Multidisciplinary approaches to childhood learning disabilities

The Winston Churchill Memorial Trust Fellowship project

Paediatricians provide care to children of all ages. An important component of the Paediatricians knowledge is in the area of normal growth and child development. Child development is a complex process dependent on many factors, of which only one is health. Other factors include cognitive ability, any associated learning disability, physical ability and the social environment in which the child lives. Any one of these factors can influence learning potential. Therefore it is important that the contributions of these factors are recognised and addressed. Whilst the Paediatrician may not have all the necessary skills to address all the complexities of these difficulties, he or she is frequently the first professional to have contact with the child and their family. When this occurs, it is important that the Paediatrician is able to assist the family and act as an advocate for the child.

This Fellowship project recognises the important role that a Paediatrician has when consulted to evaluate a child suspected of having developmental problems in the preschool years, or learning problems in the school years. A multidisciplinary approach to childhood learning issues is the most appropriate way to obtain an assessment and recommend strategies to address learning issues. The Medical role in assessment of children with ‘learning difficulties’ is only one component of a multidisciplinary team approach to this problems.¹
Acknowledgements

This Fellowship would not have been as extensive and valuable without the enthusiasm, interest and support of everyone I had the opportunity to meet. In particular I wish to thank the Winston Churchill Memorial Trust for their support. I also thank Professor Euan Ross, Professor of Community Paediatrics at King’s College Medical and Dental School, London, who provided me with the opportunity to extend the United Kingdom component of the Fellowship with a Lecturing position in Community Paediatrics. Professor Ross was also an invaluable source of advice and encouragement throughout my United Kingdom stay. I also thank the numerous professionals who made me welcome during my visits and placements. These individuals include Professor Aidan Macfarlane, Dr Christopher Verity, Dr Tony Waterston, Dr Simon Lenton, Dr Zoë Dunhill, and Dr Carolyn Frazer.

I also thank my fiancé, Carlos Jimenez. Without his support and daily help, I would never have been able to start, let alone finish this Fellowship.
Executive Summary

The Winston Churchill Memorial Trust - 1997

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Project: To study multidisciplinary approaches to childhood learning disabilities

This project has been undertaken in the United Kingdom and the United States of America. To achieve the project aims, I worked with a Community Paediatric Department in South London and I visited Community Paediatricians throughout the United Kingdom. In the United States of America, I participated as an observer with the learning disabilities programmes at The Children’s Hospital, Boston. This provided an insight into the United Kingdom approach to childhood learning disabilities as well as the opportunity to observe the approaches of individual units in the United Kingdom and the United States of America to these complex problems.

Highlights:

I was fortunate to have the opportunity to work with the Community Child Health Services in the United Kingdom during this Fellowship. This provided essential knowledge and experience for this Fellowship project.

Major lessons:

There is one major lesson from this Fellowship project. Multidisciplinary collaboration is essential in the assessment and management of childhood learning disabilities. No professional can comprehensively work independently. Each professional has an important role in the overall assessment and management of learning disabilities.

Disseminate and implementation:

The learnings and recommendations from this Fellowship will be disseminated in medical, educational and social service environments. This can be effectively achieved in the forum of multidisciplinary seminars, workshops and conferences.
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<tr>
<td>DSM-IV</td>
<td>Diagnostic and Statistical Manual of Mental Disorders– fourth edition</td>
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<td>IQ</td>
<td>Intelligence quotient</td>
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<td>AD/HD</td>
<td>Attention deficit hyperactivity disorder</td>
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<td>ICD-10</td>
<td>International Classification of diseases – tenth edition</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>LEA</td>
<td>Local Educational Authority</td>
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<td>IPP</td>
<td>Individual Personalised Plan</td>
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<td>SENCO</td>
<td>Special Educational needs Co-ordinator</td>
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<td>IEP</td>
<td>Individualised Educational Plan</td>
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<td>seiph</td>
<td>South East Institute of Public Health</td>
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1. Programme

United Kingdom

Jan 6th to March 31st  Kings College Medical and Dental School as Lecturer in Community Paediatrics
Visit with Professor Euan Ross, Professor Community Child Health

April 7th - April 9th  AD/HD’97 Oxford
The First European Conference for Health and Education Professionals on Attention Deficit / Hyperactivity Disorder
Held at Christchurch College - Oxford University

April 10th - April 11th  Newcastle - visit with Dr Tony Waterston, Community Paediatrician, President of British Association of Community Child Health

April 12th - April 18th  York - Royal College of Child Health and Paediatrics Annual Scientific meeting

April 21st - April 25th  Royal Free Hospital London - visit with Professor Brent Taylor, Professor Community Child Health

April 28th - May 2nd  Bath - visit with Dr Simon Lenton, Community Paediatrician

May 2nd - May 8th  Edinburgh - visit with Dr Zoë Dunhill, Community Paediatrician

May 9th - May 12th  Aberdeen - visit to the Readen Centre

The United States of America

June 7th - July 14th  Children’s Hospital, Boston and Harvard Medical School - visit with Dr Carolyn Frazer and the 1 Learning Disability Programmes
**Meetings attended**

**January**

Friday 10th January  
British Association of Community Child Health  
Practice since Polnay. How are we meeting the health needs of the school-age child?

Friday 17th January  
Royal College of Paediatrics and Child Health  
Paediatric surveillance unit meeting

Monday 20th January  
The North London Child Health Network  
Managing the Head Injured Child and Adolescent

Wednesday 29th January  
STICCH (Senior Trainees in Community Child Health)

Friday 31st January  
First Annual South Thames (East) Region BACCH Meeting for Community Child Health Doctors

**February**

Friday 7th February  
South East Institute of Public Health  
School Exclusions

**March**

Friday 7th March  
BACCH Child Development and Disability Group  
The Evaluation of Intervention in Childhood Disability

Friday 14th March  
South East Institute of Public Health  
School Bully

Friday 21st March  
South East Institute of Public Health  
Promoting Mental Health in Pre-School Children

**April**

Monday 7th - Wednesday 9th April  
AD/HD’97 - The First European Conference for Health and Education Professionals

*Multidisciplinary approaches to childhood learning disabilities*
Tuesday 13th -Friday
18th April
Royal College of Paediatrics and Child Health
Annual Scientific Meeting York University

Multidisciplinary approaches to childhood learning disabilities
2. Introduction

My Winston Churchill Memorial Fellowship commenced in January 1997 following my arrival in the United Kingdom. From January to April 1997, I was primarily based in London at King’s College Medical and Dental School’s Department of Community Paediatrics. During this time I had the opportunity to experience Community Paediatrics as a participating multidisciplinary team member based in an underprivileged area of South-East London, in the Borough of Lambeth. During this time at Lambeth and King’s College, I had the opportunity to attend and participate in seminars and conferences applicable to Community child health and child development.

In April and May I visited Community Paediatricians and their associated multidisciplinary teams in the United Kingdom. This allowed me to expand on my initial knowledge gained from the placement with King’s College. It reinforced the importance of the multidisciplinary approach to childhood learning disabilities involving health, educational and social service professionals.

In June and July, I visited The Boston Children’s Hospital and Harvard Medical School as an observer with their numerous programmes for children with learning disabilities. This provided the opportunity to participate in multidisciplinary team assessments and contribute to discussion sessions.

The following report summarises my experiences during this Fellowship. I have included brief descriptions and definitions of the various multidisciplinary health professionals and of the wide range of childhood learning disabilities that are referred to in the body of this report. For the multidisciplinary meetings that I had the opportunity to attend in the United Kingdom, I have included a detailed summary of the presentations in the Appendixes. For each of the educational visits, I have tried to describe the aim of the visit and my impression of how this visit can be useful in the approach to childhood learning disabilities.
3. Definitions

3.1. Childhood learning disabilities

This Fellowship was to study multidisciplinary approaches to childhood learning disabilities. From the start of my Fellowship it became apparent that different health professionals have different working definitions for childhood learning disabilities. There is no strict definition that is universally adhered to by professionals in different countries and in research publications. I have therefore included a working generalisation of the term ‘childhood learning disabilities’ for this fellowship:

*A childhood learning disability is any factor that influences the child’s physical, cognitive or emotional development, which leads to impairment of the child’s ability to learn. Environmental factors, whilst not implicitly stated in this definition, are noted to be a significant contributors to emotional development.*

Alternative definitions

In preparing this report, I have come across many definitions as applied by health and education in all three countries. This highlights the lack of clarity as to what is and is not a learning disability. It also highlights why objective research and study is not readily available on this important topic.

The term ‘learning disability’ often is used interchangeably with dyslexia, specific language disorder, perceptual motor problems, attention deficit disorder and minimal brain dysfunction, as noted by SPELD. SPELD is an organisation established in New South Wales. It is an important source of support and information with respect to learning disabilities for Australian families. The term ‘learning disabilities’ adopted by SPELD describes a number of different kinds of handicaps that can lead to a discrepancy in a child’s or adult’s ability. These may include any or all of the following:

- “Problems in Processing information, - that is, registering and remembering visual, auditory, spoken or written verbal material.
- Problems in some aspect of memory (immediate memory; memory span; rote memory; memory for words, capacity for imagery; memory for sequences).
- Difficulties in understanding or using spoken language.
- Problems in visual-motor integration (these may show up in drawing or writing or any activities that demand eye-hand co-ordination or imitation of movement).
- Problems in spatial orientation (judging distance, direction, understanding concepts of right-left; learning to read maps, charts, graphs).
- Organisational problems - keeping track of details, keeping track of time.
• *Problems in attention* - maintaining attention, deploying attention, focusing attention."


An alternative description of learning disabilities is documented by Dr Melvin Levine in Nelson’s Textbook of Pediatrics. This refers to neurodevelopmental dysfunction’s as central nervous system impairments that can generate frustration and anxiety in school-aged children. Often these are associated with academic underachievement, behaviour difficulties and difficulties with social adjustment. In the United States of America, it is estimated that 5-15% of school aged children have a neurodevelopmental dysfunction.

### 3.2. Examples of Childhood learning disabilities

I have provided a general definition of childhood learning disabilities to assist the reader of this Fellowship project. The Fellowship project also refers to specific identified childhood learning disabilities frequently encountered by multidisciplinary teams.

I have approached my explanation of each disability from the Community Paediatricians perspective. Health, Educational and Social Service professionals may have different approaches to each of these disabilities. This is the essence of a multidisciplinary approach as it allows for the entire problem with all its complexities to be addressed from different perspectives.

**Cognitive impairment / Mental retardation**

Cognitive status is related to formal Intelligence Quotients (IQ), as assessed by standardised, individually administered psychometric tests. A cognitive impairment (referred to in DSM-IV as mental retardation), is qualified by a range of IQ scores. IQ scores have a statistically normal distribution with the mean IQ score equal to 100. The DSM-IV classifies mental retardation into the following categories, mild, moderate, severe and profound. The essential feature is a significant subaverage intellectual functioning accompanied by significant limitations in adaptive functioning.

Mild mental retardation is specified by an IQ score 50-55 to 70
Moderate mental retardation is specified by an IQ score 35-40 to 50-55
Severe mental retardation is specified by an IQ score of 20-25 to 35-40
Profound mental retardation is specified by an IQ score of below 20-25
An additional category of Borderline intellectual functioning describes an IQ
range as one higher than the range for Mental retardation, usually falling in the 71-84 range.³

**Specific learning impairment**

A Specific learning impairment is often referred to when a child has a significant learning disability in one area of development. Other developmental skills or academic performance are considered to be appropriate for the child’s cognitive status. In the DSM-IV, this type of learning disability is referred to under the category of Learning Disorders,³ and is applied when the achievement of the individual in one area (e.g. Mathematics, reading, written expression) is substantially below the expected abilities for their age, schooling and level of intelligence.

**Global Developmental Delay**

Global Developmental delay is often used to describe a young child who demonstrates delayed acquisition in all components of development (e.g. motor, communication, social, and reasoning). The term is frequently applied when a young child is first assessed to have disabilities and it is unclear as to what potential progress the child will achieve. Subsequent review of the child after a period of time and intervention will then provide valuable information as to whether the child has a cognitive impairment, psychiatric diagnosis, a specific learning disability or if the child’s skills lie within the boundaries of normal.

This term is a confusing term and it is frequently misinterpreted. It is important to be aware that it does not mean that a child noted to have delayed development will eventually catch up to their age related peers.

**Attention deficit hyperactivity disorder (AD/HD)**

This is a diagnosis applied to a constellation of behaviours that are related to impulsivity, poor attention and hyperactivity. Extensive discussion on AD/HD is documented in a subsequent section.

