EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO GENERAL HEALTH SCREENING OF CHILDREN AT PRE-PRIMARY AND PRIMARY SCHOOL LEVEL

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 11 JUNE 2008

SESSION ONE

Members

Mr T.G. Stephens (Chairman)
Mr J.H.D. Day
Mr P. Papalia
Mr T.K. Waldron
Mr M.P. Whitely

Hearing commenced at 9.15 am

FLETT, DR PETER THOMAS
Acting Director General, Department of Health,
examined:

McBRIDE, MS SHARON
Senior Portfolio and Policy Officer, Child and Adolescent Health Service,
examined:

CRAKE, MR MARK
Acting Director, Department of Health,
Child and Adolescent Community Health,
examined:

MORRISSEY, MR MARK
Executive Director, Community Health, Department of Health,
examined:

ABERNETHY, MRS MARGARET ROSE
Senior Portfolio and Policy Officer, Department of Health,
examined:

The CHAIRMAN: Thanks very much for being here this morning. As well as welcoming you, my task is to formally read the procedure for the examination of witnesses. This committee hearing is a proceeding of Parliament and warrants the same respect that proceedings in the house itself demand. Even though you are not required to give evidence on oath, any deliberate misleading of the committee may be regarded as contempt of Parliament. I am required under standing orders to ask four questions and you are required to give an audible answer for the purposes of Hansard. I suggest we go from the left of the table—my left, your right—round. Have you completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIRMAN: Do you understand the notes at the bottom of the form?

The Witnesses: Yes.

The CHAIRMAN: Did you receive and read an information for witnesses briefing sheet regarding giving evidence before parliamentary committees?

The Witnesses: Yes.

The CHAIRMAN: Do you have any questions relating to your appearance before the committee today?

The Witnesses: No.

The CHAIRMAN: Thanks very much; firstly, for being here and, secondly, for the submission that you have made in reference to the terms of reference of the inquiry. Normally, Acting Director General, I ask for opening comments from you without repeating the general gist of your submission but as an overview of what you would like to say to the committee in reference to our terms of reference, against the backdrop of the committee's interest specifically in knowing what

you are currently doing in this area, how it is working and perhaps what the gaps are. Against that backdrop, please feel free to make an opening comment.

Dr Flett: Thank you, my comments will be brief. We are pleased to be here to talk about early childhood and we recognise in health that this is a very important issue and something which has a huge amount of bearing later on as these children move into adulthood. Today I have four experts who I believe will be able to supply you with all answers to the appropriate questions that you will put to us, ranging from not only that of preschool, but also school health services and looking at particular issues identified, for example, autism, deafness and developmental issues.

The CHAIRMAN: Are there any other opening comments from any of your officers to be given at this point? My question back to you as a group is: can someone from your group guide us verbally as to what currently happens in terms of the health screening for children?

Dr Flett: Yes, one of my officers will be able to give you full details of the screening processes involved with this for sure.

The CHAIRMAN: Thank you.

Mr Morrissey: We will probably start and I will ask Mark to respond. There is the early screening at birth and then there is the screening at school. Is there one area that —

The CHAIRMAN: No, we want you to describe what happens.

Dr Flett: So, start with early screening.

Mr Crake: Western Australia has a comprehensive program of health screening for children which commences—we have scheduled starts—just after the birth of a child. Ms Abernethy has responsibility for that portfolio area, so my initial comments will be general and I will pass to Margaret for the detail. At the point of school entry, another health screening process occurs and I will defer to Sharon McBride who is the portfolio officer responsible for that area to get more detail, if the committee wants more detail. Shortly after the birth of a child, there is a universal visit offered to the parents of the newborn child.

The CHAIRMAN: Sorry, could you please be tough on the words “comprehensive”, “universal” and “offered” because we want to understand what those words mean.

Mr Crake: Sure. It is a voluntary service, so contact is made with the parents with the newborn and a visit is offered by the child health nurse. I say “universal” because it is offered to all families who have a newborn child in Western Australia. I guess Margaret can give some more detail about the comprehensive nature of the service provided during the visits, but following on from that first contact within 10 days of birth, there are three other contacts in the first year that coincide with peak developmental stages of the child. Following those contacts in the first year, another contact is offered at 18 months and then at three years. The next universal service that is offered to families occurs at the point of school entry. That is the school entry health screening check process which commences at the point a child enters formal learning, which could be between kindergarten through to grade 1. Therefore, there is a range of times at which children may make contact with the formal educational system and at that point, again, comprehensive screening is offered to parents. Having made those initial comments, perhaps we can go back to Margaret who can detail what actually happens.

[9.20 am]

Mrs Abernethy: I guess our approach in Western Australia is similar to the other states and territories in that we offer a universal service. Ideally, we want to see all parents as soon as possible after the baby is born so that we can start that early identification work—working very closely with the family. Our whole approach is about engaging with the family during those early days because they are an important element of our work in terms of identifying if there are any problems. Also,

we follow up with the family about any concerns they may raise, any additional support they may need or if they need a referral into the system.

As Mark has alluded to, the six times that we see the family universally in those first three years are at key developmental times. The evidence has informed us that these are the key times that we should be seeing children. Those visits are a good opportunity to identify problems and they also give us an opportunity—if problem areas are identified, whether they be developmental delay or a speech or hearing problem—to work with the family at those key developmental times. This is the universal platform that all states and territories work with. The model supports a targeted approach as well. As a result, those families who need extra support are offered that additional support at that point in time. For example, we may see a family within ten days of birth and, if they have a problem—for example, a feeding or a developmental or a social family problem—we may then see that family only a week later. Our service is based on a universal contact model. Then we would follow each contact up with additional support as required.

