia WA, 8 May 2008, p 1; Submission No. 26, Professor Peter Howat, Public Health Association of Australia, WA Branch, 8 May 2008, p 1.

CHAPTER 6 HEARING

6.1 Terms of Reference 1 – adequacy and availability

In terms of optimal timing, Associate Professor Harvey Coates advised that neonatal hearing testing enables the "early detection of and rehabilitation of children with mild, moderate, severe or profound sensori neural hearing loss."[210] He added that testing at regular intervals in the early years also had significant merit because the number of children who "start with normal hearing and then progress to hearing loss as they get older, or they acquire hearing loss through meningitis, mumps or measles or head injury, doubles by age five and triples by age 10."[211] The need for testing at regular intervals is particularly important for Indigenous children (see Chapter 4.3 (a) above).

Deafness Forum Australia reinforced the value of neonatal screening for hearing, claiming that "children who enter early intervention before six months of age will have the greatest opportunity to achieve their fullest potential across all developmental domains."[212]

The DOH, through its Child and Adolescent Health Service, offers a "limited newborn hearing screening program",[213] which is available at King Edward Memorial, Joondalup, Osborne Park, Rockingham, Armadale and Princess Margaret Hospital's Neonatal Unit. Outside of the newborn program, a hearing assessment is offered at three-and-a-half years of age under the Department's *Birth to School Entry Universal Contact Schedule Policy* (UCS), if concern has been expressed by a parent or health professional. Otherwise, a child can access a school entry assessment, although this may not be conducted until Year One. The alternate option for parents is to utilise the Telethon Speech and Hearing's WA Infant Screening for Hearing Program (WISH),[214] a private testing service that currently costs $65.

Formal testing in schools is conducted using an audiogram in a quiet room, a standardised method that appears to be widely accepted. However, the Committee received evidence that the current 'pass-level' for screening (25 decibels) could be lowered to 20 decibels to improve the accuracy of results. While not always practical, especially for school assessments, results would be enhanced if tests were conducted in specialised sound-treated audiology booths, such as those available in the Variety Club's Ear Bus.[215]

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210 Submission No. 3, Associate Professor Harvey Coates, 17 April 2008, p 1.

211 Associate Professor Harvey Coates, Paediatric Otolaryngologist, Princess Margaret Hospital for Children, *Transcript of Evidence*, 6 August 2008, p 3.

212 Submission No. 19, Deafness Forum of Australia, 9 May 2008, p 3.

213 Submission No. 30, Department of Health, 16 May 2008, p 11.

214 Submission No. 16, Telethon Speech and Hearing, 9 May 2008, p 8.

215 Submission No. 18, Gabi Levi, 9 May 2008, p 1; Submission No. 3, Associate Professor Harvey Coates, 17 April 2008, p 2.

6.2 Terms of Reference 2 – access to appropriate services

While one in six Australians has some form of hearing impairment (projected to increase to one in four by 2050[216]) corrective technology is now available for many infant hearing conditions. There are three forms of intervention available once a child is diagnosed with a hearing loss:

- Hearing devices;
- Language and communication intervention; and
- Assistive technology devices (usually in older children and adults).

Associate Professor Coates advised of recent tests that showed that children who receive cochlear implants "before age 12 months have virtually 'normal' speech and development."[217] He added that these implants, and other devices, are now available through funding provided by the Commonwealth under the *Australian Hearing* program.[218] *Australian Hearing* provides services to 1,252 children in Western Australia. yet, evidence was provided that the benefits of this scheme are not being fully realised within WA. Deafness Forum Australia reported that for 2007 "of an estimated 34 babies with hearing loss expected at the rate of 1.2 per 1,000 births, *Australian Hearing* only fitted nine WA babies with hearing aids by 12 months of age."[219]

Failure to utilise national remedial initiatives is not surprising, given the lack of coordination identified within the local child health system in previous chapters. A stakeholder group, commissioned by DET in response to this Inquiry, found that in addition to the shortcomings in the State's current screening processes, there was "a time delay for services being provided….there is also a lack of follow-up to ensure that parents/carers have the capacity and commitment to access treatment."[220] Associate Professor Coates advised that:

> *The wait list at Princess Margaret Hospital for Children to be seen in Outpatients varies between 5 and 6 months and if ventilation tubes (grommets) are required then it may take another 6-12 months for this to be arranged.*[221]

Of further concern is the limited geographical availability of the current screening service. The highest estimate was that the current newborn hearing screening (NHS) program covers only 49% of babies.[222] This rate is well below the national average (see Table 6.1 below).

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216 Submission No. 19, Deafness Forum of Australia, 9 May 2008, p 1.

217 Submission No. 3 (A), Associate Professor Harvey Coates, 23 July 2008.

218 Associate Professor Harvey Coates, Paediatric Otolaryngologist, Princess Margaret Hospital for Children, *Transcript of Evidence*, 6 August 2008, p 4.

219 Submission No. 19, Deafness Forum of Australia, 9 May 2008, p 6.

220 Submission No. 29, Department of Education and Training, 21 May 2008, pp 6-7.

221 Submission No. 3, Associate Professor Harvey Coates, 17 April 2008, p 3.

222 Submission No. 30, Department of Health, 16 May 2008, p 11.

Table 6.1 Comparison of newborn hearing screening in Australian jurisdictions[223]

State	Screening status	Coverage of births	Year of data
WA	Partial	~49%	2002-03
NSW	Universal	>95%	2002
VIC	Partial	~30%	2005
QLD	Universal	>97%	2004
SA	Universal	>95%	2003

Associate Professor Coates told the Committee that Western Australia and Victoria were the only two states yet to achieve the 95% level of coverage that satisfied the definition of 'universal' screening.[224] However, the Victorian Government has committed to ensuring that all newborns are screened by the end of 2010.[225] Deafness Forum Australia suggested that access to hearing screening services for isolated communities and regional areas remains problematic, with the current services restricted to predominately metropolitan sites. Rural families faced prohibitive travel costs to access appropriate specialist facilities.[226]

Associate Professor Coates was troubled that current systemic gaps meant that children who miss the neonatal examination may not be tested until they reach school.[227] He argued that such scenarios are "not acceptable in the twenty-first century." [228] A state-wide universal neonatal screening program can be established without an excessive budgetary increase. DOH confirmed that a universal newborn screening service had been costed at $9.2 million over an initial four-year period and included all the follow-up services that flow from it.[229] A business case for a universal neonatal screening program had been prepared for Government that included a phased approach to implementation throughout rural and regional WA, hence reducing current geographical inequities:

> *The resources to raise Western Australian hearing screening, because of the size of our state, will involve initially obtaining the appropriate equipment and staff and people to teach and arrange for dissemination of information about the program throughout the*

223 Submission No. 19, Deafness Forum of Australia, 9 May 2008, p 4.

224 Associate Professor Harvey Coates, Paediatric Otolaryngologist, Princess Margaret Hospital for Children, *Transcript of Evidence*, 6 August 2008, p 2.

225 Submission No. 16, Telethon Speech and Hearing, 9 May 2008, p 7.

226 Submission No. 19, Deafness Forum of Australia, 9 May 2008, p 6. On the other hand, Associate Professor Coates said that mobile services like the Variety Club's *Ear Bus* were doing highly commendable work in remote areas, Associate Professor Harvey Coates, Paediatric Otolaryngologist, Princess Margaret Hospital for Children, *Transcript of Evidence*, 6 August 2008 p 3.

227 Submission No. 3, Associate Professor Harvey Coates, 17 April 2008, p 1.

228 Associate Professor Harvey Coates, Paediatric Otolaryngologist, Princess Margaret Hospital for Children, *Transcript of Evidence*, 6 August 2008, p 3.

229 Mr Mark Crake, Acting Director, Child and Adolescent Community Health, Department of Health, *Transcript of Evidence*, 11 June 2008, p 6.

> *state. Therefore, initially, in the first year of the three-year business plan that was submitted to the health department, the other parts of the city would have screening. For example, Swan District Hospital, where there is no screening done, would have screening started at that hospital in the birthing unit, and then it would go to the major centres in the country, and at the end of three years every birthing unit that produces more than, say, 100 births a year, or perhaps fewer, would have the ability to do newborn hearing screening.*[230]

DOH reported in later evidence that planning had commenced for the introduction of a universal neonatal hearing testing scheme at "all public birthing hospitals in WA" within two years, using existing departmental resources.[231] Associate Professor Coates suggested that the newborn screening program could be expanded through the training of midwives and maternity nurses:

> *If they are brought in on their regular job, instead of doing their midwifery work, they will actually be handling the babies and putting the equipment into the ear. It is non-invasive. It takes less than 20 minutes usually, and it is not threatening at all to the child. It is a fairly straightforward procedure.*[232]

The training of midwives and maternity nurses to undertake hearing tests removes the onus of testing from doctors and specialists who can dedicate their time to a child's remedial needs. If similar training was extended to Child Health Nurses, hearing screening could take place in the kindergarten year in order to capture children whose hearing had deteriorated since childbirth after a number of years of having middle ear fluid. Using these staff in this fashion reduces the likelihood of developmental delays impeding learning at school, and is cost-effective.

Finding 7

The benefits of introducing a universal neonatal hearing screening program in Western Australia would far outweigh the costs of such a program, as has been shown in other Australian jurisdictions.

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230 Associate Professor Harvey Coates, Paediatric Otolaryngologist, Princess Margaret Hospital for Children, *Transcript of Evidence*, 6 August 2008, p 2.

231 Submission 30 (C), Department of Health, Response to Questions on Notice, 8 April 2009 p3; Mr Mark Crake, Director, Child and Adolescent Community Health, Department of Health, *Transcript of Evidence*,, 8 April 2009, p 14.

232 Associate Professor Harvey Coates, Paediatric Otolaryngologist, Princess Margaret Hospital for Children, *Transcript of Evidence*, 6 August 2008, p 2.

Recommendation 20

That the Government provide additional funds of approximately $10 million for the Department of Health to implement a universal neonatal hearing screening program in Western Australia by 2013.

Recommendation 21

That the Department of Health assess the ability of midwives, Child Health Nurses and maternity nurses to be trained to carry out the greater number of neonatal hearing screening tests that will be required under the new universal testing scheme being implemented in Western Australia.

Indigenous hearing testing

The Department of Health reported that there are a number of service providers offering an extended version of the hearing screening to Indigenous children throughout Western Australia. However, there currently is no central coordination of these activities and it is difficult for DOH to assess the proportion of children who are receiving this service. An evaluation in 2008 of the School Entry Health Assessment program found that only 70% of Aboriginal children received health assessments by Year One.

Within metropolitan Perth, the service providers for hearing testing of Indigenous children include Derbarl Yerrigan, the Ear Bus (see below), and the Child and Adolescent Community Health (CACH) Ear Health team. Currently the CACH Ear Health team offers a universal extended screening service only to Indigenous children in schools with a high Indigenous enrolment in the South Inland and Coastal Zones of the metropolitan area. The uptake of these services range between 50% and 83% of the potential Indigenous population. Children who are identified as having a hearing concern are followed up and monitored or referred to other services.

Within the WA Country Health Service (WACHS), extended hearing screening is offered to Indigenous children by a number of different providers including the Department of Health's own school health and child health nurses, the visiting Australian Hearing Services, and local Aboriginal Health Service teams. Due to the lack of an integrated data system, it is not possible to identify the proportion of children who receive this service, or those who miss out.[233]

233 Submission 30 (C), Department of Health, Response to Questions on Notice, 8 April 2009, p 3.

Recommendation 22

The Child Development Information System (CDIS) project should be urgently expanded so that data on the screening programs delivered to Indigenous children, especially hearing screening, can be gathered across the State.

6.3 Non-government programs

Ear Bus

Associate Professor Coates reported that the Variety Club of Western Australia has provided an *Ear Bus*, which costs about $125,000, to do hearing screening, particularly in the low SES suburbs of Perth. Another one will shortly be based in Bunbury. In New Zealand there are 13 Variety Club ear buses, with the staffing provided by the NZ health department. The program is able to provide ENT surgeons to undertake 'grommet blitz' procedures if children need them. The Variety Club is planning on providing one bus per year to each region in WA.[234] The Perth Primary Care Network has applied for funding for a similar program called *Ear Doctor* to provide mobile medical assistance "from a multidisciplinary team including a GP" to work alongside the Ear Bus program when it visits schools and communities.[235]

234 Associate Professor Harvey Coates, Paediatric Otolaryngologist, Princess Margaret Hospital for Children, *Transcript of Evidence*, 6 August 2008, p 3.

235 Submission No. 24, Perth Primary Care Network, 9 May 2008, p 3.

CHAPTER 7 VISION

7.1 Terms of Reference 1 – adequacy and availability

Dr Margaret Crowley, Chief Executive Officer with the Association for the Blind of WA, argued that "screening around the age of two-and-a-half to three years is very important in identifying a wide range of health and developmental issues, including vision development." She added that the best time to detect amblyopia, or 'lazy-eye', "the most common cause of preventable visual impairment in children", is around the age of three.[236]

In a similar vein to its hearing procedures, the Department of Health (DOH) offers a neonatal visual screening assessment as part of its general health check. Following this, parents can access a limited screen, the 'Bruckner Red Reflex Test', which the DOH says is "used to detect mild cataract, small angle strabismus and refractive errors."[237] However, this test is only offered at six to eight weeks, and then three to four months of age. The next formal test is offered as part of the School Entry Health Assessment (SEHA). Under the Universal Contact Schedule, DOH has removed its former vision assessment for three-year-olds, claiming that 'emerging evidence' showed that the optimum age for screening was four-and-a-half.[238] It is only via the expressed concern of parents or health service staff that additional screening will be offered before the SEHA.

In Western Australia, the DET stakeholder group found that there was "limited availability and frequency of services, particularly in regional and remote areas."[239] In terms of adequacy and availability of vision screening, a major source of contention is the timing of the services. The concern is the gap between the Bruckner Test and the school entry assessments. Dr Crowley challenged the logic behind the decision to remove the examination for three-year-olds. As a result of this decision, "many children with low vision are not detected until poor school performance alerts parents and teachers."[240] Clear vision is essential to many early-education activities and a failure to recognise sight disorders at an early age increases the vulnerability of children to learning difficulties. Earlier testing would help alleviate this risk, as conditions like amblyopia, a major cause of visual handicaps in infants, are detectable and preventable in this younger cohort.

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236 Submission No. 12, Dr Margaret Crowley, Association for the Blind of WA, 7 May 2008. p 1.

237 Submission No. 30 (A), Department of Health, Response to Questions on Notice, 24 July 2008, p 14.

238 Submission No. 30 (A), Department of Health, Response to Questions on Notice, 24 July 2008, p 15.

239 Submission No. 29, Department of Education and Training, 21 May 2008, pp 9-10.

240 Submission No. 12, Dr Margaret Crowley, Association for the Blind of WA, 7 May 2008. p 1.

Recommendation 23

That the Department of Health review its decision to remove the vision screening test for three-year-olds, as such a test would give affected children a better chance of receiving remedial treatment prior to their commencing school.

The Committee heard little contention over the modality of current vision assessments. A recent Australian study found there is little consistency in how and when vision screening is conducted in Australian jurisdictions. It found inconsistencies in the number of vision checks, age at which screening is conducted, the tools or procedures that are used, the personnel who conduct the screening and the referral pathways used to follow up screening results. Evidence on the prevalence rate of common vision conditions in children was inconsistent, ranging from 1.4% to 3.6% for amblyopia, 0.3% to 7.3% for strabismus, and 1% to 14.7% for refractive error.[241]

7.2 Terms of Reference 2 – access to appropriate services

There are a variety of government and non-government services providing treatment of visual impairments in children. The Department of Education and Training's Vision Education Service (VES) provides support to 26 students across the state with vision impairment. Services are delivered in their home, and in both public and private schools. This support includes a visiting teacher service to support teachers, the provision of materials in alternative formats and necessary hardware and software to support students. The DET stakeholder group added that remedial services in the visual health area lacked coordination and that time delays 'from diagnosis to treatment' could be reduced.[242]

Finding 8

Children living in Western Australia's rural and regional areas have limited access to therapies to deal with vision conditions. Multi-disciplinary teams consisting of government and non-government organisations could service these needs and such a process would result in lower costs, improved sharing of resources and improved service delivery.

241 CCCH. (2008) *National Children's Vision Screening Project- Discussion Paper*, prepared by the Murdoch Children's Research Institute for the Department of Health and Ageing, Centre for Community Child Health, Melbourne, p 1.

242 Submission No. 29, Department of Education and Training, 21 May 2008, pp 9-10.

Recommendation 24

That the Department of Health and Department of Education and Training develop greater collaboration between service providers to review the possibility of multi-disciplinary teams, consisting of government and non-government organisations, to service the vision needs of children in rural and remote areas.

7.3 Non-government programs

The Association for the Blind WA provides access to various allied health services for children with vision difficulties. Clinical services are provided by the Lion's Eye Institute, Princess Margaret Hospital (PMH) and local GPs. The Association for the Blind WA said that there were concerns over the waiting times at PMH, the main provider of clinical services.[243]

A reverse integration approach

The Association for the Blind WA advised that it undertakes a 'reverse integration' approach by operating a kindergarten program that provides specialist services for children with vision impairment. The kindergarten has five places for children with vision impairment, and up to 10 places for other children from the local community.[244]

The Association provided evidence of a joint initiative with the Lions Eye Institute in developing a computer-based vision assessment tool in order to screen for a number of eye conditions. The assessment tool is presently suited to both school-age children and adults, with further development likely to enhance the tool's capacity to incorporate younger children.[245]

243 Submission No. 12, Dr Margaret Crowley, Association for the Blind of WA, 7 May 2008. p 2.

244 Submission No. 12, Dr Margaret Crowley, Association of the Blind WA, 9 May 2008, p 3.

245 Submission No. 12, Dr Margaret Crowley, Association of the Blind WA, 9 May 2008, p 2.

CHAPTER 8 SPEECH AND LANGUAGE AND FINE MOTOR SKILLS

8.1 Terms of Reference 1- adequacy and availability

Many witnesses suggested that the ideal screening age for speech, language and fine motor skills is in the kindergarten year (between the ages of three-and-a-half and four-and-a-half). Professor Zubrick from Curtin University was unequivocal in his response, "the best age to screen for a primary language disorder is at age four."[246] Occupational therapist, Ms Gayle Hillen, made similar observations regarding fine motor skills:

> *We look at kindy-aged children now because there is increasing evidence that is coming through saying that early intervention is the key. If we can identify problems at a kindy age for these children….then we can get them the services that they need far quicker.*[247]

Early testing is essential, as without proven competencies in these spheres, children will lack the fundamental foundations for early literacy and learning that will be expected of them upon entry into the formal school environment.[248] Dr Ridden gave evidence on the magnitude of the learning difficulties children with motor skills deficiencies face in primary school. As part of his comments on the adverse impact that long hours in child care may have on a child's language and motor skills development, he said:

> *There are problems for some kids in physical development. That includes such things as sight and hearing-sensory development, if you like-but it also includes simple muscle development and muscle tone. Kids do not go out playing on play equipment. They do not climb trees and things like that. We have kids who have great difficulty sitting at a desk and trying to write. Obviously, that is not something we make them do to a great degree at a very young age, but it is part of that whole development thing.*
>
> *... Holding a pen and sitting in a chair require certain bodily strengths. In a lot of families, kids do not do that. They lie on floors; they lie around on lounge chairs and so on watching television.*[249]

The School Psychologists Association of Western Australia noted that deficiencies in language and motor development also increased the likelihood of 'poor peer relations', failure at school, and the potential for later delinquent and criminal behaviours. Moreover, there was the heightened risk

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246 Prof Stephen Zubrick, Head, Division of Popular Sciences, Curtin University of Technology, Centre for Developmental Health, *Transcript of Evidence*, 30 July 2008, p 2.