**Autism**

Autism is a condition that is characterised by impairments in social interaction, communication and repetitive behaviours. Diagnostic criteria is detailed in DSM-IV³. The International Classification of Diseases – tenth edition (ICD-10)⁴, due for release in 1998, also details revised diagnostic criteria.

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*Multidisciplinary approaches to childhood learning disabilities*
**Child protection - neglect/abuse**

Any incidence of abuse (physical, emotional or sexual) to a child can potentially effect their development and ability to learn.

**Chronic medical illness**

A chronic medical illness is an illness that impairs a child’s health for a period of six months or longer. The illness may lead to hospitalisations, medications, specialised diets, and restrictions on activities. Often it can impair the child’s ability to develop age appropriate skills as well as impairing the normal everyday function of the family.

**Speech and Language**

Verbal and non-verbal language is necessary for communication. Impaired language skills are a common presentation for children with learning disabilities and may be associated with many of the learning disabilities, including global developmental delay, specific learning disabilities, and underlying medical or psychiatric conditions.

### 3.3. Multidisciplinary team

A multidisciplinary team is a working unit comprised of health, educational and social service professionals that draws on each team members skills, training and experience. The team members for each individual team will depend on the goals and needs of the team.

The multidisciplinary team can provide professional assessment, diagnosis and management of a child with learning disabilities. This team can evaluate all contributing aspects to the child’s development using the specific skills of each team member. A team environment allows for the most appropriate diagnosis and intervention to be implemented for the child.

Professionals in Community child health often work within a multidisciplinary environment. Paediatricians, Psychiatrists, Child health nurses, Speech therapists, Occupational therapists, Physiotherapists, Orthoptists, Audiologists, Psychologists, Social workers and Educational professionals often are members of these multidisciplinary teams. This does not imply that each team will consist of all of these professionals, and in some cases teams may have additional professionals with skills not named above.

It is not always easy to define the exact nature of a team and the boundaries of the teams responsibility. Where does health stop and education start? Where does
education stop and child protection start? The lack of clear distinction of these boundaries is glaringly obvious and it is for this reason that multidisciplinary approaches to childhood learning disabilities are important.

3.4. Community Child Health

This is an area of medicine that is devoted to Child health issues. Often these pertain to preventative and public health issues and child development. Educational aspects are an important part of development. There are many health professionals who work in Community child health. A brief description of each persons expertise and responsibilities is provided.

Paediatrician

A Paediatrician is a doctor who has speciality training in paediatric health. This includes as extensive knowledge of child development and medical illnesses.

Community Paediatrician

This is a Paediatrician who has completed additional training in Community child health in addition to general Paediatric training. The Community Paediatrician is an advocate for child development, schooling, health promotion, immunisations and public health issues, as well as child protection.

Psychiatrist

This is a doctor with training in psychiatry. This area of medicine can provide valuable children’s services for psychological and behavioural problems and adverse events that may occur within the family. In Community child health, this doctor has further training in child health and family related issues.

Child health nurse

This is a nurse who has completed training in child health related areas. This nurse may also have midwifery qualifications and skills to assist with feeding of a newborn. Infant review and development surveillance from neonate to schoolage as well as involvement in school health programmes and immunisation are an important component of the nurses workload.

Speech therapist
This is an allied health professional who has an extensive knowledge and training in pre language (feeding, production of sounds) and language development. This therapist can provide a thorough evaluation of language skills and provide therapy programmes for language disabilities.

**Occupational therapist**

This is an allied health professional who is able to assess and provide therapy for activities of daily living. These refer to self help and functioning abilities of the child. In childhood, they often can provide extremely valuable support to a child’s prehandwriting skills, early writing, visual and perceptual abilities as well as overall body tone, movement and capabilities.

**Physiotherapist**

This is an allied health therapist with detailed knowledge of how the body moves and how muscles work together to maintain posture and to allow mobilisation. The physiotherapist can assess muscle tone and muscular function as well as providing ways to enhance propulsion and mobilisation abilities for children with motor difficulties.

**Orthoptist**

This is an allied health therapist who is trained to assess eye movements and vision for any abnormality. This involves examination for abnormalities in visual development including squint (a common problem) to rarer visual abnormalities.

**Audiologist**

This is an allied health therapist who can assess the child’s ability to hear across all frequencies and ranges of hearing. Hearing is an important component in the development of communication.

**Psychologist**

This is an allied health professional who can assess the child’s ‘performance’ as well as assist with behaviour and management strategies. Performance can refer to general developmental skills, cognitive skills or behavioural issues that arise at home or at school.
**Social worker**

This is an allied health professional who can provide support to the child and their family. The social worker can often assist with problems with behavioural management, housing, finances, child protection, as well as providing co-ordination of case management for an individual child when many professional are involved.

**Health visitor**

In the United Kingdom, Health visitors are an important health professional in early childhood services. Health visitors are specially trained nurses who provide support to infants and their families from ten days of age. The first contact is through a home visit to the new infant and their family. Contact with the child and family continues through services in community child health clinics, usually until the child commences school.

**Other professionals**

There are also numerous other medical and allied health professionals not defined above, who are involved in Community child health. Whilst these professionals are not specifically described, their skills and contributions to children’s learning disabilities should not be forgotten.
4. United Kingdom Fellowship experience

The Fellowship programme in the United Kingdom included placement with a Community Paediatric Department in South London, observational visits with several Community Paediatric Departments in the United Kingdom, attendance of multidisciplinary meetings relevant to childhood learning disabilities both as a delegate and as a presenter, and visits to relevant facilities and historical sites in the United Kingdom.

As a background to the United Kingdom experiences it is useful to understand the School Health Medical Service, the Educational Code Of Practice and School admission procedures.

Background to the School Health service in the United Kingdom

The School Health Service was set up following the Boer war in response to poor health of the youth of the nation. It has evolved over the years and in 1997 continues to promote health for all children. The current role of the School Health Nurse is a professional role which promotes advocacy for children in all health areas and provides public health services. The school health service functions at its full potential when education, health, school, social services and volunteer welfare workers all co-ordinate together.

The National Health Service (NHS) in the United Kingdom is designed to be a universal health system for all citizens. The service relies on each person being registered with a nominated general practitioner. Currently many families in disadvantaged areas do not register with a general practitioner. Possible explanations include difficulty with physical access to the service, families may perceive that they do not require the service, nor understand its availability, or it may be that the families are itinerant. One way to ensure that all children have access to health care is to supplement the National Health Service General Practitioner service with the School Health Service. Each school operated by the Local Education Authority (LEA) has a nominated school health nurse and paediatric doctor. All new enrolments in the school are invited for a health interview with the school health nurse. This provides the opportunity to promote children’s unique health needs.

The school health service has also produced a package kit that can be utilised for every child with medical needs in the school. It allows for an explanation of the child’s medical needs, medications that the child may require and emergency instructions. The school health nurse and doctor are an available resource for every school to learn more about the health needs of their pupils. This service will also provide training and guidelines for emergency management in the school.

In the United Kingdom, there is no legal requirement for teachers or school staff to administer prescribed or emergency medications to their pupils. It is each schools responsibility to determine the course of action for each child.
Background to the Education Code of Practice for United Kingdom schools

The United Kingdom Education Department defines a learning difficulty as one that calls for a special educational provision to be made for the child.\(^5\) It is a three step definition:

“The child has a learning disability if he or she:

a) has a significantly greater difficulty in learning than the majority of children of the same age

b) has a disability which either prevents or hinders the child from making use of educational facilities of a kind provided for a child of the same age in schools within the area of the local education authority

c) is under five and falls within the definition of a) or b) above or would do if special educational provision was not made for the child.”

Special Educational provision is defined by:

“a) for a child over two, educational provision which is additional to, or otherwise different from, the educational provision made generally for children of the child’s age in mainstreamed schools, other than special schools, in the area

b) for a child under two, educational provision of any kind.”

There are numerous documents that pertain to special educational needs for children in United Kingdom schools. The most significant is the Code of Practice - on the Identification and Assessment of Special Educational Needs 1994.\(^5\) This Code is the ‘gold standard’ for which special needs provision is recommended for each child. It has documented staged procedures. If a child requires a Statement of Educational needs, there is a recognised process for obtaining this within a strict time schedule.

The Code of Practice document estimates that 20% of children will require some form of special educational needs. A minority of children, 2%, will have complex enough needs to warrant a full statement with the Local Educational Authority.

The fundamental principles of the Code are:

- “the needs of all pupils who may have special educational needs either throughout, or at any time during, their school careers must be addressed; the Code recognises that there is a continuum of needs and a continuum of provision, which may be made in a variety of different forms
• children with special needs require the greatest access to a broad and balanced education, including the United Kingdom National Curriculum

• the needs of most pupils will be met in the mainstream, and without a statutory assessment or statement of special educational needs. Children with special educational needs, including children with statements of special educational needs, should, where appropriate and taking into account the wishes of their parents, be educated alongside their peers in mainstream schools

• even before he or she reaches compulsory school age a child may have special educational needs requiring the intervention of the LEA as well as the health services

• the knowledge, views and experience of parents is vital. Effective assessment and provision will be secured where there is the greatest possible degree of partnership between parents and their children and schools, LEAs and other agencies."

The practices and procedures to meet these principles are as follows:

• “all children with special educational needs should be identified and assessed at early as possible with consistency and thoroughness

• provision for all children with special educational needs should be made by the most appropriate agency. In most cases this will be the child’s mainstream school, working in partnership with the child’s parents: no statutory assessment will be necessary

• where necessary, the LEAs must make assessments and statements in accordance with the prescribed time limits; must write clear and through statements, setting out the child’s educational and non-educational needs, the objectives to be secured, the provision to be made and the arrangements for monitoring and review; and ensure the annual review of the special educational provision arranged for the child and the updating and monitoring of educational targets

• special educational provision will be most effective when those responsible take into account the ascertainable wishes of the child concerned, considered in the light of his or her age and understanding

• there must be close cooperation between all the agencies concerned and a multidisciplinary approach to the resolution of issues.”
The Educational Stages are as follows:

“STAGE 1: class or subject teachers identify or register a child’s special educational needs and, consulting the school’s Special Educational Needs co-ordinator take initial action

STAGE 2: the school’s Special Educational Needs Co-ordinator takes lead responsibility for gathering information and for co-ordinating the child’s special educational provision, working with the child’s teachers

STAGE 3: teachers and the Special Educational Needs co-ordinator are supported by specialists form outside the school

STAGE 4: the Local Educational Authority consider the need for a statutory assessment and, if appropriate, make a multidisciplinary assessment

STAGE 5: the Local Education Authority consider the need for a statements of a special educational needs and, if appropriate, make a statement and arrange, monitor and review provision.”

The Department for Education produces parental information brochures about their child’s rights to education included in the Parent’s Charter.6-7 Each school must produce:

- “a report about each child
- regular reports from independent inspectors
- performance tables for all local schools
- a prospectus or brochure about individual schools
- an annual report from the schools governors”

**Background to League tables**

League tables are tables that document a schools performance relative to all other schools. This is judged by their students performance at national assessment of national curriculum skills. The tables examine the overall school performance without taking into account the individual child’s educational abilities at school entry or whether the students have any learning disabilities. The level of support the school is providing with additional educational needs is not represented in these league tables.
Background to School entry criteria

Schools may be under the Local Education Authority budgetary control or they may elect to be ‘Grant Maintained’. Grant maintained schools are allocated a budget and then are independently run by the Head teacher and school governors. Children in Grant maintained schools must have their special educational needs met from the school budget. The Head teacher of a Grant maintained school, along with school governors, has the authority to stipulate entry and selection criteria for the school. These schools can nominate which students they will except. Furthermore the Grant maintained school is able to exclude students, according to the school discipline procedures.

Parents can choose the school placement for their child, regardless of where they live. The process is complicated with Grant maintained schools versus Local Educational Authority schools. Grant maintained schools require an entrance exam be sat by the student prior to entry. If parents nominate a Local Educational Authority school, the school has an obligation to accept the child if spaces are available.
4.1. Meetings attended

I attended several seminars and conferences relevant to Childhood learning disabilities during the United Kingdom component of the Fellowship. This was as a delegate and presenter. I have documented an extensive record of these meetings in the Appendixes.

The meetings I attended in London were for a multidisciplinary audience, with delegates from health, education and social services. It was evident that school services and the health of school children was an important agenda. Multidisciplinary professionals collaborated together to discuss issues, such as bullying in schools, mental health of young children and ways to further develop the school health system.

I attended a detailed conference on Attention Deficit Hyperactivity Disorder (AD/HD), at Oxford. This meeting attracted an International audience and produced debate about the different definitions and management strategies of AD/HD in the United Kingdom and the United States. This meeting discussed many important issues.

