

**CHILD HEALTH SCREENING
AND SURVEILLANCE:
SUPPLEMENTARY DOCUMENT –
CONTEXT AND NEXT STEPS**

Prepared by the Child and Youth Health Intergovernmental Partnership (CHIP), a subcommittee of the National Public Health Partnership, in response to the National Health and Medical Research Council report *Child Health Screening and Surveillance: A Critical Review of the Evidence*, completed in February 2002

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Purpose

The report *Child Health Screening and Surveillance: A Critical Review of the Evidence* (February 2002), has now been endorsed by the National Health and Medical Research Council (NHMRC) for public release. The report is available on the NHMRC website at <http://www.nhmrc.gov.au/publications/synopses/ch42syn.htm>.

This paper, which is a companion paper for the report, provides the context for the Review and outlines the next steps in taking the work of this Review forward. It has been developed by the National Public Health Partnership subcommittee - Child and Youth Health Intergovernmental Partnership (CHIP). At the request of the National Public Health Partnership, CHIP is beginning to formulate a National Child Public Health Strategy and Action Plan. A key operational component of this Strategy and Action Plan will be the development of mechanisms for the prevention, early detection and early intervention of child health problems, using information from the Review and other international literature.

A range of organisations have contributed to this paper including the Commonwealth and State and Territory Governments, the Australian Institute of Health and Welfare, the Centre for Community Child Health and the National Community Child Health Council.

Introduction

Child health screening and surveillance was initially considered in 1993 by NHMRC and a report was published *Review of Child Health Surveillance and Screening* (AGPS 1993). The 2002 Review was initiated by the Commonwealth Department of Health and Ageing and managed through a Steering Committee of the Health Advisory Committee of the NHMRC. The 2002 Review looks at the available national and international clinical evidence for some child health screening tests. A summary of the diseases and conditions considered and the Review report recommendations are at [Attachment A](#).

For the screening topics considered, the Review found that for the general Australian child population¹:

- there is insufficient available evidence to make recommendations for or against many screening tests (14 cases);
- there is fair or good evidence that some screening tests are not effective (11 cases); and
- there is fair or good evidence that some screening tests are effective (4 cases being congenital hypothyroidism, cystic fibrosis, neonatal hearing and PKU).

¹ The recommendations may not apply to Australian sub-populations with different demographics and risk factors for diseases and conditions. In particular they do not specifically address the additional health needs of Aboriginal and Torres Strait Islander people.

This outcome raises some important issues and questions in relation to implementing or continuing effective screening and surveillance practices. The Review notes that although the evidence does not necessarily support screening in some cases, early detection of child health problems and their risk factors is beneficial. However, early detection needs to be linked with early interventions to prevent poor health and well-being outcomes later in life. Further work is required to determine the role of screening and other activities to assist with the early identification and intervention of children with additional health needs such as Aboriginal and Torres Strait Islanders and those from vulnerable families.

The Review concludes that early detection of health and other problems in children is a worthy goal and that there is a need to re-conceptualise how best to provide a quality early detection system for child health problems that also incorporates links to quality interventions. Such an approach would incorporate health promotion, prevention, management, treatment and monitoring and evaluation. This paper outlines such a framework and will be further explored by the NPHP in developing an overall national child public health strategy.

The evidence

There is substantial national and international evidence that comprehensive early intervention programs for children and their families have long term benefits for physical and mental health, educational achievement and emotional functioning. This paper does not attempt to summarise this evidence, which can be reviewed in publications such as Barker (1992), Keating and Hertzman (1999), McCain and Mustard (1999), Cohen and Radford (1999), Shonkoff and Phillips (2000) and Acheson et al (1998).

Key points from the literature indicate:

- brain development in the period from conception to six years sets a base for subsequent learning, behaviour and health over the life cycle;
- biological embedding of early life experiences contributes to socioeconomic gradients in health and wellbeing outcomes and affects subsequent responses to stressful circumstances;
- low birthweight and poor infant nutrition are associated with chronic disease later in life;
- social disadvantage has a detrimental effect on health throughout the lifespan;
- children who are better nurtured in early life are healthier and do better in adult life;
- health problems in children reflect a complex interaction between children and their family as well as their social, environmental, cultural and economic circumstances;
- early childhood development programs appear to reduce a range of risk factors (or enhance a range of protective factors) and have the potential to influence outcomes related to physical health, child abuse, crime, drug use and mental health problems.

