8th May 2008

The Principal Research Officer
Education and Health Standing Committee
Legislative Assembly
Parliament House
Perth WA 6000

Re: Inquiry into the General Health Screening of Children at Pre-Primary and Primary School Level

Dear Committee Members.

I am writing in order to provide insight into the Parliamentary Inquiry into screening assessment and management of preschool children in Western Australia. I very much welcome this enquiry and the opportunity to write to the Committee. I would be happy to further discuss the issues that I will raise.

I am writing as Western Australian representative of the Child Development and Behaviour Special Interest Group of the Chapter of Community Child Health, Division of Paediatrics, Royal Australasian College of Physicians. I am a West Australian trained paediatrician and I have undertaken an international specialist training Fellowship in Developmental Paediatrics. My medical work is completely undertaken in the field of developmental paediatrics – assessing and managing children with diverse developmental and behavioural difficulties. I spend the majority of time in the public medical sector, but I also have a small private practise. Additionally, I am involved in teaching, research, administration and policy and planning in this field. I am committed to the needs of children and families.

There is no doubt about the positive evidence for early intervention for children who have developmental and behavioural concerns. There are benefits to the child and family in the short, medium and long-term. Adequate child development services lessen reliance on medication and access to other costly medical services. The ultimate financial savings for a society that invests in early intervention are reckoned to be in the order of seven-fold. The children of Western Australia are the future of our state. Unfortunately, the state of Western Australia does not adequately invest in our future and we are losing our greatest asset.

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). Unfortunately, my perception is that the Government responds to the cries of tertiary centres and the media this attracts, and increasingly neglects the community health sector.

Most clinicians are fairly cynical of government policy and reactivity on these matters. It is a political reality that short-term programs reflect short terms of government. It takes an extraordinary government with considerable vision to invest in services that will not reap rewards in a three year term of government. This Government does have an opportunity to do something extraordinary!

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. Children cannot vote and we must seek to represent the needs of children.

I am encouraged recently by reform processes that are underway for the Community Child Health Nursing and Child Development Service. I believe that the fledgling management teams of the Child and Adolescent Health Service, Community Child Health Division, are doing a great job. I believe that there

is support in the executive structure of Child and Adolescent Health Service. For example, the new joined-up Child Development Service has derived some common treatment criteria and clinical pathways, and we are anticipating a single clinical electronic database system. However, we are yet to see any substantial or permanent increase in resources to these community children's services.

I will now provide greater detail addressing aspects within the scope of this inquiry.

With regards to the screening of preschool children, the Committee will be aware that this can be undertaken at a number of levels. Ideally, all professionals (for example, nurses, general practitioners, teachers), and indeed all care-givers would be vigilant to the developmental progress of children. The main publicly (State-funded) screening service is through the community child health nurse program. This is a highly motivated and knowledgeable workforce. Under recent reform processes, there have been advances in achieving recommendations for uniformity of surveillance and reporting systems. However, there has not been any sustained and permanent growth of the workforce, or in the infrastructure. Business cases that have been mounted in application for funds have consistently failed.

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. 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. 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 between relatively well-off and relatively poor in this area is larger than in any other area of child health service, and is akin to a surgeon saying – "we only had enough funds to take out half your appendix"!

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.

There are systematic problems that inhibit the growth of the service. When there are any funds available (for example the "Gap Funding" announced for Child and Adolescent Health Services a few years ago), the various Heads of the various Medical and Surgical Departments spend considerable periods of time filling in forms and trying to make their application the most compelling and attractive. The State Child Development Centre competed with almost 200 applications for the "Gap Funding". In comparison to the perceived needs of Emergency Departments or other acute and immediately life-threatening medical services, the Child Development Service is a poor competitor for the limited growth funds that are available. Historically, other child development centres have also fared very poorly for growth funding. Other child development centres have had to compete for funds against the needs of the adult health sector. It is hoped that there may be some improvement in this matter, with the child development services now joined up and part of Child and Adolescent Community Health Services. However, no specific growth funds have yet been identified.

These limitations in growth – the inability to respond to demand, simply do not apply in the private sector. In the private sector, if there is demand, a service can grow.