247 Ms Gayle Hillen, Occupational Therapist (Private), representing OT Australia (WA), *Transcript of Evidence*, 30 July 2008, p 3.

248 Submission No 21, Speech Pathology Australia, 9 May 2008, pp 1-3.

249 Dr Phil Ridden, School Head, St Stephen's School, *Transcript of Evidence*, 30 July 2008, p 3.

of "developing emotional and behavioural disorders."[250] When asked whether appropriate screening, conducted at an early age, could avert the onset of these subsequent behavioural disorders, Ms Hillen advised:

> *I think that is very true. Certainly, we have seen that if children are left with the developmental difficulties they experienced at the age of three-and-a-half, and they are still experiencing the same difficulties at the age of seven years, the difficulties will have become far more complex because a behavioural overlay comes into being. Often by this age children have lost self-esteem and will try to rectify things because everything has been so hard for them for all those years.*[251]

DET confirmed that "there are currently no universal, standardised screening processes in place" for speech and language or motor skills testing.[252] The School Entry Health Assessment (SEHA) does include some language items but, according to Speech WA, these "may not be sensitive to the range of communication difficulties presented."[253] An evaluation of the SEHA found that only 25% of the children had been assessed for speech and language, compared to over 98% for vision and hearing.[254] Schools can employ their own speech pathologists to undertake testing but these assessments are not standardised. For pre-school children, from 2009 the Universal Contact Schedule (UCS) offers Parent Evaluation of Developmental Status (PEDS) questionnaires containing "two specific questions relating to speech and language. If a parent or nurse is concerned about the child's speech and language, then brief interventions/support and referral processes are put in place."[255]

Motor skills are subject to a similar evaluation program as speech and language, although there is an opportunity for parents to have their children's early motor development observed at six to eight weeks of age as part of the UCS. This test allows the baby's 'posture, tone and development' to be measured against a checklist.[256] After this time, the UCS offers no formal screening for motor skills, unless parental or teacher concern is expressed.

The adequacy of the current screening methods for these conditions, and their timing, was strongly criticised. With the limited speech and language screening services offered as part of the UCS, the onus is on teachers or concerned parents to determine whether formal assessments are required.

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250 Submission No. 15, Mr Stuart McKenzie, School Psychologists Association of Western Australia Inc, 9 May 2008, p 2.

251 Ms Gayle Hillen, Occupational Therapist (Private), representing OT Australia (WA), *Transcript of Evidence*, 30 July 2008, p 7.

252 Submission No. 29, Department of Education and Training, 21 May 2008, p 4.

253 Submission No. 23, Speech WA, 9 May 2008, p 1.

254 Submission No. 30 (C), Department of Health, Response to Questions on Notice, *School Entry Health Assessment Program- Statewide Evaluation 2008*, 8 April 2009, p 1.

255 Submission No. 30 (A), Department of Health, Response to Questions on Notice, 24 July 2008, p 18.

256 Submission No. 30 (A), Department of Health, Response to Questions on Notice, 24 July 2008, p 13.

Many teachers are either insufficiently trained to make such assessments, or are not in possession of reliable screening tools that have been developed for this purpose.[257]

Similarly, the one-off developmental assessment for motor skills that is offered under the UCS is dependent upon the quality of parental feedback and the expertise of the assessing nurse. Equally troubling is the fact that any testing that is undertaken is often not conducted at the optimal age. As a result, children with developmental delays that could have been identified and referred for treatment at an earlier stage are reaching the school environment predisposed to learning difficulties.

Finding 9

The current screening methods for speech, language and motor skills are even less adequate than that provided for hearing and vision.

8.2 Terms of Reference 2 – access to appropriate services

Speech and language difficulties

The deficiencies highlighted in the speech and language screening processes are compounded by remediation services that Speech Pathology Australia described as "inadequate and inconsistent".[258] A number of submissions provided anecdotal and quantitative evidence in support of this view.

The Child Development Service has only five Language Development Centres, each with a client capacity of 200 places, to treat children with speech and language disorders. All of these centres are in the metropolitan area.[259] The demand for LDC services far exceeds the supply of available positions, meaning that those children with the most severe conditions are given priority. Speech WA advised the Committee that children with disorders that do not meet the eligibility criteria for these services are particularly vulnerable. In these circumstances:

> *parents have no other option in the public system than to enrol their child in a local Primary school in a regular mainstream classroom of age peers….[Yet] their speech and*

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257 Prof Stephen Zubrick, Head, Division of Population Sciences, Curtin University of Technology, Centre for Developmental Health, *Transcript of Evidence*, 30 July 2008; Submission No. 15, Mr Stuart McKenzie, President, School Psychologists Association of Western Australia Inc, 9 May 2008, p 2. The architect of the MELS screening tool (see chapter 8.3 below), Lynne Middleton, argued that this system has produced a very low number of false-positive diagnoses.

258 Submission No. 21, Speech Pathology Australia, 9 May 2008, p 5.

259 Submission No. 21, Speech Pathology Australia, 9 May 2008, p 4.

> *language impairment still impacts the ability to perform successfully in a regular mainstream classroom setting.*[260]

Where children with disorders are discovered in the school system, the DOH speech therapists may only be "able to provide one school visit for the purpose of a teacher and family case conference."[261] Some schools, as a consequence, have entered into private arrangements to hire their own speech therapy services.[262] Schools can seek the services of one of the DET Support Officers for Speech and Language (SOSL) who are based in district offices. However, the small number of SOSL staff available means that access to these services is limited. Where available, these language specialists can provide professional development for teachers and assist with the development of Individual Education Plans (IEPs) for children. An IEP identifies a child's strengths and weaknesses and details appropriate goals and objectives. SOSL does not extend to assistance with instruction for children in the classroom.

The *Baby Talk* program is offered by some Child Health Teams in the metropolitan area. It involves a pre-language screening by a Child Health Nurse when a baby is eight months old. If the child is not displaying the communication behaviours expected at this early age the family are referred to a team of two speech pathologists who work with the family in order to help the parents recognise and respond to the child's communication cues. This program, also known as the *WILSTAR* program, originated in the UK, where research showed it to be an effective method of promptly addressing potential language disorders in young children.[263] Evidence from the WA *Baby Talk* program has produced similar results; with speech pathologists reporting that usually only four interventions are required for positive results to be achieved.[264] Alternatively, for children of pre-primary age, there are opportunities within Child Development Service Centres to receive therapy sessions, but waiting times for these can be as long as 12 months. Moreover, some centres limit the treatment to five sessions in order to cope with the demand.[265]

Finally, direct access to private services is available. However, the costs involved are likely to challenge the finances of many lower SES families. Curtin University, Bentley Health Service, Therapy Focus, some country health services and a small number of private speech pathologists provide paid screening services to a very limited number of government schools.[266] Dr Phil Ridden, Head of the Primary School at St Stephen's School, Carramar Campus, reported "a

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260 Submission No. 23, Speech WA, 9 May 2008, pp 3-4.

261 Submission No. 20, Ms Judy Walsh, OT Australia WA, 8 May 2008, p 2.

262 Submission No. 21, Speech Pathology Australia, 9 May 2008, pp 2-3.

263 BBC, "Boosting baby's IQ? It's all talk", (2009). Available at: http://news.bbc.co.uk/1/hi/health/193239.stm. Accessed on 23 April 2009.

264 Submission from CHILD Australia to the Community Development and Justice Standing Committee's *Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children*, 27 February 2009, p 12.

265 Submission No. 21, Speech Pathology Australia, 9 May 2008, p 4; Submission No. 7, Mrs Shirley McInnes, RUCSN, 9 May 2008, p 6; Submission No. 23, Speech WA, 9 May 2008, p 4.

266 Submission No. 21, Speech Pathology Australia, 9 May 2008, p 3.

referral for speech or language delay costs around $400, and, if a course of therapy is required, this can quickly amount to a further $1,000."[267] The Speech WA submission argued that, even if timely screening was conducted, "the inadequacy of access to appropriate services wastes the opportunity to prevent difficulties from jeopardising literacy and learning levels."[268] This was a common theme throughout the Inquiry, but concern was greatest in this domain of health. The HRIT report also highlighted the disproportionate demand for speech pathology services (see Appendix Five) compared to other health domains.

Finding 10

Access to remedial treatments for children with speech and language difficulties is fragmented, inadequate and unacceptable in all regions of Western Australia.

Recommendation 25

That the Government give a high priority to provide additional staff and other resources to address the current inadequacies in Western Australia's speech and language services.

Motor skill difficulties

Appropriate remedial services exist for children with motor skill difficulties. However, they are difficult to access without resorting to private sector services. DET did not quantify current delays but conceded that there is a "lack of specialist staff to provide required services when students have been identified."[269] The RUCSN submission claimed that there was a delay of between six and nine months to access occupational therapists and physiotherapists for a post-screening assessment, let alone to begin a course of remedial treatment.[270] This situation they rightly described as 'unacceptable', both in terms of the child's welfare and the ability of the family to cope with such developmental difficulties.

267 Submission No. 25, Dr Phil Ridden, 12 May 2008, p 3.

268 Submission No. 23, Speech WA, 9 May 2008, p 2.

269 Submission No. 29, Department of Education and Training, 21 May 2008, p 14.

270 Submission No. 7, Mrs Shirley McInnes, Resource Manager, RUCSN, 9 May 2008, p 6.

8.3 Non-government programs

Cluey Coastal Kids

The *Cluey Coastal Kids* program is a partnership between the City Beach Primary School and the Departments of Health and Education and Training. It is a language and skill development program for pre-kindergarten children and their parents. The program is delivered through an interactive story-telling session presented by a team consisting of an early education teacher and a speech pathologist. Funds are provided by the school Parents and Citizens group to pay for the allied health professionals who participate in the program. Evidence was given of similar programs running at other government schools, including primary schools in Wembley (who have an occupational therapist who works in the program), Claremont and Mosman Park.[271]

Communication Capers

Willandra Primary School in Armadale has trialled a three-year long program in its Pre-Primary and Kindergarten units known as *Communication Capers*. It was described by teachers at the school as an 'excellent program', as all children in the Kindergarten and Pre-Primary units were screened by a speech pathologist. Children requiring treatment were then referred on to a speech therapist at the local Community Health Clinic.[272]

Let's Read

Let's Read is a national initiative launched in 2005 to promote reading with young children aged six months to five years and was developed by the Centre for Community Child Health (Murdoch Children's Research Institute) in partnership with The Smith Family.[273] It has been designed to encourage and empower parents and carers to read with their children, and to make the transition to school as easy as possible.[274] It was described as 'promising' by a study on effective interventions for children with language and learning difficulties.[275]

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271 Mrs Rosemarie Candler, Speech Pathologist, Private Speech Pathologists' Association of WA, *Transcript of Evidence*, 30 July 2008, p 2.

272 Submission No. 6, Willandra Primary School, 7 May 2008, p 1.

273 The State Library of WA initiated in 2004 the *Better Beginnings* program which aims to encourage parents to read to their children as early as possible. State Library of WA, "Books Build Better Futures", (2007). Available at: www.better-beginnings.com.au/. Accessed on 14 April 2009.

274 Let's Read, "Overview", (2008). Available at: www.letsread.com.au/pages/overview.php. Accessed on 2 September 2008.

275 Centre for Health Service Development, "Strategies for Gain—the evidence on strategies to improve the health and wellbeing of Victorian children", (2005). Available at: http://chsd.uow.edu.au/Publications/2005_pubs/Strategies%20for%20gain_Vic%20Kids_CHSD_final_March05.pdf, page xi. Accessed on 2 September 2008.

MELS

The *Middleton Early Language Screening* (MELS) tool was developed by Ms Lynne Middleton (President, Private Speech Pathologists' Association of WA). It was developed to provide screening consistency in the kindergartens across the region in which she was working. MELS is designed as a simple precursor to more complete professional assessments. Ms Middleton describes its development:

> *as a clinical tool that I had devised to identify the children who we thought would be at risk. However, when we started to look at the validity of it, it showed quite nicely that the findings of the children who had had a complete assessment agreed thoroughly with the findings of this screening assessment. We found that very few children were false positives. The screening test was not saying that there was a problem when there was not a problem.* [276]

Ms Middleton provided information that MELS is currently used in the following schools: Two Rocks, Tapping, Anzac Tce., City Beach, Doubleview, Glendale, Merriwa, Joondalup, Middle Swan, Midvale, North Woodvale, Poynter, Sawyers Valley and Beldon Education Support Centre.[277] Another private speech pathologist who used MELS in a kindergarten said "Out of 26 children, it picked up two children with severe language problems and one with a speech problem. That is a brilliant result in this area."[278]

8.4 Standardised speech and language screening programs

The standardisation of speech and language screening programs prior to a child attending school is an area of childhood development that offers significant preventative potential and future cost savings. For children, competency in early language skills will "underpin the transition to literacy."[279] Untreated speech and language disorders will increase the risk of social, emotional, and behavioural problems. Developmental delays in speech and language can also have a profoundly negative impact on the bonding between a parent and child.[280]

MELS and *Catch Them Before They Fall* are two diagnostic apparatus that warrant further scrutiny as future models for screening the State's children. *Catch Them Before They Fall* is a joint research project between DET and the Child Study Centre at the University of WA aimed at pre-primary school-aged children. DET's Mr John Brigg (Acting Director, Inclusive Education

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276 Ms Lynne Middleton, President, Private Speech Pathologists' Association of WA, *Transcript of Evidence*, 30 July 2008, p 4.

277 Ms Lynne Middleton, President, Private Speech Pathologists' Association of WA, Correspondence, 11 August 2008.

278 Mrs Rosemarie Candler, Speech Pathologist, Private Speech Pathologists' Association of WA, *Transcript of Evidence*, 30 July 2008, p 4.

279 Submission No. 21, Speech Pathology Australia, 9 May 2008, p 2.

280 Mrs Rosemarie Candler, Speech Pathologist, Private Speech Pathologists' Association of WA, *Transcript of Evidence*, 30 July 2008, p 11.

Standards) said that this tool "appears to promise to be a reliable and valid instrument for on-entry screening to detect those children who are seriously at risk of literacy failure."[281]

MELS is further along the developmental path and promises many benefits. It is a 20-minute test which, like the audiogram procedure for hearing, does not require specialist supervision. Teachers and early child educators can quickly learn how to conduct the test in the classroom, an ideal environment in which to improve the accuracy of the results. If *MELS* is as accurate as early trials indicate, this tool could also have a major impact on reducing the incidence of misdiagnosis of behavioural disorders such as ADHD.

Like *Catch Them Before They Fall*, *MELS* has only had limited usage but its results look promising. Although the cost of implementing programs such as *Catch Them Before They Fall* and MELS has not yet been assessed, commitments to either are not likely to be financially onerous to the Government of Western Australia.

Finding 11

Developmental delays in speech and language can have a profoundly negative impact on a child's education and socialisation. There is promising evidence that tools such as *MELS* and *Catch Them Before They Fall* offer a reliable and valid tool for screening children's competency in early language skills.

Recommendation 26

That the Department of Health and Department of Education and Training develop a joint business case for government on the introduction of a standardised speech and language screening tool, such as *MELS* or *Catch Them Before They Fall*, to be used at pre-primary level throughout Western Australia.

281 Mr John Brigg, Acting Director, Inclusive Education Standards, Department of Education and Training, *Transcript of Evidence*, 11 June 2008, p 4.

CHAPTER 9 GENERAL HEALTH

9.1 Terms of Reference 1 – adequacy and availability

In regards to general health conditions, the Department of Health (DOH) advised that a physical examination is conducted on newborn babies as part of the UCS. After this, an "observation/discussion of milestones for physical, social and emotional development" is offered to parents at regular intervals through to school entry.[282] It is not clear what these sessions entail, although DOH says that such contacts promote partnerships between parents and health workers that "focus more holistically on the child's physical and psychosocial development and address specific concerns of the family."[283] The Department of Education and Training (DET) stakeholder group had concerns over the methodology employed in this area, particularly for the school entry assessment:

> *The lack of universal screening processes for key areas of general health can impact on educational outcomes. There is also a lack of early screening and assessment tools in social and emotional development.…The dependence upon teacher and/or parent referral, particularly in the area of mental health is problematic. Given that identification and definition of mental health issues are complex, and the potential for confusion of those with behavioural problems, it places a lot of pressure on teachers to make accurate assessments. Passive students who may not be displaying overt behaviour problems may be overlooked for further assessment. Parents may also be reluctant to identify mental health issues in their child and to seek out assessment and/or services*.[284]

Deficiencies exist in other areas of children's general health and several conditions are not part of any current formal screening process. One such condition is Foetal Alcohol Spectrum Disorder (FASD), which was discussed in detail above. The lack of an integrated data system precludes DOH from reporting the number of children referred to the Child and Adolescent Mental Health Service (CAMHS), but they estimate that 5-10% of children seen by CDS in metropolitan Perth would warrant a referral – approximately 1,100- 2,200 children.[285]

9.2 Terms of Reference 2 – access to appropriate services

Some aspects of general health screening, such as the School Dental Service, appear to function adequately. DOH described this service as a comprehensive one, underpinned by 40 mobile clinics. Staffed by dentists and dental therapists, these clinics are mostly located in non-metropolitan areas and follow an annual circuit, spending "several weeks in each location dependent upon treatment needs."[286] The service's main limitation was the fact that having only

282 Submission No. 30, Department of Health, 16 May 2008, pp 30-32.

283 Submission No. 30 (A), Department of Health, Response to Questions on Notice, 31 July 2008, p 4.

284 Submission No. 29, Department of Education and Training, 21 May 2008, p 16.

285 Submission No. 30 (D), Department of Health, Response to Questions on Notice, 11 May 2009, p 1.

286 Submission No. 30, Department of Health, 16 May 2008, p 18.

one public dental theatre (based in Perth) meant that about 1.5% of children who required procedures under general anaesthetic faced delays with their therapy. The adequacy of the School Dental Service was not addressed by other submissions and therefore the Committee was not able to test the claim by the Department of Health that "WA offers the most comprehensive child dental care service in Australia." The child health checks undertaken in the Northern Territory after the Federal intervention has shown that 44% of Indigenous children had oral health problems, such as untreated tooth decay.[287] It is likely that a similar problem of dental decay confronts Indigenous children in Western Australia.

Recommendation 27

That the Department of Health undertake a review of dental health services offered in rural and remote regions of Western Australia and report to the Ministers for Health and Indigenous Affairs on the dental health of children in regional and remote regions.

Evidence was received that the accessibility of Western Australia's current mental health referral and treatment facilities is problematic. National Investment for the Early Years (Niftey) advised that there were delays of up to 12 months for treatment by clinical psychologists. The DET stakeholder group confirmed that resource constraints had generated long waiting lists for psychologists and that this problem was worse in rural and remote areas. According to the School Psychologists Association of WA, some rural and remote families "never receive appropriate treatment for these problems."[288]

The issue of accessibility for rural areas was confirmed by a submission from a Port Hedland primary school. Ms Melissa Marquis, the Short Term Principal at St Cecilia's Catholic Primary School, told the Committee that the general health work of the local School Health Nurse was 'thorough and informative'. However, the long delays for subsequent referrals and remedial treatments "defeat[ed] the purpose of aiming for early intervention and all of the benefits that go hand in hand with this when it occurs."[289]

An overarching concern was that the current challenges facing Western Australia's public health system meant that many of those most reliant upon it, particularly the children of lower SES family groups[290], were least likely to access its services. As Dr John Wray argued:

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287 In terms of other general health issues, the Northern Territory health checks of 8,300 children also showed 10% had four or more skin sores and 16% had anaemia. NTER, "Report of the NTER Review Board", (2008). Available at: www.nterreview.gov.au/docs/report_nter_review.PDF, p 36. Accessed on 1 April 2009.

