Department of **Health**
Government of **Western Australia**

Ref: Document Number 8060 V1

OFFICE OF THE DIRECTOR GENERAL

Hon Tom Stephens MLA
Chairman
Education & Health Standing Committee
C/- Parliament House
PERTH WA 6000

Attention: David Worth

Dear Mr Stephens

EDUCATION & HEALTH STANDING COMMITTEE's INQUIRY INTO THE GENERAL HEALTH SCREENING OF CHILDREN AT PRE-PRIMARY AND PRIMARY SCHOOL LEVEL

I refer to your letter of 19 March 2008 regarding the above and apologise for the delay in responding.

The Department of Health's written submission on matters related to the terms of reference for the above inquiry is enclosed. The Department of Health is available to appear before the Committee if required and has nominated [redacted] to represent the Department. [redacted] contact details are as follows:

[redacted]

Yours sincerely

[redacted]

A/DIRECTOR GENERAL

16 May 2008

[redacted]

189 Royal Street, East Perth, Western Australia 6004
Tel (08) 9222 4222 TTY-1800 067 211
Letters PO Box 8172 Perth Business Centre Western Australia 6849
http://www.health.wa.gov.au
ABN 28 684 750 332

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

WESTERN AUSTRALIAN DEPARTMENT OF HEALTH'S SUBMISSION TO THE EDUCATION AND HEALTH STANDING COMMITTEE

MAY 2008

EXECUTIVE SUMMARY

The Western Australian Parliament Legislative Assembly's Education and Health Standing Committee resolved to conduct an enquiry into the general health screening of children at pre-primary and primary school level. The Committee invited the Department of Health to provide a written submission on matters relating to the following Terms of Reference:

1. **Adequacy and availability of screening processes for hearing, vision, speech, motor skills difficulties and general health for children at pre-primary and primary school.**

2. **Access to appropriate services that address issues identified by an appropriate screening process**

The purpose of this paper is to inform the Committee about the Department of Health's (DoH) role in the prevention, early detection, early intervention and treatment of child health and developmental problems and to describe in detail the current universal and targeted early detection health and development assessments (including screening tests/programs), early intervention and treatment strategies delivered by the Department for young and school aged children in Western Australia.

The aim of this paper is to provide information on:

- Health status of Australian children
- Rationale for prevention and early intervention
- Principles and Processes for Service Delivery
- Birth trends and demographics
- Demographic characteristics of Western Australian (WA) school-aged children
- Services delivered by the Department of Health
- Services delivered by other sectors
- Analysis of the adequacy and availability of screening processes
- Assessment of the access to appropriate services

The paper highlights that early identification and treatment of child health conditions and developmental delay is an integral function of primary health care providers. Whilst the current services provided by the DoH are universally available to the majority families who need to access the service, there are certain populations who are under utilising these services for a variety of reasons, including capacity restraints, availability and accessibility.

INTRODUCTION

The term "screening" can be used in the context of a task which is intended to identify health or developmental needs or can be used to describe a program (screening program) that may include a more comprehensive range of services including treatment and support. In this paper the term "screening" is used predominantly to describe the former. This paper also is focused upon community health and in this context it is important to note that the term "child health surveillance" is used to describe a systematic approach to screening and responding to identified needs. (See attachment 1 for a list of definitions used in this paper).

Early childhood is a time of rapid development in many domains especially physical development (including fine and gross motor skills), language, behaviour and social and emotional development. Delay in any of these domains at this age is a strong predictor of problems at school and beyond. Similarly, general health conditions such as hearing, vision and overweight and obesity problems are related to adverse health and social outcomes in later life. The early detection of health and development risk factors and then subsequent treatment and management can alleviate a significant individual and societal burden of lifelong impairment.

Families have the biggest influence on the ways in which children grow and develop. The capacity of families to support their children in reaching their potential is affected by their immediate physical and social environment, parent background and circumstances as well as by broader factors in society. A growing body of evidence has emphasised the importance of effective health interventions that involve health providers working collaboratively with families and carers at critical points along the developmental pathways.

Prevention and early intervention in childhood has become a priority for Australian governments and non-government organisations. In Western Australia (WA), the Department of Health (DOH) has a central role in the provision of services and responses for the prevention, early detection, early intervention and treatment of child health and developmental problems. As well, General Practitioners (GPs) have a pivotal role in primary care services; families attend the GP whenever they have health concerns about their child. The GP can identify, provide ongoing monitoring and access specialist services for children with health and developmental concerns.

The DOH's approach, like most other States and Territories in Australia is to provide a foundation universal child health service supplemented by more targeted and specialist services. In general the services are universally available to the majority of families in WA; however increasing numbers of births, escalating numbers of children and families with complex health and social problems and resources constraints are affecting the capacity of DOH services.

There are as well, a range of other sectors from across State and Commonwealth Government agencies involved in delivering services in this area.

The purpose of this paper is to provide a detailed description of the current universal and targeted early detection health and development assessments (including screening tests/programs), early intervention and treatment strategies delivered by the Department for young and school aged children in Western Australia. It has been developed in consultation with various work units within the DOH, principally:

- The Child and Adolescent Health Service; Child and Adolescent Community Health which has responsibility for the provision of community based child and maternal, school health and child development services.
- School Dental Service
- Child and Adolescent Mental Health Service
- Office of Aboriginal Health
- Western Australia Country Health Service
- Western Australia Child and Youth Health Network

Health Status of Australian Children

In Australia, the overall health, development and wellbeing of children is high on many indicators. Childhood mortality rates have halved over the last two decades and the incidence of vaccine-preventable diseases has been reduced since the introduction of immunisation. However, concerns are emerging about health issues related to rapid social changes and the associated new morbidities. There are increasing proportions of children and young people with complex diseases such as asthma, diabetes, over-weight and obesity, increasing levels of behavioural, developmental, mental health and social problems, and, the significant disparities between Indigenous and non-Indigenous children (Australian Institute of Health and Welfare, 2005).

A number of these poor outcomes have consequences later in the life course. Many of the health and wellbeing problems seen in adults such as obesity, diabetes, heart disease, mental health problems, family violence, poor literacy, unemployment and welfare dependency have their origins in pathways that begin earlier in life.

Many health problems among school-aged children are related to one or more risk behaviours, including poor nutrition and unhealthy diet, lack of physical activity, consumption of alcohol, tobacco products and other drugs, or unsafe sexual behaviour. Such behaviours have both short-term and much longer term impact on individuals. Rates of overweight and obesity among Western Australian children have nearly trebled over the last two

decades, making future adult population at much higher risk of poor glucose tolerance, type 2 diabetes and hypertension (Hands B, Parker H, Glasson C, Brinkman S & Read, H, 2004).