Mr M.P. WHITELY: How is the service offered? Is it offered in the hospital or is it offered in —

Mrs Abernethy: Yes. The parents are advised at birth, in the hospital, about the service. The child health services are notified through what we call the birth notification system. Every birth is recorded in WA through the midwifery notification system. That notification is then passed on to each of the child health nurses who are notified that there has been a birth in their local government area. The child health nurse then makes contact with the parents.

Mr M.P. WHITELY: Does the child health nurse visit while mum is still in hospital?

Mrs Abernethy: No. The first visit is at the home.

Mr M.P. WHITELY: Okay: the child health nurse knocks on the door and says hello.

Mrs Abernethy: Generally, they make first contact by phone and the parents have already been notified to expect the service.

Mr M.P. WHITELY: What percentage take-up is there?

Mrs Abernethy: Very high in the first year; at the first visit approximately 95 per cent access the service. I guess the reason for that is that we are seen to be a non-threatening service. Many parents see us as supportive of the family, both in terms of looking after parents and their children.

Mr M.P. WHITELY: You made reference to six contacts in the first three years. Can you advise the committee about the developmental milestones linked to each of those visits?

Mrs Abernethy: The first visit is within the first two weeks of the child's birth although generally we hope to visit within the first ten days—allowing for notification systems and the normal issues about gaining access to parents. We then see them again at six weeks.

Mr M.P. WHITELY: As you go, can you very briefly outline what you are looking for at that point?

Mrs Abernethy: Yes. We visit the family. We make an assessment, alongside the family, finding out how they are doing since the birth of the child. We find out how the child is doing. We ask if the baby is feeding well and if there are any concerns. We ask about the family's medical history; for example, we ask if there is a family history of deafness or any other developmental problems that could potentially be an issue for the child. We have "alert references".

Dr Flett: If I could, I will make a comment here. These first two visits have a huge impact on mothers of first-born children. This is the time when mums are very uncertain—it might be breastfeeding issues, it could be anything, it could be impacts on the family—and these nurses have a profound impact on the mothers' confidence about how they are handling their first-born child. That is why we have a high uptake of that service. It is interesting that even the most educated of

mothers all go along with this service because they are getting information about things that they have no knowledge of from their past experiences.

Mrs Abernethy: We do an assessment of the child. However, as I said, a lot of our work is in supporting the families and providing them with information about all of those issues, including health, breastfeeding and sleep. One of the big issues, for new parents in particular, is how often the baby sleeps—there are many issues around that.

Mr M.P. WHITELY: Obviously you ask how mum is going.

Mrs Abernethy: Mums and parents.

Mr Morrissey: Is it appropriate to —

The CHAIRMAN: Everyone else appears to be, so go ahead.

Mr Morrissey: Mental health is another really important issue that we look at. It is a good opportunity to screen for the base-line mental health of the mother and also any history of post-natal depression—giving us an early flag that allows us to put in place the necessary follow-up. We can then tap into a whole range of services. It is a significant issue and we are on to it.

Mr M.P. WHITELY: To follow up on those comments: if mum is displaying symptoms of post-natal depression what is the pathway then?

Mr Morrissey: I am not an expert. I would suggest it is probably a bit early to diagnose post-natal depression at that time, but if there are any potential contributing factors or a previous history, we then initially tap the at-risk mother into their local GP—an important first point of contact. We would then look at some very gentle and careful screening and assessment of the mother who can then be hooked into the relevant Medicare item; that is, one of the ten or twelve psychology assessments. The pathway depends on the mother and what is going to be best for the individual mother. The non-government services offer some excellent support in this area also.

Mr M.P. WHITELY: I want to go through this whole six-step process but members can jump in.

The CHAIRMAN: No, I think it best if we complete the process. Go ahead.
[9.20 am]

Mrs Abernethy: Based on that first assessment, there would be an assessment then with the parents as to how often we see the parents. The next universal time is at six weeks, but as you say, we could be seeing that family weekly between those first weeks, depending on their needs and depending on the assessment.

Mr M.P. WHITELY: So is that another phone call?

Mrs Abernethy: It could be a follow-up home visit again.

Mr M.P. WHITELY: If everything is fine at one week, six weeks is another phone call.

Mrs Abernethy: No, at six weeks we will book in and we will see the parents. At the first visit we will already have made this arrangement with the parents—that we will be coming back in six weeks, and we advise them what we will be doing. That is when we do a full physical assessment of the baby, and another assessment of the family's needs, whether they have any needs, and whether they have high needs or low needs, and again an assessment is made of that. The next universal contact is at three to four months. At the same time—just to go back to the six weeks—it is when Mark alluded to, we do an Edinburgh postnatal depression scale on the parents at six weeks. We do not do it before that because the parents are very anxious in those first six weeks. The evidence is saying that this is not a good time to be doing the assessment. We do it at six weeks. Also, again we repeat it at three to four months, and we repeat it again at eight months, so we get a good baseline where we know where the parents are.

Mr P. PAPALIA: You put in your report that the newborn hearing screening program is nowhere near as comprehensive in coverage as the rest of the program. Is that considered to be part of the screening program, or is it just an adjunct that does not get enough focus?