I had the opportunity to attend the British Paediatric and Child Health inaugural meeting at York. This meeting is a significant Paediatric meeting. The audience is drawn from Paediatricians in the United Kingdom. The meeting is a forum for all Paediatric interest groups to meet and raise issues of importance. Community Child Health and Childhood disabilities were represented in interest groups and dedicated presentation sessions. I found this extremely valuable as I had the opportunity to meet many Paediatricians with similar interests in Childhood learning disabilities and informally discuss the differences between the United Kingdom and Australian approaches.
4.2. Community Paediatric visits

Oxford

Professor Aidan Macfarlane, Consultant in Public Health. Professor Macfarlane operates an Adolescent information unit with a Public health perspective. He and his colleagues are compiling extensive data records of adolescent studies, both published and unpublished. The school health questionnaire information is utilised to obtain information about adolescence health practices and health knowledge.

Cambridge

The Addenbrookes hospital in Cambridge has a local child development unit based within the hospital grounds. Multidisciplinary assessments are conducted in this unit. Allied health professionals provide therapy within the local community at outside clinics as well as providing home based services. Hospital and community services can access this child development unit.

Newcastle upon Tyne

Dr Tony Waterston is the president of the British Association for Community Child Health. He is a Community Paediatrician who works in Newcastle upon Tyne. Previously he has worked in Scotland and Africa.

I met with Dr Waterston in his locality and learnt about the provision of Community Paediatric services in this disadvantaged area in the North of England. The problems in this area are similar to the deprivation I experienced in South London. However the population is not as mixed, with fewer African descendants. By contrast, this is an area with an enormous Pakistani migrant population, which was not prominent in South London.

The Community Paediatric service provides extensive infant, childhood and adolescent services with an emphasis on primary prevention, special needs, child protection and access to care. A special interest of this unit is with the poverty and deprivation of the Newcastle area and the associated failure to thrive of many of the infants in the area. Newcastle’s Community Paediatricians actively attempt to identify this failure to thrive early so that intervention can be provided to reverse the child’s nutritional state.

One way that failure to thrive can be identified is through weight and height measures at routine child health clinics with health visitors. The Child Health record for this area actively seeks this growth data, and it is entered into a database for collation. As this is linked with a computer programme, there is recognition when...
growth parameters fall below the 3rd percentile, therefore allowing identification of children at risk and subsequent action.

Dr Pat Francis is another of the Community Paediatricians that I met during this visit. Dr Francis oversees the Vision and Hearing screening in Newcastle. Newcastle have a vision screening programme that screens at three years of age. This programme is currently being evaluated for its effectiveness. There are only a few other areas in England with a routine vision screening programme. This is an area of interest for myself as I have been involved with the Queensland Photorefraction Vision Screening Project, which is evaluating vision screening using photographic equipment with children as young as 12 months. The issue of Childhood vision screening is an important and unresolved issue that requires further attention and interest from Community Paediatricians.

Dr Francis also spoke of their trials with hearing screening in the neonatal and early infancy period using otoacoustic emissions. This is a promising technique and ideally could be used to screen for hearing deficits within the first 24 hours following a baby’s birth. However manpower issues and hospital discharge soon after birth counteract a routine screening programme at present. One way Dr Francis and her team have got around this problem is by trialing screening at 6 weeks of age. Their preliminary experience suggests that a similar number of infants are accessed for screening at this age as with the first 24 hours. This is an area that urgently requires more research by Community Paediatricians.

Hearing screening is also of interest to me, as I have previously been involved with discussions about the potential of widespread otoacoustic emission screening in early infancy for potential hearing deficits in Northern Sydney.

I also met with the Senior Register, Dr Emma Curtis. Dr Curtis has assisted Dr Waterston and Dr Simon Lenton (Community Paediatrician–Bath) with the development of training guidelines for Senior Trainees in Community Paediatrics. This is relevant to Australian Community Paediatrics as the College of Paediatrics has a commitment to establish a formal training programme for Community Paediatrics.

**Royal Free Hampstead Trust**

This is a hospital and Community Health Trust based in North London. This area contrasts to Lambeth, as it is a more affluent area with less public housing. During this visit, I had the opportunity to meet and observe many of the allied health therapists associated with the Integrated Community Child Health Service.

This service is locally based and provides nursing services to children with medical conditions and associated learning disabilities in the local special schools as well providing a home visiting nursing service to these children. I met with the Home Care nursing staff and participated in home and school visits. The advantages of these visits is that care is taken into the family home. It avoids the need for the
family to visit the hospital and wait in outpatients for many procedures. This home visiting service can be successful in this local area because the area does not cover large distances (approximately 4 km radius). The service liaises with the large major children’s teaching hospital, Great Ormond Street, and provides shared care for children who need tertiary Paediatric services.

I met with Betty Hutchon, Head Paediatric Occupational Therapist. The Occupational Therapy department is very active in this area and provides many therapy services to the local special schools. In addition, the service is investigating new procedures to implement in the Neonatal Special Care nurseries through a programme of neurodevelopmental observation. This programme requires the care giver to observe the baby’s vital signs and neurological responses when settled, during a period of care giving procedures (feeding, washing, dressing, touching) and then immediately after these care giving procedures. Recommendations to reduce the baby’s stress responses to these necessary care procedures can then be recommended and implemented by drawing from the observed responses and behaviours. This programme has been developed in the United States with the aim to provide optimal nursing and medical care to premature and ill neonates. This is relevant to children with learning disabilities, as premature birth, low birth weight and an unstable neonatal periods are significant risk factors to a child’s development. These children often require prolonged admissions in neonatal special care units. They are at increased risk of cognitive and learning disabilities as well as medical complications.

The Community Physiotherapy services are based at Swiss Cottage Special School. The day I visited the service, they were conducting Pool sessions based on the Halliwick method. This aims to teach floatation skills and assist with body support in water. The method is based on providing assistance by a therapy provider who supports the child by various parts of the body except the head. This will allows the child to retain head control and therefore independence in the water with safety. In this setting, children with physical disabilities, and in particular, children with abnormal muscular function and abnormal body tone to gain confidence in water and eventually confidence with their movements abilities.

I also had the opportunity to visit the Child Development unit for this Area Health Trust. This unit is based in the basement of a Local Council Housing Estate, and provides medical, psychological and allied health therapist assessments and ongoing therapy review. The unit accepts referrals from health and educational professionals for all age children. They are currently reviewing their referral criteria to ensure that the service provides assessment for children with developmental difficulties.
Bath and Royal United Hospital NHS Trust

Bath is in the South Western area of England. I met with Dr Simon Lenton and his colleagues and attended local schools and playgroups for children with learning disabilities. I visited numerous facilities in this area which made me realise that children with special needs, including learning disabilities, are often identified early in this district. This allows for therapy programmes and nursery placements to be initiated to address the child’s disabilities. It was apparent that many of these programmes have been developed with the collaboration of health, education and social services. This collaborative approach is a model that I believe would be useful to promote and expand upon in Australian services.

The Cynthia Mossman school is located adjacent to the Paediatric ward at Royal United Hospital, Bath, and is staffed and funded by education resources. The school was initially set up in the 1970’s by the Spastic Foundation to provide education to children with cerebral palsy in preparation for mainstream schooling. Currently the school caters for children aged 4-11 years with a physical impairment and mild learning disabilities, although recently the pupil intake has also included children with moderate learning disabilities and behavioural problems without a physical impairment. The school has a Head teacher, three class teachers and at a minimum one additional teacher’s assistant for each class. The school receives therapy support from health therapists, who are able to assist and advise on therapy programmes for individual pupils as well as advise on suitable class activities.

This school appears to be unique in that it is located on hospital grounds but remains under educational statutory requirements. It is an example of education and health services combining together to provide an integrated educational and therapy programme in the one location for children to meet their educational and therapy needs. An example is that children with physical impairments often require special seating arrangements and assistance with hand skills. The Occupational Therapist attached to the school is able to work with each child and their teacher, to advise on appropriate chairs, including wheelchairs and mobility buggies, as well as advising on tables and writing instruments for the child to use.

On the hospital site adjacent to the Cynthia Mossman school is a preschool special needs nursery operated by the Health trust. This nursery provides a full day programme, two days a week, for a six month period, for children aged 0-5 years with multiple therapy needs. This programme is for a limited period, which allows for the child’s appropriate educational placement to be assessed and preparations arranged. Children accepted for this nursery are usually children with physical impairments, most commonly cerebral palsy, requiring multimodal therapy programmes. Many of the children have associated learning disabilities. The nursery is staffed by trained nursery teachers and the programme is one of nursery educational skills combined with a therapy programme integrating speech, physiotherapy and occupational therapy. The programme also assesses the mobility of the child and assists in obtaining appropriate mobility aids. Similarly, swallowing and eating difficulties can be addressed in this setting as part of speech and language therapy.
The Margaret Coates unit is a two class unit situated in a mainstream school and caters for up to twelve students aged 4-11 years, with autism. The unit is obliged to follow the national curriculum, but also includes day to day social and living skills as part of their regular programme. Children in these classes all have statements of educational needs and this allows for additional classroom support and therapy sessions in school. The school has a part-time speech therapist and a music therapist. The children are encouraged to work with each other and school meal times are as much of a learning experience as are the class educational activities. The children occasionally join the remainder of the school in playground and social activities. The classes are currently preparing for a school camp and a musical festival.

Opportunity groups are another special needs service available within this district. I visited the Group at Trowbridge, which has been operating for 22 years. I also visited the Devizes group site, which is a new facility with a purpose built building, and has a sensory integration room. These groups are advised by health professionals and are multiagency funded, in particular by a social services grant and donations. They function independently of each other and are run by a parent committee. The aim of the group is to provide nursery activities with a special needs focus. There is no direct education input, however some children attending these groups will have an educational statement and others may be receiving home based schooling, through Portage programmes.

The groups are situated in several towns in the district, and each group is individually run by a parents committee. They have nursery group leaders to co-ordinate each session as well as classroom helpers. Each group has a nominated Community Paediatrician available for advice and medical support. The groups are also provided with therapy sessions from speech and occupational therapists to complement their programme. In addition, the groups have recently started to purchase additional speech therapy sessions with their social services funding. One group has also started sessions with a music therapist.

Each group is situated in a permanent location and operate up to four days a week, with two two hour sessions. They have facilities comparable to nursery schools. Additional sensory integration toys are available in these groups, and in one location there is a purpose built sensory integration room. Children of similar ages and abilities are assigned to regular two sessions a week. These sessions are conducted without parent attendance. Children can be referred to the opportunity groups by parents, general practitioners, paediatricians, therapists and other professionals. The groups are often able to accommodate a new referral within one month.

Each child identified with special needs prior to school entry in this district is eligible for an Individual Programme Plan (IPP), reviewed on an annual basis. This plan aims to identify the child’s strengths, needs and goals. When a plan is drawn up, parents, therapists and other professional involved with the child are invited to attend a meeting and contribute their observations and recommendations. These meetings are chaired by the nominated Community Paediatrician. Whilst the IPP is not a statutory document, it is a useful document that allows all professionals involved to work together to meet the child’s individual programme. It is also a useful exercise.
in that it provides the parents with the opportunity to have a central role and express their concerns and needs for their child.

Respite care for children with disabilities is also provided for through various resources in the area. I visited the facility in Devizes, Canon’s House, which is administered by Social services. This is a residential house and lodge that caters for up to ten children. The department aims initially to provide respite care in the community in family homes wherever appropriate. The residential unit is usually for children aged 11 years or older. It often will provide regular respite for families, for example, one night a week and one weekend per month.

The Woodside Centre at Kingswood (Bristol) is available for children with visual impairments, deafness and other multi-need sensory impairments. This centre has a variety of facilities to promote sensory integration activities, including open space rooms for pre-school based activities (with a focus on visual impairment), a Snoezelen room, a Toy Library, a sensory sound trail and a parents meeting area. This centre is funded by charitable donations and is associated with ‘SENSE’, The National Deaf-Blind and Rubella Association. The centre is open five days a week for families to use on a drop in basis. Parents are required to stay on the premises.

Three mornings a week, education services provide a nursery teacher to co-ordinate crèche and nursery groups for the attending children. The visual impairment team provide facilitation of school term activities and there is input from the Multi Needs Sensory Impairment Team. At present the centre does not have allied health therapy support, health input or resources from social services. Referrals are often made through parent networks and local support services. The centre does not charge for attendance. The toy library has numerous toys to stimulate visual sensory input available on loan. A minimal annual charge is requested to be eligible to borrow from this library.