There are sub-population groups of children in Western Australia (WA) who are at higher risk of various health issues. These include children who have parents with mental illness, have backgrounds of socio-economic disadvantage, are geographically isolated, are involved with the juvenile justice system, are homeless, or are from culturally and linguistically diverse backgrounds. Aboriginal and Torres Strait Islander children are a particularly vulnerable group. This is evidenced by the over representation of Aboriginal children in prevalence rates for nearly all health problems, and with the relative mortality risk among Aboriginal and Torres Strait Islander children remaining between 2 to 4.5 times higher than other children for the past 20 years (Freemantle J, Stanley F, Read A & de Klerk N. 2004).

Mental health and wellbeing is an area of growing concern, with approximately 14% of children reported to be experiencing a diagnosed mental illness. The mental health of young children is primarily dependent upon a secure and positive relationship with their parents or parental figures (Queensland Government, 2006).

It is estimated in Australia that approximately 15% of children have some form of developmental delay. Developmental delay is indicated when a child does not reach developmental milestones at the expected age. The delay may result from primarily biological factors such as chromosomal disorders or environmental factors such as maternal depression.

Children with mild developmental delay generally have no obvious physical anomalies. Only rarely does a family history contribute to the identification of a developmental delay and it is not until they reach the school environment that the problems become more apparent due to academic tasks requiring complex cognitive and behavioural skills.

The Australian Early Development Index (AEDI) has been offered in 23 communities across WA. In some areas, results have shown that 22% of children aged 4-6 years were vulnerable in one or more of the developmental domains and 11% were at high risk of having learning difficulties. The AEDI is a community measure of young children's development, based on the scores from a teacher-completed checklist consisting of over 100 questions. The AEDI checklist measures five areas of child development: Physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, and communication skills and general knowledge (Hart, Brinkman & Blackmore 2003).

Rationale for Prevention and Early Intervention

There is now overwhelming evidence confirming the significant influence of early childhood experiences on brain development and on the development of ill health in later life. Research points to the importance of identifying child health behavioural and developmental problems early and commencing interventions in the preschool years (Australian Research Alliance for Children and Youth, 2006).

While the early years are crucial, it is also important to address the needs of children, adolescents and their parents across multiple life phases and transition points. Transition points such as birth, commencing school and transitions between stages of schooling provide opportunities to assist children and their families who might not otherwise recognise the existence of a problem with their child's health or development or if they do, have not sought help.

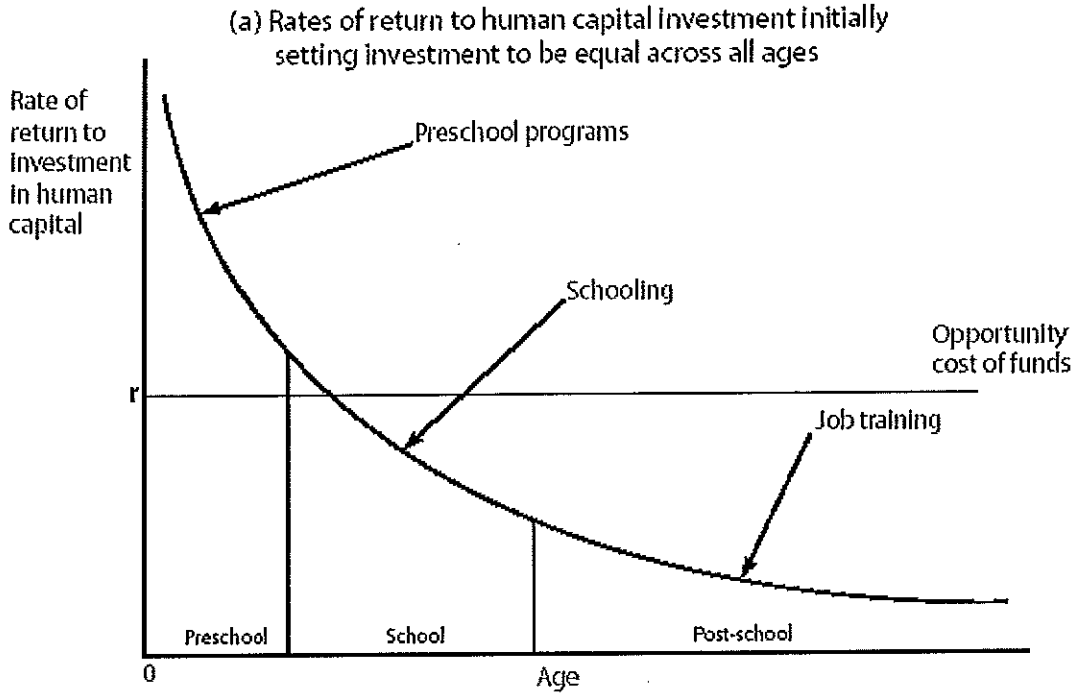
The early detection and treatment of health and other problems in childhood is an important strategy because it can alleviate a significant individual and societal burden of lifelong impairment, especially when for some health problems late treatment is ineffective and often expensive.

Overwhelmingly parents and families are concerned for the wellbeing of their children. Child and school health services are perceived as non-threatening, supportive and accessible services. Consequently, such services are able to engage with hard to reach, vulnerable and at risk families and support those who need to access other services. The added benefit for vulnerable and at-risk families is that these services provide avenues to lessen the transgenerational impacts of poor health, social exclusion, and economic and educational disadvantage that have deeply affected groups such as Aboriginals, single parents, and culturally and linguistically diverse (CALD) populations.

According to Heckman (2006), investment in disadvantaged young children has high economic returns. Early interventions for disadvantaged children promote educational outcomes, raise the quality of the workforce, enhance the productivity of schools and reduce crime, teenage pregnancy and welfare dependency. They also raise earnings and promote social attachment. The economic benefits are substantial with reported returns on investment of up to $17 for every dollar spent

As shown in the graph below, the rates of return on human capital investment in early interventions is much higher than that of later interventions (Heckman, 2006). Children are placed at an early disadvantage when they are brought up in environments that are not stimulating and fail to cultivate both cognitive and non-cognitive skills. If a child falls behind, they are likely to remain behind and the process of resolving this problem

becomes progressively more costly the later it is attempted in the child's life.



Principles and processes for service delivery

The following principles and processes have been identified in the literature as important for the delivery of quality prevention, early identification, intervention and self management community based services for children and families:

- Family centred practice - Acknowledging that the best interests of the child are paramount and wherever possible, working in partnership with the child's family and carers in the context of the child's natural environment.
- Family Partnership approach - This approach recognises that parents and family members have knowledge and skills on their child's development. They are important partners in the provision of services to their children.
- Screening, surveillance and prevention/promotion are core components of service delivery, but the early detection of problems, early intervention and health promotion should not be confined to the health sector alone.
- Provision of an accessible and universal service system - providing numerous opportunities over periods of time to detect emerging or established problems and to implement activities designed to improve outcomes.