Mrs Abernethy: That actually occurs in the hospital situation, so it happens at the birth, and it happens in the public health —

Mr P. PAPALIA: When I experienced it—I can remember it—it did not seem to be the same as the rest of it, where they come and visit you in your home, and give excellent service. There is almost no way you can resist them. As you said, everyone is keen to receive that, but it is a bit easier for a parent to maybe not make the appointment to go into King Edward Memorial Hospital, say, if you are in the city, to have that hearing test; I refer to the one after leaving hospital. Is that six weeks or something?

Mrs Abernethy: No; it actually happens at birth, so it happens within the first two days.

Mr P. PAPALIA: I knew about the at-birth one, but I thought there was a subsequent one.

Mr Crake: Before discharge from the hospital.

Mr P. PAPALIA: Maybe that is different from what we experienced.

The CHAIRMAN: That is only if you are lucky enough to be in a metropolitan hospital.

Mr P. PAPALIA: We did that eight years ago.

Mr T.K. WALDRON: The tests at birth happen in the metropolitan area, but if your baby is born in the country, what is the process then for those same tests? Do they have them at a later date? Is that part of what you do when you follow up?

Mrs Abernethy: That is one of the limitations of our current program. In the public system it is within the metropolitan hospitals. There is a private service for some of the country private hospitals in Bunbury and Geraldton. That is one of the limitations.

Mr T.K. WALDRON: Is there advice to those parents that they should get that done, or is that done as part of your follow-up?

Mrs Abernethy: That can be done as part of our follow-up when we first visit the parents and ask about any family history of deafness.

Mr T.K. WALDRON: If there is something there, would you encourage them to follow it up?

Mrs Abernethy: It would be through a private system.

The CHAIRMAN: So that is an obvious gap in the statewide servicing. What is the system doing about fixing that statewide gap?

Dr Flett: In fact, there is a proposal with the minister at the moment to fix that gap. It went to ERC about three months ago, and failed to gain funding then. However, I have brought it to the notice of the minister more recently because I believe it needs to be done.

The CHAIRMAN: What level of funding would be necessary to secure a universal service?

Mr Crake: It would cost $9 million over four years.

Mr P. PAPALIA: The figure you suggested that we are getting to is only 49 per cent of births. That would suggest that a lot of people in the metropolitan area are not being tested as well, would it not?

Mrs Abernethy: It is done in six public hospitals in the metropolitan area, so it is not in all of the public hospitals.

Mr P. PAPALIA: But your estimate of the number of births that are covered by that initial testing is only 49 per cent, is it not?

Mrs Abernethy: That is correct.

Mr Crake: At this point in time, it is not a universal service.

Mr T.K. WALDRON: So does that $9 million over four years pick up the other ones in the metropolitan area as well.

Mr Crake: Yes. At this point in time the proposal for newborn hearing screening is not just for screening; it is for all the follow-up services that flow from that. Once a problem is identified, there is all the other stuff that goes into further diagnosis and treatment support, which could flow on for a number of years thereafter.

Mr P. PAPALIA: At birth, they cannot always determine whether there is any problem, can they?

Mrs Abernethy: With the newborn hearing screening, they can pick up congenital hearing loss, which can be picked up within the first one or two days after birth. That is the ideal time to pick this up, so that we can start identifying and start treatment and management before the children start into that sort of speech area at six months. That is why it is so important that we want to expand that program.

Mr M.P. WHITELY: How is the testing done? Is it just reactivity to sound?

Mrs Abernethy: They stick a sensory probe into the ear.

Mr P. PAPALIA: It is pressure, is it not? They can test the actual eardrum response.

Mr Crake: It stimulates the eardrum, but they measure the responsiveness and electrical impulses in the brain stem. If that does not occur, they know there is some neural pathway problem that does not allow the child to hear. It really is about congenital hearing loss.

Dr Flett: It is a connectivity problem.

Mr M.P. WHITELY: Talking about 51 per cent getting access at a cost of just over $2 million a year, it would seem to be fairly good value for money, would it not?

Mrs Abernethy: Yes.

Mr P. PAPALIA: So obviously work has been done to determine the costs associated with resolving that issue. Is the assessment of the cost recent?

Mr Crake: There has been a process of development. Western Australia was the first state in Australia to cost out and implement a pilot program for newborn hearing screening. It has subsequently been picked up in other jurisdictions at various points along the pathway of testing the idea through the pilot program, and finding that it was effective such that other jurisdictions also picked it up. Mind you, this is also happening internationally. Business cases have been developed in the past couple of years to look at what it would cost to implement. Bear in mind that this is a comprehensive program—not just screening. There is all the other stuff that attaches onto it. As the director general said, the last submission for the budget was in this financial year.

Mr T.K. WALDRON: You mentioned earlier that there is a 95 per cent take-up where this is offered. Do some people refuse; and, if so, why? Does that drop off as mothers have their second, third or fourth child and decide that they do not need to do it?

Mrs Abernethy: The short answer is yes. The service is very attractive to first-time mothers for a number of reasons. It is a very supportive program. Some families may choose not to take up the service. Other services are available through the non-government sector or through general practice. Generally you find that, in the first year in particular, the service is taken up very highly while the baby is progressing through that first year of life. It drops off in the second and third year, mainly because families are returning to work. Then there are other opportunities for child health nurses to see children, either through playgroups or other postnatal parenting type situations, so in the second year we have to look at our service delivery and work out where families are, and that is how we see the children.

[9.40 am]

The CHAIRMAN: There will be other questions relating to this area that we will come back to. I want to have the opportunity to discuss another area briefly; that is, the large number of additional births that have occurred in Western Australia and the resource allocations to respond to that. What has the department done to respond to this dramatic increase in births in Western Australia in the past four years?

