

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, 6 AUGUST 2008**

SESSION THREE

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 11.00 am

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

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

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

GAUNTLETT, MS ERIN
Department of Health,
examined:

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

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

The CHAIRMAN: Welcome. I have the task of reading you the same formal questions. The committee hearing is a proceeding of Parliament and warrants the same respect as a sitting of the house itself. You are not required to give evidence on oath. Any deliberate misleading of the committee may be regarded as contempt of Parliament. The following questions require audible answers for Hansard. I will go from the left of the table through to the right. Have you completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIRMAN: Do you understand the notes attached to it?

The Witnesses: Yes.

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

The Witnesses: Yes.

The CHAIRMAN: With the 15 questions that I want to put to you, I will put them all to you as Acting Director General. We are looking for succinct answers and then my colleagues will take their questions in the areas they have particular interest in.

In reference to page 2 from the questions on notice response, there is reference to "The second and third phases will see this system [CDIS] expanded respectively into metropolitan and Statewide

community and school health services. However, these stages will require a budget commitment.” Question one is: what is the status of your requests to obtain further budget funding for your ongoing development of the child development information system, and how much is required to roll out these other phases?

Mr Morrissey: I am happy to respond. We are in the early stages of undertaking that body of work. We are looking at procuring an existing system from another state that is used for community health purposes and I believe that we can actually progress the project out of our existing budget. We have identified a project directly for that role.

The CHAIRMAN: Therefore the level of funding required from government is not necessarily to be increased to do this?

Mr Morrissey: The funding is not prohibitive and we believe we can do it within our existing budget allocation.

The CHAIRMAN: When then could the system be fully operational?

Mr Morrissey: My vision and plan is we should have it ready to trial in 12 months. Hopefully, it should be up and running within 18 to 24 months.

The CHAIRMAN: Page 3 —

The ability to share electronic client information across government departments would require a review of legislation and information sharing policy.”

Has a review of legislation and information sharing policy to allow data sharing commenced? This is page 3 of the answers to questions on notice. Has there been any formal review embarked upon?

Mr Crake: Review of legislation, no; not that I am aware of. There are matters such as the privacy legislation which I think government is currently considering. There are a number of other matters in the general area of information sharing related to privacy etc which I understand the government has got processes in place with regard to.

The CHAIRMAN: Does your department have any intention of triggering a process for a review of the legislation and information sharing policy? You refer to it as being “would require”. It is not something that you are going to put some momentum behind?

Ms McBride: I believe the commonwealth privacy legislation has been changed and I believe that our lawyers have been involved with that. We have been asked to comment and we have provided feedback requesting that we be able to have easier sharing of information between departments. There are other legislation updates that we have provided advice on the same.

Ms Gauntlett: It is a slightly different issue but related: in relation to the child development information system that is currently under development, because it is a web interface product there will be capacity in the future for us to enable other people limited access to that system. So we could open that up, for example, to enable GPs to kind of input and do direct referrals and that sort of thing. It is not currently designed as information sharing where we would be sharing data with other government departments.

The CHAIRMAN: I refer to page 5 —

Children are prioritised on basis of age, severity of the condition/disorder, presence of complexities, and the timeliness of intervention.

Question 4: do parents or schools have the right to challenge a decision by a CDS on a child’s prioritisation?

Ms Gauntlett: Sorry, I did not hear the last bit.

Mr P. PAPALIA: He is going too fast.

The CHAIRMAN: I will go more slowly. Is there a right for parents or schools to be able to challenge a decision by a CDS on a child's prioritisation?

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

The CHAIRMAN: Thanks very much for that.

Mr Morrissey: Can I just add to that?

The CHAIRMAN: Yes.

Mr Morrissey: Currently, people do appeal; and, yes, they can.

The CHAIRMAN: I refer to page 5 —

As a result of resource restrictions, many CDS sites have been unable to effectively manage children older than eight years of age."

What happens to children with a developmental delay who are older than eight years of age?