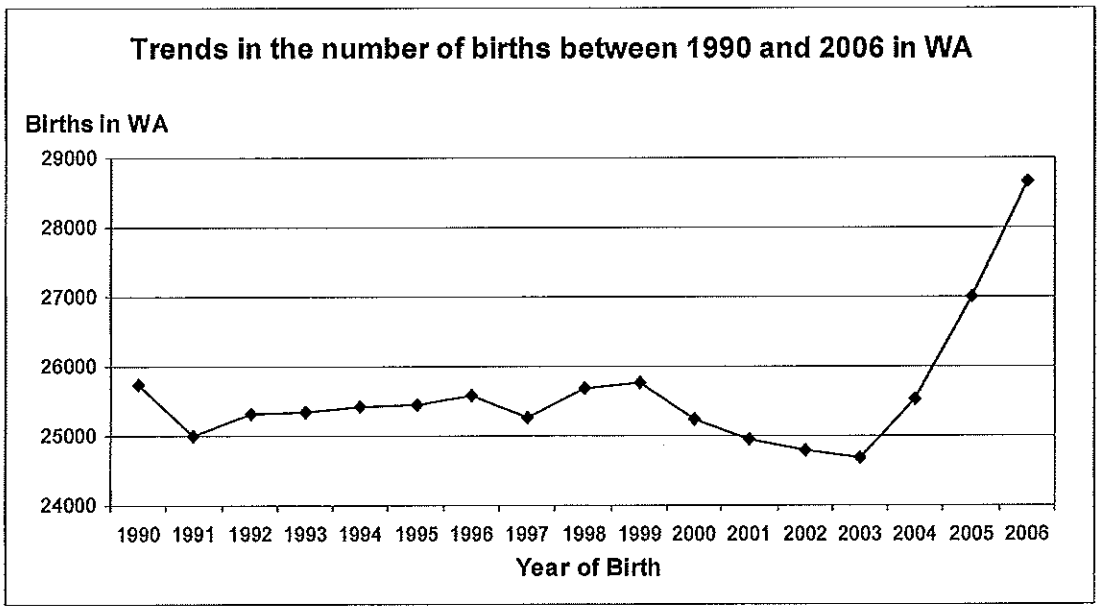
- Provision of referral pathways to services for children and families which are appropriate to their needs.
- A focus on evidence based prevention, promotion, early detection and early intervention responses.
- Community-focused - Services are based in the context of communities and work collectively with shared processes that develop, implement and sustain actions which foster positive changes according to priority issues and community preferences.

The health screening of children in the community and responses to identified need is highly dependent upon engagement with and support of parents. Consequently there is a strong emphasis upon principles that are important to developing and maintaining quality relationships with clients, families and communities.

Birth Rates

In Western Australia, there has been a 15.6% increase in the number of births between 2002 and 2006 (from 24782 to 28647) (Table 1).

Table 1:



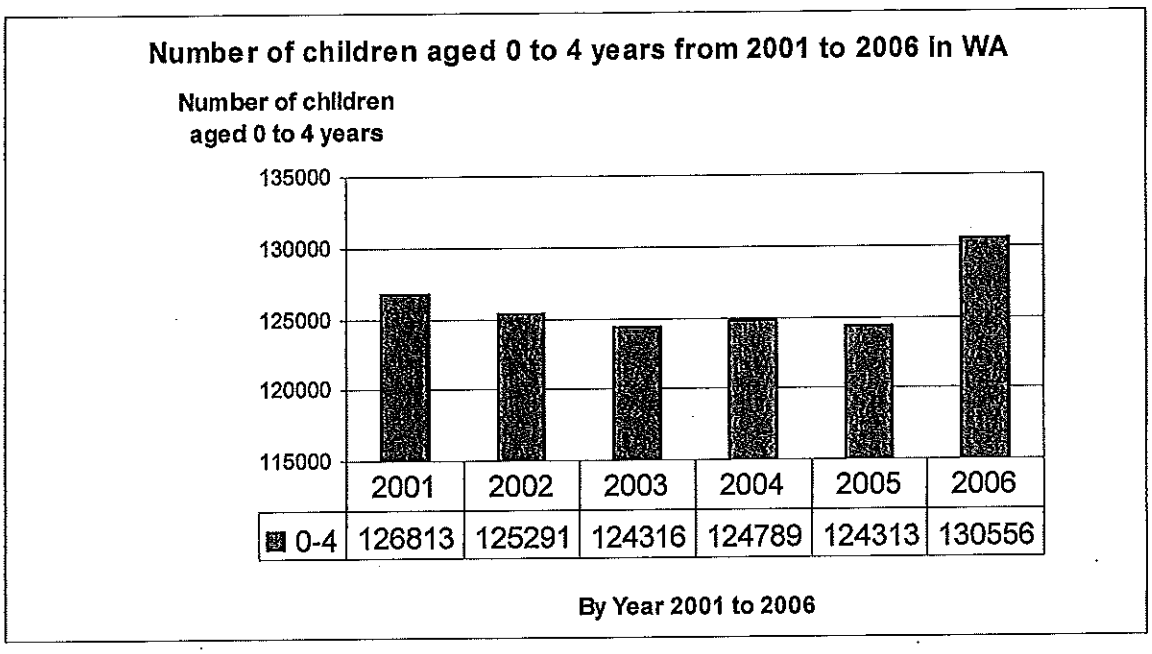
Improving Maternity Services: Working Together Across WA - Policy 2007

Increase in the 0-4 Population

The number of children aged 0-4 years in WA increased by 3743 between 2001 and 2006, an increase of almost 3% (Table 2). There is considerable variation between geographical areas, and there are particular pressures in the expanding outer metropolitan areas of Perth and in the Pilbara (in connection with the mining boom). For example in Wanneroo Local Government Area there was a 21% increase in the 0-4 population from 2001-

2006 and similarly in the West Pilbara there was a 13% increase in the 0-4 population from 2001-2006.

Table 2:



Over the next few years, numbers of children entering school for the first time will increase significantly as indicated by the 15.6% increase in the number of births in WA between 2002 and 2006. In 2008 compulsory schooling extended to Year 12, therefore numbers of students enrolled will increase significantly again. These increases have implications for the capacity of community based child and maternal and school health services.

Demographic Characteristics of Western Australian (WA) School-Aged Children

In February 2007, there were almost 375,000 children and adolescents enrolled in WA schools, representing a significant and important section of the population. For health screening purposes, school settings offer an opportunity to reach almost all children, which is especially important for those who are more disadvantaged and are at higher risk of health problems (Department of Education and Training, Western Australia, 2005).

Data from 2004 indicates that the largest percentages (74%) of school age children are located in the Perth Metropolitan area. Regional areas with high proportions of children include the Kimberley (17.6%) and the Pilbara-Gascoyne (16.9%). Within the Perth metropolitan area, the Local Government Areas with the highest proportions of children (16-18% of the total population of the area), are Wanneroo, Joondalup, Swan, Rockingham, Armadale and Kwinana. Areas with the lowest proportions (3-8%) are Perth,

Fremantle, Victoria Park, Vincent and Subiaco (Department of Education and Training, Western Australia, 2005).

The Department of Education and Training allocates all government schools a Socioeconomic Index (SEI) number. This is based on information from the Australian Bureau of Statistics and local school data including: the education of parents (double weighted); occupation of parents (double weighted); Aboriginality (double weighted); household income; and single parent families. Schools receive additional (Education) staff resources and other funding contributions commensurate with a lower than average SEI rating.