Dr Flett: You are right. On average, there has been a 15.6 per cent growth in births from 2002 to 2006. In some areas it is much higher than that. For example, there was a 20 per cent increase in Wanneroo. We are struggling to cope with this unexpected and substantial growth. At the moment we are responding on two fronts. Firstly, we are spreading our resources as well as we can to cover this. Secondly, a paper has been put forward for an increase in staffing numbers for child health nurses to address this issue. I do not know whether Mr Morrissey can add any more detail to that answer.

The CHAIRMAN: I suppose we have to get you to start from the beginning.

Mr Morrissey: What did you want me to cover?

The CHAIRMAN: There are two things. At some stage we want to hear about the processes for screening, but you will not have the issue of unexpected numbers so we will want to know what you are doing in relation to these numbers.

Mr Crake: It would be fair to say that all jurisdictions have been caught out by the sudden leap in births. It is affecting both maternity services and child health services and will in time flow into the school health services. There are a number of reasons for the sudden increase in births. It has been linked to the demographic of the Australian population. For example, women who put off child rearing have suddenly started to start a family, as well as the baby bonus implemented by the previous commonwealth government. It was unexpected. There are quality improvement activities within community health in the metropolitan area relating to the restructure of child development services and bringing together an integrated child health service in the metropolitan area. We are trying to make better use of the resources that we have through restructuring and reorientating. As the director general has said, submissions have been made for additional resources that have been considered by government.

Mr M.P. WHITELY: I am going to ask an idiot question. Obviously hearing can be tested at birth. Is it far too early to test eyesight?

Mrs Abernethy: Eyesight is tested at birth and also at six weeks and three to four months.

Mr M.P. WHITELY: How would eyesight be tested?

Mrs Abernethy: Initially, at the birth we are looking at any abnormalities such as glaucoma or tumours. That is a good indication.

Mr M.P. WHITELY: What about assessment of vision?

Mrs Abernethy: Vision is not tested until later.

Mr M.P. WHITELY: At what age can you effectively do such a test?

Mrs Abernethy: Around three to three and a half years old. The early indications are looking at abnormalities of vision.

Mr M.P. WHITELY: We went through the first six visits. We have not yet spoken about pre-primary or primary screening. Can you outline what is available?

Ms McBride: Shortly after children enter school, their parents are provided with the offer of an assessment. We call it the school entry health assessment. All parents in all schools are offered that assessment, whether their child starts at kindergarten, pre-primary or year 1.

Mr M.P. WHITELY: Does that include private schools as well as government schools?

Ms McBride: Yes. There is the Catholic education system, the independent school system and the public system. We try to approach all those students. A handful of students are home schooled, and from time to time we make services available to them but they tend to pursue their own services through their local GP. That is a very small percentage. Once we have parent consent to pursue the school entry health assessment, the community health nurse will visit the school and conduct vision and hearing assessments on all children. The tests are universal. After collecting information from the parent and the teacher, a number of other assessments may be offered depending on what issues may be present. Speech and language are very important, as is fine motor control, social interaction with their peers, psych-social and behavioural type issues. The teacher may pick up on those sorts of issues because early childhood education teachers are very good at looking at what is outside the norm. The community health nurse will also conduct a weight assessment if required. These are what we call targeted assessments; they are only provided if there is an indication that they need to be done.

Mr M.P. WHITELY: Testing for eyesight and vision and hearing is generalised. Speech and language and psycho-social and other issues are only tested —

Ms McBride: Yes, if there looks like there is a problem.

Mr M.P. WHITELY: What would a vision test entail?

Ms McBride: I may throw that back to Ms Abernethy because she will be able to answer from a clinical point of view.

Mrs Abernethy: They make an assessment of the vision. They would be looking at the child's eyesight, looking at both eyes to make sure they are symmetrical. That would be the first assessment. They also conduct some family history. They would ask whether the child normally wears glasses. They may have turned up to school that day not wearing glasses and the school nurse may not know. Those basic questions are asked. The parents are asked whether there is any family history of any eye problems. Then they do an assessment using a chart that is used for distance vision testing. The nurse will assess the child with a set number of figures, move the child away, test each eye individually and make an assessment. Sometimes the child may not pass that assessment. They may be distracted or it could be done in the afternoon instead of the morning. They would then do a follow-up assessment.

Mr M.P. WHITELY: Do they need to recognise shapes?

Mrs Abernethy: Yes, they need to recognise shapes and sizes. They all come in different shapes and sizes. There is a set system across that chart as to what the child needs to be assessed for.

Mr M.P. WHITELY: What about hearing?

Mrs Abernethy: Hearing is done through an audiology assessment. Again, the ear is assessed first, checking for any abnormalities in the ear. Family history is checked. All the basic stuff is done before the ear is assessed. An oroscope examination is done where a scope is put into the ear to check the eardrum. Then an audiometry assessment is conducted to see whether the child can listen to minimum sounds or decibels.

Mr M.P. WHITELY: This testing is voluntary. How is the offer made and what proportion of parents take it up? Is there a pattern between different socioeconomic areas? It is taken up more in the leafy green areas?

Ms McBride: The first question asked is: how is it offered? We send a form home. I have one of those forms here if you would like to see it. It collects family history, details about the child and the family, as well as consent from the parents to carry out the assessment, and also to share that information with the classroom teacher, which is quite important.

The CHAIRMAN: It would be useful for us if you could formally table that. Perhaps you could leave it with us.

