Child and Adolescent Health Service
Child and Adolescent Community Health; School Health Portfolio

School Entry Health Assessment Program

Statewide Evaluation 2008

Summary and Update

The statewide evaluation of the School Entry Health Assessment Program was initiated in 2008 and the analysis of data is continuing. This report is prepared for the Education and Health Standing Committee Inquiry into the *General Health Screening Of Children At Pre-Primary and Primary School Level* meeting of 8th April 2009 to inform it of progress to date.

Background

Early detection programs aim to improve the health outcomes for individuals identified as having health or developmental issues. The *School Entry Health Assessment Program* is an important early detection program conducted by community health services across Western Australia (WA).

As per Government policy, school entry health assessments are to be offered to all children as early as possible after school entry. Typically, a community health nurse conducts a first level assessment and if warranted, makes a referral for more specialised assessment and intervention. Community health services are available to all primary schools, public and private, in WA.

The evaluation of the *School Entry Health Assessment Program* aimed to assess the reach of the Program throughout WA. In addition, it examined the associated assessment and referral activity undertaken, and the outcomes which resulted. A total of 886 questionnaires were distributed and there was a 98.4% response rate.

Findings

There were over 27,500 Year 1 students enrolled in WA in mid 2008, and by November, 83.7% were known to have received school entry health assessments. Of children who were known to be Aboriginal, 69.8% received assessments.

Of all children known to have received school entry health assessments, approximately half (53.1%) were assessed during Pre-primary, 38.4% in Kindergarten and 8.2% during Year 1. The timing of assessment varied considerably across the State. The vast majority of students who received school entry health assessments were assessed for vision (98.31%) and hearing (98.4%). Tests for speech and language were the third most common assessments (24.95%).

Of the children who are known to have received an assessment, 17.22% were referred for further assessment and/or intervention for specific issues. Most commonly, referrals were made for speech and language (27.20%), vision (26.27%) and hearing (23.27%).

Of the reported 5162 referrals (known to be) made for this cohort of children, for 23.17% the intervention was completed with good outcomes, for 17.09% the intervention was in progress, and for 9.07% further assessment identified no need for intervention. For 6.12% of referrals parents did not pursue an intervention, and for another 3.20% parents did not support the intervention provided. The outcome was not known for 29.45% of referrals.

In summary, most children for whom a concern was raised, received appropriate interventions leading to positive outcomes.

Child and Adolescent Health Service
Child and Adolescent Community Health; School Health Portfolio

Suggested Future Directions

Strengthen the *School Entry health Assessment Program* through:

- Support the conduct of school entry health assessments early as possible after children commence school to enable early responses to identified health and development issues.
- Strengthen systems for the monitoring of responses provided to transient and vulnerable children.
- Review professional development and performance monitoring systems for staff and managers.

Responsible Officer:
Sharon McBride,
Senior Portfolio and Policy Officer, Child and Adolescent Community Health
Child and Adolescent Health Policy (Statewide)
.
7 April 2009.

*Child's Name:*_____ *Class:*_____ *Calendar Year:*_____ *MRN:*_____

*Retain Until:*_____

Government of Western Australia
Department of Health

School Entry Health Assessment

Dear Parent/Guardian

The School Health Service is pleased to offer health assessments for your child. With your permission, the following will be carried out by a Community Health Nurse at your child's school:

- **Vision assessment** (This includes testing your child's distance vision and using a small light to look into the eye and watching the movements of the eye);
- **Hearing assessment** (This includes testing your child's hearing and looking into the ear canal for abnormalities);
- **General developmental health assessment** if you, the nurse or the teacher has a concern. (This generally involves assessing achievement of developmental milestones, speech and language development and conducting observational assessments regarding any other issues that may affect your child's learning).

The Community Health Nurse will contact you if any further action is needed. This may include a follow-up assessment, or a referral on to other services if needed.

A copy of the assessment results will be returned to you to keep with your child's Personal Health Record. A copy of the results will be kept with your child's academic record at the school and may be accessed by school staff if needed. Another copy will be kept by the Community Health Nurse.

Sometimes information that may help in the management of your child's learning, health or wellbeing may need to be shared between the Community Health Nurse and appropriate teaching staff. Information about your child's health and wellbeing may be gathered by the Community Health Nurse whilst conducting the school entry health assessment or at other times the nurse is in the school. The Community Health Nurse will share information about your child with teaching staff only when the Nurse considers it to be in the best interests of your child. In appropriate circumstances and where a particularly sensitive or personal issue arises, the Community Health Nurse will contact you to discuss the sharing of information with teaching staff.

If you agree to your child being assessed by the Community Health Nurse, please complete the inside of this form and sign below. Please return it to your child's school as soon as possible.

You are welcome to contact the Community Health Nurse at your child's school to discuss this health assessment or any concerns about your child's health at any time during their school years.

We hope your child has a happy and healthy time at school. Thank you for your cooperation.

IMPORTANT

I have read and understand the above letter and consent to:

- A health assessment of my child by the Community Health Nurse as described above; and
- A copy of the assessment results being kept with my child's academic record; and
- Sharing of information about my child between the Community Health Nurse and relevant school staff where it helps in the management of my child's learning, health or wellbeing.

Signature of parent or guardian:_____ Date_____ / _____ / 20_____

Name:_____ Relationship to child:_____

If you would like assistance completing this form or require it in an alternative format or language please contact the Community Health Nurse at your child's school.

(Please tick if you would you like a copy of this letter translated into Chinese/Arabic/Vietnamese)

如果你想看本函的中文译本，请在方框上打钩。 ☐ *(Chinese)*

اذا كنت ترغب في الحصول على نسخة من هذه الرسالة باللغة العربية، يرجى وضع علامة في ☐ *(Arabic)*

Xin vui lòng đánh dấu vào ô vuông nếu bạn cần là thư này bằng tiếng Việt ☐ *(Vietnamese)*

Please complete details inside

PRIMARY SCHOOL HEALTH RECORD

PARTICULARS OF CHILD

Boy ☐ Girl ☐

School:_____

Family name:_____

Given name(s):_____ Preferred name:_____

Address:_____

_____ Postcode:_____

Child's date of birth ___/___/___ Weight at birth:_____

Country/State of birth:_____

Is your child of Aboriginal or Torres Strait Islander origin? Yes ☐ No ☐

Child's Medicare Number: ☐☐☐☐ ☐☐☐☐☐ ☐ Child's reference number: ☐

Child's brothers or sisters:

1. Full name:_____ Year of birth:_____
2. Full name:_____ Year of birth:_____
3. Full name:_____ Year of birth:_____
4. Full name:_____ Year of birth:_____
5. Full name:_____ Year of birth:_____

Parent or guardian for contact

Family name:_____

Given name(s):_____

Phone No. (Home):_____ (Work):_____ (Mobile):_____

Email: _____

Mother's country of birth:_____ Father's country of birth:_____

Main language spoken at home:_____ Interpreter needed? Yes ☐ No ☐

Please indicate if there is any family history of medical, vision or hearing conditions:_____

_____

Has your child attended any of the following?

Child Health Centre? Yes ☐ No ☐ If yes, which one most recently?_____

Other School? Yes ☐ No ☐ If yes, which one most recently?_____

4 Year Old Healthy Kids Check with doctor Yes ☐ No ☐ If yes, please give details of health concerns_____

_____

IMMUNISATION

You are reminded that it is an enrolment requirement that you provide a photocopy of your child's immunisation record to the school. Have you done this? Yes ☐ No ☐ *If no, please attach a copy with this form.*

Has your child had the 4 year old immunisation?