Ms Gauntlett: Currently, up until now, some child development service sites have provided services to children older than eight; some have not. There has certainly been lack of consistency across the 15 sites. The area where there would possibly be the most consistency is in relation to the ongoing review and management provided by paediatrician staff within the service; for example, to children who are eligible through the Disability Services Commission can receive ongoing paediatric review and management from CDS paediatric staff. That has been an area of much more consistent provision of services to older children. As part of the reform process—and the prioritisation kind of framework links into this—we have identified, in terms of bringing all of the sites together as a single service, that that is a significant service gap at the moment. At the moment, we are developing service models and strategies to look at how we can provide that service more consistently. Having said that, we have talked more broadly, I think at the previous inquiry and in our submission, about how there are some factors that are always going to make—demand for services will always create pressures for the department in terms of births and migration and complexity of needs of families. We are always going to be facing those challenges. In terms of the way we are prioritising our service, clearly there is provision to target our services to children in the earliest years of their lives based on the significant body of evidence that says that is where you can have the most effective interventions.

[11.10 am]

However, the prioritisation framework also allows for children of an older age group to be able to receive a priority 1 category due to the severity of their condition or if we are going to have a significant deterioration that would arise from delayed intervention. So, that will enable us to provide services more consistently, but within current resources there is a fairly limited capacity to meet the needs of that age group. There are other services that they can access, school services; if they are eligible for Disability Services Commission; if they are eligible for the child and adolescent mental health service; also I guess there is potential through the GPs to look for them to play more of an active role in terms of ongoing medical management, perhaps with some sort of consultative role from our paediatricians in supporting them in that.

The CHAIRMAN: I am sorry, I might have missed this in your answer, but did you indicate there whether there were plans to increase the FTEs in the CDCs?

Ms Gauntlett: We do not have any allocations at the moment for increased FTEs.

Mr Morrissey: As a result of the new database, we will actually be collecting data in this area for the first time, which will enable us to produce a business case that is credible and mount the argument that we will put up through the system for more FTEs.

Dr Flett: And I will be supporting that.

The CHAIRMAN: Thanks very much. Page 6 of your paper states —

The variability within the system, the lack of standardised reporting and electronic data management, means that it is not possible to derive average, median or mode wait times in the CDS.

In an answer to a question without notice on 1 April 2004 from Dr E. Constable, the health minister provided an average waiting time in five specialist areas of the CDS for the financial years covering the period 1999 to 2004. Why can this not be done now?

Mr Crake: I believe the parliamentary question referred to the state child development service—again it is the use of terms—which was the main child development service based in Rehola Street; in responding to the parliamentary question we took it to mean that particular service outlet, as opposed to what we have now, which is the whole metropolitan child development service. We could certainly talk about, I guess, Rheola Street having probably the better information system.

Ms Gauntlett: They currently have a very small locally managed database system that they can generate data from.

The CHAIRMAN: Thanks very much. Page 6 states —

... in the sites that are able to provide services to children older than 7 years of age; most children are seen within 10 months.

How many of the 15 CDCs and four satellite services in the metropolitan area and the seven WA Country Health Service regions are not able to provide services to children older than seven years of age?

Ms Gauntlett: We might have to take that question on notice in terms of providing the exact numbers.

The CHAIRMAN: Thanks very much.

Mr Morrissey: Just to respond, in the future I guess one of the key goals of the new database is to be able to do that; so we have had, I guess, a shortcoming in collecting data which we have addressed.

The CHAIRMAN: Thanks for that, and I am happy to take any additional information that you are able to provide in the way that you have offered. Page 8 states —

It is estimated that by 2015/16, there will be a 9.7% shortfall in the number required.

That is, of nurses and midwives. Has the department considered ways in which some of the child health screening processes could be conducted by staff other than nurses who have received specialist screening training; for example, childcare workers, preprimary teachers or others?

Ms McBride: There has been some thinking but not a lot of action as yet. We consider that enrolled nurses specifically trained could fulfil some roles in screening and assessment teams, but enrolled nurses are like most other health professionals in that they are difficult to recruit. The aged care sector and the acute care sector use enrolled nurses for a range of tasks and there are just not enough out there. So, yes, we are going to be exploring some of that in the future.

The CHAIRMAN: Thanks very much. Page 10 states that the strategies to address workforce issues include —

- Business cases seeking an additional 135 school health nurses, and an additional 91 child health nurses and 3 community health nurse managers.