A number of reports have considered summaries of the known risk and protective factors for children, eg Centre for Community Child Health (2000). These are summarised at Attachment B. Key risk factors include low birth weight, abuse or neglect, family instability and socioeconomic disadvantage, and key protective factors preventing adverse outcomes include social skills, breastfeeding, consistent parenting and positive social networks.

These factors would form part of an early detection system with complementary intervention programs aimed at reducing risk factors and increasing protective factors for child health and well being. Tools and effective models on which to base such a system will need to be identified. The relationship between screening, surveillance, early detection and interventions would also need investigation.

In relation to early childhood interventions, there have been a number of papers and reports including Karoly et al (1998), Barbour (2000), Centre for Community Child Health (2001), Linke (2001). These papers and reports highlight a number of common characteristics of successful and effective interventions including:

- comprehensive, intersectoral and flexible;
- community based and within the context of family and community;
- are based on prevention and are planned for the long term;
- adequately resourced and take account of capacity building for sustainability;
- maximise continuity of care/services through multidisciplinary teams.

Screening, surveillance and early detection – what is the distinction?

The Review includes a chapter on definitions (page 19) and a chapter on the clarification of the terminology (page 220). For “screening”, it is suggested that this term be used for situations where a “pass/fail” testing for unrecognised diseases or conditions identifies individuals who are more likely to have the disease or condition. A screening test is generally quick to administer and is not intended to be diagnostic. Further testing is necessary to confirm a diagnosis. It is also important that the outcomes of screening tests and diagnosis are matched with appropriate treatment/management, which could substantially alter the outcome for that child. The Review notes screening tests can work well for very defined health conditions.

The Review notes that the term “surveillance” is subject to a number of interpretations. In the *Dictionary of Epidemiology*, surveillance is defined as “continuous analysis, interpretation, and feedback of systematically collected data ... observing trends in time, place and persons..” (Last 1995). The term “child health surveillance” is often understood by child health professionals to include monitoring of growth and development, screening tests and preventative activities including vaccination, health education, advice and support. Hall (1996) uses the term “child health promotion” to broaden the scope and restricts “child health surveillance” to secondary prevention activities such as screening.

Surveillance can be at the individual level, such as monitoring a child’s growth and development over time, and using this information to treat where necessary. Surveillance can also be at the population level to monitor the changes or trends in prevalence and/or incidence of a condition in that population, thereby enabling assessment of the need for population based interventions. Surveillance data may come from screening programs or from other sources such as surveys. The Review report suggests that there should be a restricted definition of surveillance (page 222) and for some conditions, such as overweight and hypertension, surveillance could be more appropriate than the pass/fail screening test. The report notes that evidence in this area “is almost non-existent”.