Yes ☐ (Date Vaccinated ___/___/___ Where Vaccinated_____) No ☐ Unsure ☐

CONFIDENTIAL RECORD

PRIMARY SCHOOL HEALTH RECORD

PARENTS' EVALUATION OF DEVELOPMENTAL STATUS (PEDS)

1. Please list any concerns about your child's learning, development and behaviour.

   _____

2. Do you have any concerns about how your child talks and makes speech sounds?

   Circle one: No Yes A little COMMENTS:_____

3. Do you have any concerns about how your child understands what you say?

   Circle one: No Yes A little COMMENTS:_____

4. Do you have any concerns about how your child uses his or her hands and fingers to do things?

   Circle one: No Yes A little COMMENTS:_____

5. Do you have any concerns about how your child uses his or her arms and legs?

   Circle one: No Yes A little COMMENTS:_____

6. Do you have any concerns about how your child behaves?

   Circle one: No Yes A little COMMENTS:_____

7. Do you have any concerns about how your child gets along with others?

   Circle one: No Yes A little COMMENTS:_____

8. Do you have any concerns about how your child is learning to do things for himself/herself?

   Circle one: No Yes A little COMMENTS:_____

9. Do you have any concerns about how your child is learning preschool or school skills?

   Circle one: No Yes A little COMMENTS:_____

10. Please list any other concerns:

    _____

    _____

    _____

GENERAL HEALTH

- Does your child have any ongoing health problems or conditions? Yes ☐ No ☐
  *(If yes, please indicate)*_____
- Has this condition been attended to by a health professional? Yes ☐ No ☐
  *(If yes, please indicate)*_____
- Do you consider your child to be: Healthy weight ☐ Underweight ☐ Overweight ☐
- Does your child have a Medic Alert? Yes ☐ No ☐
  *(If yes, what is its inscription and ID number?)*_____
- Is there any other information you feel would be helpful for the Community Health Nurse (for example changes or major events in the family)?

  _____

  _____

  _____

CONFIDENTIAL RECORD

Please continue over page

PRIMARY SCHOOL HEALTH RECORD

VISION

- Do you have any concerns about your child's vision? Yes ☐ No ☐
  *(If yes, please indicate)*_____
- Has your child had any of the following? *(Mark all that apply)*
  Poor sight ☐ Squint/turned eye ☐ Eye injury ☐ Operation on eyes ☐
- Has your child been prescribed with glasses? Yes ☐ No ☐
  *(If yes, when should they be worn?)*_____
- Has your child received or are they receiving medical care for his/her eyes/vision? Yes ☐ No ☐
  (If yes, please describe) _____Date of last appointment (month/year)_____ /_____

HEARING

- Do you have any concerns about your child's hearing? Yes ☐ No ☐
  *(If yes, please indicate)*_____
- Has your child had any of the following? *(Mark all that apply)*
  Repeated ear infections ☐ Discharging ears ☐ Hearing loss ☐ Grommets ☐
  Other ear operation_____
- Has your child received or are they receiving medical care for his/her ears/hearing? Yes ☐ No ☐
  *(If yes, please describe)*_____Date of last appointment (month/year):_____ /_____

If you wish to discuss any of these health concerns, please contact the Community Health Nurse at your child's school.

Progress Notes

Office use only:

Child's name:_____ DOB:_____ /_____ / _____

Date & Time	Comment	Name, signature & designation

HP 3168 Oct '08 23452

CONFIDENTIAL RECORD

CHS 409-1

Government of **Western Australia**
Department of **Health**
Office of the Director General

Our Ref: EH19

Dr J M Woollard MLA
Chairman Education and Health Standing Committee
Parliament of Western Australia
Level 1, 11 Harvest Terrace
WEST PERTH 6005

Attention: David Worth

Dear Ms Woollard

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

Thank you for your letter 24 March 2009 regarding the opportunity to provide evidence to the committee. I attach for your consideration responses to the 12 questions you have asked the Department.

I confirm that the following staff of Department of Health (DOH) are available to appear before the Committee on Wednesday 8 April 2009.

- Mr Mark Morrisey (Executive Director, Child and Adolescent Community Health) attending on behalf of the Director General.
- Mr Mark Crake (Director, Child and Adolescent Community Health),
- Ms Kate Gatti (Area Director Population Health WACH),
- Ms Erin Gauntlett (Senior Portfolio and Policy Officer),
- Mrs Margaret Abernethy (Senior Portfolio and Policy Officer), and
- Ms Sharon McBride (Senior Portfolio and Policy Officer)

For further information, please contact: Mr Mark Morrisey, Executive Director, Child and Adolescent Community Health (Mark.Morrisey@health.wa.gov.au)

Yours sincerely

Dr Peter Flett
DIRECTOR GENERAL

3 April 2009

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Department of Health. Response to questions from the Education and Health Standing Committee Inquiry into Child Health Screening – April 2009.

Education and Health Standing Committee Inquiry into Child Health Screening

Response to questions on notice April 2009

1. The progress of the CDS Reform Project and the development of the Child Development Information System.

The reform of child development services has continued. Achievements since August 2008 include:

- The Child Development Information System (CDIS) has been completed and installed. Rollout has commenced with an anticipated end date of June 2009.
- Memoranda of Understanding between the Child Development Service (CDS) and the Disability Services Commission; and the CDS and Child and Adolescent Mental Health Service have been finalised.
- A standard referral form and Pre-Assessment Questionnaires have been developed and implemented.
- A range of standard policies, procedures and resources have been developed.

2. The Commonwealth privacy legislation and DOH's request that it be able to have easier sharing of information between departments.

The *Commonwealth Privacy Act* specifically excludes the coverage of public sector agencies, including the Department of Health (DOH). In the absence of Western Australian privacy legislation, the DOH has developed policies that comply with national privacy policies.

Neither Director's General from the Departments of Education or Health has any legislative authority to routinely share personal information about students. Any disclosure of confidential health information beyond its primary purpose, leaves the individual health professional vulnerable to a claim of a breach of confidentiality. Despite that, collection and storage of health (and other) information in a school context is considered appropriate if consent is obtained from the parent/guardian.

Ideally, WA requires privacy legislation to provide clear direction on the facilitation of information sharing between Government agencies, particularly confidential client information.

3. The progress of developing a prioritisation framework for the child development service that will clearly set out the various priority categories for different children who are referred to the DOH services and the reasons and the rationale for which they receive a priority category.

The prioritisation framework for the Child Development Service (CDS) has been completed and implemented.

The CDS prioritisation framework has been developed to reflect the overwhelming evidence regarding the importance of the early years and the need to intervene in the first few years of a child's life.

A copy of the prioritisation framework is provided as attachment 1.

4. **The number of DOH's 15 CDCs and four satellite services in the metropolitan area and the seven WA County Health Service regions that are not able to provide services to children older than seven years of age.**

All child development services across WA Country Health Services (WACHS) provide services to children older than seven years of age; however priority is generally given to the younger age group as this is often where the greatest positive effect is achieved.

All metropolitan Child Development Service (CDS) sites currently provide services to children over 7 years of age, although the intensity and type of service provided varies.

As part of the metropolitan CDS reform process, an eligibility policy has been developed to ensure consistency across the metropolitan sites. The policy states that children aged 0-16 years, who have or are at risk of a developmental delay/ disorder are eligible for referral to the Service. Children (and their families) who have been receiving services from the CDS may continue to receive services until the age of 18 years according to relative need, prioritisation and available resources.

The eligibility policy is currently being implemented and it is anticipated that consistency across the Service will be achieved by July 2009. At this point in time, all sites are providing services to children up to 12 years of age and there are ten (10) sites currently providing services to children over the age of 12. The remaining sites have recently commenced accepting referrals for children over 12 years of age. A service model for children older than 12 years is currently being developed and is due to be completed by July 2009.

5. **The progress of DOH's business cases seeking an additional 135 school health nurses, and an additional 91 child health nurses and 3 community health nurse managers.**

The 2009-10 budget process is currently underway. Advice from Health finance is that it is unlikely that these business cases will be successful in the current environment.

6. **The progress of DOH developing a strategic plan for looking at how we can respond to foetal alcohol syndrome.**

The Department of Health Fetal Alcohol Spectrum Disorder working party, a subgroup of the WA Child and Youth Network, has continued to progress the development of a model of care with the first round of consultations due to occur in April 2009. The model of care will provide a state-wide framework for prevention, detection, diagnosis, intervention, education and supports for family.

The model of care is a Department of health response with input by other departments and agencies on how it can integrate with broader responses.

The Department of Health is also working with The Department for Communities and the Drug and Alcohol Office on these issues as information to service providers on

the issue and prevention through responsible alcohol consumption by pregnant women is are key issues.