Education Districts which have a high proportion of schools with a lower SEI score include Swan, Pilbara, Northam, Katanning, Midwest, Kimberley, Goldfields, Canning and Fremantle/Peel areas. Most schools in the Kimberley region (95%) and Midwest (80%) have high proportions of disadvantaged families (Department of Health, Epidemiology Branch 2005).

Services delivered within the Department of Health

The Department of Health (DOH) recognises the importance of identifying child health conditions and development problems early, before they become entrenched. By intervening early in the course of a health condition or problem, there is an increased chance of a positive outcome, and the earlier an intervention is commenced the more likely it is to be effective and less expensive.

This section of the paper provides a description of the current universal and targeted early detection health and development assessments (including screening tests/programs), early intervention and treatment strategies delivered by DOH for young and school aged children in Western Australia. Also included, where possible is a description of the evidence-based policies underpinning service delivery, the availability of these services statewide and the strengths and challenges currently being faced.

The services include:

- Child and Adolescent Health Service - newborn hearing screening program
- Child and Adolescent Community Health Services - child health, school health and child development services
- School Dental Service
- Child and Adolescent Mental Health Services
- Hearing and other health screening services purchased from the non-Government health sector by the Office of Aboriginal Health

Child and Adolescent Health Service - Newborn Hearing Screening Program

Universal newborn hearing screening is a strategy to improve the learning and life outcomes (and reduce the cost to society) for hearing-impaired and deaf children through very early intervention. Advances in the technology of hearing screening mean that babies with congenital hearing loss can now be detected within a few days of birth. This allows for intervention during the first six months of life which is critical to the development of speech and language skills. Without newborn hearing screening, three quarters of children with congenital hearing loss are still undiagnosed by 12 months and the chance of normal language and cognitive development is greatly diminished.

Through the Child and Adolescent Health Service, the DOH supports a limited newborn hearing screening program which is confined to the metropolitan hospitals: King Edward Memorial, Joondalup, Osborne Park, Kaleeya, Rockingham, Armadale and Princess Margaret Hospital's Neonatal Unit.

The Telethon Speech & Hearing Centre has established a private Newborn Hearing Screening Service which is now being offered at six private hospitals, a fee is charged for this service.

Universal newborn hearing screening programs are rapidly becoming the standard of care internationally, with programs being established or already implemented in the United Kingdom, most states in the United States as well as many other developed countries. All other States and Territories in Australia have introduced or are trialling programs of universal newborn hearing screening.

Current Challenges

Western Australia's newborn hearing screening program is disjointed and limited and only covers approx 49% of births. The current system has established important links with the hospitals involved in the screening and developed many basic processes important for the implementation of a screening program. There are serious equity issues, with access depending on place of birth and/or ability to pay.

Child and Adolescent Community Health Services (Statewide)

Child and adolescent community health services across the State fulfil a central role in the early detection and prevention of child health and developmental problems. A three tiered approach is used:

- Screening for defined conditions
- Child health surveillance

- Promotion of health

In addition, early intervention and specialist services are in place to respond to the diagnosis and management of identified conditions. The service supports the engagement of parents, families and carers of young children through a family centred and partnership approach. Services include: child health, school health and child development services. Service delivery is both universal and targeted. Groups at risk of poorer health outcomes, such as Aboriginal and Torres Strait Islander peoples and newly arrived refugees, are of particular focus.

It is important to note that the approach to 'early detection' in child and adolescent community health services has moved away from the notion that children's health and developmental problems can be picked up with single screening tests delivered at a single point in time. The current system has an emphasis on ongoing surveillance from birth to school entry which actively elicits and addresses parental concerns and has systems in place that promote health and well-being of all children, recognising that a number of adverse circumstances, especially environmental, may have significant impacts on outcomes.

Child and adolescent community health services are underpinned by evidence-based policy informed by research evidence such as that provided by the *Child Health Screening and Surveillance: A Critical Review of the Evidence* published by the National Medical and Research Council (NHMRC, 2002). The report outlined several recommendations in regards to population based screening and surveillance programs which have historically been delivered in the child and school health setting (See Attachment 2). However, it is important to note that there are many groups, professionals and others that have views on these matters that need to be taken into account in the formation of policy that establishes the framework for service delivery.

Child Health Services

The core function of the Western Australia's Department of Health, child health services involves providing a universal schedule of contacts at the following key developmental ages: 0-10 days, 6-8 week, 3-4 months, 8 months, 18 months and three years. Included in these contacts are: developmental screening and surveillance (See Appendix 3), psychosocial assessment, information regarding parenting, child health and development, child behaviour, maternal health and well-being, child safety, immunisation, breastfeeding, nutrition and family planning and referral to other community services. Parents can also seek additional support from the child health nurse if they have concerns about the health, development or wellbeing of their child, or are experiencing their own health or family troubles that may affect the wellbeing of their children.

The provision of screening services has been an important part of the work of child health nurses for many years. However in recent years there has been a shift in emphasis from screening to providing a more holistic approach to working with families. While child health nurses continue to address the health and development issues of infancy and early childhood they also provide psychological support for parents and families. This shift in approach was consolidated by the release of the **Birth to School Entry Universal Contact Schedule Policy in 2006.** If health or development problems are identified a referral may be made to a GP or to child development service.

Strengths of the service model

Western Australia (WA) has a similar child health service to other Australian States and Territories. It is a key entry point for families into preventive health services and aims to promote healthy outcomes for babies, young children and their families across Western Australia. Community child health nurses are registered nurses with specialised qualifications and experience in family and child health nursing. They provide a positive non-threatening service, identifying and engaging with at risk families, providing additional support, intervention and referral. The service is offered universally and the uptake by families with newborn babies is high, approximately 95%.

Current Challenges

Demand for community child health services has increased in the past five years due growing numbers of births in the Western Australian community (See Table 1, Page 8), an escalation in migration to WA by young families as a result of the mining boom and increasing numbers of vulnerable families with complex health and social problems.

The increase in births and migration was unforseen and is affecting both maternity and child health services. In 2007 there were 196 Full Time Equivalent (FTE) of child health nurse positions across Western Australia (WA), 129 FTE in the metropolitan area and 67 FTE in the WA Country Health Service. This number has remained static since 2002. From 2002 to 2007 the ratio of birth notifications to child health nurse FTE has increased by 12% from 1:149 to 1:167. Relative to other jurisdictions with comparable service models the ratio of child health nurses to births in WA is poor. The corresponding ratios in Victoria, South Australia, Tasmania and Australian Capital Territory range from 1:78 to 1:98.

As a result, families with older children (1-3 years) have longer waiting periods before they can access the child health nurse as families with newborn babies are a priority. This may result in missed opportunities to identify and respond to parental concerns about their child's development at critical developmental ages.