Have these business cases been put forward to government?

Mr Morrissey: My only comment is that they have been put forward to government. We are awaiting an outcome.

The CHAIRMAN: Thank you. Page 11 states that the department is exploring options for introducing the foetal alcohol spectrum disorder 4-digit diagnostic code in order to improve recognition of the disorder. Is there any more detail on the status of this particular development?

Ms Gauntlett: There has recently been developed a strategic plan for looking at how we can respond to foetal alcohol syndrome and the disorder, and that has just been drafted in the last little while; so it is currently before the department for consideration.

Mr Morrissey: To add to that, we are currently training some of our staff in the diagnosis of FASD.

The CHAIRMAN: Thanks for that.

Ms Gauntlett: And I should just say in terms of the strategic plan, it is looking at across the whole continuum—so, from prevention, what our role is, and how we can work with this in terms of prevention, screening, early identification, diagnosis and treatment.

The CHAIRMAN: Thank you. Page 12 states that children in rural or remote areas with or at risk of developmental delays or behavioural problems are offered assessments and ongoing treatment through the WA Country Health Service. Could you please provide us with more information regarding the general scope of these services and their level of adequacy? Who has come here from WA Country Health Service to be able to do that?

Mr Morrissey: Mark may be able to speak on behalf of them.

Mr Crane: Is that the second paragraph?

The CHAIRMAN: It is on page 12, yes.

Mr Crane: I will have to take that question on notice. I do not feel comfortable speaking for the Country Health Service.

The CHAIRMAN: That is fine, thank you. There are two there so that will be appreciated. Page 21 states —

In some rural/remote settings, one nurse may fulfil multiple roles when visiting a small community i.e. child health, school health and immunisation.

Has the department given any thoughts to combining its metropolitan child health and school health nurses into one workforce to undertake these two roles at different times of the week or semester, especially given the under-servicing of primary school needs? Who tackles that?

Ms McBride: I think in some rural and remote settings it is a good use of human resources to do that, but it means the nurses have to do a good deal of training across those three more areas—a bit of downtime. They also go into a community offering primary care of the whole family, which is great for those families, but, as I said, the training requirements are high for that individual. We work differently in the metropolitan area, I think, with more specialised needs. Even within school health or child health there are more specialised skill sets, and we can do that because of the economies of scale. I do not think there would be any benefit in combining the workforce in that way.

The CHAIRMAN: Thank you. Page 23 states —

The CAHS budget for 2008-09 is \$248.3 million.

Has the department done any planning or preparation of business cases for government to increase the number of school health nurses for primary schools, which is presently only 0.006 per cent of this year's health appropriation?

Mr Morrissey: I think that we could respond in a similar way. We put a business case up for extra staff, extra nurses, and that will deal with that cohort to a degree.

[11.20 am]

The CHAIRMAN: I refer to page 23 of your submission where it states —

This is \$36.9 million or 17.5% higher than the comparative 2006-07 CAHS budget.

Has the \$36.9 million increase in funding for this budget been mainly for technology or for new staff positions?

Mr Morrissey: I would like to take that on notice.

The CHAIRMAN: Thank you very much.

Mr T.K. WALDRON: I refer to a couple of things said by Ms Gauntlett and Ms McBride. You said that there were 15 child development service sites. They are all metropolitan are they not?

Ms Gauntlett: Yes.

Mr T.K. WALDRON: What happens in the rural areas with regard to what is delivered? Is that done through country health services? How is a similar service provided, and is it adequate?

Ms Gauntlett: I do not feel comfortable speaking on behalf of country health. We can probably take on notice further questions about adequacy. Generally, there are child development services within WA Country Health Service throughout the different regions. The composition of those services varies in different regions in terms of number of FTEs and the kinds of disciplines they have access to and all of that. In addition, the metropolitan child development service—this has primarily been through the state child development centre, which is now one of our 15 metropolitan sites—has provided a service of complex assessment, secondary opinions and tertiary services to country clients. The metropolitan child development service will continue to provide that role. We are now looking at whether it is out of every site and how we can provide that across the metropolitan area more broadly as opposed to sitting solely out of state CDC.

