EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO GENERAL HEALTH SCREENING OF

PRE - PRIMARY AND PRIMARY SCHOOL CHILDREN

Submission from the Department of Education and Training

May 2008

For further information, please contact:

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1.0 INTRODUCTION

The following submission has been compiled by the Inclusive Education Standards and Early Childhood Education Directorates on behalf of the Department of Education and Training in response to the Education and Health Standing Committee's *Inquiry into General Health Screening of Pre-Primary and Primary School Children.*

Information was gathered from key stakeholders through written statements and consultation conducted during a half day forum. A list of participating stakeholders is provided as an attachment to this report (Appendix One).

1.1 TERMS OF REFERENCE

The Inquiry has the following terms of reference:

1. Appraisal of the adequacy and availability of screening processes for hearing, vision, speech, motor-skills difficulties and general health.

2. An assessment of access to appropriate services that address issues identified by an appropriate screening process.

1.2 BACKGROUND

The Department recognises that there is a clear link between children's health and development and positive educational outcomes. Health screening and early intervention at pre-primary and primary school age can be a useful adjunct to the Department of Health program which offers comprehensive health and developmental screening and referral as required for children in the 0-4 year age group.

The importance of health and developmental screening programs has been acknowledged by the Australian Federal Government which is currently developing screening tools for the proposed *Healthy Kids Check (HKC)*. The HKC will involve universal health screening for all four year olds. The scope of this screening program and implementation details are yet to be finalised. Early indications are that the HKC will contain many elements of the school entry health assessments currently conducted in WA by school/community nurses.

It is intended that a Medical Benefit Scheme number will be allocated to enable the HKC to be conducted by General Practitioners. It is not known at this stage what additional resources will be provided at the state level for implementing the HKC screening program and whether further resources will be provided to states for services needed to support the outcomes of the screening. To avoid future duplication of programs and services, the Federal Government initiatives will need to be taken into account in future planning in WA.

1.3 SCHOOL HEALTH SERVICES

The Department has approximately 35 000 pre-primary and 119 000 primary school students throughout Western Australia. Most of the formal health screening within the school setting is conducted by the School Health Service which is funded jointly by the Departments of Health (DoH) and Education and Training (DET), line managed by the Department of Health and delivered primarily by school / community health nurses. A Memorandum of Understanding between the Departments of Health and Education for the delivery of School Health Services has been in place since 2004.

School Health Services use surveillance activities and screening tests to identify and monitor the health status of school aged children throughout their school life. Health screening conducted by School Health Services includes a universal school entry health assessment as well as targeted screening as required in subsequent years. Hearing, visual acuity and strabismus screening is offered to all children as they enter school (kindergarten, pre-primary or Year 1 - the first compulsory year of schooling in WA) and on receiving parental consent. Any child for whom there is an identified concern regarding language development, behaviour, or general development including weight issues, receives targeted assessment to evaluate the need for further, more specialised assessment and intervention.

A more detailed overview of the screening and services provided by the School Health Service is attached (Appendix 2).

1.4 SUBMISSION STRUCTURE

This submission is organised using the following structure:

Part A: Provides an outline of the Department's general attitude towards the issues under inquiry, some general findings and overarching recommendations.

Part B: A response to both terms of reference in relation to each of the identified health areas, followed by specific recommendations for each area.

2.0 PART A: FINDINGS AND OVERARCHING RECOMMENDATIONS

2.1 FINDINGS

Context

The Department offers the following preliminary findings; however, further research may be required by relevant stakeholders to determine whether an evidence base can be established to support the viability of what is proposed. It should also be noted that some of the following suggestions go well beyond the scope of the Department's core business and resources. Where this is the case, the Department could have a role in working collaboratively with other agencies to develop, and/or disseminate such programs/resources.

Overall the Department of Education and Training believes the School Health Service delivered by school nurses provides an effective universal screening program for vision, hearing and general development. However, 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.

There are currently no universal, standardised screening processes in place for speech and language, motor skills and general health. Additional resources to expand the existing School Health Service screening program would enable school nurses to undertake a broader range of standardised tests and follow up as required.

2.2 OVERARCHING RECOMMENDATIONS

While some of the overarching recommendations relate to screening, the issue of greatest concern for the Department is the adequacy of services available to respond to issues identified through the screening process.

a. Conduct an audit of relevant programs and services (Government and non government) with a view to developing a community services directory of services for parents of children 0-17 years. A structured dissemination strategy would ensure the directory reaches the parents of children who are most at risk.

b. Enhance existing partnership links between the Department of Health and Education and Training to improve co-ordination of health services.

c. Conduct research to determine if there is an evidence base for expanding existing screening programs and if required, the development of appropriate screening tools.

d. Investigate barriers to families accessing services and provide programs/resources to address these barriers, particularly in at risk groups with poor levels of compliance in accessing services for 0-4 year olds.

e. Improve community education to increase understanding of the link between children's health and development and positive educational outcomes.