Ms McBride: There is a result sheet attached to that, too.

Mr Crake: For the committee's interest, we also brought the child health record, which is used at the birth to school entry screening process as well.

The CHAIRMAN: I might get you to leave those documents here and we will table them at the end. I interrupted you. Please continue.

[9.50 am]

Ms McBride: There are some translated materials also, so that if parents speak Arabic or Chinese or Vietnamese they are able to access this material through those languages as well. When parents have limited literacy skills, quite often the nurse or someone else in the community will assist them to read the form. If it is, say, an Aboriginal community in the north west, the nurse has a presence fairly frequently in the community and would assist the parent to read the material and work out what is going on. I will not go too much into that because it really depends on the individual family situation, but we can reach most people by using that form, but we do endeavour to reach families with difficulties or with non-English speaking backgrounds through other methods. That moves on really to the second question. We suspect that we reach about 90 per cent of children, so we get consent to test about 90 per cent of children. We are doing a thorough evaluation of that this year. We had planned to do that this year regardless of this standing committee, and so we should get a fair indication towards the end of the year of how well we are reaching children in WA for school entry health assessments.

The CHAIRMAN: That 10 per cent gap is the great fear, is it not? What is it made up of? Is it the people most or highly at risk?

Ms McBride: Quite possibly. There are people who are highly transient. They may not receive a test or they may receive two or three tests if they are using aliases and other names. So we are not sure about that group. There are groups of non-attenders at schools who we may miss, because the day the nurse turns up to do the test they may not be there. This could occur on multiple occasions. There are parents, for their own reasons, who choose not to consent. They choose to pursue other avenues or none at all, but that is a fairly small percentage.

The CHAIRMAN: Is there a correlation between the data that is acquired around Perth and this school entry data in terms of the numbers of people that turn up in the school entry data who are not being dealt with at birth?

Ms McBride: That is something that I do not think we can tell at this point.

The CHAIRMAN: So is there no effort to do that?

Ms McBride: I do not think there is a really good means to do that because the data does not match.

The CHAIRMAN: Is there a reason the data does not match? Presumably there is a health department file created for a person at birth.

Ms McBride: Some areas of the state have quite good data systems to track individuals. Others, especially where there has been rapid growth, have had some difficulties doing that.

Mr Morrissey: Could I comment?

The CHAIRMAN: Yes.

Mr Morrissey: We recognise, I guess, some issues with the data, and we have taken some fairly strong steps in the last couple of years. We are just in the process of implementing a very robust data collection system across child development services, which does link into the overall Department of Health data. That is pretty well up and running. We plan to extend that right across

school and child health in the next couple of years. IT projects do usually take some time; we recognise it and have moved on it quite quickly. So we hope to have that addressed in the short to medium-term future.

The CHAIRMAN: I am keen for us as a committee to have available details about the IT project. I do not need it now, but I would like the committee to receive from the Department of Health a description of how that is proposed to work. Specifically I would like to know whether it is a web-based program that gives operatives in the health system, as well as beyond the health system in the education department, access to data of an individual birth through to school entry with some level of prospective universality. That is the issue. I want to know what is being done to ensure that there is data that starts at birth and then we can correlate what is happening with it.

Mr T.K. WALDRON: I was just going to ask a question. You said that sometimes a child might miss out simply because a child is not at school; mum and dad might be in Perth or the child might be away sick. Is there a mechanism in place then to follow up that child so that the child does not miss out?

Ms McBride: Yes, there is a good tracking system. Typically a nurse would keep a class list of all the children that she needs to see; whether they are coming into the program. She would have names and know how many of these forms she has had to send out and then what sort of follow-up she has done with phone calls and so forth. She would track what assessments she has done, referrals she has made and outcomes she knows about. I am using the word "she" because there are very few male community school health nurses.

Mr T.K. WALDRON: I guess my point is that it would be rare for someone to actually miss out on that test if they want to have the test. I am thinking about someone who is away, gets overlooked and misses it and later on finds there is an issue.

Ms McBride: It is the transients and multiple non-attenders, who are unusual, but they are the vulnerable group.

Mr M.P. WHITELY: If the parents do not respond, is that assumed that it is because of a lack of consent?

Ms McBride: Yes.

Mr M.P. WHITELY: Rather than that the form just got lost?

Ms McBride: We send out more than one form. If it does not come back, there will be another one.

Mr M.P. WHITELY: Are they posted out?

Ms McBride: No, they usually go home with the child. There are a lot of forms that go home with the child. Sometimes they are handed out to the parent through the teacher as the children are picked up.

Mr M.P. WHITELY: I am amazed that you get a 90 per cent response when you send things with the child.

Mr Morrissey: It is remarkable.

Mr M.P. WHITELY: It is astonishing. Maybe our kids are doing very well.

Mr Crake: I think the message, though, is that it is a persistent follow-up; it is not just a once-off. The nurses are actually very persistent in making sure that the kids get this checked.

Mr M.P. WHITELY: I think they would have to be.

Ms McBride: And teachers; so they will put an envelope in the child's bag or, as parents come and pick their child up as often they do when they are little and at the young end of the school, they will hand it directly to them.

Mr P. PAPALIA: Who administers the test? Is it Community Health Services everywhere or is it in some remote and regional areas the school health service?

Ms McBride: The school health service is part of Community Health Services.

Mr P. PAPALIA: Do they all have the same training and the same category of qualifications?