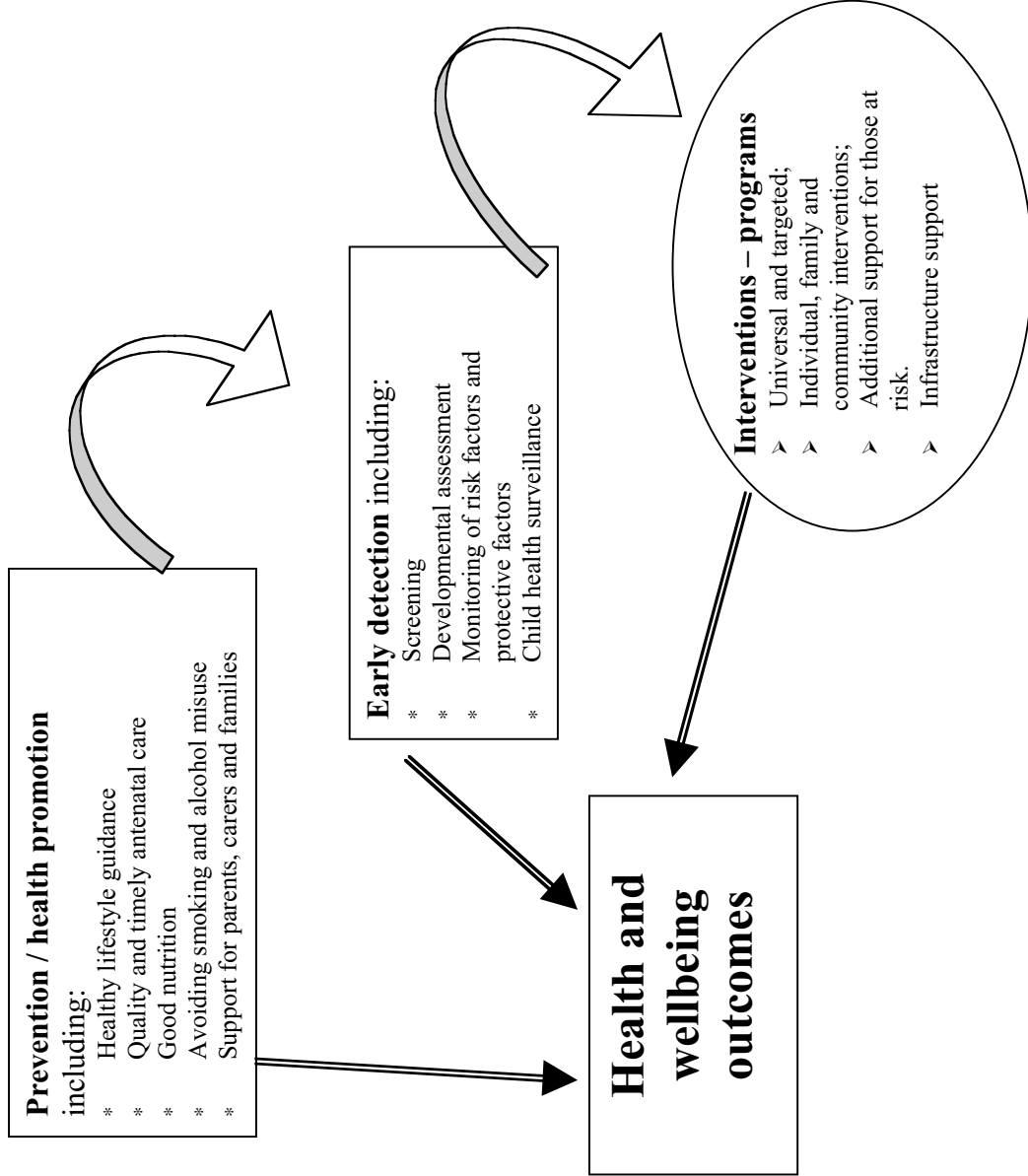
Summary of context

Given the complex and interrelated nature of child health and development, there is a good case for a system of prevention and early detection that encompasses and goes beyond screening and surveillance for improving child health outcomes. For many early childhood risk factors it may not be possible to have simple screening tests or well defined surveillance: for example, risk factors associated with child social development, language, behaviour and family psychosocial environment. Poor outcomes in these areas affect the child's health outcomes as well as their health in adulthood. The Review notes that these are complex areas that cut across sectors other than health and where variables exist on a continuum.

Early detection would incorporate the identification of risk and protective factors for health and well-being outcomes such as those outlined in Attachment B. This approach would be in line with the principles of health promotion taking account of the social determinants of health.

The Review report highlighted some areas where there was insufficient evidence to recommend a specific screening test. However, this does not mean that some form of screening, surveillance or early detection in these areas is unwarranted. Ideally, there should be an integrated system that incorporates prevention, screening, surveillance and early detection with effective interventions to improve outcomes. A preliminary summary mapping of these areas follows.

Preliminary map of early detection within Public Health



Important considerations

Principles and themes

- Life course perspective
- Attention to risk and protective factors, including social determinants of health
- Partnership and collaboration
- Attention to high needs and inequity
- Evidence-based action

Approaches for initiatives

- Intersectoral action
- Building community capacity
- System integration
- Participation by parents and carers
- Access, efficacy, effectiveness
- Settings approach
- Culturally appropriate and family centred

Support systems - infrastructure

- Workforce capacity building
- Information systems
- Monitoring and reporting of key indicators and outcomes
- Sustainable resources
- Evaluation/ Review of activities and feedback

Early detection and its role

Various reports have emphasised the principles for maximising effort to improve child health and well-being. Examples of these are on the right side of the figure above. In relation to early detection, the important principles include:

- ensuring that early detection covers health, development and well-being aspects of children, their family and environment;
- providing continuity of care between early detection and effective interventions;
- taking into account lifecourse and pathways to health outcomes;
- ensuring that there are sufficient resources and capacity to undertake the early detection and support referral for interventions;
- ensuring participation and involvement of parents in assessment and intervention; and
- providing universal programs with additional services for high risk children /families/ communities. All children and families are likely to benefit from contact with a universal platform of health, childcare and educational services.