The Snoezelen concept refers to a special environment designed to encourage a sense of well being, whilst also being fun and relaxing. The aim is to enhance residual senses and encourage learning. At Woodside, the Snoezelen room is a room designed as a quiet, relaxing environment. It has subdued lighting and it has a variety of visually stimulating activities suitable for all age children. These include a visual fibreoptic cradle area for small infants, a water bed surrounded by fibreoptic apparatus and bubble tubes and a sound bed (a bed in which speakers lie underneath so the child can feel the vibrations of music, usually classical music).

The sensory music trail is an outside pathway. Along the pathway are a variety of musical devices such as windchimes, percussion triangles and xylophones that the children come into contact with to act as a musical stimulus.
Edinburgh

I met with Dr Zoë Dunhill, Clinical Director of Community Child Health and Child and Family Mental Health Services. Dr Dunhill provided an overview of the Community Child Health services in Edinburgh. In addition, Dr Dunhill has developed a special needs register database. The usefulness of this database is that it will be able to provide information on current needs and services and can be used to anticipate future needs and therefore provide adequate health services. A functioning database, if comprehensive, can also be a useful research tool to provide information about population needs.

The learning disabilities clinic at Edinburgh primarily reviews school age children identified by educational psychologists as having a specific learning disability, with unclear aetiology. The clinic is a medical clinic with special skills in the area of Neuropsychology assessments. The value of this clinic is in identifying possible aetiologies in children with the more atypical learning disabilities.

I attended a lecture on the new Griffiths Infants scale. The Griffiths Mental Developmental Scales is a developmental assessment test widely used in the United Kingdom and also in Australia, to provide objective information about a child’s developmental skills. This test was developed in the 1950’s. Revalidation became necessary for the Infants scales (0-2 years component) as the population general quotient mean over the years has shifted upwards. Ruth Griffiths original scores for each subscale and the overall population mean, were presented. The procedures followed in revalidating the scales and the introduction of new test items as well as a new test scoring procedure were detailed. Approximately 600 randomly selected children throughout the United Kingdom were assessed in the revalidation. The 2-8 year extended scales are currently under revision in South Africa, with a revalidation proposed.

I met with Dr Jacqueline Mok, Consultant Community Paediatrician responsible for Child Protection services. Dr Mok explained the process of referral and the increasing referrals initiated by school services (teachers, health). This is one of the recognised learning disabilities in school aged school.

I met with Dr Jackie Grigor, Consultant Community Paediatrician responsible for audiological services in Edinburgh. Dr Grigor co-ordinates a hearing assessment clinic which utilises audiologists, Ear Nose and Throat surgeons and teachers of the deaf. Edinburgh is preparing to instigate a targeted neonatal hearing screening programme using otoacoustic emissions to identify children with sensorineural hearing loss at an early stage. (Targeted - neonates at high risk - preterm, congenital infection, neonatal sepsis, aminoglycoside antibiotic administration, family history of hearing loss, and syndromal diagnosis). This technique has been evaluated and trialed in other areas of the United Kingdom with promising results.

Dr Pat Jackson is responsible for medical disabilities services in association with hospitalisation needs. This service has demonstrated a role for Community Paediatric nurses as a liaison between hospital services for children and the Community. The availability of a liaison service can ensure that the child receives...
optimal care in all environments. This visit provided important observations and information to assist with my current clinical practice at Fairfield Hospital in South Western Sydney, in which a Paediatric Home care programme is being developed.

I also attended a “record of needs” review meeting for a child with special educational needs in a mainstream school. This is the Scottish equivalent of the Statement of Educational needs, and it allows for a child’s additional needs in the school setting to be identified. This visit demonstrated a commitment from multidisciplinary professionals to collaborate together to determine a management plan for children.

Aberdeen

The Raeden Centre is an assessment and intervention unit for pre-school children for the Aberdeen and Grampian area (including islands), run jointly by the local NHS Trust and Council. Children with developmental delay, physical disability or special needs can be referred to this unit.

The unit operates on a weekly assessment process. The child attends the centre each day for a week and is observed in a nursery setting as well as by individual therapists and professionals of the multidisciplinary team (medical, clinical psychologist, educational psychologist, nursery nurse, occupational therapist, physiotherapist, speech therapist, health visitor for the child). At the end of the week, all professionals join a case conference, in which observations and recommendations from the weeks’ assessment are discussed. Following the assessment, children can then be referred to the special needs nursery at Raeden or elsewhere in the district for ongoing intervention, as well as being referred for allied therapy as appropriate.

I was impressed by the thoroughness of this unit. It was an outstanding example of a multidisciplinary service for pre-school children in which there was availability of professionals to observe each child in the same setting over the week period. There was a diversity of situations in which the child could be observed. Overall this process served as an example of how important observations are and the case conference process is with multidisciplinary assessments.

Of all the units I visited in the United Kingdom, this is the unit that that I would preferentially adopt as a standing model in establishing a Child Development unit in South Western Sydney, if given the opportunity and resources.
4.3. School visits

Jessop school visit

I attended Jessop school to participate in a SENCO meeting. United Kingdom schools have a nominated person who is responsible for the children in the school with special needs. This is the SENCO - special educational needs co-ordinator. This is defined by the United Kingdom educational act and code of practice. There are different levels that children can be assigned, and this refers to their extra needs. Once a child progresses from Level 1 to Level 4, a statement of educational needs is required. This is a legal document that documents the child’s individual needs and is used to ensure that the individual school meets these needs.

Each child with special needs at school requires regular review of their status with the SENCO, school nurse and school doctor. If the child has a statement, then update of the statements should occur each six months.

Hillmead Infants school

I visited this infants school to assist the school medical service with behaviour management in the classroom with reference to post traumatic stress disorder. This is relevant to students who have experienced personal losses and traumas. The students reaction to these experiences is exhibited in the classroom environment resulting in significant behaviour problems. These behaviour problems can be addressed through co-operation of parents, school staff, the School medical health service and local child guidance and mental health support.

Behavioural problems that manifest themselves in the school classroom are significant learning disabilities for the child as they interfere with everyday experiences in class. They are also a significant learning problem for the remainder of the class as behaviour difficulties can lead to disruption to the daytime class activities.

Harrow on the Hill school

This is one of the Schools Sir Winston Churchill attended. It is situated on magnificent school grounds in the North of London. The school is well equipped including a school hall, drama theatre, tennis courts, sports centre, golf course, fishing pond and numerous old school buildings. This provides an enthusiast learning environment.
4.4. Fellowship related activities

Churchill war rooms

One of the first visits of my Fellowship was to the Churchill war rooms as part of a guided historic walk through Westminster and its surroundings. This provided background to the English parliamentary system with particular reference to World War II and the events in London at the time of the Blitz under Churchill’s leadership.

Tower of London

This is considered to be one of the primary tourist attractions in London. However I saw it more as an educational facility that is not being utilised to its full potential in teaching the English National Curriculum to English children.

In Lambeth, many of my colleagues reported that most children in this under privileged area had never visited the Tower - despite living within 5 miles of the Tower grounds.

The Tower is rich in English History. It provides a unique appreciation of the history of the monarchy and how it has influenced Britain through the centuries. The Tower has an extensive collection of armour from Medieval Britain.

As an Australian who has not previously been exposed to historical sites it struck me that English historical sites were being under utilised as an educational tool. Learning disabilities are often assisted by creating enthusiasm and interest in the learning activity. This historical site has immense potential to create enthusiasm within a student.

Education must appeal to the child’s want to know. As I continued my Fellowship and had the opportunity to view other historical sites of significance this thought kept reoccurring. Often in learning difficulties with attention difficulties or language delay it is important to show the child what is expected of them and to continually bring their attention back to the important task. Visual stimuli are important, as also are examples. London and its surroundings, is rich in these learning experiences.

Royal Ballet chance to dance programme

The Royal English Ballet operates an educational programme. They have special programmes for children with educational disabilities to teach these children to express themselves through dance, movement and music. They also operate “Chance to Dance” sessions, where they yearly audition and select children with dance potential for further ballet training. These children would otherwise not be able to afford these classes or be provided with these opportunities.
I had the opportunity to observe one of these sessions. The children were in their first year, aged 5-6 years. They enjoyed their one hour session. They were intent on following verbal and visual instructions and participation in group activities. This session was providing good movement and stance exercises, but also discipline in a class setting, turn-taking activities and co-operation. Many of these children accepted into this programme are at risk of learning disabilities, primarily because of a lack of opportunities and stimulation related to environmental influences.

**Election May 1st**

I was in the United Kingdom at the time of the Election in which Labour gained office after 18 years in Opposition. This provided an interesting time to be in the United Kingdom, as I was able to observe the difficulties each Health Trust had in approaching a long term goal in a time of political change and upheaval.

Health, Education and Social Services have general policies as dictated by government. In the case of health, Trusts exist, to administer health policies. During the time that I worked as part of the NHS service as well as during my visits, I tried to understand the administration of health, education and social services, and how these three services interacted with each other. It was apparent that the boundaries for health services, education and social services provisions for the same families were themselves not the same. This leads to potential inequalities as what one family is entitled to is not consistent in different districts. This becomes even more confusing with the administration of Hospital Trusts and Community Trusts, as these frequently did not cover the same population area. Therefore a Community Paediatrician may be required to arrange services and referrals of children to different service providers according to the child’s address. In addition, the child’s general practitioner, may or may not be a Fund holding General Practitioner. This had implications on what services a Community Paediatrician could provide or refer a family to, as this depended on their General Practitioners preferences and existing contracts with service providers. As an outsider, it was apparent that children with identical needs could potentially receive quite different services and levels of support.
5. United States component June 7th - July 14th

5.1. The Children’s Hospital, Boston and Harvard Medical School

The last weeks of my Fellowship were undertaken at The Children’s Hospital, Boston. This is a Paediatric teaching hospital for the Harvard Medical School. Outpatient assessment programmes for children with learning disabilities are part of the clinical programme of this hospital. The programmes I attended included the Developmental Consultation Programme, the Preschool Function Programme, School Function Programmes, the Young Adult Team, the Early Childhood 3-6 years team, the Centre for Autism and Related Disorders clinic and the Feeding Programme. I also visited Boston State Schools as well as the Higashi school for autism.

The experience that I was able to gain during my visit to Boston was as a participant in these assessment programmes. This allowed me to observe the child with multidisciplinary health professionals throughout their assessment and then contribute to the case discussion formulation of a diagnosis and intervention programme for the child. This was an invaluable experience.

The programmes offered at Boston in learning disabilities are all multidisciplinary. This impressed me as to how important a multidisciplinary approach is when assessing and managing children of all ages with learning disabilities. The ability of a team to work together and observe each others assessments of the child was invaluable. With more than one professional as part of an assessment, it is possible to observe the child, the parents and interactions with professionals and family. At the conclusion of the formal assessment it is then possible for the professionals to discuss observations and findings when compiling a diagnosis and intervention programme.

The Boston programmes are that of a tertiary referral hospital for the New England region. Children seen in these programmes may not be from the immediate local area and therefore recommendations from the assessment on how to access and obtain services within their own locality was an important component. When school performance was a concern, the children often had previously been reviewed by the Educational System for a “Core” evaluation. The core evaluation can identify in the school/educational setting important educational supports that can assist the child.

Each State in the United States is legally required to provide an appropriate education for all children with disabilities. The state education agencies are required to identify, locate and evaluate children with disabilities and then prepare and implement an individual education plan for each child.

In Massachusetts the statutory requirement for special educational needs is documented in Chapter 766 Regulations. An Evaluation and Individualised Educational Plan (IEP) is provided by the Educational System to the family. If the
family agree with the plan, then services can be provided as documented. If the family do not agree with the plan then they have the option of meeting with any member/s of the team to discuss the IEP and to review the papers relevant to the Evaluation. Parents have the right to request an independent second evaluation. This can be obtained either at the family’s expense, or it may be approved for payment by the school system. The Learning disorder clinics at The Children’s Hospital, Boston, are recognised as approved facilities to provide an independent evaluation.

The medical component of the Learning Disability Programmes included detailed medical history as well as neurological examination. In some of the clinics, the Paediatrician also conducted an age appropriate neurodevelopmental assessment. The assessment tools utilised have been validated for use in this population. They are discussed later in this section.

Psychologists in these programmes were able to assess emotional, behavioural and performance aspects of the child as well as interview parents on these contributing factors. Educational psychologists examined academic skills more formally, often relating a child’s academic performance to expectations for their age and current school status. Allied health therapists also contributed by reviewing the child’s skills and by providing therapy recommendations.