7. The progress of implementing a universal neonatal hearing test in WA.

The current publicly funded newborn hearing screening program is provided through metropolitan birthing hospitals, except Swan Districts and Bentley hospitals. It is also provided through the neonatal unit at Princess Margaret Hospital. The Telethon Speech & Hearing Centre has established a private Newborn Hearing Screening Service at six private metropolitan hospitals and one private hospital in Bunbury. A fee is charged for this service.

In March 2009 the Department commenced planning for the extension of newborn hearing screening to all public birthing hospitals in WA.

8. The proportion of WA's Indigenous children who receive an extended version of the hearing screening.

There are a number of service providers offering an extended version of the hearing screening to Indigenous children throughout Western Australia. However, as there currently is no central coordination of these activities, it is difficult to assess the proportion of children who are receiving this service.

Within metropolitan areas the service providers include Derbarl Yerrigan, the Ear Bus through Telethon Speech and Hearing, and the Child & Adolescent Community Health (CACH) Ear Health Team.

Currently the CACH Ear Health Team offers a universal extended screening service to Indigenous children in schools with high Indigenous enrolment within the South Inland and Coastal Zones of the metropolitan area. This team offers ear examinations and hearing screening using a tympanometer. The uptake of these services range between 50% and 83% of the potential Indigenous population. Children who are identified as having a hearing concern are followed up and monitored and/or referred to other services as appropriate.

The CACH Aboriginal Health Team have nominated Indigenous ear health as a priority and are working towards the development of reporting frameworks to accurately identify the number of children receiving this service and any related gaps. Available resources limit the ability to fully meet the needs of this cohort.

Within WA Country Health Service (WACHS), extended hearing screening is offered to Indigenous children by a number of different providers including Department of Health school health and child health nurses, the visiting Australian Hearing Services, and local Aboriginal Health Service teams. Due to the lack of an integrated data system, it is not possible to identify the proportion of children who receive this service.

9. The progress of introducing the FASD 4-Digit Diagnostic Code in order to improve recognition of this disorder in WA.

A copy of the diagnostic manual has been purchased for all Child Development Service sites with training being provided by paediatrician Dr Amanda Wilkins. It is anticipated that all CDS paediatricians will be trained by the end of June 2009.

10 The number of child development services within WA County Health Services throughout the State's different regions and the composition of the services offered in terms of number of FTEs and the kinds of allied health disciplines they have access to.

Child development services within WACHS are delivered in a wide range of settings and by a variety of practitioners. These vary from region to region according to the location, population size and need, and available resources. These practitioners deliver community based services, working from community health centres, schools and clients' homes. The distances between towns and service delivery sites add a very real extra challenge for the practitioners out in the field. A great amount of their time is taken with travelling to deliver services to clients and communities.

In the majority of situations across WACHS, allied health practitioners are generalists, also delivering services to clients of all ages from babies to the elderly; they also deliver in patient and out patient services to hospital based clients.

The larger regional centres and towns or cities, for example Albany, Geraldton and Bunbury do have specialised paediatric teams to provide child development assessment and management services for developmentally delayed clients. Some of these child development services also have access to a paediatrician – either under an employment or contractual arrangement. These centres operate as a referral base for their outer regional areas and are available for service delivery or professional support for other wider based health professionals.

Alternative types of child development services are available in some larger community health centres that incorporate a less formal team comprised of broad based health professionals, where referred cases are discussed at with regular and scheduled intake meetings and allocated within the available services and resources. Referrals are accepted from the community members as well as other practitioners in the town or area.

In many WACHS regions, child development services are limited to those available through an even smaller informal grouping of allied health professionals and community nurses within a rural or remote health service. In many WACHS regions this is the most common type of service delivery model. The metropolitan Child Development Service provides expert advice and support and is accessed for the assessment and management of clients as required.

At the local level, due to the impact and limitation of the mobile and transient workforce available, the skill mix and resources for the various child development services offered varies. .

Where other service delivery methods such as video-conferencing and teleconferencing are available, these are utilised. However, these facilities are not available at all sites.

A list of the child development services available in each of the WA Country Health Service (WACHS) regions is provided as attachment 2.

11. The progress of developing the Continuum of Care Framework clinical pathways.

The following metropolitan Child Development Service (CDS) clinical pathways have been developed since August 2008:

- CDS clinical pathway for school aged children presenting with attention, behaviour and hyperactivity difficulties (copy provided as attachment 3).
- Child Development Service/ Disability Services Commission pathway for children aged 0 – end of pre-primary with global developmental delay (copy provided as attachment 4).
- Child Development Service/ Disability Services Commission pathway for school aged children with global developmental delay/ intellectual disability (copy provided as attachment 5).
- Child Development Service/ Disability Services Commission pathway for children aged 0 – end of pre-primary with Autism Spectrum Disorder (ASD) (copy provided as attachment 6).

12. The progress of implementing the parent-completed Parent Evaluation of Developmental Status screening tool. Also, can the Committee receive a copy of the actual PEDS tool?

As of 1 January 2009, parent completed child developmental screening tools have formed part of the universal child health developmental assessment process provided by community child health nurses. These screening tools are administered at the following contacts: 3-4 months; 8 months; 18 months; 3 years; school entry assessment; and opportunistic contacts as required.

The child developmental screening tool has been embedded into the current community health records. Therefore, the Parent Evaluation of Developmental Status (PEDS) has been written into the 2009 version of the school entry assessment form (refer to attachment 2) and similarly into the Personal Health Record (PHR – purple book). This book is currently being reprinted and will be available mid 2009. In the meantime, hard copies of the PEDS tool have been sent out to Area Health Services across the State to use until the new print of the PHR is ready for distribution.

The PEDS is completed by parents and scored by a community health nurse as part of their assessment. If either a parent or nurse has identified any child health or developmental concerns a number of options are considered including further assessment, use of a secondary child developmental screening tool (Ages and Stages Questionnaires) and/or referral to specialist agencies.

Professional development sessions have been conducted state-wide to ensure staff members are appropriately trained in the administration of the tools. To date approximately 550 staff have been trained with ongoing training occurring during 2009. Overall, staff members have been very positive regarding the introduction of use of the screening tools. Evaluations reflect satisfaction with the validated tools, and support for the standardised guidelines which contribute to best practice.

An evaluation framework has been developed to assess the implementation process, the accessibility of tools, the numbers of children requiring secondary screening tools, the numbers of referrals arising from the assessment, and impact on staff workload.

Department of Health. Response to questions from the Education and Health Standing Committee Inquiry into Child Health Screening – April 2009.

Attachment 1: Metropolitan Child Development Service Prioritisation Framework

Background

There is now overwhelming evidence that early childhood experiences lay the foundation for lifelong learning, behaviour and health outcomes.

Early experiences affect physical and social development, the ability to learn, and the capacity to regulate emotions[1]. The quality of children's experience in the first three years of their lives is particularly crucial and can impact on the wiring and sculpting of the brain's billions of neurons that can have lasting effects[2].

It is therefore not surprising that the research highlights the importance of both early identification of health, behavioural and developmental problems and the need to commence interventions in the first few years of a child's life[3]. This includes ensuring that intervention coincides with critical developmental and transition periods in children's lives when specific types of learning take place. If these 'windows of opportunity' are missed, later remediation is often more difficult and expensive, and less effective[4].

In terms of the benefit of intervening in the early years, these include improved school participation and retention rates and higher levels of workforce participation along with a reduction in crime, teenage pregnancy, welfare dependency, child abuse, obesity and mental health issues[5]. The economic benefits are also substantial with reported returns on investment of up to $17 for every dollar spent[6].