288 Submission No. 15, Mr Stuart McKenzie, School Psychologists Association of Western Australia Inc, 9 May 2008, p 3.

289 Submission No. 2, Mrs Melissa Marquis, St Cecilia's Catholic Primary School, 6 April 2008, p 1.

290 See Chapter Four for further discussion on this topic.

There is an alarming and growing discrepancy in access to developmental services between the relatively wealthy of our society and the relatively poor….The difference in services …in this area is larger than in any other area of child health service.[291]

9.3 Non-government programs

Linking Education and Families (LEAF)

The Linking Education and Families (LEAF) program is operated by a nonprofit organisation in Bunbury – Investing In Our Youth Inc. (IIOY) – in partnership with the Department of Education and Training.[292] The LEAF program is a pilot project operating at six primary schools in Bunbury and one in Harvey.[293] Its aim is to provide a framework for giving each child the best possible start to their education. The program builds on partnerships between education and health, and works with local families and communities to support them to identify priorities and develop a plan to improve the wellbeing of their children.

There have been many programs overseas that have linked the education systems with interventions for both children and their parents. Marshall and Watt mention US programs in Seattle and a Canadian program in Montreal in the late 1980s and early 1990s that received effective post-evaluations on their results. They mention the comprehensive Cambridge-Somerville program in Massachusetts, USA, that was undertaken in the mid-1930s and achieved limited success.[294]

The LEAF program was initiated when IIOY "identified a cohort of children in the kindergarten who were not fully prepared for kindergarten because of speech delays and underdeveloped social interactions."[295] This came at a time when the DET identified a need to build closer links with families during the transition of their children from home to school. The program promotes early literacy and reflects a commitment by schools to enhance students' school readiness.

In 2005, the South Bunbury primary school released their Kindergarten teacher for one day per week for an initial period of 12 months to develop strategies to connect with local families with children under four years of age. This release was funded by DET and resulted in the development of a program that provides a mechanism by which schools can make early contact with parents and families of pre-school children. Key elements of the LEAF program include:

- Training to prepare teachers for their role as program coordinators;

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291 Submission No. 10, Dr John Wray, 8 May 2008, p 2.

292 Submission No. 17, Investing In Our Youth Inc, 9 May 2008, p 1.

293 Mrs Carmen Gregg, Project Officer, Investing in Our Youth Inc, *Transcript of Evidence*, 18 June 2008, p 3.

294 Marshall, J. & Watt, P. (1999) *Child Behaviour Problems: A Literature Review of its Size and Nature and Prevention Interventions*, Interagency Committee on Children's Futures, Perth, pp 274-282.

295 Mrs Claire Philipps, Community Nurse, WA Country Health Service- South West, *Transcript of Evidence*, 18 June 2008, p 2.

- Family visiting; and
- Play Cafes.

Family visits occur early in the school year and provide an opportunity for the teacher to build a picture of the child and develop a personal relationship between the teacher and parents. Home visiting has helped identify issues such as speech delay, sleep issues, difficult behaviour, continence problems, sight and hearing issues and concerns with communication and language skills. These visits can also increase understanding of broader family issues that could influence the child's progress at school, including parental mental health problems, shared custody issues, chronic illness in the family, or family members in gaol.

In terms two and three, the school makes facilities available for families of children aged 0-4 years to have regular opportunities to interact with each other, the program coordinator for the school and other guest community members (e.g. community health nurses and local service providers) at a *Play Cafe*. Activities are provided for children, such as painting, songs, play dough, listening to a story, and cooperating in a group. These are activities that they will need to be able to do once they enter kindergarten the following year.

An evaluation of the LEAF program by Dr Katie Thomas of the Curtin University of Technology Centre for Developmental Health found the program was "clearly efficacious and cost-effective in providing a range of family, school and community linking, social capital development and early education services to families with pre-school children".[296] In 2007 the program conducted 151 home visits and interacted with 197 parents and 232 children. Over 4,500 pieces of information about the early development of children and early development services were distributed. Consistent with other evidence on recent social changes to parenting provided to the Inquiry, the LEAF evaluation reported "The main challenges to [sic] Home Visiting program were found in poorer neighbourhoods where parents were working long hours and under extreme pressure and/or were nervous, reluctant or hesitant to engage with professionals and teaching staff."[297]

In terms of assisting in the early screening of children's development, the evaluation found:

> *The LEAF program achieved some extraordinary outcomes in linking families to community services and early intervention providers, particularly given the investment of only 40 days per school area. Although it was beyond the scope of the evaluation to track all of the service provider contacts which were initiated by the program at least 107 informal referrals were made to services and 76 early interventions were conducted with children as a result of the LEAF program.*[298]

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296 Thomas, K. (2007) "*Extending the Hand of Welcome": Final Impact Evaluation of the Linking Education and Families Program*, Investing In Our Youth Inc, Bunbury WA, p 7.

297 Thomas, K. (2007) "*Extending the Hand of Welcome": Final Impact Evaluation of the Linking Education and Families Program*, Investing In Our Youth Inc, Bunbury WA, p 8.

298 Thomas, K. (2007) "*Extending the Hand of Welcome": Final Impact Evaluation of the Linking Education and Families Program*, Investing In Our Youth Inc, Bunbury WA, p 9.

Mrs Claire Phillips, a community health nurse, offered evidence that teachers attending the *Play Cafes,* in collaboration with the visiting nurse, are able to act on the provision of early referrals for speech therapy or for a child to have their eyesight checked, act on glue ear or food allergies or facilitate a parenting group such as the PPP program.[299] Thomas found that found that a significant outcome of the *Play Cafes* was:

> *parents heightened awareness of the importance of the early childhood period; of child developmental stages and of their own role in fostering their child's healthy development. Some parents contrasted the benefit of having access to this information with their experience with older children and reported that LEAF enabled them to support healthier developmental experiences for their child.*[300]

The benefits attributed to the program were that it:

- decreases anxiety in both parents and children about the transition to school;
- expands parent's support system;
- increases family links to community services;
- facilitates access to early intervention;
- provides access to early childhood information and activities;
- increases parents' awareness of the importance of early childhood development;
- increases partnerships between community and school; and
- fosters school readiness.

Play and Learning to Socialise

In a similar fashion to LEAF[301], the Resource Unit for Children with Special Needs (RUCSN) [now renamed as CHILD Australia] operates mobile play-group programs, particularly for children in regional WA. RUCSN offered information about its State and Federally-funded

299 Mrs Claire Philipps, Community Nurse, WA Country Health Service- South West, *Transcript of Evidence*, 18 June 2008, p 2.

300 Thomas, K. (2007) *"Extending the Hand of Welcome": Final Impact Evaluation of the Linking Education and Families Program,* Investing In Our Youth Inc, Bunbury WA, p 9.

301 A similar program is also offered in Armadale by the Challis Early Childhood Education Centre, who claim to be "the only school in Western Australia that caters specifically for children from Kindergarten to Year Two." (2008). Available at: www.challisps.det.wa.edu.au/ecec/index.htm. Accessed on 4 December 2008.

Goanna Gang project in Newman[302], and a LEAF-like program for children in the West Pilbara region called *3+Playgroup Program*. The RUCSN playgroup leaders hold early childhood qualifications and their playgroups provide an opportunity for observation of each child's development, as well as a chance to talk with parents, and where appropriate, support referrals for developmental assessments.[303] RUCSN's web site explains that the *3+ Playgroup Program*:

> *is funded by the Department of Families, Community Services and Indigenous Affairs (FaCSIA) – Stronger Families and Communities Strategy 2004 – 09. RUCSN's Rural Children's Support Network – Pilbara Region as the community partner has been contracted to deliver the 3+ Playgroup Program.*
>
> *The 3+ Playgroup Program's goal is to promote children's development and school readiness for children aged three to five years. This will be achieved through the development of four new supported playgroups in the West Pilbara and by building upon, promoting and supporting existing playgroup services to deliver high quality services.*
>
> *The 3+ Playgroup Program will primarily focus upon children from three to five years of age and will seek to increase and support the capacity (knowledge and skills in relation to early years and child development through training) of community members, community groups and agencies who deliver early years services in order that they are able to promote the development of children three to five years of age.*
>
> *The newly implemented playgroups will be supported by a Play and Learning Co-ordinator and will have an outreach component so as to ensure that hard to reach families (Indigenous, CaLD, young parents) are assisted in accessing the supported playgroup and/or early years services.*
>
> *The 3+ Playgroup Program intends to engage all existing playgroups within the West Pilbara (including within Indigenous communities) and support them to meet their specific needs.*[304]

A Smart Start

The *A Smart Start* program seems to have similar aims to others such as LEAF, in that it tries to engage a whole population, in this case families with children aged 0-4 years in the Central Great Southern region of Western Australia. It was established in 1999 by an early childhood teacher at the Broomehill Primary School, Ms Sue Sheridan, and has received a mixture of Federal, State

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302 RUCSN, "Project Newman", (2008). Available at: www.rucsn.org.au/Project_NewmanYMCA_reportsansphotos_003.htm. Accessed on 5 August 2008. For an updated description of these programs, see www.childaustralia.org.au/Programs---Services/East-Pilbara-Intensive-Support-Playgroups-(Mobile).aspx. Accessed on 23 April 2009.

303 Submission No. 7, Resource Unit for Children with Special Needs (RUCSN), 9 May 2008, p 4.

304 RUCSN, "West Pilbara 3Plus", (2008). Available at: www.rucsn.org.au/WestPilbara3PlusPlaygroupProgram.html, accessed 5 August 2008. For an updated description of these programs, see www.childaustralia.org.au/getdoc/3035915e-76f1-4f08-97f6-9c87858586b5/Communities-4-Children.aspx. Accessed on 23 April 2009.

and local funds totalling less than $500,000 over the past 8 years.[305] *A Smart Start* is now implemented within 10 towns in the Great Southern Region[306] and aims to develop parents' knowledge of their child's developmental milestones as they prepare for school. It gives parents an annual health book and runs activities to link parents into professional support agencies and school networks.

While it is difficult to compare the program with a similarly-named one in the US[307], a recent evaluation by WA Country Health Service found that it had "gone close to reaching all children in the target region, approximately 98% coverage", and that it had met all seven of its original program objectives.[308] The success of the program has seen it being trialled in other regions of WA, especially in the north-west.[309]

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305 WA Country Health Service. (2008) *Evaluation of 'A Smart Start'*, WA Country Health Service, Department of Health, Perth, p 1.

306 Australian Health Promotion Association WA Branch, "July 2008", (2008). Available at: http://healthpromotion.org.au/fileupload/WA/newsletters/2008%20AHPA_July%20Newsletter.pdf, p 6. Accessed on 23 April 2009.

307 Smart Start Colorado, "Home", (2008). Available at: www.smartstartcolorado.org/. Accessed on 6 August 2008.

308 WA Country Health Service. (2008) *Evaluation of 'A Smart Start'*, WA Country Health Service, Department of Health, Perth, p 1 & p 20.

309 For information on the program in Halls Creek see: Early Years WA, "Halls Creeks", (2008). Available at: www.earlyyears.wa.gov.au/communities_sites.cfm?mode=viewSite&pageContentRef=hallsCreek#site. Accessed on 6 August 2008; and in Kalbarri, see: Department of Health, "Smart Start program aims to improve the life skills of children aged 0-4", (2008). Available at: www.health.wa.gov.au/press/view_press.cfm?id=452. Accessed on 6 August 2008.

Finding 12

There is promising evidence that programs such as *LEAF* and *A Smart Start* assist pre-primary children prepare for school, while allowing carers and parents to identify health concerns well before a child enters the school system. These programs provide an ideal environment for conducting a range of health screening tests before children start formal schooling. They would benefit both the child in terms of school readiness, and reduce the current burden for school health nurses who have to deal with children suffering from a variety of disorders that could have been diagnosed earlier.

Recommendation 28

The Department of Health should develop a business case for government on a formal evaluation of programs to assist children entering school, such as *LEAF* and *A Smart Start*.

CHAPTER 10 FUTURE STRATEGIES FOR GOVERNMENT

10.1 Introduction

This Inquiry's findings confirm the Committee's initial concerns that the current approach to child health screening in Western Australia is inconsistent across regions, and that the outcomes are often inadequate and inequitable. While WA's child health system aspires to emulate principles accepted in other jurisdictions, and contained in WHO's Ottawa Charter, this Inquiry has found that it is currently inadequately funded to systematically collect and analyse data on child health conditions, and to offer treatments in a timely fashion to all Western Australian children.

However, this isn't a reflection of the dedication and quality of staff, nurses and teachers within the child health system. WA's child health screening process suffers because an under-resourced labour force works in a disjointed system that has responded too slowly to recent demographic changes and emerging conditions that impact on a child's learning. These challenges have led to the unacceptable situation where between 20 and 25% of WA's children may commence school with "significant developmental and behavioural concerns."[310] The HRIT Report confirmed that a child's chance of obtaining speedy access in WA to treatment services is subject to a 'postcode lottery'.

This final chapter proposes strategies for government that aim to rapidly improve the current situation in a timely and cost-effective way. Some of these proposals are already underway, while others need a renewed emphasis from Government, with additional funding and staff resources. However, many improvements can be made simply via better coordination and integration of existing services and programs, or by expanding successful programs developed by the non-government sector.

10.2 Coordination – Federal–State services

The Commissioner for Children and Young People, Ms Michelle Scott, stated that "there is a lack of coordination in the planning of service provision." She added that there are occasions where Federal and State agencies, as well as NGOs, act "without collaboration or discussion….[leading to] duplication or a failure to consider gaps in areas of service provision." [311] For example, the Federal Government introduced an initiative on 1 July 2008 called *Healthy Kids Check* (HKC) that allows GPs or Practice Nurses to undertake a fully refundable child health assessment:

> *The Healthy Kids Check will promote early detection of lifestyle risk factors, delayed development and illness, and introduce guidance for healthy lifestyles and early*

310 Submission No. 10. Dr John Wray, 8 May 2008, p 2.

311 Submission No. 28, Commissioner for Children and Young People, 12 May 2008, p 11.

> *intervention strategies. The Healthy Kids Check will take place at or around the same time as the four year old immunisation.*[312]

In addition to conducting formal testing on a child's sight, hearing and dental hygiene, a health professional can also conduct observational assessments of speech and language development, fine motor skills, and emotional well-being. This general health screen is universally available and fully refundable under Medicare's Enhanced Primary Care Program (EPC). In conjunction with this scheme, the Federal Government offers a $600 rebate under the EPC to cover five visits to allied health professionals and twelve sessions with a clinical psychologist while children await access to public services.[313]

Unfortunately, these programs operate without any apparent agreement with the State Government and local agencies as to how the referral process will be facilitated. Dr John Wray argued that pre-existing referrals for the Child Development Services (CDS) under the Medicare EPC are already held up "because of ridiculous State-Federal Health politics."[314] His concerns were echoed by the National Investment for the Early Years (Niftey) who added that the introduction of this new Federal initiative will extend the waiting times currently experienced due to the disjointed referral procedures.[315] Professor Stephen Zubrick from the Telethon Institute for Child Health Research said that "We do not have an integrated policy framework that guides action across our agencies in terms of advancing child development and human development broadly."[316]

DOH confirmed that the 19 metropolitan and country CDS sites under its auspices "have been highly fragmented with different ways of managing children with developmental concerns."[317] A DET stakeholder group provided further evidence that there is a lack of coherence in the provision of services across most areas of child health. A summary of this group's findings is included in Appendix Seven.

In the area of hearing screening services, the DOH confirmed that the "newborn screening program is disjointed and limited and only covers approx [sic] 49% of births."[318] This has meant that an important Federal initiative, *Australian Hearing*, is also being under-utilised. For vision services, the DET stakeholder group found that "there is a clear need for better coordination between service providers"[319], many of whom were from the non-government sector. They added

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312 Department of Health and Aging, "Healthy Kids Check – Fact Sheet", (2008). Available at: www.health.gov.au/internet/main/publishing.nsf/Content/Health_Kids_Check_Factsheet. Accessed on 13 August 2008.

313 Submission No. 20, Ms Judy Walsh, OT Australia WA, 8 May 2008, p 3; Submission No. 30, Department of Health, 16 May 2008, p 21.

314 Submission No. 10, Dr John Wray, 8 May 2008, p 3.

315 Submission No. 27, National Investment for the Early Years, 8 May 2008.

316 Prof Stephen Zubrick, Head, Division of Popular Sciences, Curtin University of Technology, Centre for Developmental Health, *Transcript of Evidence*, 30 July 2008, p 5.

317 Submission No. 30 (B), Department of Health, Response to Questions on Notice, 31 July 2008, p 5.

318 Submission No. 30, Department of Health, 16 May 2008, p 11.

319 Submission No. 29, Department of Education and Training, 21 May 2008, p 9.

that with speech and language, "communication and coordination between DOH and DET when a child is accessing services is not always evident and tracking of children is difficult."[320] Finally, it was noted that cooperation was similarly lacking in the provision of allied health services for the assessment and treatment of motor skill disorders.[321]

DET and DOH both acknowledged that future policy frameworks will require greater awareness of the impact of Federal initiatives.[322] The HRIT report found that "with no over-arching governance structure, duplication and gaps in service delivery are having a profound impact on Western Australian families."[323] The current DOH CDS reform project aims to streamline services via measures that include 'formal collaborative agreements' between agencies within the DOH and a 'collaborative working group' with the DET.[324] Appendix Eleven provides more information on the recent Federal Government initiatives in this area of health policy, and the additional funds likely to be available to the State Government.[325]

Recommendation 29

That the Department of Health (DOH) and the Department of Education and Training (DET) ensure that resources from Federal health initiatives in the area of early child health be fully utilised and integrated into current services in Western Australia. DOH and DET should include information in their annual reports on what Federal funds were available, have been applied for, accessed, and how the funds were utilised.

10.3 Coordination – A statewide 'whole of government' approach[326]

The positive experiences and lessons of a 'whole of government' approach in other policy areas and jurisdictions should be drawn upon by WA's child health sector, particularly to address the gap in availability of child health services between rural and regional areas and those in Perth. For

320 Submission No. 29, Department of Education and Training, 21 May 2008, p 12.

321 Submission No. 29, Department of Education and Training, 21 May 2008, p 14.

322 Submission No. 29, Department of Education and Training, 21 May 2008, pp 2-4; Submission No. 30 (A), Department of Health, 24 July 2008, p 4.

323 Health Reform Implementation Task Force. (2006) *Future Directions for Western Australian Child Development Services*, Department of Health, Perth, p 13.

324 Submission No. 30(A), Department of Health, Response to Questions on Notice, 31 July 2008, p 4.

325 The most recent example is funding for Intensive Support Playgroups (ISP), including mobile playgroups, in regional and remote Indigenous communities in WA. FaHCSIA, "Playgroups", (2009). Available at: www.fahcsia.gov.au/sa/families/progserv/pages/parenting-playgroups.aspx. Accessed on 12 January 2009.