There is a separate programme for children aged 3-6 years that provides evaluation, consultation and follow-up care for children who exhibit signs of intellectual, social or emotional developmental delay. Following assessment with the relevant team, children may be referred to another programme for additional evaluation and support.

The Centre for Autism and Related Disorders is a programme that provides diagnostic evaluation and psychological testing for children and adults suspected of having autism or a similar disorder. The Feeding Programme evaluates feeding difficulties of infants and children with neurodevelopmental, congenital or medical problems.

The School Function Programmes include preschool function, school function and young adult services. These programmes utilise a paediatrician, psychologist and educator. Recommendations addressed in these clinics include medication, additional assessment procedures, school placement, special curriculum and individual/family counselling. The preschool function programme usually evaluates three to six years aged children with a question about readiness for school. The school age child, six to eleven years, is usually reviewed for evaluation of learning, attention, behaviour or social problems. In the young adult team, adolescents aged twelve to eighteen years are evaluated for learning, attention, behaviour or social problems.

The Paediatric medical component of assessment in the school function clinics utilised neurodevelopmental tools such as the PEET, the Pediatric Early Elementary Examination 2 (PEEX 2), and the Pediatric Examination of Educational Readiness at Middle Childhood 2 (PEERAMID 2). The PEET was developed by the Division of Ambulatory Pediatrics, The Children’s Hospital Medical Centre and The Brookline Early Education Project. The PEEX2 and...
The PEET is designed as a neurodevelopmental assessment for the three to four year old child to aid in the early detection and clarification of problems with learning, attention and behaviour.\textsuperscript{9,12} The assessment broadly samples skills in five basic developmental areas; Gross motor, Language, Visual-Fine Motor, Memory, and Intersensory Integration. The assessment is designed to avoid providing an overall score and avoids a pass/fail level. Instead, a narrative profile of the child is generated which can identify concerns, strengths and weaknesses, and allow for these to be appropriately addressed.

The PEEX 2, is a neurodevelopmental examination for the aged six-nine years old child. Its usefulness is in providing an empirical description of a child’s development and functional neurological status. Similar to the PEET, it does not yield a score. The assessment assists in identifying areas of developmental function that warrant further assessment and intervention. It is not designed to be used as an isolated assessment tool and is most useful when included as part of a multidisciplinary assessment process.

The PEERAMID 2, is a neurodevelopmental examination for children aged nine-fifteen years. It also does not yield an overall score. It is useful as a tool to identify potential areas of weakness and selective attention. It is similar in application to the PEET and the PEEX 2 as it is designed to used as one part of a multifocal assessment process.
5.2. Fellowship activities

Boston Higashi School

I visited this International private school for children with autism located in Boston. There are 120 school students, aged 3-22 years, from all over the world. Each student has a diagnosis of Autism, Autistic-like behaviour or Pervasive developmental disorder. The primary focus of the school is educational. The school aims to establish stability of emotions gained through the pursuit of independent living and the development of self-esteem. The school programme has a physical emphasis. Artistic and musical activities are another essential part of the school day.

There has been controversy surrounding the teaching programmes of this school and its sister and founding school in Japan, primarily because of the physical emphasis in the curriculum. These are the only two schools worldwide that follow the teaching programme, known as ‘Daily Life Therapy’, as proposed by Dr Kiyoko Kitahara.

A short visit to the school is not sufficient to be able to conclude whether this approach should be adopted more widely for teaching children with autism. The basic school principles of a structured school day and the teaching of social interaction at school mealtimes and other social events is commonly included in teaching programmes for autism elsewhere where I have visited, as well as in The New South Wales Autistic Association school. The major difference at Higashi is with the focus on physical activities and the music and art sessions. The staff of the Higashi school believe that their programme is an effective educational methodology programme in comparison to alternative programmes available to parents and teachers.

The school is able to provide numerous newspaper articles about their schools successes as well as positive reports from parents. However, despite these anecdotal reports, the school does not have published scientific reports to demonstrate if their teaching programme is more effective than other programmes available to children with autism. As a Paediatrician, whilst I acknowledge these individual reports, I do not think that these provide sufficient evidence to recommend to parents of children with autism that this is the most appropriate educational programme.
6. Conclusions

Paediatricians often are the first health professional to review a child suspected of having a developmental disability or learning disability.\(^2,13\) With the infant and preschool child, it may be failure to achieve age expected milestones that alerts the family to the child’s disability. In school aged children, it may be manifestations in the classroom that are the first recognition of a learning disability.\(^13\)

The diagnosis and recognition of a learning disability is optimally achieved by the collaboration of multidisciplinary professionals. These include Paediatrician, psychologists, allied health professionals, teachers, educators and parents.\(^13\) This was confirmed by my experiences during this Fellowship.

Learning disabilities have important implications for the child, family health and educational services. Recognition of the disability is only the first step in management. The learning disability must then be supported with intervention. The goal of intervention is to achieve academic competence, prevent adverse mental health outcomes and to treat any associated comorbid factors or medical diagnoses.\(^13\)

The role of the Paediatrician in assessment of children with learning difficulties is one component of a multidisciplinary team approach to these problems.\(^1\) The medical component considers the medical, neurological and behavioural origins of school failure.\(^13\) Medical history, examination and investigations is optimally interpreted in association with assessments and observations from numerous allied health professionals with skills in child development and learning disorders. The Paediatricians approach to the diagnosis and assessment of learning disabilities has a different perspective to the approach of an educator.\(^13\) Educational Therapy is a major component of the intervention programme and is most appropriately devised by educational providers. Collaboration with health professionals is essential for an effective programme. Allied health therapy programmes are equally as important in addressing specific areas in which the child experiences weakness.

There is no absolute criteria to apply in the assessment of learning disabilities. The United Kingdom and the United States both have legislation to protect and provide for the child with learning disabilities. My experience as part of this Fellowship is that even with this legislation, the current standard of practice in the United Kingdom and the United States, is not universally defined. The multidisciplinary service that is provided to assess learning disabilities, and the collaboration between health and educational professionals is determined by each individual assessment unit and Health Trust / authority. Furthermore even within Health Trusts / authorities, the approach lacks definition and co-ordination.

In the United Kingdom, the School Statement process is a legal document that can stipulate the special educational needs required by the child. The Statement process also mandates that local Community child health professionals and educational professionals contribute to the report. However this mandate does not
stipulate that these professional work together to devise an appropriate intervention plan.

In the United States of America, the child with special educational needs, has their needs formally documented by an Individualised Educational Plan. This Plan does not require local Paediatric or allied health reports or assessments. An assessment of learning disabilities by multidisciplinary health professionals is frequently requested by the family as a second and independent evaluation to define their child’s needs.

In the context of New South Wales where I currently practice as a Paediatrician, I do not think it is appropriate or practical at this point in time to advocate for similar legislative responsibilities to provide an assessment of a child with actual or suspected learning disabilities. Before legislation of this substance can be considered, it is essential to first have the resources available to provide a meaningful assessment, and to provide appropriate intervention. The legislation that exists in the United Kingdom and the United States is ineffective because of limited provision and access to these multidisciplinary services. In Australia, the need for multidisciplinary services needs to be addressed within Community Child Health Advocacy groups as well as Educational sources. Resources, training, and facilities should be addressed collectively by Health, Educational and Social Service Departments.

In the course of this Fellowship, I gained many insights from parents about their experiences with the assessment and intervention processes. The main frustration parents reported was in trying to get a professional to understand their concerns about their child. With young children, parents often would note that their child had difficulties with language or delayed milestone acquisition. When they brought these to the attention of a health professional, it was not uncommon for parents to be reassured without any further action taken.

Parents also agreed that the multidisciplinary approach was essential to identify and provide recommendations for their child. In the United Kingdom, Health Trusts provide different child development and assessment services in different areas. For parents this is another source of frustration as it can be confusing as to what service is available or accessible. Furthermore, for areas where this service is limited, there are difficulties in getting an appointment with a multidisciplinary team. This extends into ongoing difficulties with accessing therapy services on an ongoing basis.

In the older child, parents often felt that the schools were not identifying learning disabilities that their child may have. Parents often believed that they had difficulties in getting the school to initiate an assessment. Following from an assessment, many parents believed that intervention and necessary resources were not available. This was evident in the United Kingdom and the United States of America, and it is similar to comments I have had heard from parents in Australia. Whilst this is obviously not the case in all circumstances, there is no doubt that some children and their families do experience difficulties in this identification process. Furthermore once the problem is understood by a health professional or educator, my
experience from this Fellowship is that it still may not be feasible for the child to obtain a multidisciplinary assessment owing to this assessment process not being available, or to there being an extensive wait for the assessment process.

My experience and observations during this Fellowship is similar to that of parents I spoke with. I have observed the value of a multidisciplinary assessment as opposed to an Individual professional assessment and I have observed the frustration that parents experience when informed that their child would benefit from an assessment or therapy programme, but it is not available. This observation has impressed on me that the unresourced multidisciplinary team will be impaired in its goals. An important operational requirement for a multidisciplinary assessment team is to be able to meet the needs of the community it serves. Assessments need to be available within a reasonable time period and access to therapy and ongoing support need to be established.

Educational standards and the school curriculum were topical in the press in the United Kingdom and the United States of America. The press frequently printed articles about declining school standards. This was particularly apparent in the United Kingdom during the National Election campaign. In the United Kingdom there is growing concern about the failure of students to obtain the required standards of the National Curriculum. The National Curriculum applies to all school children aged 5-14 years and pertains to basic academic skills. In the context of this Fellowship, it is recommended that a curriculum assigned to a child is appropriate for his/her learning ability.

Medication administration on school premises is another controversial issue. In the United Kingdom there is no legal requirement for teachers or school staff to take responsibility for medication administration. This was a major contention between the school health service and the Local Educational Authorities. Basic medication for common conditions such as asthma, stimulant medications for children with AD/HD and medication for children with seizures were the most frequently discussed medications. In all these examples, schools oppose supervising medication administration or responsibility for safe storage of required medication. These difficulties were addressed in the seminars that I attended without a unified solution being agreed upon. It is evident that a formal medication policy, involving both health and educational resources is required. In New South Wales this process has commenced, as demonstrated by the AD/HD Talk time booklet distributed to new South Wales schools in 1996.14

The difficulty in providing an accurate and universally accepted definition of children’s learning disabilities prompts the need for multidisciplinary professionals in children’s health and education to work together collaboratively. Multidisciplinary teams are necessary. In this context, Health, Education and Social services do not have well defined boundaries and therefore it is inefficient for each Department to function independently of each other with respect to childhood learning disabilities. The combination of resources and skills from each of these disciplines is essential to effectively understand and manage childhood learning disabilities. Whilst this may seem a logical conclusion and therefore essential to implement, it is difficult to accomplish with current government resources and funding. In New South Wales,
The Department of Health is administered separately to the Department of Education and both these are separate to the Department of Social Services. The first step to addressing these difficulties and divisions will require interagency collaboration. Protocols and legislation can then be developed to provide clear guidelines and legal responsibilities for the assessment and management of childhood learning disabilities.
7. Recommendations and Implementation

This Fellowship has provided an appreciation of the importance of a multidisciplinary assessment for children with learning disabilities. The multidisciplinary approach is well recognised in the Paediatric literature and is recommended in the management of these complex disorders. My primary recommendation from this Fellowship report is to improve access to multidisciplinary assessments for children with learning disabilities in New South Wales. This requires liaison within the existing Departments of Health, Education and Social Services. The priority needs to be the provision of adequate resources, including personnel and facilities, for multidisciplinary assessments. These resources need to extend to the implementation of recommended therapy programmes documented in the assessment report.

In the United Kingdom and the United States I have had numerous opportunities to observe these multidisciplinary programmes in operation and participate in their formulation sessions. This has allowed me to work with other professionals and appreciate their skills and strategies in managing childhood learning disabilities.

My position at Fairfield Hospital in South Western Sydney as a Community Paediatrician will provide me the opportunity to share my experiences from this Fellowship with other multidisciplinary professionals within my own working environment. I also will have the opportunity to discuss my experiences with other Health and Educational professionals within New South Wales. I will also have the opportunity to disseminate my experiences at seminars and conferences.

I am also completing a Master of Public Health Degree. This degree provides valuable experience in Public Health, of which education and child health is a component. It is also a degree that provides knowledge on the process of public policy and advocacy. I believe that my studies, and experience will provide me with additional skills to be able to disseminate my Fellowship experience through Community child health projects and advocacy within the Department of Health.