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[1] Fish, E. (2002) 'The benfits of early intervention', *Stronger Families Leraning Exchange Bulletin* No. 2, Spring-summer, pp. 8-11

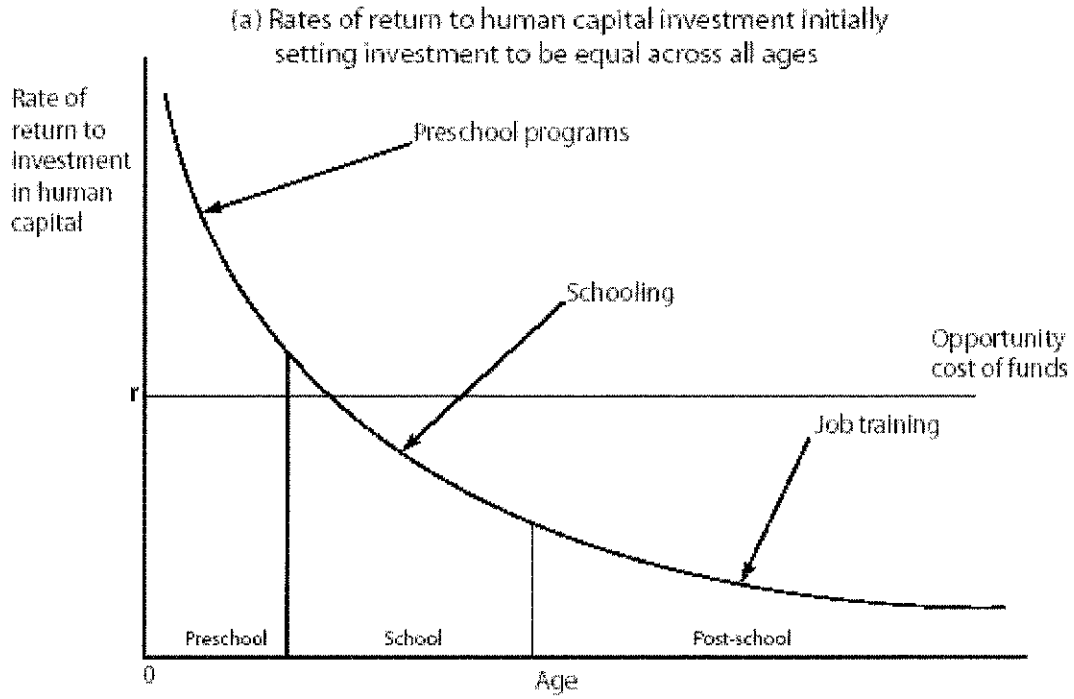
[2] McCain, M.N. & Mustard, F. (1999), *Reversing the brain drain: Early study: Final report*, Ontario Children's Secretariat, Toronto cited in Fish, E. (2002) 'The benfits of early intervention', *Stronger Families Leraning Exchange Bulletin* No. 2, Spring-summer, pp. 8-11

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

[4] Rethinking the Brain -- New Insights into Early Development; Conference Report -- Brain Development in Young Children: New Frontiers for Research, Policy and Practice, organized by the Families and Work Institute, June 1996, http://www.naeyc.org/ece/1997/11.asp

[5] See for example Heckman, J.J. (2006) *Investing in Disadvantaged Young Children is an Economically Efficient Policy*, University of Chicago, USA; Elliot, *A* (2006). *Early Childhood Education: Pathways to quality and equity for all children*, Australian Council for Education Research, Victoria; Lynch, Robert G. (2004) *Exceptional Returns: Economic, fiscal and social benefits of investment in early childhood development*, Economic Policy Institute, Washington USA; Thomas, K. (2006) *Early Childhood: Laying the foundations for life*, Curtin University of WA.

[6] Karoly, L.A., Kilburn, R.M. and Cannon, J.S. (2005) *Early Childhood Interventions: Proven results, future promise*, RAND Labor and Population, USA page 113



As indicated in the diagram above, the rates of return on investment in human capital is greatest during the preschool years[7].

Child Development Service Prioritisation Framework

There is often a greater demand for services than resources available, largely due to a significant increase in births, an increase in population due to migration, and increasing numbers of families with complex problems.

The CDS prioritisation framework has been developed to reflect the overwhelming evidence regarding the importance of the early years and the need to intervene in the first few years of a child's life.

In developing this framework, it is acknowledged that services/action could include providing direct services within the CDS and/or facilitating access to external supports/services.

Children who are not eligible for CDS services will be referred to an appropriate service/agency.

Considerations governing priority allocation

Clinical judgement

Clinical judgement plays a fundamental role in the delivery of best practice services and is one of the key principles of the CDS Strategic Intent which refers to delivering best practice through 'research, evaluation, peer review and clinical judgement;

[7] Heckman, J.J. (2006) *Investing in Disadvantaged Young Children is an Economically Efficient Policy*, University of Chicago, USA

implementing ongoing quality improvement; and complying with relevant legislative requirements'[8].

The importance of clinical judgement is also highlighted by the Institute of Medicine (IOM) which refers to best practice involving the 'integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences'[9].

All decisions regarding prioritisation are informed by evidence based practice, clinical judgement, available research, and the client's context.

Age of the child

Given the evidence regarding the early years and the importance of early intervention, a child's age is a significant factor when determining prioritisation.

Safety

Where a child is at imminent risk of harm to self or others, this must be addressed as a matter of urgency. The CDS is not a crisis service and children/families should be referred to appropriate services/support to address their 'urgent' needs/issues.

Once the 'urgent needs' have been addressed, children who are eligible for the CDS may also be referred to intake for priority allocation.

Complexity/severity/timeliness

The complexity, severity and timeliness of a child's needs/issues are significant factors when determining priority status.

Complex cases can include children

- with multiple disorders/issues and/or
- involved with/receiving services from multiple agencies and/or
- presenting with multiple risk factors[10] and/or
- requiring assessment and/or treatment from a multi-disciplinary team and/or
- where extraneous factors exist for example, social /family/ environmental factors that have a significant impact on the child's developmental needs.

Severity is assessed according to

- the impact of the child's developmental concerns on their functioning in various settings.

Timeliness relates to maximising the benefits of intervention through providing services at particular point/s in time based on

- the evidence for the disorder/delay and treatment and/or

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[8] *Child Development Service Strategic Intent* (2007), Child and Adolescent Health Service, Department of Health, Western Australia

[9] Adapted from Institute of Medicine, 2001; Sackett 2000; Gibbs, 2003

[10] Pre-term delivery; autism siblings; genetic conditions; visual/hearing impairment; post-cardiac surgery; low SES; children of parents with a mental illness (including PND); siblings of children with developmental delay; past history of child abuse/neglect; pre-natal/ peri-natal risk such as exposure to alcohol/maternal drug use or neonatal complications; teenage mothers; parental substance use; isolated families; families in crisis; children with low birth weight; children in the care of the CEO, DCP; adopted/fostered children; children who have suffered trauma; children with certain syndromes, eg Neurofibromatosis.

- the capacity to effect change with the child/family and/or
- the presenting developmental concerns are likely to be early symptoms of a life long developmental disability.

Priority categories

Priority One

The following children will be allocated a priority one status:

1. A child of any age requiring assessment/ diagnosis/ treatment within 4 weeks
   - ➢ to enable referral to external services and/or
   - ➢ due to the severity of the developmental delay/concern and/or
   - ➢ due to parental anxiety/distress.
2. A child of any age where there is a risk of significant deterioration (for the child/family) if action is delayed.
3. Children 0-3 years of age with developmental concerns/needs that
   - are complex and/or
   - are severe and/or
   - require intervention at particular point/s in time (timeliness).

Priority Two

The following children will be allocated a priority two status

1. Children 0-3 years of age with developmental concerns/needs that:
   - are NOT complex and/or
   - are NOT severe and/or
   - do NOT require intervention at particular point/s in time (timeliness).
2. Children 4-6 years of age with developmental concerns/needs that
   - are complex and/or
   - are severe and/or
   - require intervention at particular point/s in time (timeliness).

Priority Three

The following children will be allocated a priority three status:

1. Children 4-6 years of age with developmental concerns/needs that:
   - Are NOT complex and/or
   - are NOT severe and/or
   - do NOT require intervention at particular point/s in time (timeliness).
3. Children 7-12 years of age with developmental concerns/needs that
   - are complex and/or
   - are severe and/or
   - require intervention at particular point/s in time (timeliness).