326 In other jurisdictions 'whole of government' goes by different names. For example, it is called 'joined up government' in the UK and 'horizontal management' in Canada. See Podger, A. (2003) *Go Global: Public Sector Management Trends in Australia, New Zealand, the United Kingdom, Canada and the USA*, Presentation to CPA Australia Congress, 16 September, APSC, Canberra.

example, the Western Australian Commissioner for Children and Young People recently gave evidence to the Community Development and Justice Standing Committee's *Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children* of five separate government agencies that are funding disparate parenting programs.[327]

As an example of agencies working together, Dr Chalmers, the Director General of the Disability Services Commission, gave evidence that the DSC has worked closely with DOH and WA Country Health Service in delivering a new initiative to use Aboriginal allied health assistants in the Fitzroy Valley. Local Aboriginal people have been trained to take on the role of therapy assistants to actually deliver programs that are developed by therapists.[328] On the other hand, DSC provided information to the Inquiry that it has a Perth-based Health Resource and Consultancy Team (HRCT) of four FTE and a budget of $700,000. This team is not formally linked to the work of either DOH or DET.[329] The role of the HRCT is:

> *trying to raise awareness, not simply about this part of the population, but to be working alongside the mainstream health and medical service—pretty strong links into the health department, into divisions of general practice, AAWA, the medical service, generally, to try to raise awareness about the needs of people with disabilities generally.*[330]

About 4%-6% of school children within the DET system of education support units, centres and schools are eligible to access DSC services such as the *Schools Plus* program.[331] Other State agencies with a role in child health include the Department of Indigenous Affairs, the Commissioner for Children and Young People, Department for Child Protection, Department for Communities and the Office of Mental Health.

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327 Submission from the Commissioner for Children and Young People to the Community Development and Justice Standing Committee's *Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children*, 27 February 2009, p 10. Legislative Assembly, "Submission", (2009). Available at: www.parliament.wa.gov.au/Parliament/commit.nsf/(Evidence+Lookup+by+Com+ID)/67CCDB87DD62D765C8257578000912EB/$file/Sub+15+CCYP.pdf. Accessed on 14 April 2009.

328 Dr Ron Chalmers, Director General, Disability Services Commission, *Transcript of Evidence*, 30 July 2008, p 7.

329 Dr Ron Chalmers, Director General, Disability Services Commission, *Transcript of Evidence*, 30 July 2008, p 4.

330 Dr Ron Chalmers, Director General, Disability Services Commission, *Transcript of Evidence*, 30 July 2008, p 4.

331 Dr Ron Chalmers, Director General, Disability Services Commission, *Transcript of Evidence*, 30 July 2008, p 3. Disability Services Commission, Response to Questions on Notice, 13 August 2008, pp 2-3.

Recommendation 30

That the Department of Education and Training, the Department of Health and the Disability Services Commission formalise their work on improving the health of Western Australian children by establishing an across-government State-wide approach to a common child health and development strategy, including all screening programs.

10.4 Legislation – A new Public Health Act

In June 2005 the Department of Health released a discussion paper *New Public Health Act for Western Australia* which recognised the deficiencies of the present legislation and proposed a new public health act with a focus "on core public health issues". The discussion paper proposed that a new Act would strengthen public accountability and would be driven by "a philosophy of minimising risk and enhancing public health and wellbeing."[332] The discussion paper noted that specific issues, including child health, will be subject to separate reviews and envisaged that a Bill would be presented to Parliament in mid-2006. This process was delayed and a draft Bill[333] was circulated for public comment by the Carpenter Government in early 2008.[334]

Each Australian jurisdiction has a statutory authority responsible for the coordination of government policies involving children and youth. Western Australia and three other States have established independent bodies to review and advise on issues relevant to children:

- Western Australia (Commissioner for Children and Young People);[335]
- New South Wales (Commission for Children and Young People);
- Queensland (Commission for Children and Young People and Children's Guardian); and
- Tasmania (Commissioner for Children).

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332 Department of Health, "New Public Health Act for Western Australia: A Discussion Paper", (2005). Available at: www.newpublichealthact.health.wa.gov.au/publication/docs/DPaper%2030%20June%2005.pdf, p 3. Accessed on 18 August 2008.

333 Department of Health, "Public Health Bill 2008", (2008). Available at: www.newpublichealthact.health.wa.gov.au/publication/docs/D08%20(Exposure)%20Public%20Health%20Bill%202008.pdf. Accessed on 18 August 2008.

334 Department of Health, "Welcome", (2008). Available at: www.newpublichealthact.health.wa.gov.au/home/. Accessed on 18 August 2008.

335 The role of Commissioner for Children and Young People was established under an Act of Parliament in 2006. State Law Publishers, "Commissioner for Children and Young People Act 2006", (2007). Available at: www.slp.wa.gov.au/pco/prod/FileStore.nsf/Documents/MRDocument:5797P/$FILE/CommerForChildnAndYoungPeopleAct2006_00-d0-04.pdf. Accessed on 16 February 2009.

Recommendation 31

In her role promoting public awareness of matters relating to the wellbeing of children and young people, the Commissioner for Children and Young People should annually maintain a child health identification and treatment register which collects and reports data from the Department of Health on the number of children who have been identified as needing treatment for health problems, and those who have been unable to receive treatment.

The recent focus in Western Australia to coordinate government policies for children and youth includes the establishment of the Commissioner for Children and Young People in 2006 and the new Joint Standing Committee on the Commissioner for Children and Young People in 2008. On 13 January 2009, the West Australian Premier announced that an Early Childhood Development portfolio would be created and incorporated into the Minister for Education's portfolio.[336] This is a similar model to that used by the Victorian Government, which in 2007 transferred early childhood health services to the renamed Department of Education and Early Childhood Development.[337] South Australia has a similar model to that of Victoria. The Department of Education and Children's Services has responsibility for both education and childcare services, involving the provision of preschool, administration of Family Day Care, sponsorship of Outside School Hours Care programs and the establishment and enforcement of minimum standards for all types of childcare.[338]

The new WA arrangements are still not as clear as the Victorian structure, with the Department for Communities continuing to play a role in relation to children and families. The Community Services Minister continues to have responsibility for:

- child care, including legislation, licensing, regulation and support;

336 Department for Communities, "Early Childhood Portfolio changes", (2009). Available at: www.community.wa.gov.au/DFC/Resources/Early+Childhood+Portfolio+changes.htm. Accessed on 14 April 2009.

337 Department of Education and Early Childhood Development, "Directions and Priorities", (2009). Available at: www.education.vic.gov.au/about/directions/default.htm. Accessed on 31 March 2009.

338 Submission from the Commissioner for Children and Young People to the Community Development and Justice Standing Committee's *Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children*, 27 February 2009, p 14. Legislative Assembly, "Submission", (2009). Available at: www.parliament.wa.gov.au/Parliament/commit.nsf/(Evidence+Lookup+by+Com+ID)/67CCDB87DD62D765C8257578000912EB/$file/Sub+15+CCYP.pdf. Accessed on 14 April 2009.

- child, family and parenting support services through Parenting WA, including the free 24-hour Parenting WA Line, the Parenting WA Library and local parenting support and home visiting programs; and
- the Aboriginal Best Start program and for supporting local Early Years networks and activities.

Finding 13

There should be significant benefits flowing from having one State Minister with portfolio responsibility for early childhood education and development.

Recommendation 32

That the Government continue to pursue the benefits of having one Minister with portfolio responsibility for early childhood education and development.

Neither the current Western Australian Public Health Act, nor the proposed Act, provide any reference to the general screening of children at pre-primary or primary school level.[339] Western Australia should follow other Australian jurisdictions in implementing a new health Act that addresses contemporary and future health issues pertaining to both protective and preventative strategies for children.[340] The Act should encompass those relevant child health matters in which the current Act is both inadequate and ineffective and include the provision of screening programs for hearing, vision, speech and general health issues, such as childhood obesity.

339 In the UK, the *Children Act* was enacted in 2004 as a government strategy to improve children's lives. This includes universal services which every child accesses, and more targeted strategies for those with additional needs, such as creating Sure Start children's centres. In 2006 the UK enacted the *Childcare Act*. It is claimed to be "truly pioneering legislation and is the first ever exclusively concerned with early years and childcare".339 No Australian jurisdiction has established legislation similar to these two Acts.

340 For example, the NSW Public Health Act was introduced in 1991, (see www.austlii.edu.au/au/legis/nsw/consol_act/pha1991126/), the Victorian Public Health and Wellbeing Bill in May 2008 (see www.health.vic.gov.au/healthactreview/) and Queensland's Public Health Act in 2005 (see www.legislation.qld.gov.au/LEGISLTN/CURRENT/P/PubHealA05.pdf).

Recommendation 33

The Government should ensure that any new Public Health Act address the identification, prevention, treatment and evaluation of contemporary and emerging child health issues.

10.5 Integration – Joining up screening programs

One benefit of the current coordination between DET and DOH is that school screening programs are integrated within broader screening programs commencing at birth. Table 10.1 summarises a revised screening program being implemented by DOH as from 2009.[341]

Table 10.1 Screening programs in WA, from birth to six-years-old

Age	Carried Out By/Comments	Developmental Screening & Surveillance	Disease/Condition identified
Birth – 10days	Community Health Nurse	Observational assessment of baby	
6 – 8 weeks	Community Health Nurse -Observation of milestones for physical, social and emotional development Edinburgh postnatal Depression Scale is offered to the mother	Visual Appraisal - Observation of eyes, Red Reflex Test and vision behaviours Observation of Hearing Behaviours Screening examination of the Hips (Ortolani and Barlow manoeuvres) Physical Assessment: Observation of Early Motor Development Weight Measurement	Congenital eye conditions, e.g. cataracts, tumours, amblyopia Congenital Deafness Developmental Dysplasia of the Hips Abnormality or absence Developmental Delay Growth abnormality

341 Submission No. 10 (B), Dr John Wray, 3 July 2008, p 1. In this submission, Dr Wray noted that "further assessments are offered for children where there is expressed professional or parental concern, or in at risk populations." Dr Wray's submission does not include the screening tasks undertaken with newborns, which include the Guthrie test. This information was included on page 30 of Department of Health's submission.

3 – 4 months	Community Health Nurse -The parent completed Ages and Stages screening tool (ASQ:SE) if indicated. Edinburgh postnatal Depression Scale is offered to the mother	Visual Appraisal - Observation of eyes, Red Reflex Test and vision behaviours Weight Measurement In 2009, a parent-completed child developmental screening tool called the Parent Evaluation of Developmental Status (PEDS) will be offered	Cataracts, small angle strabismus and unequal refractive errors Growth abnormality Developmental Delay in various domains: Gross and fine motor Vision and hearing Speech and language personal and social behaviour
8 months	Community Health Nurse - ASQ &ASQ: SE if indicated Edinburgh postnatal Depression Scale is offered to the mother	Visual Appraisal - Eye movements, Corneal light reflex test and vision behaviours Physical Assessment: weight measurement PEDS	Examination for strabismus Growth abnormality Developmental Delay in various domains
18 months	Community Health Nurse - ASQ &ASQ: SE if indicated	Observation of milestones for physical, social and emotional development PEDS	Developmental Delay in various domains
3 – 3.5 years	Community Health Nurse - ASQ &ASQ: SE if indicated	Observation of milestones for physical, social and emotional development PEDS	Developmental Delay in various domains
4 – 6 years	School nurse - ASQ &ASQ: SE if indicated	Visual Appraisal - Eye movements, Lea Symbols Chart, Corneal light reflex, cover test and vision behaviours Hearing Screening: Otoscopy and Audiometry screening PEDS	Examination for strabismus Distance visual acuity and amblyopia Hearing Loss – congenital or acquired Developmental Delay in various domains

This revised screening program was proposed in DOH's *Policy Rationale* publication and includes new health contacts at birth and 3-4 months old, while removing the contact at 1-2 weeks. It recognised that "scientific evidence has confirmed the significant influence of early childhood experience on brain development and on the development of disease in later life".[342]

Australian jurisdictions use different ages at which to screen children and undertake health checks before they enter school. All have at least six contacts, with some having nine. Table 10.2 compares Western Australia's new program of seven contacts with that used in Queensland[343], South Australia[344], Tasmania[345], Victoria[346] and NSW.[347]

Table 10.2 Comparison between assessment age contacts in WA and other States

WA Contacts	QLD Contacts	SA Contacts	TAS Contacts	VIC Contacts	NSW Contacts
Birth – 10 days	Birth – 10 days	Birth	Birth	Birth	Birth and newborn
	1 – 4 weeks	1 – 4 weeks	1 – 2 weeks	1 – 4 weeks	1 – 4 weeks
				2 weeks	
				4 weeks	
6 – 8 weeks	6 – 8 weeks	6 – 8 weeks	6 – 8 weeks	6 – 8 weeks	6 – 8 weeks
3 – 4 months	4 months			4 months	
	6 months	6 – 8 months	6 months	6 – 8 months	6 months
8 months	12 months			12 months	12 months

342 Department of Health. (2006) *Birth to School Entry Universal Contact Schedule: Early Detection and Prevention Policy Rationale and Summary of the Changes to the Schedule*, Department of Health Child Health Services, Perth, pp 4-5.

343 Queensland Health, "Child and Youth Health Practice Manual for Child Health Nurses and Indigenous Child Health Workers", (2009). Available at: www.health.qld.gov.au/health_professionals/childrens_health/child_youth_health.asp. Accessed on 2 April 2009.

344 Childrens, Youth and Women's Health Service, "Health checks", (2008). Available at: www.cyh.com/HealthTopics/HealthTopicDetails.aspx?p=114&np=304&id=1480#1. Accessed on 1 April 2009.

345 Department of Health and Human Services, "Health Assessments and why they are important", (2009). Available at: www.dhhs.tas.gov.au/service_information/information/health_assessments_and_why_they_are_important. Accessed on 1 April 2009.

346 Allen Consulting Group. (2009) *A (draft) National Framework for Universal Child and Family Health Services*, Allen Consulting Group, Melbourne, p14.

347 NSW Health, ""My First Health Record" - The NSW Child Personal Health Record", (2007). Available at: www.health.nsw.gov.au/pubs/2007/child_health_record.html. Accessed on 1 April 2009.

18 months	18 months	18 months	18 months	18 months	18 months
				2 years	2 years
3 – 3.5 years	2.5 – 3.5 years	2.5 – 3.5 years	3.5 years	2.5 – 3.5 years	3 years
4 – 6 years	4 – 5 years	4 – 5 years			4 years

10.6 New funding

It needs to be clearly acknowledged that the level of efficiency gains required to reduce waiting lists and improve WA's child health screening program can not come purely from within existing departmental budget allocations. DOH stated that "there will remain a general problem of demand for services exceeding the capacity of the CDS to provide."[348] In 2004 the Reid Report acknowledged the lack of funds for this sector and noted that "public health systems have traditionally ranked their priorities in favour of hospital and other intervention services, to the detriment of prevention, promotion and early intervention programs." These new funds could be justified as an important component of reducing the future burden of disease.[349] Provision needs to be made urgently for an increase in funding, particularly for nursing staff, across many areas of the State's child health services.

The situation facing Community Child Health Nurses (CHNs) is compounded by the ageing of its work force and the greater burden they are facing under the new 'community-based approach' to screening programs.[350] OT Australia advised that both the community and school nursing services required a greater number of appropriately trained staff to service 'at-risk' groups, including CALD and Aboriginal families. [351] There is a 'chronic shortfall'[352] in mental health services, and the number of school-based allied health professionals such as Physiotherapists, Occupational Therapists and Speech Pathologists is inadequate. [353]

DET's own stakeholder group said "the issue of greatest concern for the Department is the adequacy of services available to respond to issues identified through the screening process."[354]

348 Submission No. 30, Department of Health, 16 May 2008, p 18.

349 Department of Health (2004) *A Healthy Future for Western Australians: Report of the Health Reform Committee*, WA: Department of Health, Perth, pp 23-24, also known as the Reid Report.

350 See Chapters 5.4 and 5.5 above.

351 Submission No. 20, Ms Judy Walsh, OT Australia WA, 8 May 2008, p 3.

352 Submission No. 15, Mr Stuart McKenzie, School Psychologists Association of WA Inc, 9 May 2008, p 3.

353 Submission No. 20, Ms Judy Walsh, OT Australia WA, 8 May 2008, p 2; Submission No. 21, Speech Pathology Australia, 9 May 2008, pp 1-3.

354 Submission No. 29, Department of Education and Training, 21 May 2008, p 4.

Well-supported business cases (e.g. for universal neonatal hearing screening) have consistently failed against what are perceived to be the more pressing needs of other sectors in the WA health budget:

> *The Government must come to understand that community health services are cheaper to run than tertiary health services, and furthermore, that community health services **are preventative** and will decrease reliance on tertiary health structures (such as hospitals) [emphasis added].*[355]

The Department of Health has prepared business cases for both the present and previous governments outlining the urgent need for and additional 126 full-time equivalent (FTE) in the CDS, 105 FTE CHNs and 135 FTE for school nurses to cope with Western Australia's increased population and increased demand for child development services.

Finding 14

The future success of Western Australia's child health screening system is contingent upon it being appropriately and adequately staffed.

Recommendation 34

The number of school health nurses, community child health nurses and allied health professionals employed within Western Australia's child health services should be urgently increased as per the business cases developed by the Department of Health. The new staff required are 126 full-time-equivalent (FTE) in the Child Development Services, 105 FTE Community Child Health Nurses and 135 FTE for school nurses.

From a school's perspective, DET reported the major limitations as:

> *limited resources restrict the capacity of school nurses to provide adequate ongoing monitoring and surveillance, particularly for at risk groups in rural and remote areas.*[356]

The Victorian Government has transferred early childhood health services to the renamed Department of Education and Early Childhood Development and itemises the budget for this program ($338 million or 16.5% of the department's budget).[357]

355 Submission No. 10, Dr John Wray, 8 May 2008, p 1.

356 Submission No. 29, Department of Education and Training, 21 May 2008, p 4.

Recommendation 35

That the Government conduct a review to assess what early childhood services can be transferred to, and resourced within, the Department of Education and Training.

DET advised that its budget for School Health Services for 2008/09 is $5,528,000 (excluding GST), approximately 0.15% of total budget outlays.[358] Similarly, DOH provided data showing the metropolitan based Child and Adolescent Health Service (CAHS) (including screening activities) budget for 2008-09 is $248.3 million, or about 6.1% of this year's health appropriation.[359] The Disability Services Commission also makes a significant budget allocation for child health services, totalling $21.7 million in the 2007-08 financial year. DSC reported that there had been an 85% growth in funding for these services over the past 5 years.[360]

DET and DOH do not presently make separate provisions in their annual budgets for school health screening services.[361] This makes it difficult for the public to monitor the level of expenditure for these services or to make comparisons to other jurisdictions.

Recommendation 36

That both the Department of Education and Training and the Department of Health report separately their allocations for school and early childhood health programs (including screening) in their annual budgets. This should show costs for screening, costs for treatment and waiting times for each program by age group.

One of the key criteria for appraising the benefits and overall efficiency of any health program is whether or not it is cost effective. More than one third of the submissions to this Inquiry cited the findings of highly reputable international research to demonstrate the potential cost benefits of streamlining WA's existing child health screening programs. For example, Dr John Wray suggests

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357 Department of Education and Early Childhood Development, "Budget", (2008). Available at: www.budget.vic.gov.au/CA257401000ED28B/WebObj/BP3Ch3_DEECD/$File/BP3Ch3_DEECD.pdf, page 67. Accessed on 28 August 2008.

358 Department of Education and Training, Response to Questions on Notice, July 2008 p 4.

359 Department of Health, Response to Questions on Notice, 4 August 2008, p 23.

360 Disability Services Commission, Response to Questions on Notice, 13 August 2008, p 2.

361 In the period 1993-2008 the health appropriation has nearly quadrupled from $1,225 million to $4,089 million, but remained about 24% of the Government's budget through this period.

that "the ultimate financial savings for a society that invests in early intervention are reckoned to be in the order of seven-fold."[362] More information on the cost benefit of screening programs is contained in Appendix Thirteen.