Mr Morrissey: We are looking at providing a better service to country health as a result of our restructuring.

Ms McBride: I will add to that, having managed a service in the country. I guess the country is not all one; it is not all the same.

Mr T.K. WALDRON: It is very varied.

Ms McBride: The south west, the great southern and the wheatbelt are fairly stable, certainly in population and staff numbers, although the population is rising in some places. Typically, there are child health nurses, school health nurses and immunisation people. Child development services will be carried out to some degree by allied health staff. They will have speech pathologists, OTs, physios and social workers—a range of staff who deal with the local population, but they liaise quite a lot with the metropolitan tertiary services.

Mr T.K. WALDRON: With regard to screening, our community health nurses and school nurses do a terrific job, but is there a possibility for those people to be upskilled or trained to do more of the screening for hearing problems and all different things?

Ms McBride: Do you mean developmental screening?

Mr T.K. WALDRON: At the moment, I understand that they do some basic testing for hearing and sight, and if there is a problem they refer it to someone. If we want to increase screening, especially in those early years, is there a possibility that the people visiting community groups and seeing most of the kids could be upskilled to do some of the higher level screening? I am not sure. I am not an expert in the area, obviously.

Ms McBride: Services are necessarily limited because of the time and the workers spreading themselves very thinly. In any one year group there are about 28 000 children. Our staff group covers a lot of children. We are undertaking a project at the moment and are looking at standardised paediatric evaluations. We will be working with parents in order to identify exactly what the problem is so that the referral can be better made to the right allied health practitioner or paediatrician.

Ms Gauntlett: There is an important distinction between screening and assessment.

Mr T.K. WALDRON: I am talking about screening. At the moment they do a fantastic job and they probably pick up lots of things that save a lot of problems down the track. However, there are obviously quite a lot that do not get picked up, whereas if they were trained they might pick up more. I just wanted your comment on that.

Ms McBride: Certainly, the more experienced people would pick up more, but they do not do specific diagnostic assessments. We rely on more specialised allied health and medical services.

Mr T.K. WALDRON: Would it ever get to the stage where they could do that?

Ms McBride: They probably could. However, in terms of workload capacity —

Ms Gauntlett: There are also some professional limitations with some of the diagnostic assessment tools that are only able to be administered by particular practitioners.

Mrs Abernethy: For some of the diagnostic assessments, such as audiology, a specific setting is needed. On a home visit we could not necessarily do a hearing test. For a diagnostic test, we need to be in the setting of an audiology booth.

Mr T.K. WALDRON: Okay, thank you.

Mr P. PAPALIA: I refer to page 4 of the submission and the clinical pathways for the child development service. The six conditions have been determined as those that will have the pathways developed for them. How did you arrive at those conditions, or what are the determining factors?

Ms Gauntlett: Firstly, many clinical pathways could be developed. This first suite of clinical pathways was undertaken to try to capture the service that the child development service provides, so you will see that, first of all, there is an overarching pathway for the service, which maps how a child and family track through the service from whoa to go. In terms of the specific conditions that we have mapped, you will notice that there are multidisciplinary pathways; for example, the pathway relating to children with attentional issues, children with autism-related issues, and the global development delay issues. Some are very specific around conditions that are generally responded to by individual disciplines; for example, the one that relates to a child's head shape and position—plagiocephaly—stuttering, which is very much a speech-related issue; and sensory processing and the occupational therapist's role in that. We chose those particular pathways because autism, ADHD and global developmental delay types are very significant in presenting concerns for our service. The more specific ones are very significant concerns, such as plagiocephaly. We were trying to get together a representative sample as the first suite of pathways. We are currently working on others. I would not like to imply that these conditions somehow are necessarily more important than other conditions that present.

Mr Morrissey: This is the first time this type of clinical pathway mapping has been done in Australian child development. It is leading work.

Dr Flett: This is fantastic stuff, because it guarantees reproducibility of outcome wherever it is done.

The CHAIRMAN: Sorry, did you mean reproducing credibility?

Dr Flett: In other words, it provides a standardised model.