Ms McBride: Yes. There are a handful of schools where the Aboriginal Medical Service provides those sorts of early intervention tests, but that is unusual and it is a very small number.

Mr P. PAPALIA: I ask that because you have identified that the ratio of school health nurses to students is way in excess of other states. Is that right?

Ms McBride: I do not know how it compares with other states.

Mr Crake: What page are you looking at?

Mr M.P. WHITELY: Page 16?

Mr P. PAPALIA: Yes.

The CHAIRMAN: It refers to schools across the state in 2002.

Mr P. PAPALIA: I thought there was an identification somewhere.

Mr Morrissey: That was in relation to child health.

Mrs Abernethy: Yes, child health.

Mr P. PAPALIA: Is it child health nurses that the ratio is way in excess of other states?

Mr Morrissey: There is some clarification required around that data that I might ask Mark to briefly comment on.

Mr Crake: The child health data or the school health data?

Mr Morrissey: If you are looking at child health nurses, there are some factors there that you need to consider before we consider them higher than other states. It is actually what they deliver, and some of the states do quite different things. So it is—to use the expression—comparing apples with oranges.

Mr P. PAPALIA: Do you consider the number of school health nurses that we have as adequate?

Ms McBride: In some places it is. I think in other places of rapid growth, in the north and south corridors and in the metro area in particular, the service is stretched.

Mr P. PAPALIA: I note there were 99 full-time equivalents in the metro area. What sort of range of schools does a school health nurse have to cover?

Ms McBride: Generally there are three types of school nurses. We have nurses who are predominantly in high schools, so they provide a quite different service; it is more like a health clinic, health promotion-type role in the school. So they will see adolescents coming with their particular issues and they will work with the school. I will not go into detail about that because that is not the subject of this committee. In primary school nurses typically move between multiple schools. So they may visit a school once a fortnight, talk to teachers and parents—mostly teachers—do their tests and do some care planning for children with particular needs.

Mr P. PAPALIA: You keep saying that we have the growth areas in the north and the south. Have we focused our concentration of school health nurses in those areas or are they evenly distributed across the city and that is why you are saying that we have a problem?

[10.00 am]

Mr Crake: The metropolitan child and adolescent community health service was brought together about this time last year—2007. Prior to that, these types of services were located within area health services. They were disaggregated. There was an overarching policy framework, but the actual

management of resources was not centralised. I think we are in a changed environment in which we are getting a better handle on how service is delivered and the gaps that occur. That is something that has become apparent in the past 12 months. We are aware of the problem and there are actions we can now take to address them, but fundamentally there will still remain increasing capacity gaps as that birth cohort flows through, if that makes sense.

Mr P. PAPALIA: They are geographically located in regions that you can identify, are they not, particularly in the metropolitan area? There is not necessarily massive growth in, for example, Nedlands.

Mr Crake: Another factor is that the other key stakeholder is the Department of Education and Training, because it actually funds school health services. Principals have an interest in the services that are provided to their schools, so sometimes it is a relationship issue about how resources are used that needs to be managed, because they are giving about a third or almost a half of the resource to support the provision of school health services. There is a bit of complexity between departments and interests at a local level. These issues have really come to the fore in the past 12 months.

Mr M.P. WHITELY: Are you saying that relations with individual principals can change how services are delivered on the ground?

Mr Crake: The education department is a stakeholder, and principals who have a service will want to keep that service, so if we want to try to reallocate our services, we have to manage that relationship.

Mr M.P. WHITELY: It is very hard to take something off them, is it not?

Mr Crake: Indeed.

Mr T.K. WALDRON: I was thinking along the same lines, but you are not saying that the principals influence what the person does at the school.

Mr Crake: No, it is just a situation in which we may want to take that person out and put them somewhere else.

Mr T.K. WALDRON: Are numbers well covered in regional areas, or are there gaps there as well?

Ms McBride: It all depends. Some areas are well covered. Some areas of rapid growth—for example, Bunbury and Busselton—are somewhat more stretched, as they are in the metropolitan area.

Mr T.K. WALDRON: What about the more remote areas?

Ms McBride: I do not think they are as stretched as services are in the city. They have far different issues, in terms of distance and working with Aboriginal communities. It is quite a different type of service they need to provide to get the same sort of outcomes, but I think getting staff up there is an issue.

The CHAIRMAN: With regard to school entry testing, is there any glaring evidence of a good number of people missing the detection of serious health issues from the early birth tests? I guess we have people who, for whatever reasons, have missed out on hearing tests, for example, but then there are new arrivals, including refugees and immigrants from other states. Is there a glaring gap here between what goes on at birth and what goes —

Ms McBride: We did an evaluation of hearing testing at schools some years ago, and we found that there are a small number of children who are detected as having profound hearing issues when they hit school, that have not been picked up before. That was quite alarming and interesting. That is quite a small number, but there is quite a large number—I do not have the figures; I would have to go back and have a look—of children who have had ear infections since birth and have got some sort of impaired hearing. They are not profoundly deaf, but the impairment might have interfered with their speech development.

Mr T.K. WALDRON: You said those numbers were surprising. Are those numbers dropping? Are we doing it better, do you think?

Ms McBride: We have only one set of data. We would have to go back and have another look.

The CHAIRMAN: At some point we will have to ask about the numbers of children picked up in these tests at school entry and diagnosed with issues who are waiting for service and responses from the health department; I am thinking, for instance, of the area of language development. I think the figure for people who were being dealt with by language development centres was 1 500, and there was something like 14 500 people on the waiting list who were in need of access to those programs. Are we doing all this diagnostic work and screening and then not having the services being rolled out across a range of areas? Would the director general like to answer that?