10.7 Prevention Strategies – Pedagogical considerations in language education

As part of its investigation into preventative measures, the Committee assessed the impact of appropriate curriculum design upon a child's learning and developmental outcomes. Since the adoption in Western Australia of a 'whole-language'[363] approach to the teaching of literacy there has been increasing criticism of it.[364]

The Department of Education and Training stated:

> *There are societal and family issues that impact on children's development, but my view as an educator is that the emphasis on the whole-of-language approach that has dominated early literacy teaching for the past generation has not been helpful for those children who are at risk. It is fantastic for children who come from language-rich environments and who have no neurological issues. You put a book in front of them and they are already reading before they get to school, and so they are just off and away. For the children who are at risk, the whole-of-language approach is not helpful.*[365]

There must be a greater emphasis on phonics and phonemic awareness[366] in Western Australia's early education curriculum to improve the developmental outcomes of the State's children. The learning potential of students currently entering the school system with a developmental delay

362 Submission No. 10, Dr John Wray, 8 May 2008, p 1.

363 A 'whole of language' (also known as whole-language) approach "views listening, speaking, reading and writing as integrated, not separate entities. It is meaning-centred and recognises that students learn the subsystems of language as they engage in it. This means that the teaching of the components of language (the phoneme/grapheme relationship, the grammar, the spelling patterns, punctuation, specific genres) is taught in meaningful contexts." DEST (2005) *Teaching Reading: Report and Recommendations*, National Inquiry into the Teaching of Literacy, Department of Education, Science and Training, Canberra, p 90.

364 The DEST (2005) *Teaching Reading: Report and Recommendations* (p 1) traces this disagreement to the 16th century. John Hart's 'An Orthographie' (1569) and Richard Mulcaster's 'Elementarie' (1582) both advocated the 'alphabetic principle' via the explicit teaching of letter-sound relationships for beginning reading. However, Fredrich Gedike (1754- 1803) was prominent in advocating a 'whole-to-part' approach.

365 Mr John Brigg, Acting Director, Inclusive Education Standards, Department of Education and Training, *Transcript of Evidence*, 11 June 2008, p 5.

366 Phonemic awareness instruction "involves teaching children to focus on and manipulate phonemes in spoken words; e.g., blending sounds to form words (/h/-/o/-/t/ = 'hot'), or segmenting words into phonemes ('hot' = /h/-/o/-/t/)." Phonics is the explicit teaching of reading and spelling via letter-sound correspondences involving decoding and phoneme/grapheme translations. DEST (2005) *Teaching Reading: Report and Recommendations*, National Inquiry into the Teaching of Literacy, Department of Education, Science and Training, Canberra, p 87.

may be further compromised by the whole-of-language approach. Mr Brigg, DET's Acting Director, Inclusive Education Standards, confirmed that a more inclusive language teaching pedagogy may help to reduce the waiting lists for services at the Language Development Centres.[367]

An earlier focus on phonemics (i.e. during kindergarten) can have a profound impact on the school-readiness of a broader range of children. Speech pathologist Ms Lynne Middleton said:

> *We can do a lot of work for four-year-olds on listening, rhyming and syllables and those sorts of things when they are in kindy and then they can do a top-up program in year 1. A few years ago we ran a program that began in a day care centre. The reason we started there was there was a little child with a severe speech difficulty in day care. We started the program in the day care centre and then we ran through with it and continued on with the phonological awareness program in kindy and screened the children again. By the end of pre-primary, those kids were performing at a year 3 level for phonological awareness, so it was well and truly worth it.*[368]

A renewed emphasis on phonemic awareness should be incorporated in the school curriculum, and as part of the State's teacher training program[369], as recommended in the *Numeracy and Literacy Review Taskforce Final Report* in 2006.[370] The Committee notes that at a national level, the Report and Recommendations of the *National Inquiry into the Teaching of Literacy* observed that:

> *The evidence is clear, whether from research, good practice observed in schools, advice from submissions to the Inquiry, consultations, or from Committee members' own individual experiences, that direct systematic instruction in phonics during the early years of schooling is an essential foundation for teaching children to read. Findings from the research evidence indicate that all students learn best when teachers adopt an integrated approach to reading that explicitly teaches phonemic awareness, phonics, fluency, vocabulary knowledge and comprehension. This approach, coupled with effective support from the child's home, is critical to success.*
>
> *The attention of the Inquiry Committee was drawn to a dichotomy between phonics and whole-language approaches to the teaching of reading. This dichotomy is false. Teachers must be able to draw on techniques most suited to the learning needs and abilities of the*

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367 Mr John Brigg, Acting Director, Inclusive Education Standards, Department of Education and Training, *Transcript of Evidence*, 11 June 2008, p 5.

368 Ms Lynne Middleton, President, Private Speech Pathologists' Association of WA, *Transcript of Evidence*, 30 July 2008, p 9.

369 Ms Lynne Middleton, President, Private Speech Pathologists' Association of WA, *Transcript of Evidence*, 30 July 2008, p 11; Mr John Brigg, Acting Director, Inclusive Education Standards, Department of Education and Training, *Transcript of Evidence*, 11 June 2008, pp 4-5.

370 Department of Education and Training, "Final Report", (2008). Available at: www.literacyandnumeracyreview.det.wa.edu.au/final-report, p 20. Accessed on 20 August 2008.

> *child. It was clear, however, that systematic phonics instruction is critical if children are to be taught to read well, whether or not they experience reading difficulties.*[371]

and found:

> *strong evidence that a whole-language approach to the teaching of reading on its own is not in the best interests of children, particularly those experiencing reading difficulties. Moreover, where there is unsystematic or no phonics instruction children's literacy progress is significantly impeded, inhibiting their initial and subsequent growth in reading accuracy, fluency, writing, spelling and comprehension.*
>
> *Much curriculum design, content, teaching and teacher preparation seems to be based, at least implicitly, on an educational philosophy of constructivism (an established theory of knowing and learning rather than a theory of teaching). Yet the Inquiry found there is a serious lack of supporting evidence for its effectiveness in teaching children to read. Further, too often emphasis is given to the nature of the child's environment or background rather than on how a teacher should teach, resulting in insufficient attention being given to both 'what' and 'how' teachers should teach children to read and write. Whereas the 'starting' levels of children from less advantaged backgrounds is lower than those from more advantaged backgrounds, findings from a large body of evidence-based research consistently indicate that quality teaching has significant positive effects on students' achievement progress regardless of their backgrounds.*[372]

Our Committee endorses these observations and findings of the National Inquiry and support the direct systematic instruction and explicit teaching of phonemic awareness and phonics during the early years of schooling that will provide an essential foundation for teaching children to read. There ***must*** be within the pre-primary and primary school curriculum (and the curriculum's pedagogy) an increased emphasis on 'phonemic awareness' that is mandatory for all teachers across Western Australia. This will play a supportive role in reducing the burden on health services by facilitating improved learning outcomes for many children.

The Australian National Curriculum Board's recent paper seeks to formalise this shift, arguing that "Many students in their early experiences of books may need systematic attention to phonological awareness and sound-letter correspondences."[373]

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371 Department of Education, Science and Training. (2005) *Teaching Reading: Report and Recommendations*, National Inquiry into the Teaching of Literacy, Department of Education, Science and Training, Canberra. Available at: www.dest.gov.au/nitl/documents/report_recommendations2.rtf, p 11. Accessed on 20 March 2009.

372 Department of Education, Science and Training. (2005) *Teaching Reading: Report and Recommendations*, National Inquiry into the Teaching of Literacy, Department of Education, Science and Training, Canberra. Available at: www.dest.gov.au/nitl/documents/report_recommendations2.rtf, p 12. Accessed on 20 March 2009.

373 National Curriculum Board, "National English Curriculum: Initial advice", (2008). Available at: www.ncb.org.au/verve/_resources/English_Initial_Advice_Paper.pdf, p 10. Accessed on 17 October 2008.

Finding 15

The move away from mandatory teaching of phonics has had a detrimental effect for a growing number of children who enter the formal schooling system without language and literacy foundations appropriate to their age.

Recommendation 37

The Department of Education and Training should adopt evidence-based language and literacy teaching for use in Western Australian schools to mandate the increased use of phonemic awareness (phonics) in the pre-primary and primary curricula.

APPENDIX ONE

SUBMISSIONS RECEIVED

The following submissions were received by the Inquiry.

Submission No.	Date	Name	Organisation
1	31 March 2008	Ms Fiona Yeats	Bruce Rock District High School
2	6 April 2008	Mrs Melissa Marquis	St Cecilia's Catholic Primary School
3	28 April 2008	Dr Harvey Coates	University of Western Australia
3 (B)	24 July 2008	Dr Harvey Coates	University of Western Australia
3 (C)	6 August 2008	Dr Harvey Coates	University of Western Australia
4	28 April 2008	Ms Francine Hyde	West Australian Orthoptic Association
5	1 May 2008	Ms Donna Philp	
6	7 May 2008		Willandra Primary School
7	8 May 2008	Ms Shirley McInnes	Resource Unit for Children with Special Needs (now known as CHILD Australia) www.childaustralia.org.au/
8	8 May 2008	Ms Patricia Kiely	Optometrists Association Australia
9	8 May 2008	Dr Ron Chalmers	Disability Services Commission
10	8 May 2008	Dr John Wray	
10 (B)	30 July 2008	Dr John Wray	
11	9 May 2008	Ms Lynne Middleton	Private Speech Pathologists Association of Western Australia www.pspa.com.au
11 (B)	30 July 2008	Ms Lynne Middleton	Private Speech Pathologists Association of Western Australia
12	9 May 2008	Dr Margaret Crowley	Association for the Blind of WA www.guidedogswa.com.au
13	9 May 2008	Hon Barbara Scott	WA Legislative Council

14	9 May 2008	Mrs Jean Ralph	Christian Science Committee on Publication for Western Australia
15	9 May 2008	Mr Stuart McKenzie	School Psychologists' Association of Western Australia (Inc.)
16	9 May 2008	Mr Paul Higginbotham	Telethon Speech and Hearing www.ichr.uwa.edu.au/
17	9 May 2008	Ms Carmen Gregg	Investing in our Youth Inc. www.investinginouryouth.com.au
18	9 May 2008	Ms Gaby Levi	State Child Development Centre
19	9 May 2008	Ms Nicole Lawder	Deafness Forum of Australia
20	9 May 2008	Ms Judy Walsh	OT Australia WA www.otauswa.com.au/
20 (B)	30 July 2008	Ms Judy Walsh	OT Australia WA
21	9 May 2008	Mr Jonathan Rafols	Speech Pathology Australia www.speechpathologyaustralia.org.au
22	9 May 2008	Ms Denise Luscombe	Early Childhood Intervention Australia (WA)
23	9 May 2008	Ms Linda Tanner	Speech (WA) Inc. speechwa.org.au/
24	9 May 2008	Mr Norman Davies	Perth Primary Care Network
25	12 May 2008	Dr Phil Ridden	St Stephen's School, Carramar Campus
26	12 May 2008	Prof Peter Howat	Public Health Association of Australia (WA Branch)
27	12 May 2008		National Investment for the Early Years hniftey.cyh.com/
28	13 May 2008	Ms Michelle Scott	Commissioner for Children and Young People WA www.ccyp.wa.gov.au/
29	21 May 2008	Ms Sharyn O'Neill	Department of Education and Training www.det.wa.gov.au
29 (B)	21 May 2008	Ms Sharyn O'Neill	Department of Education and Training

30	22 May 2008	Dr Peter Flett	Department of Health www.health.wa.gov.au
30 (B)	31 July 2008	Dr Peter Flett	Department of Health
30 (C)	8 April 2009	Dr Peter Flett	Department of Health
30 (D)	11 May 2009	Dr Peter Flett	Department of Health
31	21 May 2008	Prof. Sven Silburn	Curtin University and the Telethon Institute for Child Health Research
31 (B)	30 July 2008	Prof. Stephen Zubrick	Curtin University and the Telethon Institute for Child Health Research
32	7 April 2008	Ms Sharon Rimmer	Warnbro Primary School
33	24 June 2008	Hon Barbara Scott	WA Legislative Council

APPENDIX TWO

HEARINGS HELD

The Inquiry held the following hearings.

DATE	NAME	POSITION	ORGANISATION
11 June 2008	Dr Peter Flett	A/Director General	Department of Health
	Mr Mark Morrissey	Executive Director Child and Adolescent Community Health	Department of Health
	Mr Mark Crake	A/Director, Child and Adolescent Health Policy (Statewide)	Department of Health
	Ms Margaret Abernethy	Senior Portfolio Officer Child and Mental Health	Department of Health
	Ms Sharon McBride	Senior Portfolio Officer Child and Adolescent Health Service	Department of Health
	Mr John Brigg	A/Director, Inclusive Education Standards	Department of Education and Training
	Ms Sue Gouldson	Acting Manager, Strategic Planning and Policy, Inclusive Education Standards	Department of Education and Training
18 June 2008	Ms Sharon Rimmer	Pastoral Care Coordinator	Warnbro Primary School
	Ms Melinda Ashworth	Teacher	Warnbro Primary School
	Ms Carmen Gregg	Project Officer	Investing In Our Youth, Inc.
	Mrs Claire Philipps	Community Nurse	Child Health, WA Country Health Service—South West
	Dr John Wray	Paediatrician	
	Mr Paul Higginbotham	Chief Executive Officer	Telethon Speech and Hearing Centre

	Ms Jane Sutherland	Teacher of the Deaf	Telethon Speech and Hearing Centre
	Ms Philippa Hatch	Audiologist	Telethon Speech and Hearing Centre
	Dr Cori Williams	National President	Speech Pathology Australia
	Mr Stuart McKenzie	President	School Psychologists' Association of Australia (WA)
	Ms Grania McCudden	Vice President	School Psychologists' Association of Australia (WA)
	Ms Louella Vogel	Early Intervention Clinical Specialist	Early Childhood Intervention Australia (WA)
	Ms Leigh Dix	Early Intervention Clinical Specialist	Early Childhood Intervention Australia (WA)
	Ms Francine Hyde	President	West Australian Orthoptic Association
30 July 2008	Dr Phil Ridden	Head	St Stephens School
	Mrs Christine Benson	Deputy Head	St Stephens School
	Ms Shirley McInnes	Occupational Therapist/Resource Coordinator	Resource Unit for Children with Special Needs (RUCSN) (now known as CHILD Australia)
	Ms Cathy Hewick	Inclusion, Disability and Community Services Manager	Resource Unit for Children with Special Needs (RUCSN) (now known as CHILD Australia)
	Professor Stephen Zubrick	Head, Division of Population Sciences	Curtin University of Technology, Centre for Developmental Health at the Telethon Institute for Child Health Research

	Assoc. Professor Kate Taylor	Researcher	Curtin University Centre for Developmental Health at the Telethon Institute for Child Health Research
	Dr Ron Chalmers	Director General	Disability Services Commission
	Ms Anne Lawson	Policy Officer	Disability Services Commission
	Ms Gayle Hillen	Occupational Therapist	Occupational Therapists Australia (WA Branch)
	Ms Lynne Middleton	President	Private Speech Pathologists' Assoc (WA)
	Mrs Rosemarie Candler	Speech Pathologist	Private Speech Pathologists' Assoc (WA)
6 August 2008	Associate Professor Harvey Coates	Senior ENT Surgeon	Princess Margaret Hospital for Children
	Mr John Brigg	A/Director, Inclusive Education Standards	Department of Education and Training
	Ms Sallee Petit	Principal Consultant, Care and Protection, Inclusive Education	Department of Education and Training
	Ms Debra Shaw	Area Director, Early Childhood Education	Department of Education and Training
	Ms Kia Skonis	Principal Consultant, Speech and Language, Inclusive Education	Department of Education and Training
	Dr Peter Flett	A/Director General	Department of Health
	Mr Mark Morrissey	Executive Director Child and Adolescent Community Health	Department of Health
	Mr Mark Crake	A/Director, Child and Adolescent Health Policy (Statewide)	Department of Health
	Ms Margaret Abernethy	Senior Portfolio Officer Child and Mental Health	Department of Health

	Ms Sharon McBride	Senior Portfolio Officer School Health	Department of Health
	Ms Erin Gauntlett	Project Coordinator, Child Development Service Project	Department of Health
8 April 2009	Mr Mark Morrissey	Executive Director Child and Adolescent Community Health	Department of Health
	Mr Mark Crake	Director, Child and Adolescent Health	Department of Health
	Ms Margaret Abernethy	Senior Portfolio and Policy Officer	Department of Health
	Ms Sharon McBride	Senior Portfolio and Policy Officer	Department of Health
	Ms Erin Gauntlett	Senior Portfolio and Policy Officer	Department of Health
	Ms Kate Gatti	Director, Population Health, WA Country Health Service	Department of Health

APPENDIX THREE

A REVIEW OF SCREENING VERSUS SURVEILLANCE

The new health screening programs recently put in place in Western Australia and other jurisdictions represent a significant shift in policy approach by most western governments. This appendix provides a summary of the different approaches represented by 'screening' and 'surveillance'.

(a) Screening

Population screening for health issues is the concept of using relatively simple tests to assess the general population or in some instances a specific population in a convenient and cost effective manner in order to identify those persons who have health concerns requiring further attention or treatment. Population screening is recognised as only ever providing "an incomplete version of the true results."[374]

Adrian Heard, an epidemiologist at the South Australian Department of Health, described population screening as resulting in four groups, "two groups which benefit from the test and two which receive unhelpful information." Heard deemed that the two groups who benefited were those that were correctly identified as having a *disease* (emphasis added) and received important health information, and those correctly identified as not having a disease.[375]

The other two groups who are not well served by a screening process consist of those who give a positive screening test result but do not have a disease (false positives) and the group who return a negative screening test but do have a disease (false negatives).

According to Heard, the measure of efficiency for testing is determined by "how well a screening test identifies the truly diseased group, while keeping the false alarm group as small as possible is called the positive predictive value of the screening test."[376]

Heard argues that, although screening tests may be resource effective, such tests fail if there is inadequate sensitivity and specificity. *Sensitivity* measures the size of the truly diseased group relative to the total of the truly diseased and missed group. Thus a screening test which misses a lot of people and has poor sensitivity is to be avoided in screening programs. *Specifity* measures the size of the health group relative to the sum of the healthy and false alarm groups. Again, a test which gives many false alarms is to be rejected as a screening test.[377]

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374 Heard, A. (2006) "Sensitivity, Specifity and all that Screening Jargon", *Public Health Bulletin*, 5, p 7.