This Winston Churchill Memorial Fellowship to study the Multidisciplinary assessment of childhood learning disabilities has been a valuable experience. Childhood learning disabilities are an important cause of educational failure and underachievement in the school years. These disabilities are optimally addressed by a multidisciplinary professional assessment team. Paediatricians, with their skills and knowledge about child development, provide an essential contribution to childhood learning disabilities as part of this multidisciplinary assessment team.
8. References


6. Special Educational Needs Tribunal - Department For Education Publication, Crown Copyright 1995, UK


9. Appendixes

Meetings attended

The following is a summary of the meetings I attended in the United Kingdom as part of this Fellowship.

9.1 BACCH -School Health Day

This was a meeting of health, educational and social service professionals to discuss future directions of the School health service. The first speaker was a political representative, Baroness Margaret Jay, who expressed concern that in the United Kingdom that there is a immense difference in health of children related to socio-economic status of the family.

In the United Kingdom, there are 50 000 low birth weight infants (weight <2500 gram) born a year. One third of these low birth weight infants are born into households on state benefits. The average life expectancy of people from these socio-economic groups is 7 years less than the upper socio-economic group in the United Kingdom. Children in the lower socio-economic group are twice as likely to die up to age 15 years when compared to children in higher socio-economic groups.

These figures have an influence on schooling and children’s health. The influence these can have on school performance was emphasised and the need for a holistic approach to health and education was addressed.

Mental health needs in school

Dr Aidan Macfarlane spoke on the mental health needs of children and adolescents based on a four tier system. Impaired self esteem is the most important risk factor for impaired child health. Conflict, family breakdown, unclear discipline and hostile rejecting relationships are all detrimental to the young child. Risk factors to the child’s mental health include lower socio-economic status, homeliness, family and environmental disaster, discrimination, and any significant life events.

Resilience factors that may provide mental health protection in childhood include good self esteem and autonomy, family compassion, warmth in the family and absence of family disharmony. Starting grounds for these can include the education system with the instigation of ‘Good Parenting programmes’, more drug education programmes and truancy prevention programmes.

It is recognised that initial services to address child mental health needs (tier one) should include a preventative role with governmental input, a secure and nurturing environment, encourage prospects of employment, encourage a culture free...
from abuse, and invite programmes to build self esteem. Interventions in the United Kingdom designed to achieve these objectives should include health visitors, the general practitioner, school nurse, social services, voluntary agencies, teachers, residential care workers and social workers. The objective is to identify mental health problems and offer general advice as well as pursue all opportunities to promote mental health.

If the child’s needs or problems become more complex, progression into a second tier of support is warranted. This includes a clinical IQ and educational assessment, paediatric review and psychiatry review. Outreach services and training opportunities for all involved professionals are an important component.

Most children with mental health needs will have their difficulties addressed in this first or second tier approach. As the problems increase in complexity, the need for tier three, specialist services such as a multidisciplinary team services, is required. More complex problems are managed in tier four services. These include inpatient services and tertiary health referral to highly specialised services.

**School health nurse**

Carol Bailey, a school health nurse, spoke about the role of the nurse in developing the current school health service. This now aims to support the school child in identifying health needs. These roles include:

- promoting self esteem / physical well being / academic achievements
- addressing the wide environment of the community in which they live
- focus on public health preventative approaches
- supplemental services to the National Health Services
- School - co-ordination of education and health services
- set standards and achieve parity with colleagues

In 1998 the school nurse in the United Kingdom will be a specialist degree qualification, reflecting the increasing importance of this role.

**9.2 BACCH Annual South Thames (EAST) Region Meeting for Community Child Health Doctors**

This was the first meeting of the South Thames Paediatricians, and was co-ordinated by ‘seiph’ (South East Institute of Public Health). The meeting provided a forum to bring local Paediatric medical providers together to identify and discuss the needs of the region.

The meeting included a discussion of the development of the Royal College of Paediatrics and Child Health. It has emerged as a separate college from the Royal College of Physicians. As an Australian Paediatrician this has great relevance, as
currently the Australian College of Paediatrics is investigating whether to merge with the Royal Australasian College of Physicians. The importance of a College is to provide a universal and united representation of members with reference to health issues and policies. In the area of Child health, the College has a role to play as an advocate for Child health and therefore needs to be a recognised authority in Child Health. The College also has an important role to play with the administration of training and teaching programmes.

**CHAT study**

Dr Gillian Baird, Paediatrician with The Newcomen Centre at Guy’s Hospital, spoke on the ‘CHAT project’. This project aims to screen infants at eighteen months to identify children at risk of autism. The CHAT questionnaire has been devised and validated through their initial work with an 18 month old population. The research cohort consists of 16 000 children recruited at 18 months of age. With this large cohort, the project aims to identify the prevalence of autism as well as the prevalence of autistic spectrum disorder through longitudinal studies.

To date the group have been able to follow up many of the enrolled cohort at age 4 years with the administration of a second questionnaire. The next stage of their project is to administer a third questionnaire at age 5 ½ years.

This work is of immense significance because many children with autism or autistic like behaviours are often not recognised or provided with intervention and support until an older age.

**Computers and Medicine**

Professor Euan Ross organised a brief review of the Library resources available to the Community Paediatrician. Medicine is a rapidly changing field and much of the new information and technology needs to be readily accessible to the practising Community Paediatrician. Ways to achieve this is through the Internet and CD ROM technology. Medical textbooks still have an enormous role to play, but often they are outdated by the time of their publication. The availability of major texts on CD ROM will allow for regular updating of previously published medical information.

**9.3 School exclusions seminar**

School Exclusions have become an important issue in English schools. A school exclusion is when a child is required to remain away from school as a result of a discipline matter. It will range from one day through to a permanent exclusion. Schools commonly exclude students for wrong doings, behaviour issues and learning issues. If a child is excluded then often there are other resources to offer to the
family, including home teaching. It can be difficult for a child to be placed into a new school following a permanent exclusion. Each school has different exclusion criteria, based on the Head teacher and governors policy, funding, and the schools need to perform on the League tables as well as the need to attract other students.

Sylvia Jones, a Kent school worker, spoke on alternate programmes for these ‘displaced’ children. Her programmes aim to focus on positive self-esteem. Her concern is that excluded children currently are being set up to fail because ongoing education is denied through the inability to be accepted into an alternate school. Kent has a 12 week programme designed for children who are at risk of being excluded. The Head teachers of participating schools nominate children who are at risk of exclusion for inclusion in the programme. The programme builds on self esteem and provides these children a sense of worth and responsibility. It teaches these children about community values and aims to give the children a sense of achievement and belonging as well as experience as participating as part of a team. This is achieved through a residential weekend, art therapy classes, crime awareness, drug awareness, school problems, aggression and bullying. The programme provides adult supervision of one to one with the children.

KITE is another Kent programme aimed at truants and children at risk of exclusion. This is different to the programme above as it targets youths most likely to be associated with crime. It utilises a multiagency approach to increase educational compliance. The programme is now linked with the Duke of Edinburgh community service awards. Children in secondary school, aged 11-17, who are considered to be ‘on the edge of crime’ are targeted in this programme. It also has a strong community focus.

There is concern that children ‘in care’ or fostered are making up a large percentage of school exclusions in the United Kingdom. Again the cycle of failure with these children is set up as they have no permanent home or family and no permanent school if they are excluded.

9.4 Evaluation of Intervention in Childhood Disability

Evaluation and evidence based medicine are currently not readily integrated into disability services. This conference emphasised the importance of evaluation of disability services. It was acknowledged that quantitative evaluation is often not possible for childhood disability.

This conference investigated ways to initiate research and evaluation into current disability services so as to improve and provide future resources.
9.5 School Bully seminar

The school bully problem is rapidly growing in the United Kingdom. A school bully is considered to be any child who verbally, physically or emotionally abuses any other child in the school. This has recently been extended to include abuse of school children outside of the school environment and by teachers or school staff.

The problem of school bullying is frequently associated with racial issues. In Lambeth, South London, 48% of the population is migrant and up to 95 different languages are spoken.

Head teachers have witnessed an increase in bullying over the past five years. There have also been revised legislation and responsibilities of educational professionals with respect to disciplinary measures in the school. This has limited responses available to school staff. Many schools now acknowledge that a Bullying policy is required to determine how the school will address the problem.

Implementation of a school bullying policy was addressed at this meeting. A working group noted that different policies for different schools were required because of the different racial and social backgrounds. Each incident needs to be considered individually. No episode of physical abuse or violence should be tolerated.

A bullying policy needs to clearly define aims and outcomes. It must also have a high profile in the school. The process of staff review, from the year teacher through to school senior management and the Head teacher must be documented. The policy may require wide consultation including the school governors, head teacher, teachers and staff, parents, pupils, school health services and community involvement.

It was also acknowledged that management of the bullying required professional resources for both the victim and the bullier. It is not acceptable to turn a blind eye or believe that this is part of normal childhood development.

Dr Judith Dawkins, research Senior Registrar at St. George’s Hospital, London, spoke in depth about the consequences of bullying. It is noted that bullying is associated with serious short and long term sequelae for both the bully and the victim. The bully often learns about misuse of power and can continue to exert this in future relationships with children and adults. The victim can experience many adverse outcomes, including depression and suicide in severe cases, as well as long term physical symptomatology that can lead to long term morbidity with health and emotional development. Most of the current school bullying research today has examined the outcome of depression. Whilst depression is important it must be recognised that this is not the only health outcome of bullying.

Dr Vidya Rao, Community Consultant Paediatrician with Wallsall Community Health Trust in the West Midlands, spoke further on the consequences of bullying. It is only since 1994 that United Kingdom schools have been issued with practical suggestions for the implementation of antibullying polices. However there
is no mandatory need for a school to have a policy. Discipline responsibility still remains with the individual head teacher of the school.

Bullying often is not tackled in the school because it is not identified. This often is because it does not come to the attention of the staff. However there are occurrences where the staff may not believe the child, or may believe that it is normal and healthy for a child to experience bullying.

Dr John Balding, with The University of Exeter, co-ordinates the Schools Health Education Unit. This unit administers the School survey questionnaires that provide information on many school related health and educational issues. This Unit has previously examined bullying, from the child’s perspective and identified that it is common and a significant cause of school refusal.

9.6 Promoting Mental Health in Pre-School Children

Mental health of the preschool aged child is now recognised as an important influence on the child’s subsequent development. This seminar discussed the importance of promoting a healthy nurturing environment for a child in the pre-school years.

Dr Jonathan Dare, Consultant Child Psychiatrist with King’s College spoke on the importance of early experiences in life. As adults we draw on our personal experience from childhood and this has an impact on our professional and personal lives. It is well recognised that numerous adult patients requiring psychiatric support have had disturbing childhood experiences. If we are to avoid these experiences then it is essential to work with children and their families to be able to prevent these mental health problems developing in these pre-school childhood years. Pre-school children manifest mental health disturbance through non specific somatic symptoms such as aches and pains, behaviour difficulties and emotional instability.

Often there is circular causality that promotes mental health disturbance. Once an initiating event occurs, the next part of the cycle is adversely affected and this eventually cycles back to the first event. This cycle includes the family, the child, and their environment. When the cycle works well all members remain in harmony but when there is a problem in one part of the cycle, another part of the cycle will be adversely affected. This results in a cycle of deprivation.

The biggest stress for families is the first year following the birth of their first child. This is a time of change in the family unit and if couples are unable to work together and recognise the needs of each other and the new infant this will result in immense stress and conflict. At all times, the family heirachy needs to be clearly recognised by all family members. It is important that families do not give the child excess responsibility as it should not be the child who determines what happens in the family. The boundaries of the family need to be well defined and consistent.
These boundaries may be difficult to establish as an adult if one has not experienced these as a child. This leads to a situation in which there are insufficient adult strengths. Dr Dare advocates programmes that will recognise the early stages of deprivation in the family unit and offer intervention to teach parenting skills as well as to provide support for the child, the adult and allow for environmental enrichment.

Lennox Thomas, Consultant Director of The Inter-cultural Therapy Centre spoke on the importance of providing positive images for children. This focuses on teaching children about their society and providing role models and positive images of themselves as part of their society. This is a precursor to establishing self esteem.

Mr Thomas notes that in the United Kingdom many children’s books, television programmes and promotional posters do not illustrate the multicultural mix and range of disabilities of the society in which these children live. He reminded the audience on how children see and interpret the world from a self centred approach. If we wish children to learn about and to respect the society in which they live then the images that we should provide them with from an early age should be an accurate reflection of their environment. Children need to be exposed to the multicultural component of society and the range of disabilities that exist in our society through these story books, television programmes and promotional advertisements.