f. Provide parent education programs such as PPP (Positive Parenting Program) set in the context of broader community education programs. Such programs to also take into account the specific needs of at risk groups (Culturally and Linguistically Diverse [CALD], Aboriginal) in relation to child health and its impact on educational outcomes.

g. Enhance existing School Health Services to enable more nurse time to be allocated to a wider range of health screening e.g. targeted health assessments for diabetes and obesity and more comprehensive follow up and surveillance.

h. Provide additional resources to employ more school psychologists considering that proposed mandatory reporting of child sexual abuse is likely to make a significant impost on existing psychology services.

i. Enhance services in rural and remote areas.

j. Provide wrap around services on school sites in designated areas, with consideration given to mobile services in rural and remote areas.

k. Provide professional learning for school staff and other professionals to improve knowledge and understanding required to identify health concerns and access appropriate screening options and relevant services.

l. Investigate ways to improve parent compliance in providing consent for health screening.

m. Engage respected community members of at risk groups (eg. Aboriginal, CALD) in the dissemination of health information to their community.

3.0 PART B: RESPONSE TO TERMS OF REFERENCE AND SPECIFIC RECOMMENDATIONS

The following is a summary of the responses provided by key stakeholders through written statements and consultation conducted during a half day forum. More detailed information can be provided upon request.

3.1 HEARING

ToR 1: Availability and adequacy of screening processes	ToR 2: Assessment of access to appropriate services
<u>Availability</u> ▪ 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. <u>Adequacy</u> ▪ 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	<u>Services</u> ▪ 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. <u>Access</u> ▪ 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

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.	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.

3.1.1 SPECIFIC RECOMMENDATIONS

a. 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.

b. Explore the efficacy of universal screening occurring at the K level, in order to ensure that the earliest possible interventions are put in place.

c. 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.

d. 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.

e. 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.

f. 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.

g. Investigate strategies to ensure continuity of service provision post-diagnosis.

h. DoH to consider its capacity to lead the coordination of service provision in regional areas.

i. Reduce the time delay between diagnosis and access to relevant services.

j. Identify and implement strategies to assist parents/carers to increase their capacity and commitment to accessing services.

3.2 VISION

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>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>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>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.

3.2.1 SPECIFIC RECOMMENDATIONS

a. 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.

b. 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.

c. 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.

d. 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.

e. The development of a communication strategy to inform clinical staff regarding education support services that are available.

f. Identification of current provision of counselling services for families post-diagnosis and assess its adequacy.

g. Identification and implementation of strategies to assist parents/carers increase their capacity and commitment to access treatment.

3.3 SPEECH AND LANGUAGE

ToR 1: Availability and adequacy of screening processes	ToR 2: Assessment of access to appropriate services
<u>Availability</u> ▪ 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. <u>Adequacy</u> ▪ 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.	<u>Services</u> ▪ 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. <u>Access</u> ▪ 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.

3.3.1 SPECIFIC RECOMMENDATIONS

a. Explore the efficacy of a universal, on-entry speech and language assessment / screening tool being developed for all students.

b. Provide increased resources to provide support for children with speech and language needs. This will require an increase above existing DET budgets.

c. 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.

d. 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.

e. Identification and implementation of strategies to assist parents/carers to increase their capacity and commitment to access treatment.

f. 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.

MOTOR SKILLS

ToR 1: Availability and adequacy of screening processes	ToR 2: Assessment of access to appropriate services
<u>Availability</u> ▪ 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. <u>Adequacy</u> ▪ 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.	<u>Services</u> ▪ 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. <u>Access</u> ▪ 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.

3.4.1 SPECIFIC RECOMMENDATIONS

a. Investigation as to whether a universal assessment tool for fine and gross motor skills is warranted.

b. Maintenance of the mandatory two hours Physical Activity program in schools, with a focus on information derived from the Fundamental Movement Skills assessment tool.

c. On-going implementation of the Fundamental Movement Skills Program to provide an opportunity for teachers to globally assess children's' motor skills.

d. Consideration of a Memorandum of Understanding between DoH and DET regarding access to services for students identified with fine and gross motor skills issues.

g. Increased resources to provide support for children with motor skills difficulties. This will require an increase above existing budgets.

h. Identification and implementation of strategies to remove barriers for parents/carers accessing treatment.

GENERAL HEALTH

ToR 1: Availability and adequacy of screening processes	ToR 2: Assessment of access to appropriate services
<u>Availability</u> ▪ 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. <u>Adequacy</u> ▪ 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.	<u>Services</u> ▪ 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. <u>Access</u> ▪ 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

3.5.1 SPECIFIC RECOMMENDATIONS

a. Ongoing parent and teacher education regarding general health issues through community education programs.

b. Explore the options of increased access to school psychologist / Mental Health Services through an increased number of school psychologists.

c. Identification and implementation of strategies to assist parents/carers having the capacity and commitment to access treatment.