Priority Four

The following children will be allocated a priority four status:

1. Children 7-12 years of age with developmental concerns/needs that:
   - are NOT complex and/or
   - are NOT severe and/or
   - do NOT require intervention at particular point/s in time (timeliness).
2. Children over 13 years of age that are
   - complex and/or
   - are severe and/or
   - require intervention at particular point/s in time (timeliness).

Priority Five

The following children will be allocated a priority five status:

1. Children over 13 years of age with developmental concerns/needs that:
   - are NOT complex and/or
   - are NOT severe and/or
   - do NOT require intervention at particular point/s in time (timeliness).

Assessment

Assessment is a process that involves a face to face meeting (with parent(s) and/or the client) in order to enable diagnosis and/or the formation of a management plan for a client.

Once eligibility has been determined, referrals are presented at an intake meeting. Once a referral has been accepted at intake, a priority category is allocated to a child with the following timeframes applying to the priority categories:

Priority	Timeframe for completing the assessment
1	Within 4 weeks of intake
2	Within 3 months of intake
3	Within 4 months of intake
4	Within 5 months of intake
5	Within 6 months of intake

Allocation of priority categories is informed by a range of information including the referral form, ASQ/ ASQ-SE and PAQs. It may be necessary to obtain further information in order to allocate an assessment priority, which could include completion of a screening tool with parents and/or the client.

It is possible that different disciplines will allocate a different priority category for a child.

If a child is allocated the same priority status across a number of disciplines, it may be appropriate to spread the appointments out to take account of family needs rather than a family attending for multiple appointments in a very short space of time. It may also be appropriate to consider undertaking a joint assessment.

Treatment

Once an assessment has been completed, a 'treatment priority' will be allocated to the client based on the assessment findings. It is possible that different disciplines will allocate a different priority category for a child and priority status can change at any time.

All treatment should commence within four weeks of the initial assessment[11]. However, there may be circumstances in which this is not appropriate due to the child's needs and/or the family's circumstances. Given resource constraints,

[11] Given that group programs require a minimum number of participants, it may not be possible to commence treatment within four weeks of assessment if the child/family is undertaking a group program.

benchmarks will be developed for each priority category in relation to the maximum waiting between the first and subsequent treatment/ intervention services. These benchmarks will be reviewed and amended as appropriate.

Attachment 2: Child development services available in WA Country Health Service (WACHS) regions

Education and Health Standing Committee – Inquiry into Child Health Screening
WACHS Response

Southwest	Goldfields	Kimberley	Pilbara	Wheatbelt	Great Southern	Midwest
There are four multidisciplinary child development teams comprising of speech pathology, occupational therapy, physiotherapy and in some cases social work which are based in: • Busselton • Bunbury/Harvey/ Yarloop • Warren & Blackwood • Wellington Additional access to podiatrist, dietician and regional paediatric audiology service. FTE Individual health professionals provide	There is no dedicated child development team. Allied health staff based in Esperance and Kalgoorlie provide services across the lifespan. Outreach services are provided from these centres to surrounding populations. <u>Esperance/ Revensthorpe/ Norseman:</u> This FTE is the approximate proportion dedicated to child development services. FTE: • Audiology: 0.4 • Dietetics: 1.0 • Occupational	The Kimberley Health Region Paediatric and Child Health Service is an acute based paediatric service with community outreach. This is complimented by Aboriginal Health Workers/ Community Midwives, child health nurses, school health nurses and remote area nurses. Dedicated child development staff FTE: • Paediatrician registrar: 1.0 • Paediatrician consultants: 2.0 There is access to	There is no dedicated child development team. Allied health staff based in East and West Pilbara provide services across the lifespan including child development. Outreach services are provided from these centres to surrounding populations. <u>East Pilbara:</u> The following FTE is the approximate proportion dedicated to child development services Newman • Speech pathology: 0.6 • Occupational	There are four multidisciplinary child development teams through out the region. Teams are based in Northam, Narrogin, Merredin and the Western Wheatbelt (Jurien/Moora/Gingin). Outreach services are provided from these centres to surrounding populations Total FTE: • Speech pathology: 8.6 • Occupational therapy 5.5 • Physiotherapy: 1.2 • Dietetics: 0.4 • Podiatry: 0.3 • Health promotion	There are two multidisciplinary child development teams throughout the region. The teams are based in Albany and Katanning. <u>Albany</u> A number of programs are provided including: • The Early Childhood Program for 0-3/4 year olds not attending school • The School Readiness Program - a mainstream program for children in kindergarten and pre-primary • The Child and	There is no dedicated child development team. Allied health staff based in Geraldton, Carnarvon and Meekatharra providing services across the lifespan. Outreach services are provided from these centres to surrounding populations. Allied health and community health meet to share clinical information especially for clients with multiple health needs. Below lists the approximate allied health FTE providing child development

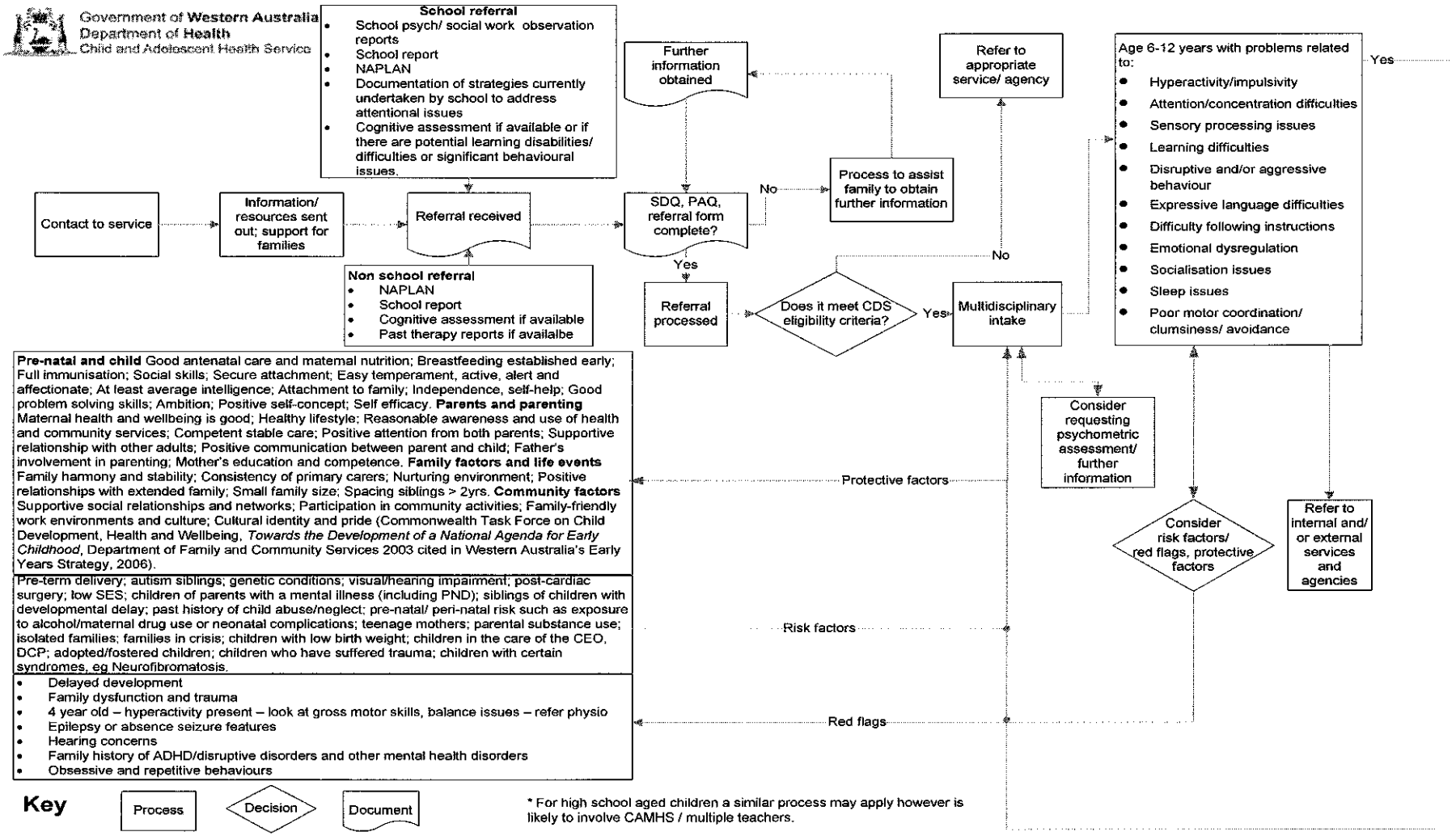
services across the care continuum in a number of districts and the FTE allocation is dependent on a variety of other factors such as inpatient activity. The figures provided are therefore approximations only. • Audiology: 0.6 (regional service) • Speech pathology: 11.3 • Occupational therapy: 7.0 • Physiotherapy: 5.8 • Dietetics : 1.5 • Social Work: 2.1 • Podiatry: 0.4 • Allied health assistant: 4.2	therapy: 2.0 • Physiotherapy: 3.0 • Speech pathology: 1.0 • Social work: 1.0 • Therapy assistant: 2.0 <u>Kalgoorlie:</u> FTE: • Audiology: 1.0 • Dietetics: 1.0 • Occupational therapy: 2.0 • Physiotherapy: 2.0 • Podiatry: 1.0 • Speech pathology: 3.0 • Allied health assistant: 3.0 • Aboriginal liaison welfare officer support: 2.0	acute based allied health disciplines however this is limited as they cover both adults and children and have a long wait list.	therapy: 0.5 • Physiotherapy: 0.6 • Child health:1.0 • School Health: 1.0 Nullagine • Visiting school and child health nurse Marble bar • Visiting child health nurse (monthly), school health nurse as required or weekly for one day Port Hedland • Physiotherapy: 2.0 • Speech pathology: 1.2 • Occupational therapy: 2.0 <u>West Pilbara:</u> The following FTE is the approximate proportion dedicated to child development services	officer as required • Aboriginal health worker as required • Paediatrician Merredin approximately 3 days/mth	Adolescent Integrated Therapy Services program for children with a permanent and sever disability. Below lists the approximate allied health FTE providing child development services FTE: • Audiology: 0.5 (accepts referrals from the whole region). • Dietetics: 0.4 • Occupational therapy: 1.6 • Physiotherapy: 1.8 • Speech pathology: 3.6 • Therapy Assistants: 1.2 <u>Katanning:</u> The only discipline that is specific for paediatrics is the therapy assistant. All other disciplines	services but as they cover all ages accurate information regarding paediatric FTE is not readily available. FTE: • Audiology: 0.4 • Dietetics: 3.0 • Occupational therapy: 7.0 • Physiotherapy: 9.0 • Speech pathology: 9.0 • Social work: 7.0 • Therapy assistant: 9.0 Visiting services: • PMH endocrinology team visits 3.4 times per year. Paediatrician employed on hospital staff Support from community and child health and Aboriginal health workers