Dr Flett: Mark, would you like to talk on that? That is correct; there are a substantial number of people on waiting lists.

Mr Morrissey: I will respond on a bigger picture level. We recognise that there are children on the waitlist. We commenced a project with the child development service around two years ago. The child development services provide treatment following screening for autism, speech, occupation therapy and a range of childhood developmental delays or disorders. When reviewing that service, we brought together 15 services that had—as Mark Crake alluded to earlier—previously been in separate government structures within health services, so their ability to deliver similar services was impeded by the structure. It was good work. We have gained a lot, particularly in the past year, in the area of practice. We have developed very strong clinical pathways—which I am happy to make available to the committee if it wishes to see them—for each of the major disorders. I believe we are leading the country in child development practice. That has had an impact on waitlists to some degree. We are using those resources far more effectively. We are ensuring that all the treatments and interventions we do are actually based on the very best evidence we have available, both nationally and internationally. We put in place a number of strategies to manage waitlists. Where possible, we talk to parents, train and educate in group contexts, as opposed to one-to-one, which is more effective and it is also quite good for parents to get together. We believe the parent is often the very best person, with the right skills, to do some of that really important work, because they spend every day with the child. We are looking at using our resources to the very best of our ability. The only waiver in that is that there has been the population growth we have talked about. I guess, in common with all areas of health, we are under major pressure. That is broadly my response.

Mr M.P. WHITELY: You made reference to the major disorders. Can you give the committee an indication of what things you are finding?

Mr Morrissey: Autism is something that occurs in one in every 160 children in Western Australia. We seem to have a higher prevalence here, but I think that is related to the skill of our clinicians and their ability to diagnose. Delays in speech development —

Mr M.P. WHITELY: What is the treatment or response for autism?

Mr Morrissey: I can respond broadly; I am not a clinician, so I would not assume to go there.

The CHAIRMAN: You offered earlier to provide the committee with the pathway responses to each of these disorders.

Mr Morrissey: If it interests the committee, we have that information.

The CHAIRMAN: Do you actually have a document that will guide us through any of the disorders you pick up?

Mr Morrissey: Yes, I think we have developed clinical pathways for eight or nine of the major disorders that are picked up at screening and they are available.

Mr M.P. WHITELY: Could you list the eight or nine disorders?

Mr Morrissey: I might ask for some input if I do not get them all. There is autism, speech, and issues related to gait and motor skills. There are some cognitive issues for which, in treatment terms, there is sometimes a fine line between disability services and health. There are emergent mental health issues in children that we deal with. The main message, without listing all the disorders, is that we have in the past found that a lot of these children have presented with disorders. It is related to our ability to diagnose, but there are also some fundamental changes happening in childhood.

Children are presenting with three or four issues that are concurrent. Children often present with some issues that actually compound what may have been one primary diagnosis. We find they have a number of other issues that go along with them, so they are more complex.

[10.10 am]

Mr M.P. WHITELY: Are they medical with mental health issues?

Mr Morrissey: Possibly. I am talking more childhood development. We might have a child with a mild form of autism. They might also have developmental delay, they might have some problems with speech, or they might have some sort of conduct behaviour disorder. They are all related. They also require specialised intervention. I am not the expert in this one to make that comment.

Mrs Abernethy: Sometimes the presenting issue might be behavioural, but when you start to unpack some of that, then you start to come across the issues of gross motor skills, speech and language, even a hearing problem. The behaviour could be down to the fact that the hearing impairment has not been picked up. That is where you start to unpack some of the issues. It could be a feeding issue, but it is actually a mechanical problem. This is where the diagnosis and treatment is so important.

Dr Flett: With the standardised models of care that have been developed here, this means that no matter who sees the child or what centre, it is all standardised; everything. It is all followed in exactly the same way. We do not have variability as would otherwise normally happen in response. There are a number of centres, which perhaps Mr Morrisey did not mention. There are 15 centres in metropolitan and country areas where these problem children, if you like, are referred to.

The CHAIRMAN: What are the waitlists for getting into those centres?

Mr Morrissey: I will make a general comment. Depending on the disorder and the potential diagnosis, there are no waitlists. We can get children in straightaway. Others, due to a range of reasons, there is often a fundamental problem in recruiting health professionals. A lot of health professionals have moved into the mining industry where they can earn a lot more money. We also endeavour to manage the waitlist as promptly as we can always, so we will prioritise a kid. We will look at them and we will assess them. If it is urgent and we can do something now, we will do it now—we will do a short, sharp treatment—but then there is sometimes a waitlist of up to 10 to 12 months.

The CHAIRMAN: The committee needs from the Health Department a description of the waitlists in these areas.

Dr Flett: Related to the models of care?

The CHAIRMAN: Yes.

Dr Flett: Yes, we can do that.

The CHAIRMAN: You will be getting a copy of *Hansard,* which will remind you of the questions that were asked of you. We have got about five minutes to wrap this up before our next lot of witnesses come.

Mr M.P. WHITELY: I will not ask questions now, but I am also interested in the efforts to standardise care. I would really be interested in bearing down as to what that means.

Dr Flett: We would be pleased to do that. We can uncouple it from giving you what would look to be somewhat complex papers into a description of what this actually means. Yes, we can do that; coupled with your request.