Mr P. PAPALIA: Part of the reason I asked was to try to get a feel for the extent of that ADHD challenge. Obviously, you have a significant number of presentations. I have felt some concerns during the course of this inquiry from other evidence about the ADHD issue. I have the sense that behavioural problems that subsequently result in children being diagnosed with ADHD or some disorder may result from an early problem with hearing or other language problem or something like that, which, over time, because it is not diagnosed and treated, escalates and results in behavioural problems. I have a concern that that is a specific pathway, but also I am aware that there has been a significant reduction in the amount of pharmaceutical treatment of that disorder. I wonder whether that has been taken into account. What is the implication of that; does that signify that we have fewer cases; or does that signify that we are using other means to treat those people? I do not know. I am trying to determine the implication of that in relation to my other concerns about perhaps treating symptoms rather than diagnosing the real problem earlier on.

[11.30 am]

Ms Gauntlett: Can I just generally make a couple of comments about the pathway, then you can go on. I guess the first thing to say about a clinical pathway is that in some sense it is a bit of an artificial separation, or an artificial representation, of the way we work. One of the very significant aspects of the child development service is the multidisciplinary nature of our work; that is certainly captured in here. Children often present with multiple presenting conditions and concerns, and all the way along the pathways you will notice there are key decision points around the need, flagging and considering is there a need to refer to other internal and/or external services. We are also making sure that we are picking up on what other things might be happening and dealing with that both internally and externally. We are considering comorbidities, differential diagnosis, those sorts of things, and mapped throughout the pathways. I guess in terms of your particular comments around children presenting with a hearing issue, and maybe it evolving into some attentional or hyperactivity-type related issues, within our service I think we are very well placed, and this pathway kind of really supports that idea that we are picking up and have got those linkages within the service. Obviously, we are presenting with a child that presents to our service with whatever issues they come to us with, so we cannot necessarily—but certainly we work really closely with child health nurses, and all of that, in terms of picking up those things. In terms of those comments around medication and stuff, we might have to take those on board.

Dr Flett: I would make just one general comment: there has been concern, particularly in Western Australia, at the incidence of the diagnosis of ADHD. Quite a lot of commentary has been made around this and the experts have considered that aspect of it. We may well be now seeing a fall-off in the diagnosis. That may well be as a result of more attention being given to the criteria by which they make this diagnosis, but I do not think there is an expert among us that could give you any detailed commentary on that.

Mr M.P. WHITELEY: I think there is actually, but I do not think—anyway.

Ms Gauntlett: I have one other thing to comment about on this pathway: it does have a strong emphasis in terms of that prevention—kind of getting in early—if you are looking at the pathway in terms of that section where we have got children presenting with issues and the kind of key role for social workers to get in early, to have those home visits, to be sort of trying to identify whether there are some group programs, some sort of family support that we can be doing at that early point to prevent the children from actually developing a formal diagnosis of ADHD. A lot of that is captured in this pathway.

Dr Flett: It actually adds rigour to making that diagnosis. It really had not been there before.

Mr M.P. WHITELY: Can I just make a few comments and then invite some comment on them. Look, the background information that you provided here on page 4 about the desire to have consistency in diagnosis is all entirely laudable, but I am going to be blunt: my concern is that often it is not the policy, it is those that are charged with the implementation of the policy that determine the outcomes. Part of the evidence that was very persuasive in the 2004 ADHD inquiry was that there is a different model of medical training that has been dominant in Western Australia as opposed to Victoria. That was one of the major reasons why our rates were lower. Specifically, it made comment about the training of Western Australian paediatricians, and paediatricians being dominant in the diagnosis and prescription for ADHD. I do not think these comments just relate to ADHD; I think they relate to any mental health disorders. My concern is that we have two services for children: we have the CAMS and we have the CDCs. You are saying we need to have an integrated and consistent process across the two. I think that is laudable and I would agree with it. However, I would think that when it comes to issues of children's mental health, they need to be driven by mental health experts—that is, child psychiatrists. All the evidence points to the fact that—and there are many exceptions to this general rule—mental health professionals—that is, child psychiatrists—are far more holistic in their approach and far less ready to follow the medical model. They have got a greater depth of training; they are open to consideration of alternative causes and the complexity of mental health. I guess my specific question is: with these guidelines that have been developed, particularly those that relate to mental health, who have been the drivers for this? Has it been paediatricians from the CDCs, which in my opinion—I will be perfectly blunt with it—have been part of the problem, or have they been driven by child psychiatrists?