The important message is that early detection is an essential part of ensuring healthy outcomes for children. However, detection must be followed up with effective interventions. The settings for interventions in the early years cover those in the health, education and childcare sectors.

Some questions that could be further explored in jurisdictional workshops are:

- What are the risk factors or indicators (health and social) that should form part of an early detection system?
- What information should be reported and shared across sectors and how could this happen?
- What are the most effective models for early detection and intervention for children, families and/or communities to receive the support, advice, treatment etc to improve health outcomes?
- What is the balance between universal and targeted programs?
- What are the special needs for the children in the most vulnerable groups?
- How can different service sectors avoid duplication and fill gaps?
- What are the contextual factors that contribute to effective links between early detection and interventions? (eg workforce protocols, availability of services)
- What are the implications for existing early detection and intervention programs? Expand? Modify?
- What are the workforce skills required for early detection and how can these be implemented?
- What processes could be undertaken to develop and by whom?

Next steps

There is now substantial evidence that preventive investment in the early years of life has significant benefits for health and well-being outcomes of children and later in adulthood. Such preventive investment would ideally include an integrated approach including prevention initiatives, early detection, intervention, monitoring and evaluation. Screening and surveillance would form a part of this system.

The Child and Youth Health subcommittee of the National Public Health Partnership will be further exploring the concept and development of an early detection system and what this would encompass. This will be in the context of a national approach to a public health strategy for child health. Principles such as intersectoral activity, partnership, equity and sustainability will be important in any re-orientation of policies and services.

This is a substantial piece of work and needs to be progressed in close consultation with key stakeholders including Commonwealth, States /Territories and local governments, NGOs and parent groups. The National Public Health Partnership (NPHP) can play a key role in facilitating this consultation. A summary of the Commonwealth, State and Territory policies relating to child health are at [Attachment C](#).

The Review report has been made available to all State and Territory Health Authorities and issues raised by them have been included in the consideration of future effort.

Suggested actions

The NPHP suggests that the next steps could be to further develop an integrated approach to early detection of child health problems within the broader context of a national child health strategy. It is well placed to undertake broad consultation.

The suggested action is for the NPHP to develop a discussion / options paper that outlines appropriate and feasible models for an early detection system. Workshop(s) would be one approach to facilitate dialogue and discussion on these issues. Some of the considerations for this paper could include:

- developing generic principles and criteria/indicators for early detection and monitoring of development, health and wellbeing problems in children;
- identifying the type and scope of information required for providers of children service to aid early detection of development, health or wellbeing problems (this may consist of protocols, criteria for service provision and/or guidelines and instruments for assessment);
- identifying the mix of services and support families need to enable effective and enjoyable promotion of development, health and wellbeing of their children;
- developing a linked system of information/access/referral across and between stakeholders; and
- putting in place skills development and training for child/community health nurses and others in the community concerned with early detection and intervention for healthy childhood development and wellbeing.

Summary of recommendations from the Review report

1. ATLANTO AXIAL INSTABILITY

Insufficient evidence to make a recommendation for or against screening.

Recommendations

Implementation of a formal screening program for atlanto-axial instability in children with Down Syndrome is not recommended.

2. CONGENITAL ADRENAL HYPERPLASIA

Insufficient evidence to make a recommendation for or against screening

Recommendations

Implementation of a universal screening program for congenital adrenal hyperplasia is not recommended at this time.

3. CARDIAC DISEASE

Insufficient evidence to make a recommendation for or against screening

Recommendations

Although there is little firm evidence to support the value of screening, we recommend continuation of newborn and 6 week cardiac examination, *provided* it is in the context of an adequate early detection program or system.

4. CONGENITAL HYPOTHYROIDISM

Good evidence to make a recommendation for screening.

Recommendations

That screening programs continue. That the impact of adding multiple new conditions to newborn screening programs is monitored, to ensure that the quality of existing congenital hypothyroidism programs is not threatened.