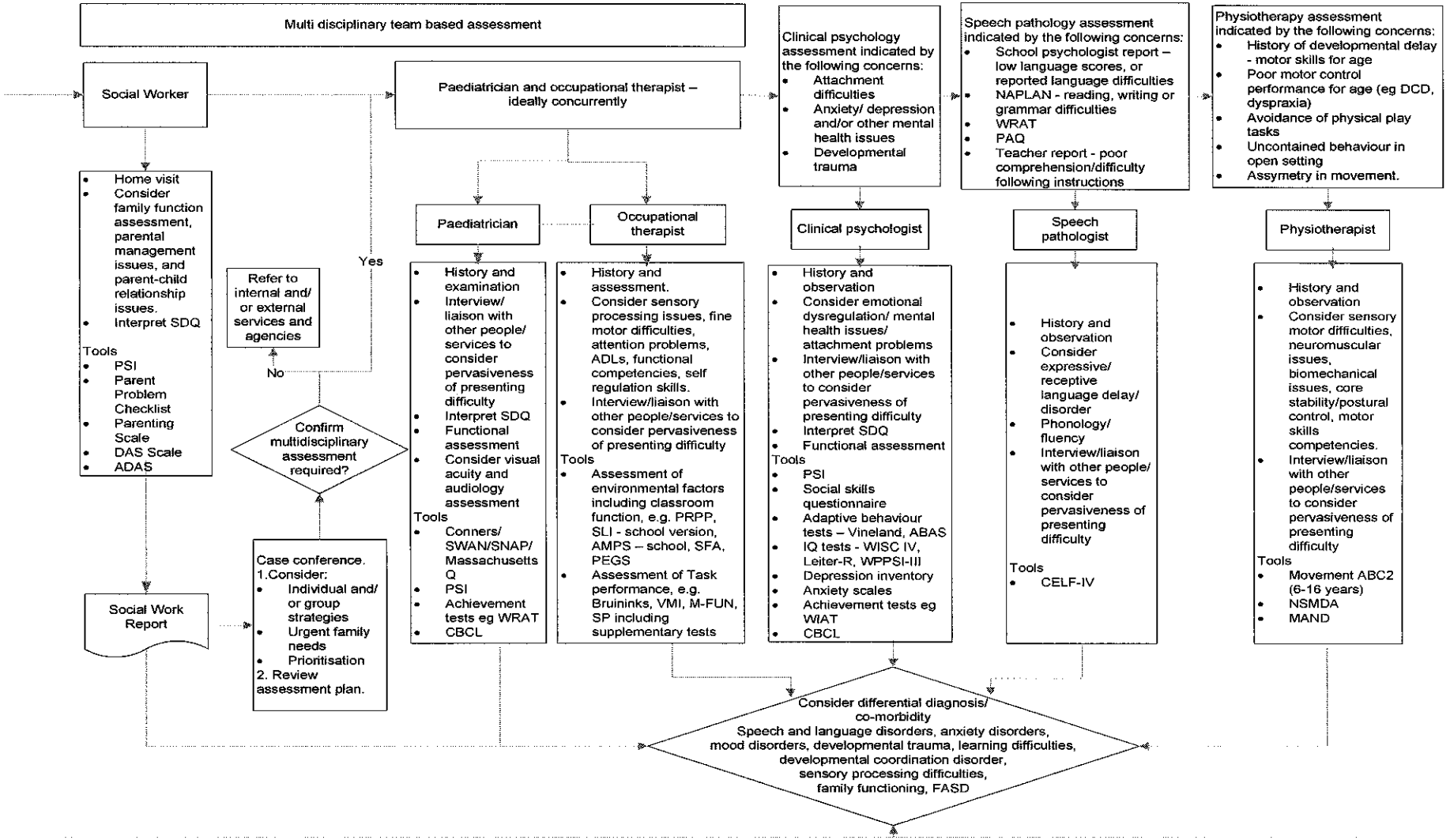
			FTE: • Physiotherapy: 2.5 • Occupational therapy: 1.8 • Speech pathology: 1.8 Visiting services: • Dietetics: 1.0 • Podiatry: 1.0 Parabadoo & Onslow Generalist Community Health Nurse in each town which component of their workload is child development.		have generalist caseloads which include paediatrics. Below is a broad estimate of the FTE allocation for paediatrics. FTE: • Therapy Assistant: 0.6 (shared by all disciplines) • Dietetics: 1.0 (minimal paediatric caseload) • Occupational therapy: 0.5 • Physiotherapy: 0.5 • Social work: 0.3 • Speech pathology: 1.0 <u>Denmark</u> • Occupational therapy: 0.5	