As a consequence of the inability to grow in order to meet demand, the state-funded child development services must either "water-down" services, develop greater efficiencies or cut services. Most of the Centres have undertaken a combination of these three strategies. There are now inadequate "watered-

down" services in many developmental areas, or children do not receive any services over the age of eight years. The Centres have developed strategies to engage in the community, and to engage with the private sector. The Centres have developed handouts and group programs instead of individual programs. There are no greater efficiencies to be made. The service runs on the smell of an oily rag!

As a consequence of the inability to grow, clinical service priorities must get shifted – for example, the Child Development Service cannot provide first class service to preschool children with ADHD symptoms, when there are other clinical issues that must be prioritised – for example, an infant with autism of a single drug-dependent mother.

The Child Development Service currently faces difficulties in achieving appropriate classification levels for the managers and clinicians. For example, the Coordinators of North and South Child Development Service, and the proposed Director of Child Development Service are poorly classified in comparison to colleagues in the acute-care health sector. This perpetuates the impression that community health work is a poor sister to acute services. These matters should be immediately addressed.

There has been recent improvements in child development services through the Federally funded Medicare system. The simple truth here, is that the Feds were required to respond to the shocking condition of state-funded services. There have been several innovative Medicare programs such as the Enhanced Primary Care Program, the Better Access to Mental Health program and special item numbers for paediatricians to conduct longer assessments and to conduct case conferences, and for GPs to construct chronic care plans. There will be new programs for children with autism introduced this year. These are significant contributions from the Federal Government, whilst the state government has done little in its health commitments. Unfortunately, the Medicare programs still have significant hurdles, including:

- For many children the limited therapy sessions available are not enough. These families will need to access other services
- Many families cannot afford the "gap" fees that are required with these medicare services
- The paediatricians and allied health clinicians of the state-funded Child Development Services are unable to make direct referrals under these medicare systems, because of ridiculous State-Federal health politics!

An opportunity to speak-out on these matters will probably not occur again in my professional career. I have engaged eagerly in the reform processes underway and clinical and management colleagues are united in the vision of the work we want to be able to complete. Our children rely on it. In the end however, if there is no substantial improvement in resources to this sector in the next five years, I shall deem my efforts to be a failure, and I shall leave the public system.

Thankyou again for considering these critical issues. I would be pleased to be of further assistance in your inquiry.

Yours sincerely

Dr John Wray MB MS FRACP
Developmental Paediatrician

Education and Health Standing Committee
Re: Inquiry into the General Health Screening of Children at Pre-Primary and Primary School Level

Response to request to Dr John Wray

Dear Committee Members

I have been asked to provide my personal views with regards to screening for children. In this matter, I am in agreement with the revised screening recommendations (for implementation in 2009) of the Community Child Health Division of the Child and Adolescent Health Service. I have provided a table with those recommendations in an abbreviated form.

Age	Developmental Screening & Surveillance	Disease/Condition identified	Comments
Birth-10days	Observational assessment of baby		
6 – 8 weeks	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	Observation of milestones for physical, social and emotional development Edinburgh postnatal Depression Scale is offered to the mother
3 – 4 months	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	The parent completed Ages and Stages screening tool (ASQ:SE) if indicated. Edinburgh postnatal Depression Scale is offered to the mother
8 months	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	ASQ &ASQ:SE if indicated Edinburgh postnatal Depression Scale is offered to the mother
18 months	Observation of milestones for physical, social and emotional development PEDS	Developmental Delay in various domains	ASQ &ASQ:SE if indicated
3 – 3.5 years	Observation of milestones for physical, social and emotional development PEDS	Developmental Delay in various domains	ASQ &ASQ:SE if indicated
4-6 years	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	ASQ &ASQ:SE if indicated

Please note that further assessments are offered for children where there is expressed professional or parental concern, or in at risk populations.

Although this would be regarded as "health and developmental screening", I would also strongly recommend screening of pre-primary children for the development of two key cognitive abilities. Difficulties with these two key cognitive abilities greatly predispose children to subsequent literacy difficulties. These abilities are not routinely tested in Health Department screening. These skills could be tested by teachers in the pre-primary period. These are the abilities of:

- Digit recall (a standard test of short-term auditory memory)
- Phonological screening (a standard test of the ability to discriminate sounds at the beginning, middle and end of words)

Thankyou for your ongoing interest in this critical matter. Children do not have a political voice – we must all speak for children. Please let me know if I can be of further assistance.

Yours sincerely

Dr John Wray
Developmental Paediatrician

3rd July 2008