5. CYSTIC FIBROSIS

Fair evidence to recommend screening

Recommendations

Continuation of current neonatal screening programs for cystic fibrosis is recommended.

6. DEVELOPMENTAL DYSPLASIA OF THE HIP

Insufficient evidence to make a recommendation for or against screening by clinical examination

Fair evidence to recommend against screening by ultrasound

Recommendations

Universal ultrasound screening for developmental dysplasia of the hip is not recommended.

Although there is little firm evidence to support the value of clinical screening for developmental dysplasia of the hip, we recommend continuation of newborn and 6 week examination using the Ortolani and Barlow maneuvers, *provided* it is in the context of an adequate early detection program or system.

7a. CONDUCTIVE HEARING LOSS

Good evidence to recommend against screening

Recommendations

Universal screening programs to detect otitis media with effusion are not recommended.

7b. PERMANENT CHILDHOOD HEARING IMPAIRMENT

Fair evidence to recommend universal neonatal hearing screening

Insufficient evidence to make a recommendation for or against genetic screening

Insufficient evidence to make a recommendation for or against school entry screening

Good evidence to recommend against distraction testing

Recommendations

1. Hearing screening before discharge for all NICU neonates and preferably all neonates admitted to special care nurseries for more than 48 hours is now accepted best practice, and should become a high priority at State level.
 2. The evidence supports some form of neonatal screening for hearing impairment. However, to be successful implementation packages require careful trialing for the situation in which they will be used. Pilot projects should be mounted to trial the feasibility of different models of infant screening, paying careful attention to processes, acceptability and costs, in both large and small communities. These should include settings other than major metropolitan hospitals (already under study in West Australia.) Models to consider could include at-risk screening with and without genetic screening, hospital based UNHS, and community based UNHS.
 3. An adequately funded economic analysis should be undertaken urgently to examine costs of different models (including genetic screening) of infant hearing screening for Australian settings. This should take into account likely achievable coverage and program sensitivity for each model at a population level.
 4. A national forum should be convened to discuss possible infant screening models in terms of logistics, coverage, acceptability, program maintenance and quality, minimum standards, data collection/reporting and outcome analysis at a population level for each state and for Australia as a whole. This should take results of the economic analysis into account. Models to consider could include at-risk screening with and without genetic screening, hospital based UNHS, and community based UNHS.
 5. Final decisions about implementation of universal neonatal screening programs in Australia should be guided by the above information when available.
 6. If the above processes lead to an agreement about proceeding with a specific model(s), planning and implementation would ideally be overseen by a national body set up for this purpose. This could draw on the experience of BreastScreen, the most recent new screening program implemented in Australia. Formal channels of communication with the UK, US, and Canada should also be established.
 7. Careful population-based documentation of a wide range of outcomes for children with permanent childhood hearing impairment should commence now, against which to assess the benefits of new programs if/when introduced.
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8. HYPERTENSION

Fair evidence to recommend against screening

Recommendations

Implementation of screening programs to detect hypertension in well children is not recommended.

9. IRON DEFICIENCY

Fair evidence to recommend against screening

Recommendations

It is recommended that primary health care professionals provide parents with age-appropriate dietary information congruent with the Australian Dietary Guidelines to assist in the prevention of diet-related iron deficiency in infants and children.

Health care professionals working in areas of lower socioeconomic status, where the prevalence of iron deficiency is likely to be higher than average, should be alert to the possibility of iron deficiency in their child patients and assess iron status based on risk factors (uncorrected iron deficiency in the mother during pregnancy, prematurity, age <24 months, introduction of cow's milk as the main milk source before 12 months of age, consumption of >600ml of cow's milk per day).

Children living in areas prone to lead toxicity and (as per current NHMRC guidelines) children with blood lead levels >0.72µmol/L should be tested for iron deficiency.

10. LEAD TOXICITY

Fair evidence to recommend against screening

Recommendations

Implementation of screening programs to detect lead toxicity in well children is not recommended.

We recommend five yearly surveys of representative samples of children, particularly those aged 1-4 years, in high and low lead exposure areas to document the prevalence of lead toxicity. We note that a similar recommendation was made in the 1993 NHMRC Review of Child Health Surveillance and Screening.