Ms Gauntlett: Can I respond by saying that we established, a little while ago, a working group between CAMS and the CES to map the service pathways.

Mr M.P. WHITELY: Who is that group chaired by?

Ms Gauntlett: I chair it, and it has representation from the north metro CAMHS, south metro CAMHS—so Patrick Marwick, Adrienne Wills from south metro—as well as some psychiatrists and some other clinicians —

The CHAIRMAN: Who are the psychiatrists?

Ms Gauntlett: We did have Barry Nurcome, who was a chair of psychiatry at PMH until recently, visiting chair. We have Caroline Goosens, we have Paul Hudman, we have—who else? Patrick Marwick, Adrienne, Claire Patterson. Caroline Goosens is a psychiatrist, Claire Patterson is a psychiatrist, Paul Hudman is a psychiatrist; Patrick is not —

Mr M.P. WHITELY: Is there anybody from the Bentley ADHD team? The parliamentary inquiry in 2004 found that they were, frankly, the gold standard.

Ms Gauntlett: A lot of the people involved on that group are also linked in and have been involved with the implementation steering committee that arose out of the parliamentary inquiry.

Mr M.P. WHITELY: Yes, I am on it.

Ms Gauntlett: Yes. So Patrick, John Wray, Brad Jongeling—we have people who are linked into both that are on that group—and Adrienne —

Mr M.P. WHITELY: I will put on the record, however, that it is not fair to portray that implementation committee as being of one voice. For instance, there are representatives from LADS on it and there is myself, and, frankly, we cross swords quite vigorously, and people like Brad Jongeling have a far different perspective than I would. There is no press here so I will say it: they would be part of that medical model training of paediatricians of which I am highly critical. My concern is that we need to have holistic child health experts driving the response to child mental

health issues. Whilst I applaud this move to a universal and consistent framework, if it is the wrong framework, driven by the wrong people, we will have the wrong outcomes.

Mr Morrissey: My only response is we can take your view on board and consider that.

Mr M.P. WHITELEY: Just for your information—you may already know it—coming out of the implementation committee is an ADHD guidelines review group which is chaired by Cathy Nottage. That is a group I have some confidence in. It is driven primarily—it has John Wray's input. John and I do not agree on everything, but I have a degree of faith in John's—but that is a group I think you should be looking to for clinical guidance.

Ms Gauntlett: We have connected with that group through Dr John Wray. I guess we have tried to pull together those threads, and that has informed—what we have been trying to do is get a clearer understanding of the service pathways between us and CAMHS. The whole issue of ADHD is one of the issues that we have mapped out in quite detail and mapped what each service's role and responsibilities are and what the gaps are and where the overlaps are and what sort of mechanism can support a stronger collaboration between us. As part of that process, we have tried to pull those threads together, but as you know, there are a lot of players that have an interest in ADHD.

Mr M.P. WHITELEY: Two specific clinics are being set up. They were set up—I am going to paraphrase the Premier's own words—to specialise in children with attentional problems.

Ms Gauntlett: Yes.

Mr M.P. WHITELEY: They were set up with a view to making medications a second or third line of treatment —

Ms Gauntlett: Yes.

Mr M.P. WHITELEY: — with the specific intention of actually lowering prescribing rates. Those two clinics will be developing—they have been called ADHD clinics, but in a sense they are anti-ADHD clinics—very strong prescribing guidelines. I would presume that, given that will be the gold standard in Western Australia, it will be applied across the health department.

[11.40 am]

Ms Gauntlett: We have had discussions with people involved in the groups that are trying to oversee the setting up of those clinics. I guess personally my understanding is that that work is just commencing in terms of the implementation of those two clinics, the first cab off the rank being in the north.

Mr M.P. WHITELEY: That will be set up by the first quarter next year, and LADS in the second quarter.

Ms Gauntlett: Yes; so it is in that kind of developmental phase. However, from what I understand to date, they may have a different role in terms of the kind of kids that we see within the child development service.