375 Heard, A. (2006) "Sensitivity, Specifity and all that Screening Jargon", *Public Health Bulletin*, 5, p 7.

376 Heard, A. (2006) "Sensitivity, Specifity and all that Screening Jargon", *Public Health Bulletin*, 5, p 7.

377 Heard, A. (2006) "Sensitivity, Specifity and all that Screening Jargon", *Public Health Bulletin*, 5, p 7.

Relatively recent work undertaken on behalf the National Health and Medical Research Council by the Centre for Community Child Health, Royal Children's Hospital Melbourne, examined the definitions and concepts attributed to screening and surveillance in its review of the evidence available to support, in particular, screening of children. The NHMRC report based its definition of a 'screening test' as being:

> *Any measurement aimed at identifying individuals who could potentially benefit from intervention, this includes symptoms, signs, lab tests, or risk scores for the detection of existing or future disease.*[378]

A 'screening program' is one that builds upon the above definition and is referred when:

> *…a test or series of tests, is performed on a population that has neither the signs nor the symptoms of the disease being sought but whose members have some characteristic that identifies them as being at risk from that disease, the outcome of which can be improved by early detection and treatment. Screening actually consists of all the steps in a program from the identification of the population at risk to the diagnosis of the disease or its precursor in certain individuals to the treatment of those individuals.*[379]

For the purposes of this report, the Committee has adopted the definitions for 'screening test' and 'screening program' as prescribed by the DOH within their submission to the inquiry:

> *A Screening Test - is any measurement aimed at identifying individuals who could potentially benefit from intervention. The include symptoms, signs, lab tests, or risk scores for the detection of existing or future disease, condition or specified adverse health outcome.*
>
> *A Screening Program - is a test or series of tests, performed on a population that has neither the signs nor symptoms of the disease being sought but whose members have some characteristic that identifies them as being at risk from that disease, the outcome of which can be improved by early detection and treatment.* [380]

(b) Surveillance

Having examined literature on health 'surveillance', as well as its own prior definition of surveillance, the National Health and Medical Research Council report documented a more comprehensive definition of surveillance specific to child health, as used by Stone:

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378 NHMRC (2002) *Child Health Screening and Surveillance: A Critical Review Of The Evidence*, National Health and Medical Research Council, Canberra, p 19.

379 NHMRC (2002) *Child Health Screening and Surveillance: A Critical Review Of The Evidence*, National Health and Medical Research Council, Canberra, p 19.

380 Submission No. 30 from Department of Health, Appendix 1, 16 May 2008, p 28.

> *Child health surveillance is the systematic and ongoing collection, analysis, and interpretation of child health, growth, and development in order to identify, investigate and, where appropriate, correct deviations from predetermined norms.*[381]

The NHMRC report considered that surveillance occurred at two levels - the individual and population levels. It continued that:

> *Individual surveillance focuses on a particular child, and will include gathering data from screening tests, physical examinations, discussions with parent and other caregivers, etc. This is also sometimes referred to as clinical surveillance.*

And further that:

> *Population surveillance focuses on groups of entire populations, and enables observation of changes and trends at a public health level. This is also sometimes referred to as monitoring.*[382]

381 National Health and Medical Research Council. (2002) *Child Health Screening and Surveillance: A Critical Review of The Evidence*, National Health and Medical Research Council, Canberra, p 22.

382 National Health and Medical Research Council. (2002) *Child Health Screening and Surveillance: A Critical Review of The Evidence*, National Health and Medical Research Council, Canberra, p 22.

APPENDIX FOUR

EXCERPTS FROM THE WA HEALTH ACT 1911

337. Examination of school children

(1) Any medical officer or any nurse duly authorised in this behalf by the Executive Director, Personal Health may examine medically and physically any child attending any school or child care centre, and such child shall submit to, and the parents or guardians of such child shall permit such examination as the medical officer or nurse deems necessary.

(2) Any school dental therapist employed in a school dental service, or any duly registered dentist authorised to do so by the Executive Director, Personal Health or by the local government, may examine the teeth of any such child, and the child shall submit to, and the parents or guardians of such child shall permit, the examination.

(3) Any medical officer or any nurse duly authorised in this behalf by the Executive Director, Personal Health who finds that any such child is in an unclean or verminous condition may, by writing under the hand of such medical officer or nurse, notify any parent or guardian of the child of the fact, and require such parent or guardian to remedy such condition forthwith, and to keep such child clean or free from vermin.

(4) In addition to making the requisition mentioned in subsection (3), the medical officer or nurse may, by writing under the hand of such officer or nurse, require the parent or guardian to keep the child's hair cut short to the satisfaction of the officer or nurse or of the medical officer of health of the local government.

(5) Every such requisition as is mentioned in subsection (3) or subsection (4) shall, in so far as it is of a continuing character, remain in force for 12 months.

(6) A parent or guardian who does not comply with a requisition made under subsection (3) or (4) commits an offence.

337A. Schools dental service

(1) There shall be established in accordance with this section a school dental service to provide dental care and treatment for pre-school and school children.

(2) With the approval of the Minister, the CEO may establish and maintain teaching schools and facilities for the training of persons as school dental therapists.

(3) There shall be appointed under and subject to Part 3 of the Public Sector Management Act 1994 , such dentists, school dental therapists and other officers and staff as may be required for the purposes of this section.

(4) The Governor may make regulations prescribing the manner in which acts of dentistry are to be undertaken by a school dental therapist.

338. Parent or guardian to provide medical or surgical treatment for child in certain cases

(1) Any parent or guardian who, after being notified by a medical officer of some physical defect in a child, which defect requires medical or surgical attention, fails or neglects to secure or provide such attention, if such failure or neglect endangers or is likely to endanger the life or the health of such child, commits an offence:

Provided that no prosecution shall be instituted for a breach of this section without the approval of the Executive Director, Personal Health and until the child has been examined by a medical officer, acting in consultation with a private medical practitioner.

(2) It shall be the duty of any such child to submit to, and of the parents or guardians of such child to permit any examination necessary for the purposes of this section.

340. Local government may provide for immunisation

(1) Any local government may provide for immunisation of any person who consents to treatment against diphtheria, whooping cough, poliomyelitis, tetanus, and such other diseases as the Governor prescribes and is hereby authorised to prescribe by regulation as diseases to which this section applies wholly free of cost to the person treated and the cost involved shall be paid by the local government, which is hereby authorised to meet the cost from the annual health rate made, levied and collected by it under and for the purposes of this Act.

(2) The Executive Director, Personal Health may provide for immunisation of any person who consents to treatment against any disease which is mentioned in subsection (1) or which is prescribed as a disease to which this section applies, wholly free of cost to the person treated and the cost involved shall be paid from money appropriated by Parliament for the purposes of this Act.

APPENDIX FIVE

SERVICE DEMAND FOR WA METROPOLITAN CHILD DEVELOPMENT SERVICES- 2005[383]

A.- By service provider type

	South Metro	North Metro (E)	North Metro (W)	Total	% of Tot.
Audiologist	1,245	0	227	**1,472**	3.6%
Clinical Psychologist	1,341	612	0	**1,953**	4.8%
Diabetes Educator	1	6	0	**7**	0.0%
Dietician	247	31	31	**309**	0.8%
Health Liaison Officer	199	0	0	**199**	0.5%
Health Worker	248	22	11	**281**	0.7%
Medical Officer (for Comm health)	770	493	59	**1,322**	3.3%
Multi-Disciplinary	301	0	0	**301**	0.7%
Occupational Therapist	4,893	2,200	0	**7,093**	17.5%
Paediatrician	872	0	0	**872**	2.2%
Physiotherapist	3,930	691	0	**4,621**	11.4%
Podiatrist	821	362	0	**1,183**	2.9%
Social Worker	1,676	334	48	**2,058**	5.1%
Speech Pathologist	14,949	3,454	425	**18,828**	46.5%
TOTAL	***31,493***	***8,205***	***801***	***40,499***	
Unspecified			6,914	**47,413**	

B.- By type of service

SERVICE PROVIDED	SOUTH METRO	NORTH METRO	TOTAL METRO	% of TOT.
Treatment	11,264	3,985	**15,249**	40.8%
Assessment	6,293	1,468	**7,761**	20.8%
Review/re-assessment	5,425	1,385	**6,810**	18.2%
Advocacy/Liaison	1,822	898	**2,720**	7.3%

383 Department of Health, "Future Directions for Western Australian Child Development Services", (2006). Available at: www.health.wa.gov.au/hrit/childdevelopment/docs/CD_Framework_Outline.pdf, pp 9-11. Accessed on 16 May 2008.

Counselling	1,431	640	**2,071**	5.5%
Equipment prov/instruction	571	115	**686**	1.8%
Case conference	444	116	**560**	1.5%
Health Education/promotion	421	46	**467**	1.2%
Drug therapy/management	186	65	**251**	0.7%
Psychometric assess	213	12	**225**	0.6%
Orthotic/insole man.	194	4	**198**	0.5%
Screening	79	103	**182**	0.5%
Client transport	118	5	**123**	0.3%
Willstaar program	15	29	**44**	0.1%
Triple P (Positive Parenting program)	14	0	**14**	0.0%
Multiple Services	7	0	**7**	0.0%
Home Maintenance	2	2	**4**	0.0%
Immunisation	3	0	**3**	0.0%
Psychiatric crisis interv.	0	2	**2**	0.0%
Palliative care	2	0	**2**	0.0%
Personal care	2	0	**2**	0.0%
Edinburgh PND	1	1	**2**	0.0%
BTSE, 3-4 months contact	2	0	**2**	0.0%
BTSE, subsequent H/V 0-12 months	2	0	**2**	0.0%
Psychiatric emergency	1	0	**1**	0.0%
Practical assistance	1	0	**1**	0.0%
Minor Surgery	1	0	**1**	0.0%
Radiology	0	1	**1**	0.0%
TOTAL	***28,514***	***8,877***	***37,391***	
Unspecified service provision	2,979	7,012	9,991	

C.- By type of health service

HEALTH ISSUE	SOUTH METRO	NORTH METRO	TOTAL METRO	% of TOT.
Speech & Language	15,035	6,831	**21,866**	46.2%
Developmental Issues	8,770	5,623	**14,393**	30.4%
Local codes	212	1,048	**1,260**	2.7%
Musculoskeletal System	2,439	680	**3,119**	6.6%
Social Health Issues	1,687	755	**2,442**	5.2%
Nervous System & Sense Organs	2,017	246	**2,263**	4.8%
Mental health	937	629	**1,566**	3.3%
Endocrine/Nutritional/Metabolic/Immunity	255	50	**305**	0.6%
Miscellaneous	45	15	**60**	0.1%
Skin & Subcutaneous Tissues	45	2	**47**	0.1%
Injuries	15	0	**15**	0.0%
Digestive System	16	2	**18**	0.0%
Immunisation	7	1	**8**	0.0%
Blood/Blood Forming Organs	1	1	**2**	0.0%
Respiratory System	1	2	**3**	0.0%
Reproductive System and Pregnancy	4	0	**4**	0.0%
Circulatory System	3	0	**3**	0.0%
Infectious & Parasitic Diseases	2	0	**2**	0.0%
Genitourinary System	2	0	**2**	0.0%
Total	***31,493***	***15,885***	***47,378***	

APPENDIX SIX

RECOMMENDATIONS FROM THE HRIT REPORT[384]

RECOMMENDATION ONE – LEADERSHIP

1.1 That the Minister in his capacity as the Board of Management of all Western Australian Health Services, direct and empower the Princess Margaret Hospital/Child and Youth Health Service to assume the leadership for child development services in Western Australia and to take responsibility, through collaboration and consultation, for coordinating and integrating guidelines and policies to support consistent screening, assessment, diagnosis and treatment of all children with developmental delay. This assignment should be supported through a realignment of the Child and Community Health Directorate and Area Health Services resources.

1.2 The development of these policies and guidelines should include resources for culturally appropriate services to support culturally secure screening, assessment, diagnosis and treatment of indigenous children and culturally and language diverse children (CALD).

There is also a significant need for a service agreement across WA Health for indigenous children specifically, to initiate the collaboration between Western Australian child development services in the development of policy and services with all service providers to that group of the population.

1.3 Area Health Services should as soon as practicable after release of this review, consider the merits of the transfer of all child development functions and resources to the Princess Margaret Hospital/Child and Youth Health Service. Such transfer should proceed unless Area Health Services can demonstrate that this action would exacerbate current fragmentation of services.

RECOMMENDATION TWO – CLINICAL GOVERNANCE OF CHILD DEVELOPMENT SERVICES.

2.1 That a clinical governance body for Western Australian child development services be established, led by the Princess Margaret Hospital/Child and Youth Health Service and inclusive of key stakeholders in the delivery of these services including medical, allied health and nursing staff, health consumers, and other relevant agencies such as the Department of Education and Training and Disability Services Commission.

2.2 The proposed governance body will be lead by Princess Margaret Hospital with other representatives selected through an open and transparent process from child health and

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384 Department of Health, "Future Directions for Western Australian Child Development Services", (2006). Available at: www.health.wa.gov.au/hrit/childdevelopment/docs/CD_Framework_Outline.pdf, pp 20-25. Accessed on 16 May 2008.

development policy sectors, allied health and community nursing. This body will define and monitor the operations of the state-wide child development programs.

2.3 The current HRIT state-wide Allied Health Reference Group for Child Development Services should continue to convene so that its members can assist in the clinical governance process.

RECOMMENDATION THREE – WAITING LISTS AND WAITING TIMES

3.1 In the absence of a comprehensive transfer of functions and resources, and to ensure a collaborative approach is taken, written performance agreements with Area Health Services will be developed by the proposed governance body that will include details of each individual service's capacity and requirements for assessment, referrals, therapy and follow-up.

3.2 To reduce waiting times, uniform processes of administration, assessment, diagnosis, prioritisation, care planning and data collection and reporting are to be developed and implemented in all child development services across WA.

RECOMMENDATION FOUR – COLLABORATION AND PARTNERSHIPS

4.1. To improve access to and the transfer of patient data between providers, a single child development information system will be developed and made available to all public child development services.

4.2. To support that system, existing legal and other requirements shall be reviewed and any unnecessary legal impediment removed to support information sharing and better integration and collaboration between services.

4.3. To increase knowledge of child development services a community services directory will be developed and provided through the Health Call Centre and, when launched, the Princess Margaret Hospital/Child and Youth Health Service website.

4.4. To improve the interface and communication between services and practitioners, a child development chapter of the existing Child Health Network will be developed to discuss and address issues of coordination and collaboration across agencies, providers and practitioners.

4.5. A joint agency agreement will be developed between the SCDC/single state-wide child development service, Area Health Services (and in particular the Child and Adolescent Mental Health Services), the Departments of Education and Training, Community Development and the Disability Services Commission to delineate roles and accountabilities for child development services and cross referral practices to ensure no child becomes lost in the system.

4.6. A memorandum of understanding should be established with research and tertiary institutions and the state child development services of WA governance body.

RECOMMENDATION FIVE – FAMILY AND COMMUNITY ENGAGEMENT

That a further function for the SCDC or the combined service, through the clinical governance process is the reinforcement of the family-centered model and the development of information and training to support a greater role for parents and carers in assessing and re-mediating developmental delay in children, particularly where that delay and/or remediation can be best addressed early by parents or carers.

RECOMMENDATION SIX – RECOGNITION AND DEVELOPMENT OF THE TIERS OF CARE

In the context of developing clinical standards of practice, including the selection of risk based assessment tools, the SCDC or combined developmental service, through the clinical governance structure should develop clear pathways for children from screening, through assessment and where necessary to therapy. This should include details of ongoing audit processes to measure the most effective outcomes that would also include consideration of reflective practice.

APPENDIX SEVEN

DET REVIEW OF SCHOOL SCREENING PROGRAMS[385]

The following is a summary of the responses provided by key stakeholders through written statements and consultation conducted during a half day forum coordinated by the Department of Education and Training.

Table A7.1 Hearing screening

ToR 1: Availability and adequacy of screening processes	ToR 2: Assessment of access to appropriate services
Availability School entry hearing screening for hearing acuity is conducted by school health nurses and is expected to be completed by the end of Year 1 for all children. In regional areas it may also be conducted during a general health check by a paediatric or community health nurse or a Department of Health audiologist or one contracted by the Department of Health.	Services A variety of services are provided to children from birth to school leaving age through DET school programs and external providers. The WA Institute for Deaf Education (WAIDE), as part of the Department of Education and Training's Statewide Specialist Services, provides a visiting teacher service in both public and private schools. This includes early intervention programs, deaf units for specialist support, Auslan (Australian sign language) sessions, educational interpreters, a resource centre and captioning services. Strong liaison occurs across all community agencies involved with deafness and hearing loss post screening when issues are identified. These agencies include: Australian Hearing, Child Development Centres, Disabilities Services Commission, the WA Deaf Society, Senses Foundation and both public and private hospitals.

385 Submission No. 29, Department of Education and Training, 21 May 2009, pp 4-17.

Adequacy	Access
Several groups of students with potential hearing problems are not always captured at the school entry level screening. These include older children transferring from interstate, students who may not be attending school at the time that screening is undertaken (a particular issue in rural and remote locations), and older migrant and refugee children, as well as children with CALD/ Aboriginal backgrounds. Students with fluctuating hearing problems can also be missed in the current one-off entry level assessment. Students with speech and language problems may also be difficult to assess through the entry level screening process. Parents can alert schools to a hearing difficulty via the new school enrolment form. Not all school health nurses are trained to do hearing screens at all levels required to detect hearing issues (air versus air and bone) and that current cut-off thresholds are not sensitive enough to detect all hearing difficulties. Screening may not occur until the end of Year 1 resulting in a significant amount of time being lost before appropriate interventions and educational management can be put in place. Given the impact on educational outcomes for students, screening should occur earlier, perhaps at K level. This may be difficult, given it is dependent upon gaining informed parental consent and Year One is the first compulsory education period. The lack of on-going screening can result in a reliance on teacher and school referral, which may result in students being missed due to lack of specialist knowledge. There is currently a limited capacity for school nurses to provide follow-up screening of absentee children who miss school entry assessments, especially in rural and remote areas. This is largely due to limited resources.	Regional and remote service delivery is difficult due to limited staffing availability. Many support services are provided on a fly in / fly out basis, which potentially reduces the impact of the intervention and follow-up. There is currently no provision for support to be provided by DET for children less than four years of age and there is also a lack of staff to support parents from diagnosis to service delivery. There can be a time delay for services being provided, and continuity of service interventions could also be improved. There is a lack of follow-up to ensure parents / carers have the capacity and commitment to access treatment. This is sometimes due to economic factors and distances required to travel, but can also be due to lack of parent / carer understanding of the impact of the disability and the need for timely and appropriate interventions. There can be a lack of understanding by teachers and other school staff of the impact of hearing loss.

SPECIFIC RECOMMENDATIONS

- Increase the time/resources available for school health nurses to improve their capacity for follow-up screening and surveillance, as the current levels of resourcing are inadequate.
- Explore the efficacy of universal screening occurring at the K level, in order to ensure that the earliest possible interventions are put in place.
- Explore the efficacy of more frequent universal screening of hearing throughout the school year to ensure that at-risk students are not overlooked. This also has the potential to reduce the current over-reliance on informal teacher assessment for referral and to minimise the time delay from diagnosis to treatment.
- Additional nurse time provided to enable children identified as “at risk” to be monitored on a 3-6 monthly basis (or more) until hearing status is normal or managed.
- Offer professional learning to early childhood teachers and other school-based staff regarding hearing loss and its impact, the monitoring of hearing and the appropriate referral process if concerns exist.
- Explore the possibility of the provision of an early intervention team approach on the school site including occupational /physical/speech pathology. Many children now have multiple disabilities.
- Investigate strategies to ensure continuity of service provision post-diagnosis.
- DOH to consider its capacity to lead the coordination of service provision in regional areas.
- Reduce the time delay between diagnosis and access to relevant services.
- Identify and implement strategies to assist parents/carers to increase their capacity and commitment to accessing services.