In the United Kingdom, Health visitors are a source of health care with preventative health skills. Ms Hazel Norman, Health visitor, spoke of how the Health visitor often has the opportunity to know and interact with the family. The Health visitor identifies health needs by their observation and interaction with the family. They have easy access to the family, they are trained in preventative work and early identification of problems, and are aware of appropriate referral and intervention. This places the Health visitor in a position of being able to recognise early within the family risk factors for mental health problems. The importance of early recognition is that it can allow for intervention that will resolve problems before they become too deeply entrenched.

Ann Glover, a Project officer and trained health visitor then spoke on the FAMILYWISE programme. This is a series of cartoon vignettes designed to initiate a discussion with families so that they can identify needs and work out how to address these needs. It allows families to look at how they are functioning and how their individual attitudes and beliefs may be reflected onto other members of the family.

This meeting identified that pre-school mental health development is important. The conclusion of the meeting allowed for working groups to identify ways in which multidisciplinary professionals can identify and assist families at risk.

To break the cycle you need to work on more than one part of the cycle. Multiagency collaboration, with education, health and social services is essential. This intervention needs to promote self esteem for all family members, provide education and parenting skills, and respect culture.
AD/HD’97-The First European Conference for Health and Educational Professionals on Attention Deficit /Hyperactivity Disorder

AD/HD’97-The First European Conference for Health and Educational Professionals on Attention Deficit/Hyperactivity Disorder (AD/HD), was held at Christchurch College, Oxford. The conference was attended by over 400 delegates including medical professionals, educational professionals and parents. This provided an effective forum for children’s professionals and caregivers to be involved in discussions about this disorder. This forum allowed professional groups to appreciate the approach that other professionals have to the diagnosis and management of this disorder. The main speakers of the Conference were American Psychologists with numerous years of clinical work and research with Attention Deficit/Hyperactivity Disorder. Their presentations are summarised later in this section.

My impression of the conference was as a useful forum to discuss current concepts and interventions for AD/HD in the United Kingdom and European environment. The approach to diagnosis, classroom management and therapy was applicable to Australian practice. The discussions on medication were aimed at the overall audience, rather than a predominate medical audience and therefore only broad working principles were discussed. The important issues discussed at this conference were the diagnostic quandary, the importance of recognising comorbid disorders and how to provide effective intervention.

It was acknowledged that there is under diagnosis of AD/HD in the United Kingdom. Multiprofessional approaches are necessary and there are numerous management options, of which medication is only one possibility. The reluctance of the English Psychologists to support medication usage was addressed and there were numerous presentations that addressed the myths of medication as well as their potential benefits.

A review of terminology was essential as AD/HD is a subjective diagnosis, based on observations. It is crucial that there is agreement of diagnostic criteria and how these diagnostic criteria are applied. The current term used is “AD/HD”. This refers to Attention Deficit Hyperactivity Disorder. Previous terms have included ADD (Attention Deficit Disorder), ADHD, and minimal brain dysfunction. AD/HD is the term used in the Current DSM-IV manual. It was also acknowledged that in the United Kingdom and Europe that the DSM-IV is not universally used. The European Alternative is the ICD-10. This immediately highlights the differences that exist across the Atlantic with relevance to understanding of this disorder. As there is no clear consensus on diagnostic criteria it is impossible to compare published prevalence rates between different countries that use different diagnostic standards.

As an Australian paediatrician, my preference is for the DSM-IV criteria. DSM-IV allows for one or more diagnosis to be applied to a child who is exhibiting a constellation of symptoms or traits. The ICD-10 only allows for one diagnosis, the Multidisciplinary approaches to childhood learning disabilities
one of most importance, and therefore may not allow for a diagnosis of AD/HD when it is associated with comorbid disorders.

The differences between the English/European approach and the American approach was evident throughout the conference. At times, I believe this interfered with information being presented, as the audience often had difficulty with the standing definition. It was also evident that the prevalence of AD/HD and its comorbid conditions in the United Kingdom is currently not known. Furthermore it would be difficult to identify these rates because of terminology difficulties and a lack of recognition of many of the characteristic features. It does not follow that these figures are accurately known in the United States. However, there is information from the United States which provides good estimates on the basis of well run conducted research trials.

**Papers presented:**

The following is a brief summary of the relevant papers presented at this conference.

**Dr Thomas Brown.**

Dr Brown is an American Clinical Psychologist and Associate Clinical Professor of Psychiatry at Yale Medical School. He spoke several times in the conference. His main interest is with high IQ children, adolescents and adults with AD/HD. The following are a summary of his presentations.

**The Nature and Identification of AD/HD**

A North American view.

This was a paper based on the diagnostic differences across the Atlantic. Dr Brown spoke on the United Kingdom focus on Hyperactivity, whereas the Americans recognise that inattention/impulsivity are the central element of AD/HD. This is an important distinction. AD/HD can exist without any hyperactivity manifestations. As the child gets older, the hyperactivity component may abate with inattention persisting.

The discussion also included causative issues. Research currently suggests that AD/HD can have a familial trait. It is postulated that there is an important neuro-chemical component. This is supported by a familial component with environmental influences and subsequent response to medication.

Dr Brown also acknowledged that there is no one diagnostic test or criteria that will define whether a person has the disorder. He discussed how effective assessment requires skilled use of a variety of measures including semi-structured clinical interviews, self-report and parental/guardian report, measures for concentration and short term memory as well as identification of any existing comorbid disorders.
He spoke on the stereotypes that AD/HD only affects young males with a low IQ and is associated with hyperactivity and behaviour problems and limited ability to concentrate. His presentation demonstrated that all these stereotypes are inaccurate.

AD/HD is a composition of three main features; inattention, impulsivity and hyperactivity. The current controversy arises as hyperactivity may not be present or be a significant part of the presentation.

Inattention refers to the quality of concentration. Often inattention refers to ‘drifting in’ and ‘drifting out’. Metaphorically, there are so many signals and noises that we are exposed to every day and it is this inability to distinguish the signal from all the background noise and interference.

The DSM-IV is the favoured diagnostic scale in American practice. This current edition qualifies a diagnosis of Combined AD/HD when six or more of nine of the inattention features are present in combination with six or more of the nine Hyperactivity-Impulsivity features. Predominate inattentive AD/HD is when six or more of the nine inattentive symptoms are present, and Predominate Hyperactivity-Impulsivity when there are six or more than nine of the Hyperactivity-Impulsivity symptoms. The Predominate Hyperactivity-Impulsivity form of the disorder is considered to be a prodromal form of the combined AD/HD.

Dr Brown quoted United States of America prevalence figures of 6-8% children with AD/HD and 3-4% of adults. His view is the male to female ratio is not the extreme six to one of early estimates, but more likely three to one. He also believes that many females are unrecognised and that this ratio could be even less marked. Dr. Brown’s experience also demonstrates that AD/HD occurs in all IQ and Socio-economic groups.

Dr Brown’s specific interest has been with high IQ people and familial studies. He estimates that one quarter of children with AD/HD also have a parent with a form of the disorder. His studies also suggest that the hyperactivity component of the disorder lessens with age, but in 50% of AD/HD children many of the other symptoms (impulsivity and inattention) will persist through into adult life.

Dr Brown’s work with high IQ children and adults demonstrates that many of these people present later that 7 years of age, as it is only when the academic work at school becomes more challenging that the inattentional features are effectively unmasked. Therefore, although the DSM-IV cautions about a diagnostic label if symptoms are not recognised prior to age 7 years, Dr Brown argues that the child’s abilities may not have been truly challenged prior to age 7 years.

Dr Brown’s closing comments emphasised that AD/HD is not a singular disorder. AD/HD has a recognised heritable and developmental process. It is dimensional as opposed to categorical, it does not always require hyperactivity for a diagnosis and there are many psychiatric comorbid disorders that may be associated. Learning disabilities are common with AD/HD and in approximately 80% of cases there will be a positive response to stimulant medication.
Brown Attention-Deficit Disorder Scales.

Dr Thomas Brown has devised rating scales for use in children and a separate scale for adolescents to provide a framework for diagnosis of AD/HD and to provide a structure for evaluation of intervention. The scales report a probability that a child or adolescent may have AD/HD. This scale provides prompts with an extensive framework for important clinical questions that need to be answered honestly by both the child/adolescent and his/her parent/s. The current DSM-IV criteria are included for completion and then there is a forty question booklet administered to the child/adolescent.

The question component is used to calculate a numerical score. This correlates with a risk probability for having AD/HD. This can then be further interpreted with reference to the DSM-IV criteria and the clinical scenario.

Dr Brown has validated his questionnaire and provided references and statistics to explain its implementation.

AD/HD and Comorbid disorders

Dr Brown spoke on the importance of considering and identifying any comorbid disorder when AD/HD is diagnosed. His estimates are that over 50% of people with AD/HD will have at least one comorbid psychiatric or learning disorder. He also spoke on the elevated risks of additional learning disorders and/or psychiatric disorders among children, adolescents and adults with AD/HD when compared to population risk rates. Some of these disorders will mask the associated AD/HD or the AD/HD may mask the associated disorder, so vigilance in identifying these is required in all cases.

Common comorbid disorders involving learning disabilities include reading, mathematics, written expression and problems with receptive and expressive language. The commoner psychiatric disorders include; depression, bipolar disorder, mood disorders, anxiety disorders and Obsessive-Compulsive disorder. Oppositional defiant disorder, conduct disorder and substance abuse also have higher prevalence rates than that of the general population. It is also recognised that social interaction impairments, including autism, Asperger’s syndrome and Pervasive Developmental Disorder can be associated with significant manifestations of AD/HD characteristics.

Dr Brown’s recommended consultation approach is to:
1. Obtain a thorough clinical history - past and present
2. Conduct an AD/HD symptom rating guide - self report and a collateral report
3. DSM-IV criteria scoring - self, collateral and clinician
4. Normal measures - these include psychometric IQ studies, verbal memory with particular reference to short term memory
5. Comorbidity screening

The treatment approach may include:
1. Treatment of the AD/HD symptoms
2. Management of comorbid disorders
3. Educational support and specific interventions
Dr Brown spoke at some length on neurochemical origins for AD/HD and hypothesised chemical explanations for the constellation of symptoms. It then follows that medication may be very effective in AD/HD treatment based on this neuro-chemical component. However medication does not always alleviate the AD/HD symptoms alone nor alleviate the comorbid disorders, and therefore the multi-modal treatment approach is important.

**Teenagers with AD/HD**

This is a speciality area for Dr Brown. The demands of the adolescent years associated with a more challenging academic curriculum, and subsequent life experiences including tertiary studies, relationships, marriage and parenthood can alter the AD/HD symptom manifestations. Untreated AD/HD at these times can lead to chronic stress and frustration, social isolation, guilt, difficulty with relationships.

Dr Brown discussed the need to evaluate and assess the adolescent with an interview environment that provides the adolescence with power and value. This may seem obvious, but in the clinical scenario it can be difficult for the parent to allow the adolescent this courtesy. It is therefore an important skill for a practitioner to be able to give the adolescent importance and first right of discussion. Allowing an adolescent to talk about their schooling, grades, sports, friends and activities will often provide many of the essential answers without the need for a questioning approach.

Adolescents may require similar therapies to other age groups including an individual approach, educational interventions, psychotherapy/counselling and medications. Adolescents must be involved in the decision making process for intervention as without their agreement and willingness to try an intervention it will not be possible to succeed.

**Dr Sam Goldstein**


Dr Goldstein was the other the keynote speaker with widespread experience in diagnosis and management of AD/HD. His first presentation again focused on definitions with some useful working concepts.

- Impulsivity - the inability to stop and think
- Distractibility - the inability to focus on the task.

Impulsivity was discussed at length with examples provided to demonstrate that impulsive children cannot wait. Even if there is a reward for waiting, they have...
the inability to delay their action so as to receive the reward. There is no focus on the long term goal.

Children with AD/HD have more difficulty learning day to day tasks and routines as they do not focus on the outcome. External cues are often not recognised by AD/HD children.

**AD/HD and the Autistic Continuum**

Language disorders are seen more frequently in AD/HD children and social impairments are a recognised comorbid disorder. This combination requires that the autistic spectrum be considered.

Dr Goldstein spoke predominately on high functioning autism and Asperger’s. He made the point that there is a difference between the two entities. Cognitive deficits are frequently associated with autism. His presentation was only with respect to autistic children and Asperger’s children with no cognitive deficit (meaning that the IQ was in the low normal range or better).