Mr M.P. WHITELEY: Okay. I have a concern. This is what Bentley did. It took the most “out there” kids, in a sense. It took the kids who were typically on dexamphetamine or Ritalin and chlonidine, and a whole host of drugs, and basically detoxed those kids in many cases, and then dug down into what the underlying problems were. It found that in the majority of the cases it was family dysfunction. There were other causes, but the majority cause—it is politically dangerous to say it—was family dysfunction. They were taking the extreme kids and the ones that were actually being hospitalised at Princess Margaret Hospital with drug overdoses, frankly, and other extreme cases. The kids that were being called your run-of-the-mill ADHD kids were still presenting at private sector paediatricians or child development centres and getting diagnosed. My concern is that instead of having two or three full-time equivalents, we are going to have 20 full-time equivalents for this thing, so they will take in a much bigger cohort, but they will not hit the full mark. Unless they are the standard setters, and others in the public health system and in private practice hopefully

do not follow them, you will still have that standard run-of-the-mill ADHD kid going off to their local CDC and getting a prescription. Therefore, my concern is that they not only need to see kids, but also be the standard setters across the public health system.

Dr Flett: I will take your concerns on notice, and I will personally look into this and determine just what the policies will be in the future, because I understand exactly what you are saying on this point.

Mr M.P. WHITELEY: If we could have that in writing—a written response—that would be wonderful.

Dr Flett: Yes. We can follow it up.

Mr M.P. WHITELEY: Thank you.

Mr T.K. WALDRON: I have a question from the member for Darling Range, who, unfortunately, cannot be here. You may have said this previously. However, he wanted to ask about the hearing and sight screening between years zero and five. At what age does it currently happen under the health department guidelines?

Mrs Abernethy: I will take that one. We have universal developmental assessments that child health nurses deliver between zero and five, and the vision assessments are at birth, at six weeks, at three to four months and at eight months. Generally, they are looking more at abnormalities within the eyes. We cannot actually assess vision testing until the child is at least three years of age, but ideally around four. That is the best way to do it, and is offered in the school entry assessment. In terms of hearing, at the moment we have a hearing screening program when babies are first born. It is not universal. It is offered to approximately 50 per cent of children. The next time that children are assessed is at school entry, which again is in that four to six age group.

Mr T.K. WALDRON: Is consideration being given to universal screening at birth?

Mrs Abernethy: Yes.

Mr P. PAPALIA: I think when you last gave evidence there was a suggestion that you applied for the budget but it did not get up.

Dr Flett: Yes. That submission will be going forward again.

Mr T.K. WALDRON: Okay. Thank you.

Mr P. PAPALIA: You are supportive of it?

Dr Flett: Yes, absolutely.

Mr Morrissey: We just updated all the dollars in it, and it is actually sitting, waiting for consideration.

The CHAIRMAN: What is the dollar figure?

Mr Morrissey: Off the top of my head, I could not respond.

Mrs Abernethy: Approximately \$10 million, off the top of my head.

The CHAIRMAN: That is universal.

Mrs Abernethy: That is universal.

Mr P. PAPALIA: Is that for implementation over a period?

Dr Flett: Over four years.

Mrs Abernethy: Yes, and it is a screening program, which includes screening, treatment, management and working with families, so it covers not just the screening test.

Mr P. PAPALIA: And staff too.

Mrs Abernethy: And staff, yes, and across the state.

Mr P. PAPALIA: That is in remote areas; it is the whole state?

Mrs Abernethy: Yes, the whole state.

Mr Morrissey: It is universal.

Dr Flett: Because they are the areas that are missing out at the moment.

The CHAIRMAN: Erin, a number of times you were trying to give evidence. Did you want to round off any of your comments on the issues that have been the subject of these pathways? Did you have any uncompleted sentences that you wanted to complete?

Ms Gauntlett: No, I do not think I have anything else to add.

The CHAIRMAN: You are happy? Okay. Could we get additional copies of this rather helpful document? It is difficult to reproduce something in that particular format, so if you have them, we would like six copies, please.

Ms Gauntlett: Yes.