Table A7.2 Vision screening

ToR 1: Availability and adequacy of screening processes	ToR 2: Assessment of access to appropriate services
<u>Availability</u> School entry vision screening is carried out by school health nurses for visual acuity and strabismus. The screening of all children is expected to be completed by the end of Year 1. In regional areas, the screening may be conducted during a general health check by a paediatric or community health nurse. This screening is able to identify many children who have previously been undiagnosed. Some targeted screening is also provided by paediatricians, PMH, optometrists and GPs. Early childhood teachers also supplement formal screening with observation within the school setting.	<u>Services</u> The Department's Vision Education Service (VES) provides statewide support to students with vision impairment at home and in both public and private schools. This support includes a visiting teacher service to work with teachers, the provision of materials in alternative formats and necessary hardware and software. VES also provides cross-sectoral support for schools through professional learning and consultation The Association of the Blind WA provides access to various allied health services. Clinical services are provided by such groups as Lion's Eye Institute, PMH and GPs.
<u>Adequacy</u> There can be a significant delay, especially in regional areas, between the diagnosis of a suspected vision impairment and access to a specialist. There is currently a limited capacity for school nurses to provide follow-up screening of absentee children who miss school entry assessments, especially in rural and remote areas. This is largely due to limited resources.	<u>Access</u> Limited availability and frequency of services particularly in regional and remote areas Lack of coordination between several service providers resulting in an expensive duplication of effort. Given that resources are stretched in this area, there is a clear need for better coordination between service providers. Lack of coordinated services for Deaf-Blind children. Lack of awareness amongst medical staff regarding post-diagnosis counselling and support services. Lack of follow-up to ensure parents / carers have the capacity and commitment to access treatment. This is sometimes due to economic factors and distances required to travel, but can also be due to lack of parent / carer understanding of the impact of the disability and the need for timely and appropriate interventions.

SPECIFIC RECOMMENDATIONS

- The Department of Health (DOH) to consider efficacy of alternative/complementary screening tools (e.g. electronic screening tool developed by Professor Yogesan at the Lion's Eye Institute). This may have the potential to provide health staff in remote areas with a more sophisticated vision screening tool.

- Explore the efficacy of more frequent universal screening of vision occurring throughout primary school to ensure that at risk students are not overlooked. This also has the potential to reduce the current over-reliance on informal teacher assessment for referral and to minimise the time delay from diagnosis to treatment.

- More collaboration between service providers to review the possibility of multi-organisational teams to service rural and remote areas resulting in lower costs and improved sharing of resources and improved service delivery.

- Consideration to be given to the creation of a Memorandum of Understanding between DET and DOH regarding state-wide provision of services for children who are Deaf-Blind.

- The development of a communication strategy to inform clinical staff regarding education support services that are available.

- Identification of current provision of counselling services for families post-diagnosis and assess its adequacy.

- Identification and implementation of strategies to assist parents/carers increase their capacity and commitment to access treatment.

Table A7.3 Speech and language screening

ToR 1: Availability and adequacy of screening processes	ToR 2: Assessment of access to appropriate services
Availability There is currently no universal screening program for speech and language. School health nurses conduct a basic, non-standardised assessment for targeted children based on teacher or parent referral. Schools conduct their own screening using a variety of tools to identify students at risk.	Services DET Statewide Speech and Language Service provides professional learning, support and consultation to all public schools to improve teacher and administrator capacity. It does not provide assessment or therapy services. DET provides 5 Language Development Centres (LDCs) which are specialist units providing intensive early intervention programs for students K-1 with identified primary language impairment as diagnosed by a speech pathologist. Some schools and parents self-fund access to private speech pathology services. Child Development Centres (CDCs) provide allied health services including speech pathology to children who have been identified as requiring assessment and/or management of detected developmental problems.

Adequacy	Access
The lack of DOH speech pathology services to screen pre-compulsory and school-aged children has significant implications for students with speech and language needs given the impact on educational outcomes. Research suggests early intervention is highly effective. The lack of a school readiness assessment tool to identify children at risk, means that there can be an over-reliance on teachers to make assessments. Teacher assessment may not always be accurate due to the complexity of the assessment process and the level of teacher knowledge in the area. The lack of community and school awareness of speech and developmental milestones results in confusion about when to refer, strategies to employ and who to contact for support. Specific issues related to at risk groups such as CALD and Aboriginal students result in some confusion over the accurate assessment of speech and language. Participation and attendance issues for some students mean that they can sometimes miss out on being identified for needed services.	There is a limited capacity to meet identified need due to insufficient resources, with the LDCs currently resourced to cater for only 1,000 of the 14,500 students identified with a primary language impairment. This results in very long waiting lists for services and increased pressure on these resources. The Statewide Speech and Language Service is a consultative service and does not provide assessment and therapy services. CDC speech pathology provide limited assessment and therapy services for school age children. Very long waiting lists reduces access. The option of accessing private services is costly and in some cases, prohibitive for both schools and parents. The limited Medicare rebate available to parents for accessing private providers makes it inaccessible for many families. There is limited access to speech pathology services in some rural areas. Lack of parent / carer understanding of the importance of speech and language and its relation to educational outcomes means that there is sometimes a lack of commitment and capacity to ensure that students get access to services. This can be particularly relevant to Aboriginal students or those with multiple challenges. Lack of flexibility in the current service delivery options, with a clinical service model rather than school-based service delivery, impacts on the pressure for resources and services. Communication and coordination between DOH and DET when a child is accessing services is not always evident and tracking of children is difficult. There are specific issues related to at-risk students (CALD/ Aboriginal / low socio-economic status) that may result in the by-passing of services provision due to the difficulty of prioritising a range of issues in the child's environment. There is also a lack of recognition of the diversity of communication capacity for CALD groups.

SPECIFIC RECOMMENDATIONS

- Explore the efficacy of a universal, on-entry speech and language assessment/screening tool being developed for all students.
- Provide increased resources to provide support for children with speech and language needs. This will require an increase above existing DET budgets.
- Professional learning to be offered to all school-based staff to improve the current knowledge and understanding of speech and language development and required teaching and learning adjustments, as well as an understanding of referral agencies and their role in assessment and therapy services provision.
- Consideration should be given to changes to the Child Development Centre (CDC) Service Model, from the current clinical model to a school-based service delivery model that provides assessment and therapy/treatment of identified students at compulsory school age.
- Identification and implementation of strategies to assist parents/carers to increase their capacity and commitment to access treatment.
- Specific focus needs to be placed on the most at-risk groups (CALD/Aboriginal and low socio-economic status) and a coordinated approach taken to ensure appropriate assessments are undertaken and appropriate services are delivered to students identified through that assessment.

Table A7.4 Motor skills screening

ToR 1: Availability and adequacy of screening processes	ToR 2: Assessment of access to appropriate services
Availability There is currently no universal, standardised screening program for assessing students' fine and gross motor skills. School health nurses conduct a basic assessment for targeted children based on referral by a parent or school. Schools may conduct their own screening of motor skills using a variety of tools such as *Kindergarten and Pre-Primary Profiles* which screens various domains of development including physical development and the *Fundamental Movement Skills: Stay in Step* assessment tool administered by trained school staff for targeted students with motor coordination difficulty. Assessment for targeted students is provided by UWA Unigym upon referral from schools.	Services The Department of Education and Training provides statewide training to early childhood teachers on the use of the Fundamental Movement Skills resource (soon to be made available electronically to DET staff). Take-up of the professional learning, however, is up to individual teachers and schools. Child Development Centres (CDCs) provide allied health services including physiotherapy and occupational therapy to children who have been identified as requiring assessment and/or management of detected developmental problems.
Adequacy The lack of a mandated screening process places a reliance on teaching staff to make referrals and/or assessments. This can be problematic, given that there can be a lack of teacher knowledge and awareness of the fine and gross motor continuum.	Access There is an identified lack of specialist staff (such as occupational therapists and physiotherapists) to provide required services when students have been identified. Lack of coordination and communication between DOH and DET regarding access to allied health services. There is a lack of understanding, amongst parents / carers and teachers as to the impact of motor skills issues and its co-morbidity with speech and language difficulties. There is a lack of follow-up to ensure parents / carers have the capacity and commitment to take children to access treatment. This is sometimes due to economic factors and distances required to travel, but can also be due to lack of parent / carer understanding of the impact of the disability and the need for timely and appropriate interventions.

SPECIFIC RECOMMENDATIONS

- Investigation as to whether a universal assessment tool for fine and gross motor skills is warranted.
- Maintenance of the mandatory two hours Physical Activity program in schools, with a focus on information derived from the Fundamental Movement Skills assessment tool.
- On-going implementation of the Fundamental Movement Skills Program to provide an opportunity for teachers to globally assess children's motor skills.
- Consideration of a Memorandum of Understanding between DOH and DET regarding access to services for students identified with fine and gross motor skills issues.
- Increased resources to provide support for children with motor skills difficulties. This will require an increase above existing budgets.
- Identification and implementation of strategies to remove barriers for parents/carers accessing treatment.

Table A7.5 General health

ToR 1: Availability and adequacy of screening processes	ToR 2: Assessment of access to appropriate services
Availability There is currently no universal screening program for assessing a range of health issues, including dietary/obesity issues and mental health. School health nurses conduct a basic assessment for targeted children based on referral by parents or teachers. Public and private schools can access school psychology services to perform behaviour and/or cognitive assessments on targeted students.	Services Schools have access to School Psychology Services which provide counselling and support to students and teachers and facilitate links to external providers of mental health services as required. Socio-Psychological Education Resource Centres (SPER) (DET) provide short-term specialist support services to public primary schools to manage students with moderate to severe social, emotional, psychological and behavioural difficulties. Hospital School Services (DET) provides educational support for K – 12 patients of PMH within the metropolitan area, and community clinics including Child and Adolescent Health Services (CAMHS), as well as students homebound due to medical reasons. CAMHS (DOH) provide specialist assessment and treatment services for children, adolescents and their families experiencing severe emotional, psychological, behavioural, social and/or mental health problems.

Adequacy	Access
Current targeted assessments make effective use of limited resources. The lack of universal screening processes for key areas of general health can impact on educational outcomes for students. There is also a lack of early screening and assessment tools in social and emotional development. The dependence upon teacher and / or parent referral, particularly in the area of mental health is problematic. Given that identification and definition of mental health issues are complex, and the potential for confusion of those with behavioural problems, it places a lot of pressure on teachers to make accurate assessments. Passive students who may not be displaying overt behaviour problems may be overlooked for further assessment. Parents may also be reluctant to identify mental health issues in their child and to seek out assessment and/or services.	There is a general lack of awareness of the range of mental health issues and relevant services. This may result in students being misunderstood and viewed as behaviour problems. Lack of timely referral to specialist services may exacerbate the problem and children miss opportunities for early intervention. There are limited mental health resources and referral options. These resources include specialist personnel to provide services required (eg. school health nurses, school and clinical psychologists, social workers and counsellors) which results in a long waiting list for services. This problem is exacerbated in rural and remote areas. There is a lack of follow up to ensure parents / carers have the capacity and commitment to access treatment. This is sometimes due to economic factors and distances required to travel, but can also be due to lack of parent / carer understanding of the impact of the disability and the need for timely and appropriate interventions.

SPECIFIC RECOMMENDATIONS

- Ongoing parent and teacher education regarding general health issues through community education programs.
- Explore the options of increased access to school psychologist/Mental Health Services through an increased number of school psychologists.
- Identification and implementation of strategies to assist parents/carers having the capacity and commitment to access treatment.

APPENDIX EIGHT

CDS ASSESSMENT AND PRIORITY CATEGORIES[386]

Assessment

Assessment is a process that involves a face to face meeting (with parent(s) and/or the client) in order to enable diagnosis and/or the formation of a management plan for a client. Once eligibility has been determined, referrals are presented at an intake meeting. Once a referral has been accepted at intake, a priority category is allocated to a child with the following timeframes applying to the priority categories:

Table A8.1 Timeframe for CDS priority categories

Priority	Timeframe for completing the assessment
1	Within 4 weeks of intake
2	Within 3 months of intake
3	Within 4 months of intake
4	Within 5 months of intake
5	Within 6 months of intake

Allocation of priority categories is informed by a range of information including the referral form, ASQ/ ASQ-SE and PAQs. It may be necessary to obtain further information in order to allocate an assessment priority, which could include completion of a screening tool with parents and/or the client. It is possible that different disciplines will allocate a different priority category for a child.

Priority One

The following children will be allocated a priority one status:

1. A child of any age requiring assessment/ diagnosis/ treatment within 4 weeks
    - to enable referral to external services and/or
    - due to the severity of the developmental delay/concern and/or
    - due to parental anxiety/distress.
2. A child of any age where there is a risk of significant deterioration (for the child/family) if action is delayed.
3. Children 0-3 years of age with developmental concerns/needs that

386 Submission No. 30 (C), Department of Health, Response to Questions on Notice, 8 April 2009, p 9.

- are complex and/or
- are severe and/or
- require intervention at particular point/s in time (timeliness).

Priority Two

The following children will be allocated a priority two status:

1. Children 0-3 years of age with developmental concerns/needs that:
    - are NOT complex and/or
    - are NOT severe and/or
    - do NOT require intervention at particular point/s in time (timeliness).
2. Children 4-6 years of age with developmental concerns/needs that
    - are complex and/or
    - are severe and/or
    - require intervention at particular point/s in time (timeliness).

Priority Three

The following children will be allocated a priority three status:

1. Children 4-6 years of age with developmental concerns/needs that:
    - are NOT complex and/or
    - are NOT severe and/or
    - do NOT require intervention at particular point/s in time (timeliness).
2. Children 7-12 years of age with developmental concerns/needs that
    - are complex and/or
    - are severe and/or
    - require intervention at particular point/s in time (timeliness).

Priority Four

The following children will be allocated a priority four status:

1. Children 7-12 years of age with developmental concerns/needs that:
    - are NOT complex and/or

- are NOT severe and/or
- do NOT require intervention at particular point/s in time (timeliness).

2. Children over 13 years of age that are
   - complex and/or
   - are severe and/or
   - require intervention at particular point/s in time (timeliness).

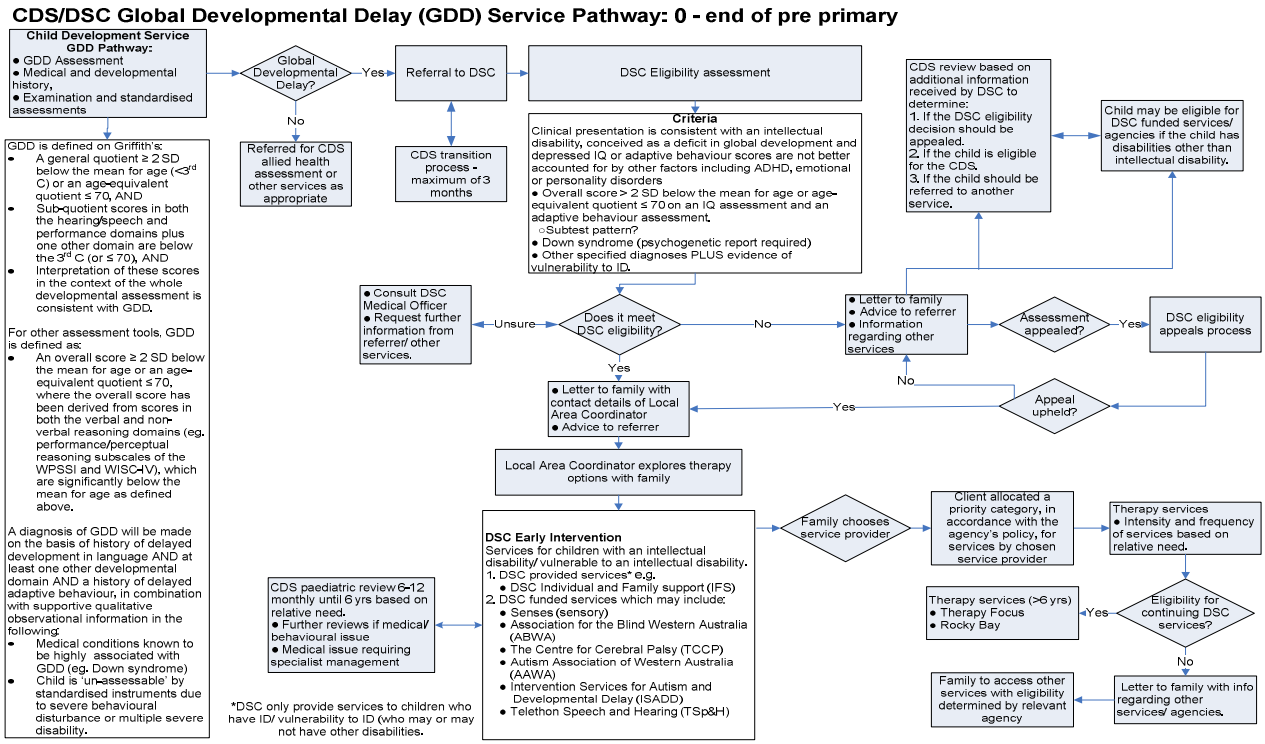
Priority Five

The following children will be allocated a priority five status:

1. Children over 13 years of age with developmental concerns/needs that:
   - are NOT complex and/or
   - are NOT severe and/or
   - do NOT require intervention at particular point/s in time (timeliness).

APPENDIX NINE

CDS/DSC PATHWAY FOR CHILDREN WITH GLOBAL DEVELOPMENTAL DELAY[387]



387 Submission 30 (C), Department of Health, Response to Questions on Notice, 8 April 2009, p 19.

APPENDIX TEN

CHILD DEVELOPMENT SERVICES AVAILABLE IN WACHS REGIONS[388]

Southwest	Goldfields	Kimberley	Pilbara	Wheatbelt	Great Southern	Midwest
There are four multidisciplinary child development teams comprising of speech pathology, occupational therapy, physiotherapy and in some cases social work which are based in: Busselton, Bunbury/Harvey/Yarloop, Warren & Blackwood, and Wellington. Additional access to podiatrist, dietician and regional paediatric audiology service.	There is no dedicated child development team. Allied health staff based in Esperance and Kalgoorlie provide services across the lifespan. Outreach services are provided from these centres to surrounding populations. <u>Esperance/ Revensthorpe/ Norseman:</u> FTE is the approx proportion dedicated to child development	The Kimberley Health Region Paediatric and Child Health Service is an acute based paediatric service with community outreach. This is complimented by Aboriginal Health Workers/ Community Midwives, child health nurses, school health nurses and remote area nurses. <u>Dedicated child development staff FTE:</u> Paediatrician	There is no dedicated child development team. Allied health staff based in East and West Pilbara provide services across the lifespan including child development. Outreach services are provided from these centres to surrounding populations. <u>East Pilbara:</u> The following FTE is the approximate proportion dedicated to child development	There are four multidisciplinary child development teams through out the region. Teams are based in Northam, Narrogin, Merredin and the Western Wheatbelt (Jurien/Moora/Gingin). Outreach services are provided from these centres to surrounding populations <u>Total FTE</u>: Speech pathology: 8.6 Occupational therapy	There are two multidisciplinary child development teams throughout the region. The teams are based in Albany and Katanning. <u>Albany</u> A number of programs are provided including: The Early Childhood Program for 0-3/4 year olds not attending school The School Readiness Program - a mainstream	There is no dedicated child development team. Allied health staff based in Geraldton, Carnarvon and Meekatharra providing services across the lifespan. Outreach services are provided from these centres to surrounding populations. Allied health and community health meet to share clinical information especially for clients with multiple health

388 Submission 30 (C), Department of Health, Response to Questions on Notice, 8 April 2009, p 19.

FTE Individual health professionals provide services across the care continuum in a number of districts and the FTE allocation is dependent on a variety of other factors such as inpatient activity. The figures provided are therefore approximations only. Audiology: 0.6 (regional service) Speech pathology: 11.3 Occupational therapy: 7.0 Physiotherapy: 5.8 Dietetics : 1.5 Social Work: 2.1 Podiatry: 0.4 Allied health assistant: 4.2	services. Audiology: 0.4 Dietetics: 1.0 Occupational therapy: 2.0 Physiotherapy: 3.0 Speech pathology: 1.0 Social work: 1.0 Therapy assistant: 2.0 <u>Kalgoorlie FTE:</u> Audiology: 1.0 Dietetics: 1.0 Occupational therapy: 2.0 Physiotherapy: 2.0 Podiatry: 1.0 Speech pathology: 3.0 Allied health assistant: 3.0 Aboriginal liaison welfare officer support: 2.0	registrar: 1.0 Paediatrician consultants: 2.0 There is access to acute based allied health disciplines however this is limited as they cover both adults and children and have a long wait list.	services <u>Newman FTE:</u> Speech pathology: 0.6 Occupational therapy: 0.5 Physiotherapy: 0.6 Child health:1.0 School Health: 1.0 <u>Nullagine:</u> Visiting school and child health nurse <u>Marble Bar:</u> Visiting child health nurse (monthly), school health nurse as required or weekly for one day. <u>Port Hedland:</u> Physiotherapy: 2.0 Speech pathology: 1.2 OT: 2.0 <u>West Pilbara:</u> FTE is the approx	5.5 Physiotherapy: 1.2 Dietetics: 0.4 Podiatry: 0.3 Health promotion officer as required Aboriginal health worker as required Paediatrician Merredin approximately 3 days/mth	program for children in kindergarten and pre-primary The Child and Adolescent Integrated Therapy Services program for children with a permanent and severe disability. FTE: Audiology: 0.5 (accepts referrals from whole region). Dietetics: 0.4 OT: 1.6 Physiotherapy: 1.8 Speech pathology: 3.6 Therapy Assistants: 1.2 <u>Katanning:</u> The only discipline that is specific for paediatrics is the therapy assistant. All other disciplines	needs. Below lists the approximate allied health FTE providing child development services. But they cover all ages, accurate information regarding paediatric FTE is not readily available. FTE: • Audiology: 0.4 • Dietetics: 3.0 • Occupational therapy: 7.0 • Physiotherapy: 9.0 • Speech pathology: 9.0 • Social work: 7.0 • Therapy assistant: 9.0 Visiting services: • PMH endocrinology

			proportion dedicated to child development services Physiotherapy: 2.5 OT: 1.8 Speech pathology: 1.8 Visiting services: Dietetics: 1.0 Podiatry: 1.0 <u>Parabadoo & Onslow</u> Generalist Community Health Nurse in each town which component of their workload is child development.		have generalist caseloads which include paediatrics. Below FTE allocation for paediatrics. Therapy Assistant: 0.6 (shared by all disciplines) Dietetics: 1.0 (minimal paediatric) OT: 0.5 Physiotherapy: 0.5 Social work: 0.3 Speech pathology: 1.0 <u>Denmark:</u> OT: 0.5	team visits 3.4 times per year. Paediatrician employed on hospital staff Support from community and child health and Aboriginal health workers.