The CHAIRMAN: Director General, the other point that Mr Morrisey made was about the shortage of health professionals. I note, for instance, some of the missing numbers of health professionals are in salary ranges that are very low in the health system. We understand market economics, but I cannot see how we can use that as the explanation. If you are paying, say, a professional a low amount one could understand why they disappear into the mining industry. That seems like a self-evident event. I am looking for an explanation as to what is going on to secure more health professionals arriving with adequate pay so that you can get a few more studying in that area. I think a classic one is speech pathology; it seems to me classic that is at the bottom end of the pay scales. I cannot see any movement in that happening, yet you are short of them and people cannot get access to them. I want some indication from the health department as to what is being done to tackle the missing professionals.

Dr Flett: Certainly. This is a conversation in its own right and I am conscious of time. In general, we have a substantial issue across whole of health with attraction retention now with staff. In every aspect we are short of staff and this happens to be one of them. On a daily basis, we can be up to 60 beds closed in our metropolitan acute hospitals through lack of nursing staff. This is a worldwide problem, not just an Australian problem. We can give you more detail in our response.

Mr P. PAPALIA: I will go back a little bit to the type of disorders that we are identifying. Margaret referred to behavioural disorders often being unpacked and being determined to be related to something else. I am looking at a reference on page 18 of the Williams and Ray report, outlining the prevalence of developmental delays and other disorders. It refers to an incidence of one in three for behavioural disorders. That seems an incredibly low threshold. In my mind, if one in three people are identified as having a disorder we have all got one, so we may as well all go to hospital! Particularly with behavioural disorders, when we are screening children, what determines the disorder and what sort of threshold determines whether or not you continue on to receive treatment?

Ms McBride: John Wray would be the right person to ask about detail. In the very low threshold we would be looking at a child's inability to sit and listen or to play with other children or to follow instructions or to play in a non-aggressive way; those sorts of very basic things for a four or five-year-old.

Mr P. PAPALIA: My concern would be that maybe sometimes we pick up a whole lot of kids who are just kids and perhaps the teacher, who is having input into the process, or the particular nurse, identifies that individual as having a disorder when, in reality, they are just having a bad day or drank Coke on the way to school or something.

Ms McBride: It is within the range of normal. As I mentioned before, early childhood teachers are very good at observing children and looking at what is well outside the norm. It would not be something you would assess in a day, it would be something that would be assessed over a period of time. The other very useful referral point for nurses and teachers is the school psychology service, which is in operation right throughout the state. They would be a first point of call for something like a behavioural disorder.

Mr M.P. WHITELY: I am not going to get on my high horse here, but I would be particularly interested in seeing those pathways around the mental health disorders and learning difficulty disorders; those that have the higher prevalence, the ones that you have mentioned, and the pathways of referral. The issue of consistency of treatment is a real issue.

Dr Flett: Yes.

The CHAIRMAN: That is what we have agreed to get.

Mr Morrissey: We can give you that.

Mr T.K. WALDRON: The condition known as Irlen's syndrome, the visual syndrome, is that something that you know about? It is something has been raised with me over the past two years. There is a van that goes around country WA that treats children with Irlen's; a syndrome where they cannot focus. Is that something the Health Department knows about or can comment on?

Mr Morrissey: I am personally not familiar with it. I am happy to find out.

The CHAIRMAN: John Day has arrived.

Mr J.H.D. DAY: Thanks, Mr Chair. My apologies for not being here. My wife has been making use of the health system!

I want to ask about the early development instrument in relation to the discussion in childhood development. Can you tell us what priority that has in relation to the health system at the moment and how much you see it being used in the future? It is a fairly open-ended question, but I think it is somewhat pertinent to what is being considered here.

[10.20 am]

Mr Morrissey: I am happy to provide a response and for the committee to then take other input.

Several years ago, and I do not know the exact date, the North Metropolitan Area Health Service, obviously part of the Department of Health, actually picked up on an instrument used in Canada to assess the general overall health issues of children in particular communities. It was developed into a local instrument and was strongly supported by the local health services. It has subsequently been picked up by the federal government and supported strongly by the Telethon Institute for Child Health Research. We, in child community health, support it. We have allocated people to making sure that that instrument is implemented in communities. Currently, they are exploring developing one for Aboriginal children. We see it as the overarching screening tool of the health of children in these communities. We pioneered it and we are very supportive of it.

Mr J.H.D. DAY: My impression is that currently it is used on a fairly ad hoc basis in different parts of the states. Do you have any comment on that and do you see the possibility of it being used on a more comprehensive basis?

Mr Morrissey: I understand from some indicators that the federal government is very supportive of funding it for its use to be much more widespread.

The CHAIRMAN: Either now or subsequently I would like to know what is being done to deal with fetal alcohol syndrome causing speaking disorders, which has been raised in police and coronial inquests and research, and whether you have the testing in the system. Do you want to make a quick comment on that?

Mr Morrissey: We are very happy to provide some written advice on this by updating what is happening.

Dr Flett: I would add that Indigenous maternal child health has identified that as part of an area of focus.

The CHAIRMAN: I would appreciate written follow up on that.

Thank you for your evidence before the committee today—I actually mean that. A transcript of this hearing will be forwarded to you for correction of minor errors. Please make these corrections and return the transcript within 10 days of receipt. If the transcript is not returned within this period, it will be deemed to be correct. From the transcript you will be able to highlight the issues that were raised for further discussion. Thank you for your time today.

Director General, we anticipate having you back. My instinct is that it is likely to be in the first week of August, but we will come back to you after we have heard from a range of other groups. You are the first group that has come before the committee on this issue.

Hearing concluded at 10.31 am