Health care professionals working in areas where the prevalence of lead toxicity is likely to be higher than average should be alert to the possibility of lead toxicity in their child patients.

Public health preventive and management strategies are likely to be most effective in further reducing childhood lead levels.

11. PHENYLKETONURIA

Fair evidence to recommend screening

Recommendations

Continuation of current universal newborn screening programs for phenylketonuria is recommended.

Screening programs should incorporate population based monitoring and management programs for women of childbearing age, aiming to systematically prevent avoidable intellectual disability in their infants. Such monitoring should meet defined, stringent quality and reporting standards, and include reporting of long term outcomes for these children.

12. SCOLIOSIS

Good evidence to recommend against screening

Recommendations

Implementation of new scoliosis screening programs is not recommended.

In communities where screening programs are already in place, continuation of these programs should be reassessed.

13. UNDESCENDED TESTES

Insufficient evidence to make a recommendation for or against screening

Recommendations

Although there is little firm evidence to support the value of screening, we recommend continuation of specific examination of the genitalia at the newborn and 6 week checks, *provided* it is in the context of an adequate early detection program or system.

14. URINALYSIS

Fair evidence to recommend against screening

Recommendations

Screening programs of urinalysis in well children are not recommended.

15. VISION

Insufficient evidence to make a recommendation for or against neonatal screening

Fair evidence to recommend against screening for risk factors for amblyopia

Insufficient evidence to make a recommendation for or against preschool visual acuity screening

Fair evidence to recommend against colour vision screening

Recommendations

1. Although there is little firm evidence to support the value of screening, we recommend continuation of specific examination of the eye at the newborn check, *provided* it is in the context of an adequate early detection program or system.

16. DENTAL HEALTH

Insufficient evidence to make a recommendation for or against screening

Recommendations

Screening programs for dental caries in the deciduous teeth are not recommended.

We recommend regular surveys to document the prevalence and severity of caries in preschool and school aged child populations.

Public health efforts should focus on preventive dental health in preschool and school aged children. This should be given higher priority than screening efforts.

17. DEVELOPMENT

Insufficient evidence to make a recommendation for or against developmental screening

Recommendations

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 inquiry at one point of time.

It is not recommended that screening programs for developmental delay be implemented at this stage.

Until there is evidence that alternatives to developmental screening programs function better, existing programs should be reviewed to ensure that adequate tools and processes are used. Community programs of developmental screening should use tools that have been demonstrated to have adequate psychometric properties (sensitivity and specificity greater than 70%). Community programs of developmental screening should allow for intervention or assistance of some degree for children who fail screening, but who pass diagnostic tests. Individualised checklists of milestones should not be used as developmental screening tests.

18. LANGUAGE

Insufficient evidence to make a recommendation for or against screening

Recommendations

Implementation of formal screening programs for language delay is not recommended at this stage.

Further research is urgently needed to better quantify early predictors of later language delay, and to confirm promising results from early, community-based secondary prevention programs.

19. HEIGHT

Insufficient evidence to make a recommendation for or against screening

Recommendations

New growth screening programs outside the research context are not recommended.

Should retrospective review suggest that age of diagnosis of growth hormone deficiency and Turner syndrome are rising following cessation of height monitoring, further study of the usefulness of height measurement as a screening tool should be undertaken.

Regular, systematic population-based surveys of height are recommended to monitor secular trends in height for the whole population and for particular subgroups.

20. WEIGHT

Insufficient evidence to make a recommendation for or against screening for failure to thrive

Fair evidence to recommend against screening for obesity

Recommendations

Routine weight monitoring at birth, at 6-8 weeks, and at 8-12 months is recommended as part of routine clinical care. This does not however constitute a screening program.

Attachment B**Risk and protective factors for child health and well-being**

The following information is compiled from Centre for Community and Child Health (2000), National Crime Prevention (1999), Cohen and Radford (1999), Zubrick et al (2000), Commonwealth Department of Health and Aged Care (2000), Shonkoff and Meisels (2000).