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APPENDIX ONE

Delegate list for Focus Group held on 5 May 2008.

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John Brigg, Inclusive Education Standards
Sue Gouldson, Inclusive Education Standards
Sallee Pettit, Inclusive Education Standards (Care and Protection)
KarenLee Clark, Inclusive Education Standards (Schools Plus)
Kia Skonis, Inclusive Education Standards (Statewide Speech and Language Service)
Rosemary Simpson, Statewide Speech and Language Service
Erin Callahan, Inclusive Education Standards (Statewide Speech and Language Service)
Anna Taylor, North East Language Development Centre
Grant Wheatley, Hospital Schools Services
Kaye Garrett, Vision Education Service
Paula Schneider, WA Institute for Deaf Education
Robyn Oliver, West Coast District Education Office
Vicki Delves, Physical Activity
Ellen Tompsett, Fremantle-Peel Aboriginal Education
Fred Penny, Canning Aboriginal Education
Lyall Garlett, Canning Aboriginal Education
Freda Ogilvie, Early Childhood Education
Dean Wynne, Pineview Community Kindergarten
Helen Skiadis, Pineview Community Kindergarten

NON GOVERNMENT EDUCATION

Wayne Revitt, Association for Independent Schools WA
Val McKelvey, Catholic Education Commission WA

PROFESSIONAL ORGANISATIONS

John Exeter, WA Education Support Principals & Administrators Association
Amanda Hill, WA Council of State School Organisations
Jacqui Macliver, WA State School Teachers Union
Jean Rice, WA Primary Principals Association
Julie Roberts, WA Primary Principals Association
Karen Webster, WA Primary Principals Association

Group facilitation by Faye Harris, PDT Consulting

APPENDIX TWO

Overview of School Health Services

The School Health Service plays a valuable role in the early identification of problems and difficulties in the areas of vision, hearing, speech and language development, psychosocial and general development, including body weight issues.

School Health Services are provided by community health staff employed by the Area Health Services and consist largely of school health nurses but also include allied health and health promotion staff.

School Health Services use surveillance activities and screening tests to identify and monitor the health status of school-aged children throughout their school life. The policy guiding practice was released in 2007.

The School Entry Health Assessment is conducted by school health nurses and offered to all children as they enter school, and on receiving parental consent. School entry may occur at Kindergarten, Pre-primary or Year 1 (which is the first compulsory year of schooling in WA). The assessment involves:

- All children are screened for hearing and vision problems (visual acuity and strabismus).
- Any child for whom there is an identified concern regarding language development, behaviour, or general development including weight issues, at school entry, receives an assessment to evaluate the need for further, more specialised assessment and intervention.

In addition to the school entry assessment, school health nurses:

- Provide assessments for individual children post school entry, where a concern regarding vision, hearing, language development, behaviour or general development is identified by the student, parent or teacher.
- Monitor vision, hearing, language development, behaviour and general development on a regular basis (as determined by local Health and Education personnel) groups of children who are considered to be at higher risk of health problems. Such groups may include: Aboriginal students, refugees, all children who require ‘educational support’, children with a family history of permanent or chronic childhood hearing and/or vision impairment, children living in out-of-home care and children who have parents with a mental illness and/or have problems due to alcohol or drug use.
- Distribute information on colour vision to all parents of children in Year 7 or Year 8, and provide relevant information and appropriate referral where a concern has been identified.
- Distribute information on scoliosis to all parents of children in Year 7 or Year 8, and provide relevant information and appropriate referral where a concern has been identified.

Definitions

Universal Services - are available to the whole of the population and are designed to promote positive functioning and decrease the likelihood of specific problems or disorders developing. Such services are truly universal if they are not only available to the whole population but also accessible to and accessed by most people. Factors affecting accessibility include location, cost, opening hours and inclusiveness.

Targeted Services - are available to selected groups or individuals who are known to be at risk of developing a particular health or developmental problem, and are designed to reduce the likelihood of the problem developing.

A Screening Test - is any measurement aimed at identifying individuals who could potentially benefit from intervention. These include symptoms, signs, lab tests, or risk scores for the detection of existing or future disease, condition, or specified adverse health outcome.

Child Health Surveillance - is the systematic and ongoing collection, analysis and interpretation of indices of child health, growth and development in order to identify, investigate and, where appropriate, 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.

School Dental Service

The School Dental Service is a statewide service, basic care is free to children and it is the most comprehensive child dental care service in the country. There are 40 mobile clinics, some are in the metropolitan area but most are in the country areas. They follow an annual circuit and spend several weeks in each location dependent on treatment needs. There are 105 fixed Dental Therapy Centres located mostly in primary school grounds, providing care for children at the base school and nearby primary and high school children. Enrolled school children up to 17 years of age are contacted and offered routine preventive and operative dental care subject to parental consent. Children are recalled for check-ups periodically. Treatment is delivered by dental therapists, dentists or referrals are provided for specialist treatment.