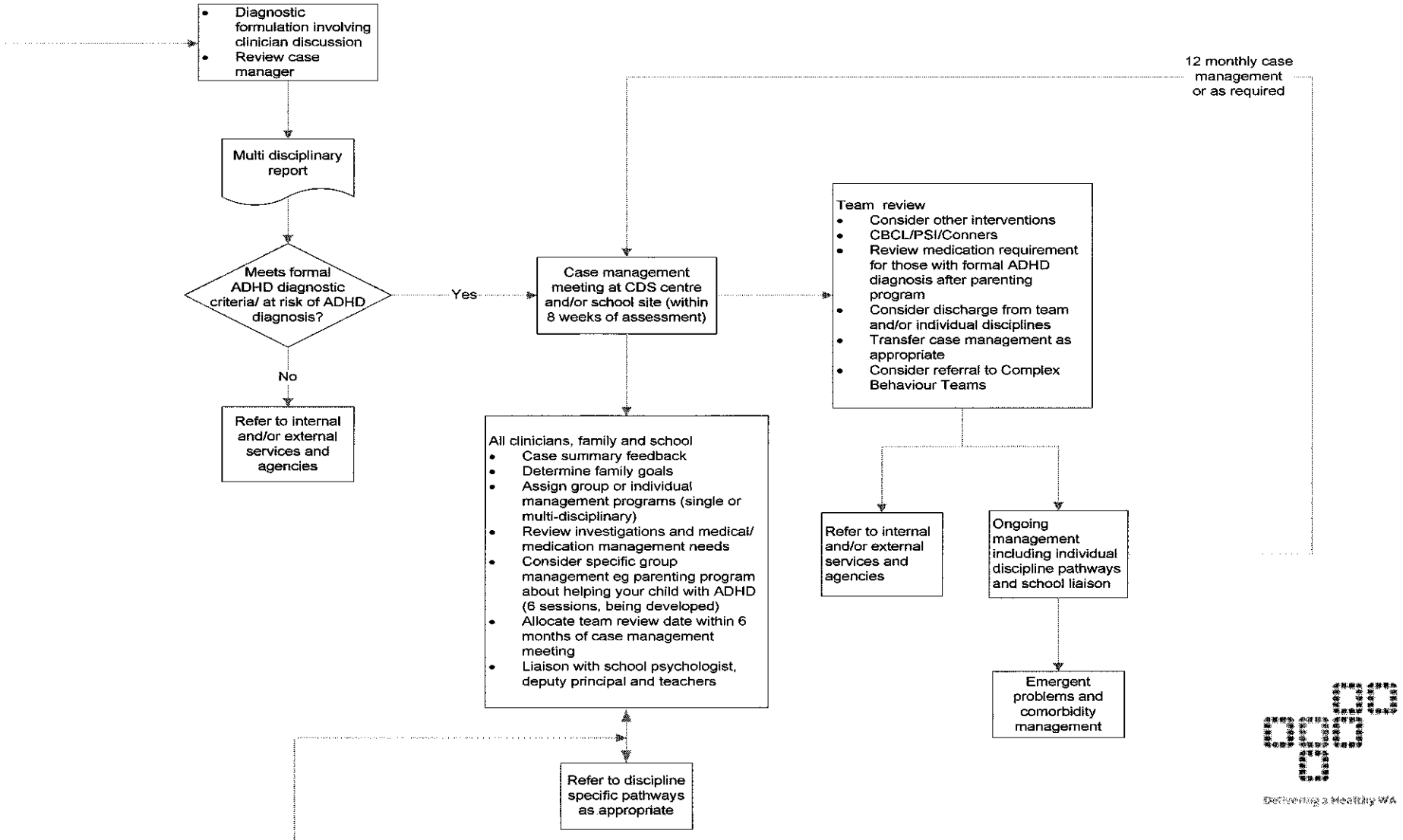
Department of Health. Response to questions from the Education and Health Standing Committee Inquiry into Child Health Screening – April 2009.

Attachment 3: CDS Clinical pathway for school aged children presenting with attention, behaviour and hyperactivity difficulties

Child Development Service clinical pathway for children with attention, behaviour and hyperactivity difficulties (school age 6-12 years*)