In addition to the population increases there are escalating numbers of families with problems of mental illness, family stress, drug and alcohol abuse, family violence, financial difficulties, poor housing, social isolation, and more families who are from cultural and linguistically diverse backgrounds, particularly refugees and recent immigrants. Aboriginal & Torres Strait Islander children are a particularly vulnerable group. Families with complex needs are often harder to reach and less likely to engage in services and these families are those who need the service the most. Strategies to try and engage these families include; home-visiting and opportunistic out reach visits, both of which are resource intensive.

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

School Health Services

Schools are ideally placed to support and enhance the health and wellbeing of children and adolescents. School Health Service staff support school communities in promoting the health of all students through health promotion strategies. The School Health Service also plays a role in the early identification of problems and difficulties in the areas of vision, hearing, speech and language development, psychosocial and general development, including body weight issues. In addition the School Health Service contributes specialist expertise to enhance the care and optimal development of students with particular health needs. School Health Services are provided by community health personnel employed by the Area Health Services and consist largely of school health nurses but also include allied health and health promotion staff.

School Health Services use surveillance activities and assessments to identify and monitor the health status of school-aged children throughout their school life. This system of early detection aims to ensure that children who may be at risk of developing health problems are detected as early as possible. Surveillance activities and screening programs are delivered at a population (universal), group or individual level (targeted).

The School Health Service: Early Detection Policy 2007 aims to ensure that the majority of children in Western Australia (WA) have access to basic health assessments as needed. The policy is evidence based taking into account National and Western Australia research.

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

- All children are screened for hearing and vision problems (visual acuity and strabismus).
- Any child for whom there is an identified concern regarding language development, behaviour, or general development including weight issues, at school entry, receives an assessment to evaluate the need for further, more specialised assessment and intervention. For children who need a diagnostic assessment, a range of specialists are considered depending on the identified need and availability including: Child Development Services, General Practitioner, School Services Team, School Chaplain, School Speech Therapist, School Psychologist and the Child and Adolescent Mental Health Service,

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

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

Strengths of the service model

School health services, with few exceptions, provide early detection services in primary schools across Western Australia. Therefore, almost all children are offered assessments and are linked to services when problems are identified. Schools include community kindergartens, Government, Catholic and Independent schools where primary school students are enrolled. In a small number of schools, other service providers operate, for example Aboriginal Medical Services, Aboriginal Lands Services and Independent schools nursing services as per local arrangements. In 2008, a statewide evaluation of the School Entry Health Assessment Program will be conducted.

The evaluation will:

- Assess the reach of the School Entry Health Assessment Program throughout WA.
- Assess the activity relating to assessment and referral undertaken within the Program.
- Assess the outcomes which result from the program

Current Challenges:

Demand for school health nurse services has increased as the numbers of children entering schools has risen as a result of the escalation in births since 2002 and increased migration. Demand for school health services are expected to grow strongly in the current positive economic environment.

The rise in numbers of school-aged children is particularly marked in the rapidly growing north and south corridors of metropolitan Perth. Certain areas of rural Western Australia have also experienced rapid growth, particularly in connection with the mining boom. Over the next few years, numbers of children entering school for the first time will increase significantly as indicated by the 15.6% increase in the number of births in WA between 2002 and 2006. In 2008 compulsory schooling extended to Year 12, therefore numbers of student enrolled increased significantly again.

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

Capacity is also being stretched by:

- An increase in the proportion of students with complex health and social problems due to physical disability, mental illness, socio-economic disadvantage, family violence, alcohol and other drugs
- The need to respond to new arising health issues in school populations such as overweight and obesity, mental ill-health and other associated chronic conditions

<u>Child Development Services</u>

Child Development Services (CDS) provide a range of assessment, early intervention and therapy services to children with or at risk of developmental disorders and delay. Services are provided at 15 sites across the metropolitan area and within Western Australia Country Health Services by a range of professionals including speech pathologists, physiotherapists, occupational therapists, clinical psychologists, social workers, nurses, podiatrists, child care assistants, therapy assistants, audiologists, paediatricians and medical officers, along with administrative staff.

The CDS also plays a key role in health prevention and promotion through the delivery of community education, professional development and programs aimed at preventing the occurrence of a delay/disorder, minimising the impact of a disorder/delay and/or preventing the progression of a disorder/delay.

In July 2005, a CDS Reference Group was convened by the Department of Health Reform Implementation Taskforce to examine child development service provision within the State, and to develop a framework for improvement of services.

The report of the Review, *Future Directions for Western Australian Child Development Services* (2006) found that the varied history of each site had resulted in a fragmented service with a variety of different models of care and approaches to therapy for developmentally delayed children.

The outcome of the report was the establishment of a single integrated metropolitan child development service within the Child and Adolescent Health Service. Child development services in rural and remote areas of the State remain within WA Country Health Services.

Strengths of the model

The Western Australia CDS model is strong comparative to other States and Territories. The service is embedded within child and adolescent community health services statewide. Children and their families who require further assessment, early intervention and therapy services have the opportunity to access seamless clinical pathways to treatment and management of conditions.

The establishment of a single metropolitan CDS has been a significant reform, making better use of resources and strengthening service quality. The reform process is continuing with the development of:

- a continuum of care framework for the Service
- a list of presenting conditions/disorders that are eligible for referral to each of the disciplines
- standard referral and intake processes
- standard eligibility criteria
- clinical pathways both for the service and in relation to specific conditions/disorders
- data requirements for the Service
- service Level Agreements/Memoranda of Understanding with the:
    - Child and Adolescent Mental Health Service
    - Disabilities Services Commission
- working groups with the Western Australian Country Health Service and the Department for Education and Training.

Current Challenges

The prevalence of developmental delays and disorders varies between 1 in 1000 for hearing/vision, 1 in 160 for Autism Spectrum Disorder, 1 in 10 for language disorders, 1 in 20 for Attention Deficit Hyperactivity Disorder, 1 in 7 for learning difficulties/disorders and 1 in 3 for behavioural disorders (Williams, K. Wray 2006)

While the CDS reform project has made efficiency gains there will remain a general problem of demand for services exceeding capacity of the CDS to provide. This is particularly problematic when there are certain critical developmental stages during which timely responses are required if best outcomes are to be achieved.

A number of at-risk groups, including Aboriginal & Torres Strait Islander and Culturally & Linguistically Diverse families, young mothers and single parent families, are under-represented in the CDS population. Whilst engagement of at-risk families has been identified as a priority for the CDS, it is recognised that additional resources and the development of accessible and appropriate services will be required.

School Dental Service

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

Current Challenges

Approximately 35% of children have some form of oral disease, 17% will not require any intervention apart from health education on diet and oral hygiene. The number of children, who need extensive treatment including fillings for dental decay is low, estimated at 15%. Of these children, 10% cannot be treated in the dental chair and will require a General Anaesthetic. The only public dental theatre in Western Australia is located at Princess Margaret Hospital and this service is fully committed. The only other alternative for families is through private dental care which for families is expensive. There is a currently a major shortage of dentists and dental therapists nationally and internationally.