Risk Factors from antenatal period to about 5 years.

| Child characteristics | Parents and their parenting style | Family factors and life events | Community factors |
|---|--|--|--|
| Low birth weight Prematurity Prenatal exposure to toxins or infections Poor maternal nutrition Prone sleeping position Birth injury Disability Low intelligence Chronic illness Delayed development Difficult temperament Poor attachment Poor social skills Poor problem solving Disruptive behaviour Hazardous environment Unsupervised play Impulsivity Poor self esteem Alienation | Single parent Young maternal age Postnatal depression or other mental illness Drug and alcohol misuse Parental tobacco smoking Harsh or inconsistent discipline Lack of stimulation of child Lack of sensitivity, warmth and affection Criminality Separation from or rejection of child Abuse or neglect Poor supervision / involvement Lack of parenting knowledge | Family instability, stress, conflict or violence Marital disharmony Poverty Divorce Disorganised Large family size/rapid successive pregnancies Absence of father Very low level of parental education Social isolation Long term unemployment War / natural disasters Death of family member Family history of ADHD Frequent relocations | Socioeconomic disadvantage Housing and urban conditions – unhealthy cities (eg poor sewage, low water quality, limited access to nutritious food) Neighbourhood violence and crime Lack of support services Social or cultural discrimination Community behaviour norms |

Notes:

- as risk accumulates so does effect especially > two risk factors present;
- the variation between individuals in vulnerability and resilience to these risk factors is high.

Protective factors

from antenatal period to about 5 years

| Prenatal and child characteristics | Parents and parenting style | Family factors and life events | Community factors |
|---|--|---|---|
| Good antenatal care and maternal nutrition Breastfeeding established early Full immunisation Social skills Secure attachment Easy temperament, active, alert and affectionate At least average intelligence Attachment to family Independence, self help Good problem solving skills Ambition Positive self concept Achievement at school | Maternal health and well-being is good Healthy lifestyle Reasonable awareness and use of health and community services Competent stable care Positive attention from both parents Supportive relationship with other adults Positive communication between parent and child Fathers involvement in parenting Mother's education and competence | Family harmony and stability Consistency of primary carers Nurturing environment Positive relationships with extended family Small family size Spacing siblings > 2yrs | Supportive social relationships and networks Participation in community activities Family friendly work environments and culture Cultural identity and pride |

Questions to consider in developing an early detection approach.

What factors foster adaptive behaviour for parents?

What factors encourage resilience in children (good outcome despite risk factors)?

Which circumstances lead to resilience in a situation of high risk?

What interventions promote exposure to and uptake of these factors and circumstances?

Commonwealth, State and Territory policy or strategies relating to child health

What special contribution can the health portfolio make?

The health portfolio has a specific contribution to make to prevention, early detection and early intervention for child health and wellbeing. It has a particular role in improving health outcomes for children and young people. This is especially the case during pregnancy and throughout the early years of children's lives. This period is identified as a time when families look directly to health professionals and health services as a first point of contact for advice, service and support.

In Australia, responses have traditionally been concentrated on problems late in causal pathways (eg addressing issues such as binge drinking, smoking, heroin overdose, and teenage pregnancy). There is a need to realign responses to include intervention much earlier in life and much earlier in causal pathways.

Policy context

Commonwealth

At the Commonwealth level the health portfolio has implemented some important initiatives for children, notably through a national program of immunisation and a child nutrition strategy including breastfeeding. However, the health system's response has been somewhat distant from other related family/children services.

Several Commonwealth portfolios have strategies and models that address the development, health and wellbeing of children and young people, notably *Strengthening Families and Communities* and *Youth Pathways* (Department of Family and Community Services) and *Pathways to Prevention* (Attorney Generals Department).

Renewed attention to development, health and well-being of children has seen the formation of a cross-portfolio taskforce to consider issues such as the evidence-policy linkage and integration of programs across the portfolios of health, family/community services, education and crime. This taskforce is developing coordinated effort for Australian children at the Commonwealth level. The Department of Health and Ageing is also developing a policy statement on child health including consideration of how to best coordinate effort within the health portfolio.

State and Territory

The States and Territories have a range of policies and strategies in place, or being developed, for children's health. For example NSW has a child health policy document *The Start of Good Health – improving the health of children in NSW* which is related to the *Families First* policy framework developed in the NSW Premier's Department. Queensland has recently finalised a *Strategic Policy Framework for children's and young people's health*. In the main, States and Territories are seeking to re-orient their child and youth services to ensure better integration and coordination, including screening practices and related services. Workforce, monitoring, implementing change and addressing the health of Indigenous children are key considerations in integration and coordination of services.