The CHAIRMAN: Has the department done any planning or considered the implications of moving the school health screening activities from year 1 to the preprimary, kindergarten or even childcare age groups?

Ms McBride: It is optimal developmentally for kids to be screened around the time they enter kindergarten, so that is at four years of age, or into their fifth year. About half the children across the state will get their hearing and vision and other screening done in the kindergarten year; that is, about 80 per cent of kids going to school in the kindergarten year. We still have some work to do in the north metropolitan area—they are still screening at preprimary, which is the next year—but that is going to require quite an injection of resources, because they need to do a double-up of screening one year. Half of all the children in the state are in the north metro area, so it is a significant pile of children. We are planning to do that. Even this year, I think some of the health regions are starting to eat into the kindergarten numbers in terms of doing screening.

Mr P. PAPALIA: I will say this to get it on the record. Professor Coates is obviously very strongly in favour of universal screening of newborns, but he also recommended that we try to identify children at risk and that they be tested at least six monthly on an ongoing basis, predominantly targeting, I guess, Indigenous children. That would be the real group of the population he is talking about. Can I get a comment on that? Is that included in the plan, or would it even be possible?

Mr Morrissey: Margaret would be well placed to answer that.

Mrs Abernethy: In the current hearing screening program in the neonatal period, those children who are identified as being at risk are followed up at eight months through child development services automatically. For Aboriginal children, who we recognise would have a high rate of otitis media, particularly in the country areas, much of the screening includes not only audiometry, but also tympanometry, which identifies otitis media. Therefore, I guess our country health colleagues are the ones who would be more likely to be offering an extended version of the hearing screening.

Mr P. PAPALIA: Do you have any understanding of what percentage of children in that group are covered?

Mrs Abernethy: I would probably take that one on notice.

Mr Morrissey: We have just actually got that data together in the past few weeks, so we are happy to provide it.

Mr P. PAPALIA: Beyond that, in the event that it is not everybody, do you have any estimate of cost to achieve that, if it is feasible or viable?

The CHAIRMAN: Mr Morrissey, I will take that as an offer to provide that, and we would like to take you up on that offer.

Mr Morrissey: Yes.

The CHAIRMAN: Thank you. I want to finish with one question of my own that deals with the description of the youngsters in the given cohort. The statistics show a figure of six per cent with hearing and learning difficulties—that has been given by the education department and signed up to as being their assessment of the cohorts—and there is a figure of up to 25 per cent with global developmental delay. The statistic they give for any cohort varies between 15 and 25 per cent. For me, they seem like very large numbers of people who are showing up in this spectrum of challenges that they are facing as youngsters. Is the health department engaged with the education department in getting a structured classroom response, an evidence-based response, to the pedagogical needs of cohorts with that level of challenge?

[11.50 am]

Ms McBride: Very much so. The nurses do the school entry health assessments and other assessments. Every child is offered a school entry assessment, and then, whenever a teacher or a parent picks up a concern after school entry, the assessment can be done again by the nurse. There are two levels. Nurses do those assessments in the school, usually talking to the teacher first about any particular needs. I think I mentioned last time that teachers are very good at looking at a group of children and understanding what the norms are for all sorts of different behaviours and developmental milestones. A parent may well indicate that there is an issue with behaviour when in fact the teacher will say, “That’s okay; it’s within the realms of normal, and I can see the child is moving along.” Those conversations happen on a daily basis. Very frequently, nurses work with the teacher, especially for small children.

Ms Gauntlett: Can I also just add to that? As part of the child development service reform project, I think I mentioned before that a working group is looking at developing a formal collaborative relationship with CAMHS and a similar group has been set up with the Disability Services Commission. We are also making sure a group is looking at services with the Western Australian Country Health Service, and trying to get all those issues considered. A lot of collaboration happens informally, but getting that more formally structured is important. Another key agency we need to do that work with, and which we will be commencing shortly, is the Department of Education and Training. That will further develop.

The CHAIRMAN: Acting director general and colleagues, thank you very much. You will receive a copy of the transcript, and then you have 10 days to correct any errors. The additional information you have offered to send, or any additional commentary you would like to provide, should be returned with the transcript within that 10 days. Thank you very much.

Hearing concluded at 11.52 am