Child and Adolescent Mental Health Service (CAMHS)

Child and Adolescent Mental Health Service (CAMHS) provide specialist mental health services for children and adolescents and their families. Services are provided by CAMHS multi-disciplinary teams comprised of clinical nurse specialists, social workers, clinical psychologists and consultant child and adolescent psychiatrists, who work in liaison with families and carers. Individual and family assessment and therapy and group and educative work is undertaken. In addition specialist educational services and liaison are provided. Services are targeted at infants, children and adolescents up to 18 years of age who present primarily with severe mental disorders.

The Child Health Survey identified approximately 5% of the WA population of children and adolescents as suffering from severe mental disorder, (international prevalence rates are between 3% and 7%). Currently community CAMHS in Western Australia have a capacity to provide specialist assessment and intervention services to approximately 1% of the target population.

The Western Australia Government has committed funds to CAMHS for two metropolitan specialist multidisciplinary teams (North and South areas) to assess and treat complex behaviour disorders including Attention Deficit Hyperactivity Disorder (ADHD). The first of these teams will be based in the north metropolitan area and implementation is on target to commence clinical services early in 2009.

Currently planning is underway to develop models of specialist mental health care for infants, children and young people in care and juvenile offenders. The models of care will inform funding bids within the Mental Health Plan 2009-2014 to develop and enhance specialist mental health services available to these special needs populations. It is estimated that of approximately 2,500 children and young people approximately 70% may have a severe mental disorder. Meeting the needs of this group will present significant challenges for CAMHS. The models of care under development propose enhanced interagency collaboration and care coordination to more effectively meet the needs of these special needs populations.

The Office of Aboriginal Health (OAH)

The Office of Aboriginal Health (OAH) purchases screening services for Aboriginal children from various primary health care service providers including: The Telethon Speech and Hearing Centre and Aboriginal Community Controlled Health Organisations (ACCHOs):

The Telethon Speech and Hearing Centre operate from the Ear Health Clinic in Perth and a Mobile Ear Health Screening Service. Details of the range of services provided include:

- Mobile ear health screening services for indigenous children 0-12 years of age living in identified "at risk communities" within the Bunbury, Peel and Perth greater metropolitan regions
- Middle ear screening for children under 6yrs of age. Assess results and on-refer children who exhibit Type B or Type C tympanogram
- General Practitioner & Ear Nose & Throat treatment services to children with Otitis media
- Allied health service assessments (including speech, pathology, audiology, occupational therapy, psychology) as required to children with Otitis media and enrol children into specialised early intervention programs on the basis of assessed need in the area of speech and language delay.

The Aboriginal Community Controlled Health Organisations (ACCHOs) provide the following services to Aboriginal Children:

- Development of linkages with schools to facilitate screening and treatment of children's hearing
- Checking for infection/communicable disease including gastrointestinal, skin and parasitic infections as necessary
- Opportunistic and targeted screening for chronic conditions such as diabetes/hypertension, cardiovascular and respiratory disease where indicated
- Opportunistic and targeted screening and treatment for Sexually Transmittable Infections (STI's) where indicated
- Opportunistic and targeted screening and the development of linkages with schools to facilitate screening and treatment of children's hearing where indicated
- Early childhood screening for disability and disease where indicated and initiate treatment

Other Sectors

As already noted, prevention and early intervention in childhood has become a priority for Australian governments and non-government organisations. In addition to the above services, the Commonwealth Government has introduced or is in the processing of introducing a number of initiatives funded through the Medicare system to enhance services in this area. The initiatives include: The Enhanced Primary Care Program, Healthy for Life Program, Autism Initiative and a Healthy Kid's Check for four year olds.

Enhanced Primary Care Program

The Enhanced Primary Care Plan (EPCP) and the Better Access to Mental Health Program provides up to five private allied health and 12 clinical psychology sessions each year as part of the care plan for adults/children with chronic health conditions. Anecdotal evidence suggests that many child development service families experience difficulty obtaining a General Practitioner referral to EPCP services for their child's developmental difficulty. Additionally, this number of services will not satisfy the requirements of many children with developmental and behavioural concerns.

Healthy for Life Program

The Healthy for Life Program is funded for $102.4 million over four years, to enhance the capacity of over 80 Aboriginal and Torres Strait Islander primary health care services across Australia to improve the quality of child and maternal health services and chronic disease care, and to improve the capacity of the Indigenous health workforce. Six Aboriginal Community Controlled Health Organisations (ACCHOs) in Western Australia and one Aboriginal Health Service based in the Great Southern and managed by the WA Country Health Service are involved in this initiative and the program includes annual health checks for children (0-15 years).

Autism Initiatives

The Commonwealth Government has allocated $127 million over five years to the Helping Children with Autism package. The package comprises the following elements:

- Education and Support
    - National education and support program
    - Website
    - Autism Spectrum Disorder (ASD) Data & Research including national ASD Register
- Early Intervention
    - Childhood Autism Advisors
    - Intensive support
- Playgroups

Specialised child care and early intervention services for children with autism will also be established as part of the Commonwealth Government's commitment to build up to 260 new child care centres. The initial commitment is to establish 6 centres across Australia to provide dedicated early intervention and care for children with autism spectrum disorders.

Negotiations are currently taking place between the Commonwealth and States/Territories regarding the implementation of this initiative. The service model is not clear at this time.

Healthy Kid's Check for four year olds

The Commonwealth Government will invest up to $35 million to introduce a Healthy Kids Check for four year olds:

- The Healthy Kids Check is a basic health check-up and includes height, body mass index (BMI), eyesight and hearing checks.
- The provision of a Healthy Habits for Life Guide and an information session for parents, which will provide parents with practical accessible tips on their child's health and development.
- The Healthy Kids Check, Healthy Habits for Life Guide and the information session will be offered with the child's four year old immunisation.
- These initiatives will be delivered by:
    - General Practitioners (GP) or Practice Nurses through a new Medicare item valued @ $45. The Medicare item will be claimable in conjunction with the four year old immunisation. It is anticipated that approximately 70% of children across Australia have their immunisations at the GP.
    - Local Government Agencies and community health services who operate immunisation clinics. Block funding will be provided to these immunisation providers. It is expected that approximately 30% of children across Australia receive their immunisation from these services.
- The Commonwealth Government plan to monitor the need for follow up services, particularly any services not available under existing referral arrangements.
- The Healthy Kids Check will be rolled out nationally in 2009.

This initiative will encourage GPs to focus on early detection of child health developmental problems. However, as with previous initiatives, GP and Practise Nurse uptake without a dedicated training agenda may be variable depending on the professional's skill sets and interests. This check also replicates many aspects of the current WA universal school entry health check and it is likely that there will be duplication

Response to the Inquiry's Terms of Reference

1. ***Adequacy and availability of screening processes for hearing, vision, speech, motor skills difficulties and general health for children at pre-primary and primary school.***

Adequacy

In WA, universal child health and development surveillance, including screening and assessment, begins at birth and is completed at the school entry assessment. The current health screening for children at school entry (kindergarten, pre-primary, year 1) is not a stand alone screening process, rather, it is embedded in an early detection, early intervention and treatment system, which provides a more comprehensive picture of a child's health and development. This system represents contemporary good practice and is similar to those in place in other States and Territories.