A summary table of the State and Territory child health policy and strategy documents is below and includes a short statement of the policy goals with comments on any specific mention of screening, surveillance and/or early detection. Some States also have policy documents on maternal health, women's health and parenting policies. These have not been included although there are clear links.

A national approach for early detection will need to take into account and build on these existing initiatives to strengthen action.

| | |
|---|--|
| <p>NSW</p> <p>a) <i>Families First</i> (1999)</p> <p>b) <i>The Start of Good Health</i> (1999)</p> | <p>This is a coordinated cross-portfolio strategy to increase the effectiveness of early intervention and prevention services in helping families to raise healthy, well-adjusted children.</p> <p>The strategy provides direction and guidance to the health system to ensure the provision of appropriate and effective health services for children and their families. The document outlines a number of key interventions for improving the health of children. Surveillance, screening and early detection are not specifically discussed.</p> |
| <p>VIC</p> <p><i>Best Start</i></p> | <p>This is a prevention and early intervention pilot project that aims to improve the health, development, learning and well-being of Victorian children up to 8 years. It is jointly auspiced by the Dept of Human Services and the Dept of Education, Employment and Training. The information available briefly describes the demonstration project, which includes a "universal early years service platform" and monitoring outcomes. Surveillance, screening and early detection are not specifically discussed.</p> |
| <p>QLD</p> <p><i>Draft Strategic Policy Framework for Children's and Young People's Health 2001-2006</i></p> | <p>This framework aims to give children the best start and support the nurturing role of families; promote healthy growth and development in safe, supportive environments; and ensure quality treatment, management and maintenance.</p> <p>The document contains a model for health services for children and young people including screening for appropriate discharge pathways following birth; surveillance and screening for health and wellbeing and school entry screening. The intention is to reorient screening practices to facilitate effective early detection and intervention.</p> <p>It is also intended to review child health information requirements to effectively monitor outcomes.</p> <p>One of the strategic priorities is to develop and implement evidence-based practice guidelines service protocols, clinical pathways and interventions for treatment and management conditions and diseases.</p> |

| | |
|---|--|
| <p>SA</p> | <p>South Australia will be releasing a Child and Youth Policy in 2002. SA has commissioned review papers including:</p> <ul style="list-style-type: none"> * <i>A Healthy Start to Life- a review of Australian and international literature about early intervention</i> J.Barbour August 2000. * <i>What works – a literature review of the evidence for the effectiveness for parenting strategies</i> P. Linke June 2001 * <i>Every Parent – a policy framework and implementation strategies for delivery of parenting programs by Child and Youth Health.</i> P Linke July 2001 |
| <p>WA <i>New Vision: Community health services for the future (2000)</i></p> | <p>is a new policy direction of effective prevention, health promotion and early intervention to achieve healthy people and healthy communities. This includes a focus on early life and life course determinants. Triple P parenting program pilot sites have been established.</p> |
| <p>TAS</p> | <p>Tasmania is currently developing a whole of government approach to child health and well-being. A policy document is anticipated this year.</p> <p>Tasmania has included a schedule of activities around early years intervention in the draft Commonwealth-State bilateral agreements. These agreements are to establish greater collaboration within the primary health care and community care sectors.</p> |
| <p>NT Draft Children’s and Young People’s Policy (2002)</p> <p>Preventable Chronic Diseases Strategy</p> <p>Draft Policy Framework for Children’s Care and Development</p> | <p>This recognises the ecological contexts of child development and the wider determinants of health. It takes a life course approach from the early years through school-age to youth. Intersectoral and community partnerships, support to families and early identification and intervention through child health screening and other activities are prioritised. Specific activities will depend on the local health needs of children in urban, rural and remote areas. Issues of access, best practice, workforce planning and development and monitoring and evaluation are highlighted.</p> <p>Improving birth weight and infant growth and reducing childhood infections are identified as “best buys” This links with the <i>Strong Women, Strong Babies, Strong Culture</i> and <i>Growth Assessment and Action</i> programs in remote Aboriginal communities.</p> <p>A joint venture between health and education departments to form a collaborative approach to promote children’s care, development and learning.</p> |
| <p>ACT</p> | <p>ACT is currently working on a strategy towards a consolidation of child health and well-being.</p> |

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