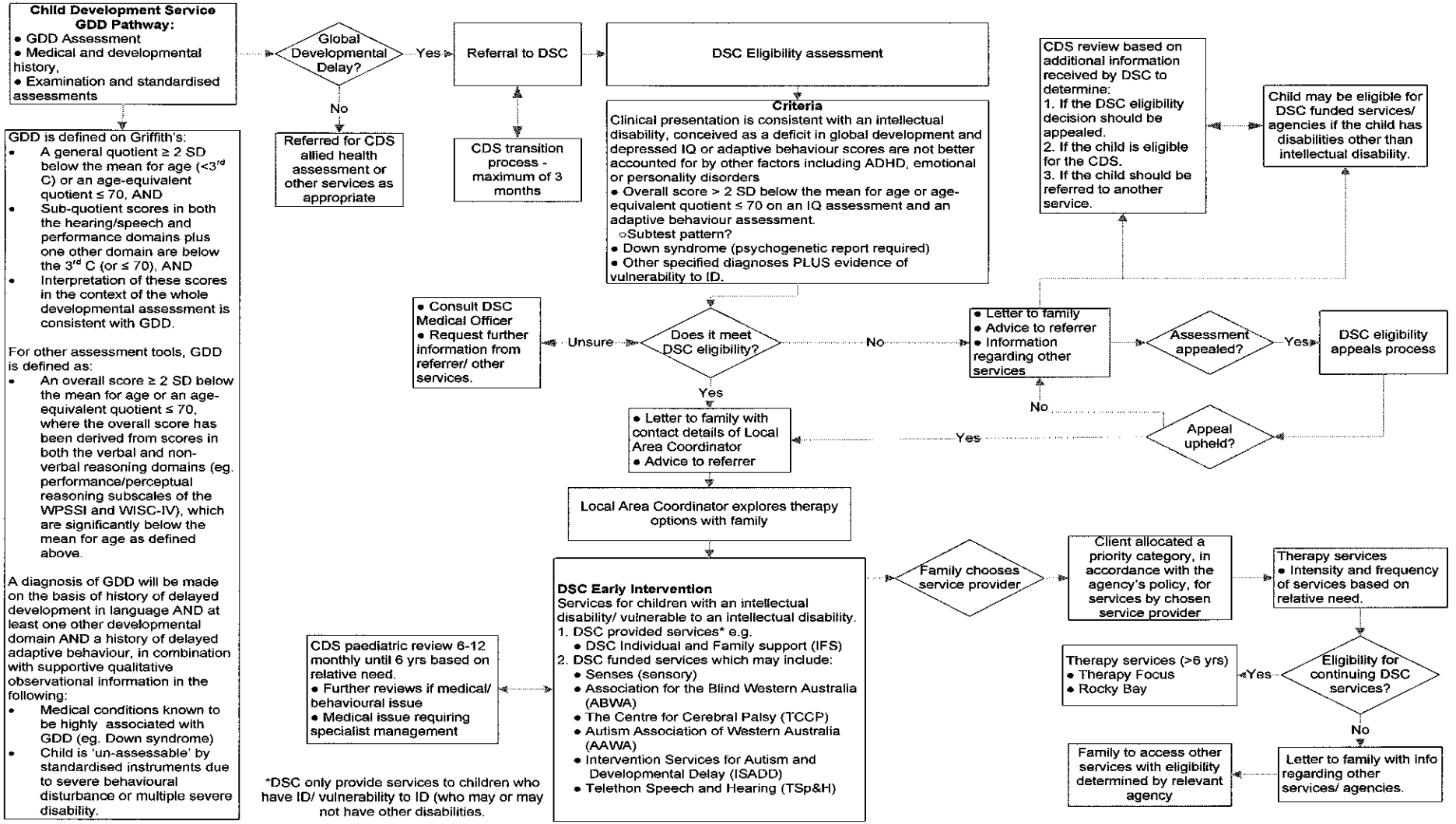

Multi disciplinary team based assessment
Social Worker
Paediatrician and occupational therapist – ideally concurrently
Clinical psychology assessment indicated by the following concerns:
Attachment difficulties
Anxiety/ depression and/or other mental health issues
Developmental trauma
Speech pathology assessment indicated by the following concerns:
School psychologist report – low language scores, or reported language difficulties
NAPLAN - reading, writing or grammar difficulties
WRAT
PAQ
Teacher report - poor comprehension/difficulty following instructions
Physiotherapy assessment indicated by the following concerns:
History of developmental delay - motor skills for age
Poor motor control performance for age (eg DCD, dyspraxia)
Avoidance of physical play tasks
Uncontained behaviour in open setting
Assymetry in movement.
Home visit
Consider family function assessment, parental management issues, and parent-child relationship issues.
Interpret SDQ
Tools
PSI
Parent Problem Checklist
Parenting Scale
DAS Scale
ADAS
Refer to internal and/ or external services and agencies
Yes
No
Confirm multidisciplinary assessment required?
Paediatrician
Occupational therapist
Clinical psychologist
Speech pathologist
Physiotherapist
History and examination
Interview/ liaison with other people/ services to consider pervasiveness of presenting difficulty
Interpret SDQ
Functional assessment
Consider visual acuity and audiology assessment
Tools
Conners/ SWAN/SNAP/ Massachusetts Q
PSI
Achievement tests eg WRAT
CBCL
History and assessment.
Consider sensory processing issues, fine motor difficulties, attention problems, ADLs, functional competencies, self regulation skills.
Interview/liaison with other people/services to consider pervasiveness of presenting difficulty
Tools
Assessment of environmental factors including classroom function, e.g. PRPP, SLI - school version, AMPS – school, SFA, PEGS
Assessment of Task performance, e.g. Bruininks, VMI, M-FUN, SP including supplementary tests
History and observation
Consider emotional dysregulation/ mental health issues/ attachment problems
Interview/liaison with other people/services to consider pervasiveness of presenting difficulty
Interpret SDQ
Functional assessment
Tools
PSI
Social skills questionnaire
Adaptive behaviour tests – Vineland, ABAS
IQ tests - WISC IV, Leiter-R, WPPSI-III
Depression inventory
Anxiety scales
Achievement tests eg WIAT
CBCL
History and observation
Consider expressive/ receptive language delay/ disorder
Phonology/ fluency
Interview/liaison with other people/ services to consider pervasiveness of presenting difficulty
Tools
CELF-IV
History and observation
Consider sensory motor difficulties, neuromuscular issues, biomechanical issues, core stability/postural control, motor skills competencies.
Interview/liaison with other people/services to consider pervasiveness of presenting difficulty
Tools
Movement ABC2 (6-16 years)
NSMDA
MAND
Social Work Report
Case conference.
1.Consider:
Individual and/ or group strategies
Urgent family needs
Prioritisation
2. Review assessment plan.
Consider differential diagnosis/ co-morbidity
Speech and language disorders, anxiety disorders, mood disorders, developmental trauma, learning difficulties, developmental coordination disorder, sensory processing difficulties, family functioning, FASD


Diagnostic formulation involving clinician discussion
Review case manager
Multi disciplinary report
Meets formal ADHD diagnostic criteria/ at risk of ADHD diagnosis?
Yes
No
Refer to internal and/or external services and agencies
Case management meeting at CDS centre and/or school site (within 8 weeks of assessment)
All clinicians, family and school
Case summary feedback
Determine family goals
Assign group or individual management programs (single or multi-disciplinary)
Review investigations and medical/ medication management needs
Consider specific group management eg parenting program about helping your child with ADHD (6 sessions, being developed)
Allocate team review date within 6 months of case management meeting
Liaison with school psychologist, deputy principal and teachers
Refer to discipline specific pathways as appropriate
Team review
Consider other interventions
CBCL/PSI/Conners
Review medication requirement for those with formal ADHD diagnosis after parenting program
Consider discharge from team and/or individual disciplines
Transfer case management as appropriate
Consider referral to Complex Behaviour Teams
Refer to internal and/or external services and agencies
Ongoing management including individual discipline pathways and school liaison
Emergent problems and comorbidity management
12 monthly case management or as required

Department of Health. Response to questions from the Education and Health Standing Committee Inquiry into Child Health Screening – April 2009.

Attachment 4: Child Development Service/ Disability Services Commission pathway for children aged 0 – end of pre-primary with global developmental delay

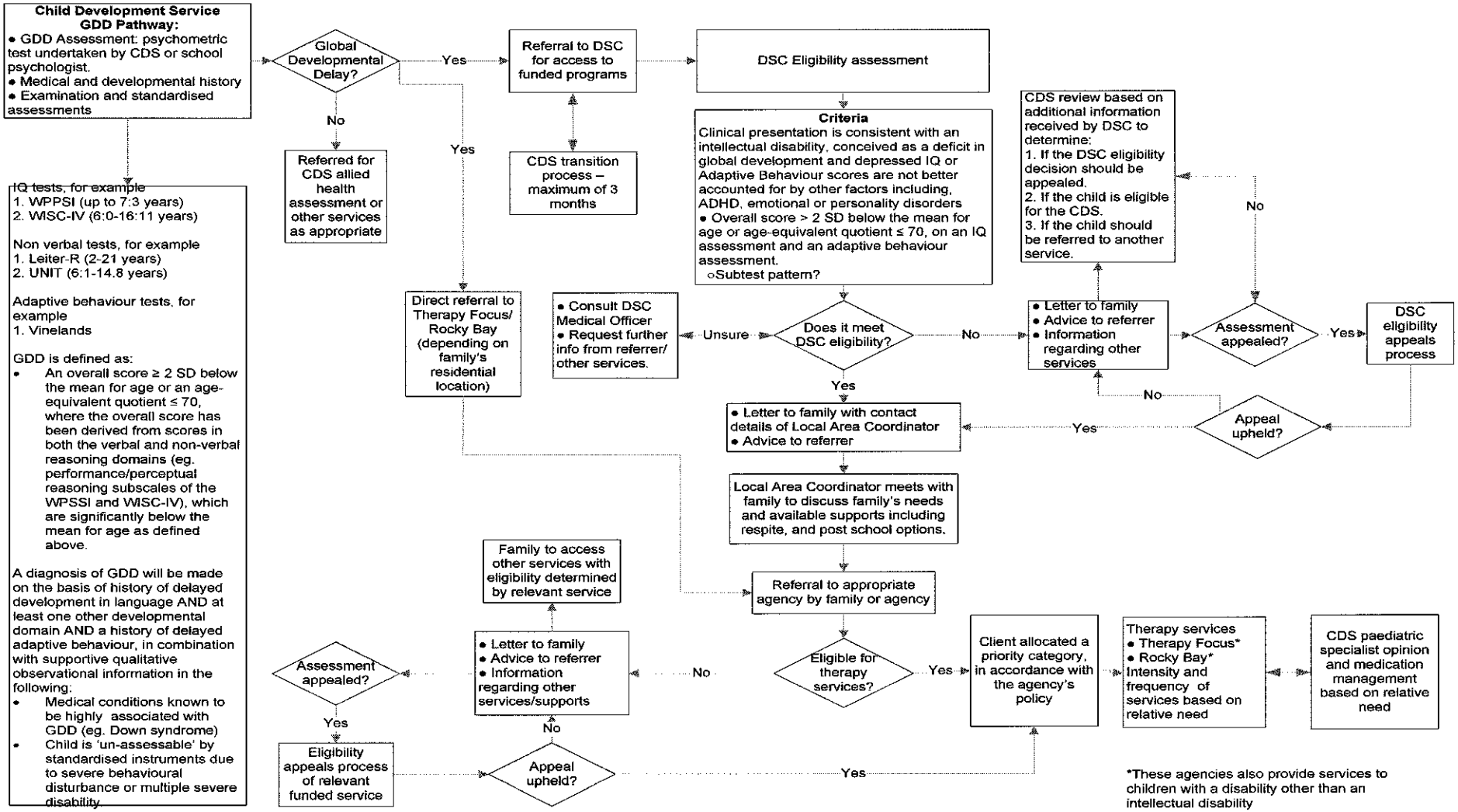
CDS/DSC Global Developmental Delay (GDD) Service Pathway: 0 - end of pre primary



Department of Health. Response to questions from the Education and Health Standing Committee Inquiry into Child Health Screening – April 2009.

Attachment 5: Child Development Service/ Disability Services Commission pathway for school aged children with global developmental delay and intellectual disability

CDS/DSC Global Developmental Delay (GDD)/ Intellectual Disability Service Pathway: School aged children



Attachment 6: Child Development Service/ Disability Services Commission pathway for children aged 0 – end of pre-primary with Autism Spectrum Disorder (ASD)

CDS/DSC Autism Spectrum Disorder (ASD) Service Pathway: 0 - end of pre primary