The DOH universal school entry assessment process is based on the latest research evidence to ensure that the general health and developmental screening tests used are valid, reliable, easily replicated across large numbers, and cost effective. A key principle is that it is conducted in partnership with parents. Due consideration has been given to the systematic scientific evidence that was collated in the NHMRC Review of child health screening and subsequent evidence since this report.

The current school entry assessment involves gathering information about the child's health, development and behaviour from multiple sources including direct observation of the child, compiling a developmental history, responding to parental concerns and a vision and hearing assessment.

The system relies on:

- The engagement of parents in the assessment process to respond to questions about their child's health and development
- The professional skills and judgement of the nurse in completing the screening tests and identifying those children who require further assessment.

Anecdotal evidence reveals that the majority of referrals to child development services are from child and school health nurses and the referrals are relevant and of a very high quality.

The current universal system will be strengthened in 2009, by the Statewide roll out of "parent completed child developmental screening tools" at the key developmental ages of 3-4 month, 8 months, 18 months, 3 years and school entry. Western Australia will be the second State after New South Wales to introduce child developmental screening tools into this system.

The DOH believes that its policy and guidelines for the delivery of universal birth to school entry health and developmental screening is evidenced based and very adequate. This policy framework is under constant review and refinement. The policy requirements for universal school entry health assessments is being met, however the capacity to provide follow up services to respond to identified needs is under pressure.

In addition, there are certain populations, children who are refugees, Aboriginal and Torres Strait Islander, in out of home care and children of parents with a mental illness or a drug and alcohol addiction whom require more comprehensive assessment, monitoring, early intervention, treatment and follow up.

Availability

The school setting offers a unique opportunity to assess children's health and wellbeing because in WA it is compulsory for children to attend school from 5 to 17 years of age. Therefore, by offering a universal school entry assessment means that there is a good opportunity that the assessment is not only available but accessible to all families. With few exceptions, school health nurses, where possible provide early detection services in primary schools across Western Australia. For children who move through the education system or commence school at year 1, processes are in place to identity those children and offer an assessment.

In the latter part of 2008, a comprehensive evaluation of the School Entry Health Assessment Program will be undertaken across Western Australia. This evaluation will enable community health services to assess the reach of early detection services in schools including the proportion of children receiving assessment, referrals and outcomes of the process.

2. *Access to appropriate services that address issues identified by an appropriate screening process*

In WA, there are a range of services for children who are identified with health and developmental concerns as a result of screening and assessment processes. The DOH has a central role in service provision for these children; however, there are a number of other referral pathways available to families' including General Practitioners, School Services Team, School Chaplain, School Speech Therapist, School Psychologist, Disability Services and private service providers.

As noted earlier, the Child Development Service (CDS) has a range of professionals including speech pathologists, physiotherapists, occupational therapists, clinical psychologists, social workers, nurses, podiatrists, child care assistants, therapy assistants, audiologists, paediatricians and medical officers providing diagnostic assessments and specialist services for children with developmental delay. Similar to other parts of the DOH, the service is heavily impacted by increasing numbers of children because of the rise in

numbers of births and migration, also increasing numbers of children with complex health and developmental issues, and static resources.

The CDS is the metropolitan area is undergoing reform, one of the most significant changes currently being progressed in the CDS is the development of standardised clinical pathways. The clinical pathways are designed to ensure the best outcomes for children and are based on contemporary practice. They establish standardised policies for eligibility, prioritisation, assessment and treatment and outline specific procedures for the care and management of children from the point at which they are referred to the CDS until they are discharged.

In addition, the CDS is working to improve linkages with a number of agencies, such as CAMHS and the Disability Services Commission, to develop strategies to enable these agencies to work together to care for children with more complex needs.

The reform process is also addressing; The relocation of services, Improving access by at risk groups including Aboriginal and Torres Strait Islander families and Culturally and Linguistically Diverse families, services for families with older children and the provision of services in the child's normal environment. Child development services in rural and remote areas will also be involved in this process to enable consistency in service delivery across Western Australia.

Currently in WA, access to CDS's across the State is not consistent and dependant on availability of appropriate staff. It is anticipated that an outcome of the reform will be that children and their families who need diagnostic assessment and specialist support will have the service provided by the right practitioner, in the right place and at the right time.

In WA, there is limited access to free dental health services for children who are 2-3 years of age with oral disease. Usually these children require a general anaesthetic for intervention and treatment and the only public facility is located at Princess Margaret Hospital, this service is fully committed.

Western Australia like other States does not have a preventive dental health service for children 18 months to 4 years of age - parents who attend child health services are given health education on diet and oral hygiene and encouraged to access dental services.

There is currently a shortage of dentists and dental therapists. A number of strategies have been put into place to address workforce issues, the outcomes of the strategies will not be a reality until 2015.

Conclusion

Early identification, intervention and treatment of child health conditions and developmental delay are an integral function of primary health care providers. The object of this activity is to improve the long term health outcomes and life opportunities of individuals through support to parents and timely and appropriate clinical interventions. As well as the immediate benefit to the child and parents there are significant economic benefits to society through preventing the development of chronic diseases and increased productivity.

The DoH, and GPs play a central role in the delivery of services. Families have the choice about whom they access when they seek support for their child who may have a health condition or developmental problem.

The DOH provides suite of child health and development surveillance, intervention and treatment services which begins at birth and continues into the school years. This approach and the services are evidence based and under constant review.

The WA public health system through its universal child and school health surveillance frameworks provides strong foundations for the provision of more targeted approaches or more intensive services to at risk populations with higher needs, such as Aboriginal people, and to respond to new and emerging health issues, such as over weight and obesity in children.

Challenges facing the DoH provided services include responding to increasing demand for services as a result of the unanticipated significant increase in births and population growth since 2003 and finding adequate staff to provide services in remote areas, and in regional areas where resource development is occurring. This has particular implications for the provision of services to the 'at risk populations' who are less likely to access or remain engaged with mainstream services, but whose children are more likely to be in need.

References

Australian research Alliance for Children & Youth, Evidence into Action Topical Paper - The Importance of the Early Years: June 2006

Department of Education and Training, Western Australia (2005). *School Statistics Reports 2006 Semester 1.* Department of Education and Training: Perth

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

Freemantle J, Stanley F, Read A & de Klerk N. (2004) *The First Research Report: Patterns and trends in mortality of Western Australian infants, children and young people 1980-2002.* Advisory Council on the prevention of death of children and young people. Department for Community Development: Perth.

Hands B, Parker H, Glasson C, Brinkman S & Read, H. (2004). *Physical Activity Levels in WA Children and Adolescents: Report.* University of Notre Dame Australia.

Hart, B., Brinkman, S., Blackmore, S. 2003. How well are we raising our children in the north metropolitan area? Results of the early development instrument. Perth: Population Health Program: North Metropolitan Health Service.