APPENDIX ELEVEN

SUMMARY OF THE NEW INTERGOVERNMENTAL AGREEMENT FROM THE COAG MEETING, 29 NOVEMBER 2008[389]

Scheduled for the period through until 2012, this agreement between the Federal and State governments includes an overall increase of $15.2 billion on the previous arrangement. A component of this is the $7.1 billion increase in Specific Purpose Payments (SPPs) and a revision of the framework from the 90 separate SPP areas under the former framework into five new categories. The total funding of these categories, which amounts to more than $100 billion, is listed below:

1. $60.5 billion in a National Healthcare SPP (increase of $4.8 billion from previous agreement).

- + $500 million for 1,600 sub-acute beds (aged care) [2008-2009].
- + $1.1 billion [Federal] and $540 million [State] funding for 'workforce reform package to bolster staff levels.
- + $750 million relief package for emergency departments [2008-2009 - National Partnership payment (NP)].
- + $872.1 million over six years - Health Prevention NP.
- +$806 million [Federal funds] and $772mln [State funds] over 4 years - Indigenous Health NP.
- +$118 million [Federal funds] and $118mln [State funds] over 4 years - E-Health NP.

$564 million was allocated to an Indigenous Health NP in October 2008. It includes establishment of Child and Family Centres in remote areas as well as increased access to ante-natal services and child and maternal health services. A further $1.6 billion has been added over four years to this NP.

2. $18 billion in a National Schools SPP.

Includes $807 million to meet additional costs for implementation of National Secondary School Computer Fund.

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389 COAG, "Council of Australian Governments' Meeting 29 November 2008", (2008). Available at: www.coag.gov.au/coag_meeting_outcomes/2008-11-29/index.cfm. Accessed on 2 December 2008.

- + $1.5 billion over seven years - Low SES School Communities NP. States agreed to match Federal Government's $1.1 billion allocation over the five years to 2012.
- + $540 million over five years - Literacy and Numeracy NP.
- + $550 million over five years - Quality Teaching NP.
- + $970 million over five years - Early Childhood NP. Includes $955 million to realise the Gillard plan for universal access to one year of early childhood education. States responsible for implementation that targets areas of greatest need first, while ensuring improved provision of services. Part of a strategy aimed at improving 'children's school readiness'.

3. $6.7 billion in a National Skills and Workforce Development SPP.

Includes $8.5 million to waive fees for Diploma and Advanced Diploma courses in children's services at TAFEs.

4. $5.3 billion in a National Disabilities Services SPP.

5. $6.2 billion in a National Affordable Housing SPP.

Each National Agreement contains the objectives, outcomes, outputs and performance indicators, and clarifies the roles and responsibilities that will guide the Commonwealth and States in the delivery of services across the relevant sectors. The performance of all governments in achieving mutually-agreed outcomes and benchmarks specified in each SPP will be monitored and assessed by the independent COAG Reform Council and reported publicly on an annual basis. COAG agreed that the new SPPs are central to achieving service delivery improvements and reforms.

The new agreement has also incorporated National Partnership Payments (NPs) to fund specific projects and to provide incentives for the satisfaction of federal benchmarks for service provision.

Starting in 2009, these NPs will come under a variety of categories:

- Hospitals and Health Workforce Reform;
- Preventative Health;
- Taking Pressure off Public Hospitals;
- Smarter Schools - Quality Teaching;
- Smarter Schools - Low SES School Communities;
- Smarter Schools - Literacy and Numeracy;
- Productivity Places Program;

- Fee Waiver for Childcare Places;
- Indigenous Remote Service Delivery;
- Indigenous Economic Development;
- Remote Indigenous Housing;
- Indigenous Health;
- Social Housing;
- Homelessness; and
- Seamless National Economy.

COAG Funding Package						
$ million	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**Total**
Healthcare sector						
Healthcare SPP	***500.0***	***674.5***	***913.5***	***1,190.9***	***1,500.1***	***4,779.0***
Additional base and indexation	500.0	674.5	913.5	1,190.9	1,500.1	4,779.0
Healthcare NPs	***1,286.5***	***212.4***	***401.2***	***566.0***	***593.9***	***3,059.9***
Hospital Reform and Workforce	536.5	166.1	294.9	379.8	375.7	1,753.0
Preventative health	-	17.6	67.05	145.2	218.2	448.1
E-health (NEHTA)	-	28.7	39.2	41.0	-	108.9
Additional investment in Emergency Departments	750.0	-	-	-	-	750.0
Productivity agenda sector						-
Schools SPP	***868.1***	***171.4***	***213.1***	***268.1***	***333.8***	***1,854.5***
Additional indexation	-	40.9	73.8	120.5	177.2	412.4
10% AGSRC for primary schools	61.1	130.5	139.3	147.6	156.6	635.1
Upfront payment including Digital Education Revolution	807.0	-	-	-	-	807.0
Productivity agenda NPs	***33.3***	***191.9***	***265.0***	***618.0***	***548.8***	***1,657.0***
Smarter schools - Quality Teaching	22.0	40.0	60.0	243.0	185.0	550.0
Smarter schools - literacy and numeracy (a)	-	-	-	-	-	-
Smarter schools - Low SES schools	11.3	151.9	205.0	375.0	363.8	1,107.0
Universal Access (a)	-	-	-	-	-	-
Trade training centres	-	-	-	-	-	-
Skills and workforce development sector						-
Skills and workforce development SPP	***-***	***4.2***	***9.8***	***11.3***	***11.4***	***36.7***
Additional indexation	-	4.2	9.8	11.3	11.4	36.7
Skills and workforce development NP	***-***	***-***	***-***	***-***	***-***	***-***
Productivity Places Program	-	-	-	-	-	-
Disability Services sector						-
Disability services SPP	***70.0***	***23.0***	***70.9***	***101.3***	***142.6***	***407.8***
Additional SPP for disability reform	70.0	23.0	70.9	101.3	142.6	407.8
Disability services NP	***-***	***-***	***-***	***-***	***-***	***-***
Disabilities services reform	-	-	-	-	-	-
Affordable housing sector						-
National Affordable Housing SPP	***-***	***1.3***	***7.4***	***14.9***	***22.7***	***46.4***
Additional indexation	-	1.3	7.4	14.9	22.7	46.4
Affordable Housing NPs	***200.0***	***275.0***	***105.0***	***110.0***	***110.0***	***800.0***
Homelessness recurrent	-	75.0	105.0	110.0	110.0	400.0
Social Housing	200.0	200.0	-	-	-	400.0
Indigenous reform sector						
Indigenous reform NPs	***439.5***	***213.7***	***245.2***	***494.1***	***574.2***	***1,966.8***
Indigenous economic development	15.0	39.8	39.8	38.9	39.2	172.7
Indigenous family and community safety	-	-	-	-	-	-
Indigenous health	-	82.7	157.2	247.6	318.0	805.5
Indigenous remote service delivery	24.5	31.2	32.4	33.4	32.5	154.0
Indigenous housing	400.0	60.0	15.8	174.2	184.5	834.6
Other sectors						-
Business regulation and competition NP	***100.0***	***-***	***-***	***200.0***	***250.0***	***550.0***
Seamless national economy	100.0	-	-	200.0	250.0	550.0
Total COAG Funding Package	**3,497.4**	**1,767.5**	**2,231.2**	**3,574.6**	**4,087.5**	**15,158.1**

(a) Funding in forward estimates.

APPENDIX TWELVE

AEDI REPORT FOR ROCKINGHAM[390]

This page is from the summary community profile, maps and tables that can be downloaded for the Rockingham region from the Australian Education Development Index web site.

The AEDI tables: Rockingham WA

Table 1 The AEDI domains

Physical health and wellbeing	Social competence	Emotional maturity	Language and cognitive development	Communication skills and general knowledge
• Physical readiness for the day • Physical independence • Gross and fine motor skills	• Overall social competence • Responsibility and respect • Approaches to learning • Readiness to explore new things	• Prosocial and helping behaviour • Anxious and fearful behaviour • Aggressive behaviour • Hyperactivity and inattention	• Basic literacy • Interest in literacy, numeracy and memory • Advanced literacy • Basic numeracy	• Communication skills and general knowledge

Table 2 Average AEDI domain scores

Suburb or area	Average Score				
	Physical health and wellbeing	Social competence	Emotional maturity	Language and cognitive skills	Communication skills and general knowledge
Baldivis	9.30	9.38	9.42	8.85	8.44
Cooloongup	8.18	8.62	8.27	8.08	7.50
Golden Bay	9.09	9.17	8.56	9.23	8.13
Hillman	8.64	8.15	8.08	9.58	8.75
Port Kennedy	9.00	8.96	8.27	9.23	8.75
Rockingham	9.32	8.96	8.46	8.80	8.13
Safety Bay/ Shoalwater	8.50	8.75	8.08	8.40	7.50
Secret Harbour	9.00	8.33	8.64	8.65	8.44
Singleton	9.09	8.54	8.46	9.23	9.38
Waikiki	9.09	8.96	8.46	8.85	8.75
Warnbro	9.00	8.85	8.27	8.85	8.75

390 The Royal Children's Hospital, "The AEDI tables: Rockingham WA", (2008). Available at: www.rch.org.au/emplibrary/australianedi/T_Rockingham_WA.pdf, p 1. Accessed on 19 September 2008.

APPENDIX THIRTEEN

COST BENEFIT EVALUATION OF SCREENING PROGRAMS

One of the key criteria for appraising the benefits and overall efficiency of any health program is whether or not it is cost effective. Wilson and Junger argue that "the cost of case-finding (including diagnosis and treatment of patients diagnosed) should be economically balanced in relation to possible expenditure on medical care as a whole".[391] Such cost benefit analysis is inherently subjective and depends on what costs are allocated to the program and how the later benefits (including broader social benefits) of a program are measured, or are expressed in monetary terms.

The Department of Health submission quoted Heckman when proposing that:

> *the rates of return on human capital investment in early interventions is much higher than that of later interventions. If a child falls behind, they are likely to remain behind and the process of resolving this problem becomes progressively more costly the later it is attempted in the child's life.*[392]

A research report from 2005 by the Australian Institute of Family Studies (AIFS) found:

> *Very few sound cost-benefit and cost-savings analyses of early childhood intervention programs with long-term follow-ups have been conducted. Of the 108 interventions that were initially identified, only eight interventions included a cost-benefit study. With the exception of a cost-effectiveness study of* Triple P*, there have been no cost-benefit analyses undertaken of Australian interventions...*[393]

Notwithstanding the AIFS finding, more than one third of the submissions to this Inquiry cited the findings of highly reputable international research to demonstrate the potential cost benefits of streamlining WA's existing child health screening programs. For example, Dr John Wray suggests that "The ultimate financial savings for a society that invests in early intervention are reckoned to be in the order of seven-fold."[394] The Western Australian Commissioner for Children and Young People acknowledged:

> *There are significant cost benefits in providing early years programs for children and many of these cost benefits have been identified in actual dollar terms, as pointed out by a senior economist:*

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391 Wilson, J. & Jungner, G. (1968) "Principles and Practice of Screening for Disease", *Public Health Papers* No. 34, World Health Organization, Geneva. Available at: http://whqlibdoc.who.int/php/WHO_PHP_34.pdf. Accessed on 18 May 2009.

392 Submission No. 30, Department of Health, 16 May 2008, p 6.

393 Australian Institute of Family Studies, "Research report no.14", (2005). Available at: www.aifs.gov.au/institute/pubs/resreport14/12.html. Accessed on 2 September 2008.

394 Submission No. 10, Dr John Wray, 8 May 2008, p 1.

> *"Investing in early years programs is good economic policy. If society intervenes early enough it can affect cognitive and social emotional abilities and the health of disadvantaged children. Early interventions promote schooling, reduce crime, promote workforce productivity and reduce teenage pregnancy. These interventions are estimated to have high benefit-cost ratios and rates of return."*[395]

and later quoted:

> *evaluations of the* Perry Preschool Project *(conducted in the 1960's) found that for every $1 invested $7.16 of government money was saved by the time the participant turned 27. When the children in their study reached the age of 40 years a total benefit/cost ratio of $17.07 for each $1 was found.*[396]

Some witnesses suggested that the short terms of West Australian governments do not lend themselves to policy decisions being made for long-term investments, such as early childhood intervention. The potential benefits of a child health program may not be obvious or measurable for several decades, and usually long after the term of the government that initiated the project. The non-government group National Investment for the Early Years (Niftey) also referenced a cost benefit ratio of about 17:1 for early health interventions:

> *The 1996 Nobel prize economist James Heckman, has established that in social capital terms $1 spent in the early years saves at least $17 in later service demands. Health surveillance and screening are an essential component of early years investment.*[397]

The Hon Barbara Scott, MLC provided information that gave lower cost benefit ratios for early educational and developmental interventions than Niftey, but suggested these ratios drop as the child ages, as represented in Figure A11.1 below.[398]

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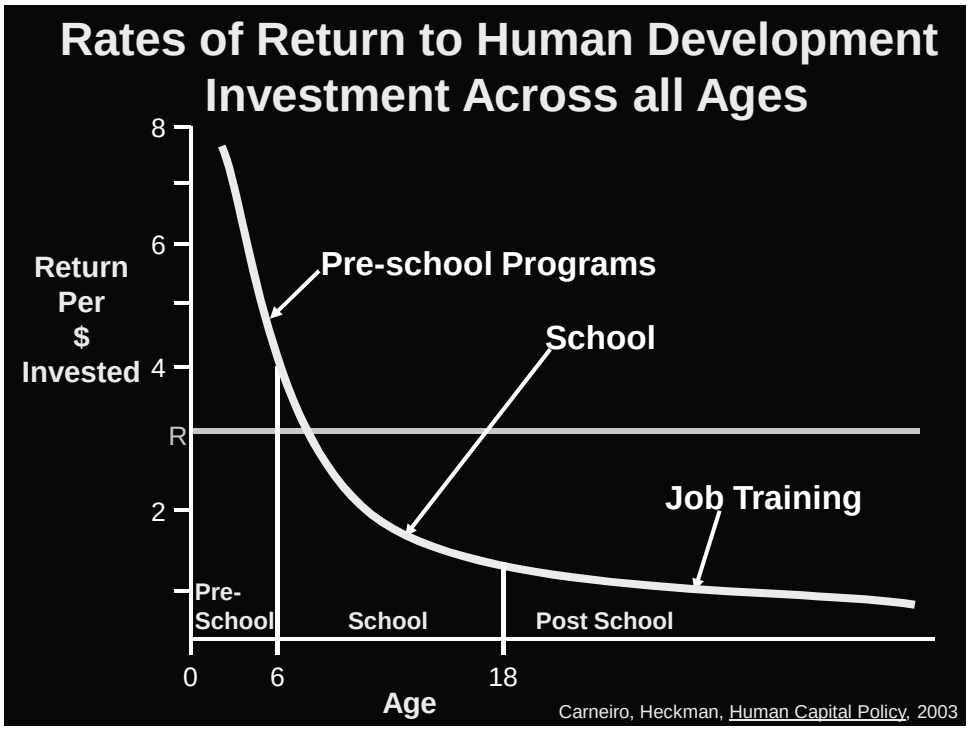
395 Submission No. 28. Ms Michelle Scott, Commissioner for Children and Young People WA, 12 May 2008, page 9. Flavio Cunha's 2008 presentation *Investing in Disadvantaged Young Children Is Good Economics and Good Public Policy*, Business Leadership for America's Youngest Citizens: The Economic Promise of Investing in Early Childhood, 17 April 2008. Available at: www.ced.org/docs/presentation200804prek_kansas_cunha.ppt.

396 Submission No. 28 from Ms Michelle Scott, Commissioner for Children and Young People WA, 12 May 2008, p 9.

397 Submission No. 27 from the National Investment for the Early Years, 12 May 2008, p 2.

398 Submission No. 13 from Hon Barbara Scott, MLC, 8 May 2008, p 3 quoting Carneiro & Heckman (2003 7).

Figure A11.1 Returns on investment over time



A senior ENT surgeon at Princess Margaret Hospital, Clinical Associate Professor Harvey Coates AO, gave an actual monetary value to the benefits of a universal newborn hearing program, which operates in all Australian jurisdictions other than WA. He claimed:

> *the community savings for each child picked up by the universal newborn hearing screening program amount to $1.2 million per child and the 80 children detected so far* [in WA] *since the program began in 2000 amounts to $100 million of community savings for a relatively small outlay.*[399]

Importantly, Associate Professor Coates reported that these high cost benefit ratios are based on Australian research conducted for the Medical Services Advisory Committee by Flinders University in Adelaide, and represent the savings for the community over a child's lifetime in future medical, educational and vocational spending. The figure of community savings of $1.2 million per child in WA is similar to findings published in the US for similar programs, which are about $US1 million per child, and European estimates of about €800,000 per child.[400]

399 Submission No. 3 from Associate Professor Harvey Coates, 28 April 2008, p 1.

400 Associate Professor Harvey Coates, Paediatric Otolaryngologist, Princess Margaret Hospital for Children, *Transcript of Evidence*, 6 August 2008, p 3.

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