Heckman, J.J. 2006, 'Investing in Disadvantaged Young Children is an Economically Efficient
Policy', *Building the Economic Case for Investments in Preschool forum,* New York.

National Health and Medical Research Council, 2002 'Child Health Screening and Surveillance: A Critical Review of the Evidence'.
http://nhmrc/publication/publications/synopses/ch42sdn.html

Queensland Government 2006, The Policy Challenges in Early Childhood and Early Intervention, Premier's Policy Alert Edition 18, Queensland.

Williams, K. Wray 2006 *Prevalence of Autism in Australia*

ATTACHMENT 1
DEFINITIONS USED IN SUBMISSION

Universal Services - are available to the whole of the population and are designed to promote positive functioning and decrease the likehood of specific problems or disorders developing. Such services are truly universal if they are not only available to the whole population but also accessible to and accessed by most people.

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

Treatment Services - are specialist services that are available to individuals or families who have an established condition or problem, and designed either to eliminate the condition or problem, or, if this is not possible, to minimise its negative impact.

Clinical Pathways - are standardised, evidence-based multidisciplinary management plans, which identify an appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for a homogenous patient group.

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

A Screening Program - is a test or series of tests, performed on a population that has neither the signs nor symptoms of the disease being sought but whose members have some characteristic that identifies them as being at risk from that disease, the outcome of which can be improved by early detection and treatment.

Child Health Surveillance - is the systematic and ongoing collection, analysis and interpretation of indices of child health, growth and development in order to identify, investigate and, where appropriate, correct deviations from predetermined norms aims to optimise the health of children through the ongoing overview of the physical, social and emotional health and development of all children. Child health surveillance is initiated by health professionals but involves partnerships with parents.

Health Promotion -is the process of enabling people to increase control over and improve their health. It involves the population as a whole in the context of their everyday lives, rather than focusing on people at risk for specific diseases, and is directed towards action on the determinants or causes of health.

ATTACHMENT 2

Child Health Screening and Surveillance: A Critical Review of the Evidence published by the National Medical and Research Council (NHMRC)

Findings and recommendations for screening/surveillance programs

Conductive hearing loss -
Universal screening programs to detect otitis media with effusion are not recommended

Permanent childhood hearing impairment -
Fair evidence to recommend universal neonatal hearing screening
Good evidence to recommend against distraction testing
Insufficient evidence to make a recommendation for or against school entry screening

Undescended testes -
Examination @ birth & 6-8 weeks

Vision -
Insufficient evidence to make a recommendation for or against preschool visual acuity screening
Fair evidence to recommend against screening for amblyopia

Development -
Insufficient evidence to make a recommendation for or against developmental screening

The identification of children who would benefit from early intervention should not be based solely on the use of developmental screening tests or limited to a single point in time

Language -
Insufficient evidence to make a recommendation for or against screening

Height -
Insufficient evidence to make a recommendation for or against screening
New growth screening programs outside the research context are not recommended

Weight -
Insufficient evidence to make a recommendation for or against screening for failure to thrive
Fair evidence to recommend against screening for obesity
Routine weight monitoring @ 6-8 weeks and 8-12 months is recommended

APPENDIX THREE

Age	Place and Type of Contact	Developmental Screening & Surveillance Schedule - Universal Contact	Comments	Additional Targeted Assessments
Newborn	Hospital (by hospital staff)	Physical Examination Visual Appraisal - Observation of eyes, Red Reflex Test and vision behaviours Screening assessment for Developmental Dysplasia of the Hips Weight, Length and Head Circumference Guthrie Test - Newborn Screening Blood Test Newborn Hearing Screening	 After 72 hours Limited in WA	
Birth < 10days	Home visit (where possible) (by community child health staff)	Observational assessment of baby	Assessment of Risk and Protective Factors Further assessment if there are concerns indicated from history, or expressed parental/professional concern	Physical assessment Weight may be measured in at risk populations For families considered at risk, additional contacts and/or more intensive home visiting may be scheduled as appropriate and where resources available
6 - 8 weeks	Home or child health centre (by community child health staff)	Physical Assessment including: Visual Appraisal - Observation of eyes, Red Reflex Test and vision behaviours Observation of Hearing Behaviours Screening assessment for Developmental Dysplasia of the Hips Examination of Testes, Genitalia and Anal region Observation of Early Motor Development Observation of Milestones for physical, social and emotional development Weight Measurement	Assessment of Risk and Protective Factors Further assessment if there are concerns indicated from history, or expressed parental/professional concern	For families considered at risk, additional contacts and/or more intensive home visiting may be scheduled as appropriate and where resources available Length and Head Circumference in at risk populations or where there is expressed professional or parental concern

APPENDIX THREE

3 - 4 months	Home or child health centre (by community child health staff)	Visual Appraisal - Observation of eyes, Red Reflex Test and vision behaviours Observation of Milestones for physical, social and emotional development Weight Measurement	Assessment of Risk and Protective Factors Further assessment if there are concerns indicated from history, or expressed parental/professional concern	Physical assessment in at risk populations, or where there is expressed professional or parental concern Length and Head Circumference in at risk populations or where there is professed professional or parental concern
8 months	Home or child health centre (by community child health staff)	Physical Assessment including; Visual Appraisal - Eye movements, Corneal light reflex test and vision behaviours Observation of Milestones for physical, social and emotional development Weight Measurement	Assessment of Risk and Protective Factors Further assessment if there are concerns indicated from history, or expressed parental/professional concern	Red Reflex eye test, where vision risk factor identified. Length and Head Circumference in at risk populations or where there is expressed professional or parental concern
18 months	Home, child health centre, or community venue or phone contact with parent. (by community child health staff)	Observation/Discussion of Milestones for physical, social and emotional development	Assessment of Risk and Protective Factors Further assessment if there are concerns indicated from history, or expressed parental/professional concern	Red Reflex test and Corneal Light Reflex Test where vision risk factor identified. Weight & Length in at risk populations or where there is expressed professional or parental concern

APPENDIX THREE

3 - 3.5 years	Home, child health centre, or community venue or phone contact with parent. (by community child health staff)	Observation/Discussion of Milestones for physical, social and emotional development	Assessment of Risk and Protective Factors Further assessment if there are concerns indicated from history, or expressed parental/professional concern	Red Reflex, Corneal Light Reflex, Cover Test and Lea Symbols Chart where vision risk factor identified, or where there is professed professional or parental concern Audiometry and Otoscopic examination where hearing risk factor identified, or where there is expressed professional or parental concern Weight & Length in at risk populations (Indigenous, pre-term etc) or where there is expressed professional or parental concern
School Entry	School or Kindergarten (by community school health staff)	Visual Appraisal - Eye movements, Lea Symbols Chart, Corneal light reflex, cover test and vision behaviours Hearing Screening - Otoscopy and Audiometry screening Observation of Milestones for physical, social and emotional development	Further assessment at any age if there are concerns indicated from history, or expressed parental/professional concern	