The table he provided to differentiate the two entities is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Asperger’s</th>
<th>High functioning autism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social</td>
<td>Poor</td>
<td>very poor</td>
</tr>
<tr>
<td>Motor</td>
<td>Clumsy</td>
<td>Good</td>
</tr>
<tr>
<td>Circumscribed interests</td>
<td>usual</td>
<td>Variable</td>
</tr>
<tr>
<td>Family history</td>
<td>usual</td>
<td>Occasional</td>
</tr>
<tr>
<td>age at onset</td>
<td>&gt;24 months</td>
<td>&lt;36 months</td>
</tr>
</tbody>
</table>

Asperger’s children, as referred to in this presentation, have a developmental delay disorder characterised by major impairments in social interaction with restricted and unusual patterns of interests and behaviour. To assist with clarifying a diagnosis; observation, academic measures and behaviour assessment (including adaptive behaviour scales, CARS scales, Autism Behaviour Checklist) may be useful.

**AD/HD and Depression**

Depression is a condition that can occur in childhood. With the increasing recognition of AD/HD it is also being observed that children with AD/HD have a greater incidence of depression in comparison to the normal childhood population. Depression is recognised as a comorbid condition.

The overall incidence of childhood depression is estimated at 4-6%. If a parent is depressed this increases the child’s risk of depression (13% of children of a depressed parent are depressed) and if the parents has a bipolar depression this incidence is further elevated. For children with AD/HD the comorbidity of depression may be as high as 25%. Environmental risk factors that contribute to childhood depression include children of divorced parents, children with anxiety,
attention deficit problems or a conduct disorder, mild cognitive deficit and children of the lower socio-economic strata.

There are ten core symptoms reported in childhood depression:
1. flat affect with a distinct look of unhappiness
2. inability to find pleasure
3. low self-esteem
4. feelings of guilt
5. social isolation
6. impaired school work
7. chronic fatigue
8. low energy level
9. difficulty with sleep or appetite
10. suicidal thoughts

A child with a depressive illness has a high risk of recurrence within the next 5 years (up to 70% recurrence). Intervention is obviously important but there is limited research on the most effective way to manage childhood depression with AD/HD. It is thought that cognitive therapy techniques with cognitive restructuring, attribution training, self-control training, social skills support and problem solving/conflict resolution skills are successful therapy techniques. These programmes can involve an educationally based programme with a variety of treatments and family members.

Dr Michael Goldstein

Child neurologist and Associate Clinical Professor at the University of Utah.

Dr Goldstein has extensive experience with medication treatment in AD/HD. In the USA the most commonly used medication in the treatment of AD/HD is Methylphenidate (Ritalin). Overall it accounts for 90-98% of USA children on medication. The dose needs to be individualised for time of administration and amount. Extensive trials comparing Methylphenidate to placebo combinations do support a definite clinical response to active medication. It is presumed that this action is a result of altered neurochemical reactions.

All medications are associated with side effects and Methylphenidate is no exception. In 2% of children the medication may need to be stopped because of unacceptable side effects. Mild side effects are noted in 20-50% of children. These included weight loss (short term), sleep disturbance, loss appetite, headache and irritability. These need to be compared with potential benefits of medication in the classroom including less impulsive responses and improved academic achievements. Tics are a potential side effect of medication and treatment may unmask Tourette’s syndrome. Rarer side effects can include seizures, aggression and psychosis.

When medication is introduced it is important to evaluate the following considerations:
• is there a disorder that may respond to medication
• what side effects are experienced
• what non medication interventions are in place
• what additional treatments are available as alternatives or adjuvants
• are the symptoms significant enough to warrant a trial of medication
• what follow-up / evaluation is available.

**Advanced Medication**

This was an overview on medication options.

There are several medications available for use in AD/HD. The first line medication is the stimulant derivatives. The predominate medication is Methylphenidate, a short acting stimulant. Dexamphetamine is a similar medication with a similar side effect profile. It costs less than Methylphenidate, but in controlled trials it has been shown to not be as effective as Methylphenidate. (In Australia, Dexamphetamine is the preparation available on the Health Authority Scheme and therefore is subsidised. Methylphenidate is available for use in Australia but usually with a significant cost factor to the family). In the United States of America, a sustained release long acting derivative is available (Pemoline). This only requires a once daily dosage. It is not as effective as the two shorter acting medications. It has a similar side effect profile with the addition of potential liver failure.

Tricyclic antidepressant are an alternative treatment to the stimulants when they are not successful or are contraindicated. They have a slower mode of action and often require a trial of 2-4 weeks to assess effectiveness. Usually they are administered once daily, usually of an evening as the major side effect is drowsiness. Their use is recommended with caution as there have been reported cases of sudden death (cardiac related, associated with larger dosages). This emphasises the need for caution in their usage and a basic cardiac evaluation when they are administered.

Alternatives when these are not successful, or contraindicated because of side effects include Clonidine and the new SSRI medication class (example - Prozac).

Caution is warranted, especially in young children (<6 years age) when medication is prescribed. Polypharmacy is to be avoided and should only be used with caution. Potential drug interactions must always be considered.

**Professor Eric Taylor**

Child Neuro Psychiatrist : Hyperactivity and Risk.

This presentation at the beginning of the conference followed the American approach, with a discussion of diagnosis and the differences between DSM-IV and ICD-10.

Professor Taylor introduced early into the presentation the concept of children having biological problems with neurochemical origins. Often these require both neurochemical responses as well as psychological interventions.
The high inheritance was noted, with identical twin studies suggesting this may be as high as 80%. However it would appear that it is not a single gene defect, One or more genes can predispose to symptoms. Environmental factors can poteniate the underlying genetic tendency to the disorder and have a significant influence on outcome.

Professor Taylor then continued to discuss the risk of comorbid disorders and the importance of family support for a child with AD/HD.

Professor Peter Hill

Consultant Psychiatrist: The Need for a Comprehensive Approach in the United Kingdom setting.

This presentation provided a framework for United Kingdom and European practitioners to use when considering AD/HD. The areas covered were primary diagnosis, comorbid disorders, assessment procedures, and parental and school resources.

Primary diagnosis was discussed again with reference to the DSM-IV and ICD-10. The importance of distinguishing from normal inattentiveness and overactivity was highlighted. The mental abilities of the subject are also important as it is essential not to describe a low normal/borderline IQ as AD/HD. It follows that when assessment is undertaken this needs to be in reference to the mental age. Behavioural comorbid disorders such as conduct disorder or an autistic spectrum disorder may lead to confusion of diagnosis.

Other issues that must be considered again emphasise the importance of comorbid disorders. Self esteem, peer relationships, parental relationships, sleep patterns, general family history and any history of head trauma must be examined.

Assessment requires a thorough history from child and caregivers, neurodevelopmental examination, and psychometric consideration. Additional information can frequently be gained by contact with the school teachers and by completion of rating scales, such as the Conners rating scales. These scales are a collection of questions that can be scored for a profile to suggest AD/HD likelihood. These have been validated and widely used worldwide.

During the clinic interview the professional needs to monitor the child’s mental state and where possible obtain a psychological assessment, language assessment and physical examination.

AD/HD is a condition with potential educational, psychological and medical manifestations. It is evident that the approach suggested in this presentation requires multi-professional collaboration to ensure a complete assessment to address these potential manifestations.
Dr Katherine Ideus

Educationalist : Educational Responses to AD/HD.

Dr Ideus approached her presentation from a teachers perspective, describing classroom traits of a child with AD/HD with many of the Hyperactivity components. These include the child who often leaves his/her seat, deviates from classroom activity, fails to follow teachers instructions, talks out of turn and calls out, has a short attention span and is distractible, daydreams frequently, is often forgetful and fails to do or hand in homework.

Dr Ideus spoke of the teachers responsibility to learn about the condition so they can identify children at risk and then refer for evaluation and assist with monitoring of progress during the intervention period. Overall the teacher can offer a comprehensive role in the child's management. In the United Kingdom, Dr Ideus suggests this can best be incorporated into the Code of Conduct for Special Educational needs with the School SENCO taking responsibility for implementation.

Kate Ripley

Educational Psychologist : The Hampshire Initiative.

This initiative is a Multi-Professional framework approach to the diagnosis and management of AD/HD in the Hampshire district. It ensures the co-operation of Paediatricians, Educational Psychologists, Teachers, the school statement process and other associated professionals to provide a comprehensive assessment of each child. Their experience with this approach is that there is awareness with all involved professionals of the child’s progress and treatment. It often allows for behaviour management techniques to be introduced alongside educational support and interventions. Counselling and individual therapy are provided when necessary. When medication is initiated it also allows for comprehensive evaluation of the child’s response to medication.
9.8 Royal College of Paediatrics and Child Health - Annual Scientific Meeting

This College was founded in 1996 with Her Royal Highness, The Princess Royal as patron. This College has evolved from the British Paediatric Association, founded in 1928. The College aims to advance Paediatrics, to raise the standard of medical care to children, to educate those concerned with Paediatric health care and to advance the education of the Public on Children’s Health Care. The College members include United Kingdom Paediatricians, Paediatric Trainees and Doctors with a primary interest in child health.

The meeting provided a scientific forum with papers presented from all areas of Paediatric health care. There were Community Paediatric sessions as well as a session devoted to childhood disabilities. In addition, the need for training of Paediatricians and the newly implemented changes in paediatric speciality training were discussed.

The Donald Court Memorial Meeting held on the last afternoon of the conference discussed Community Paediatrics and its current presence in the United Kingdom, as well as future plans for Community Paediatrics. With the changing medical practices, the role of the Community Paediatrician continues to evolve. Ideally it encompasses all aspects of child health as well as promotion of primary care, medical support for educational issues and social issues, general paediatric support in outpatient environments as well as liaison with accident and emergency paediatric services.

BACCH - the British Association for Community Child Health conducts a Development and Disability Interest Group. This group presented several papers in addition to the Community Paediatric based papers. A summary of papers relevant to childhood learning disabilities is as follows:

Choice of Medical Investigation for Children with Moderate Developmental Delay.

This paper was a questionnaire survey of Paediatricians. Paediatricians were presented with a clinical scenario and asked to nominate what investigations they would suggest for the child. This is a common scenario for a Paediatrician working with children with learning disabilities. This paper confirmed that there is no clear guidelines on what investigations are necessary. The paper evoked extensive discussion that emphasised how important it is to work with each individual family and child on an individual basis when recommending investigation.

Surveillance for Thyroid dysfunction in Down’s syndrome

- longitudinal data and a completed audit cycle.

This was an audit paper that highlighted the lack of consensus of screening children with Down Syndrome for hypothyroidism. Children with Down syndrome...
are at increased risk of hypothyroidism and this can lead to additional medical and learning problems if unrecognised. There are moves for a national screening programme, collecting T4, TSH and thyroid antibodies to be implemented on a three yearly basis after age 2 years. This contrasts with the Australian recommendation of annual screening. It is not possible to state which screening method is the preferred method, and further review of this is being undertaken in the United Kingdom.

Are we giving special care to children with special needs in our hospital?

This paper discussed the preparation for hospitalisation and the subsequent in-patient care for children and families with special needs. Overall these needs are often not well met or addressed during a hospital admission. This needs to be reviewed with reference to planned admissions, acute short admissions and long stay admissions. It was recommended that the children’s ward policies need to be prepared for children with additional medical and therapy needs.

Developmental testing - Norm referenced tests and checklists

This paper discussed the various child development screening tools and formal assessment tools available. The one important observation is that many of these tests are not being administered according to their recommended guidelines, therefore this invalidates their results.

Currently the two developmental assessment tools commonly in United Kingdom practice are the Griffiths Mental Developmental Scales and the Bayley Infant Scales. These are administered by a trained and accredited Psychologist or Paediatrician. Both are used in Australia as developmental assessment tools, as well as a standardised assessment tool for research protocols.

Developmental screening tools are ideally useful for the United Kingdom Health visitor as a part of a developmental screen to identify children who will require the more extensive developmental assessment. There are several validated tools available and in use in the United Kingdom. There was discussion in this forum as to whether Health visitors should be conducting a formal developmental screen and if so, at what age. No consensus decision was researched.

A population based study of Autistic Spectrum Disorders

- current trends in investigations

This paper was an audit review of children with autistic spectrum disorder in a health authority catchment area, to determine what investigations these children had had as part of their diagnostic process. It was apparent that there is no defined protocol to follow and that investigation is determined on an individual basis. This paper is similar in findings to the paper on investigations for moderate learning disabilities, as both papers demonstrated that Paediatricians approach these problems with an individual approach. It is evident that there is a place for investigations but
these must be considered with reference to the family, the child, and the possible outcomes of an abnormal or normal result, the side effects of investigations as well as the cost of investigations.

**Special needs Database services.**

This paper discussed the need for each Health Trust to have a database record of children with special needs. The use of this database would be to identify service needs for current clinical problems as well as to predict for future service provision. The difficulties with a database include confidentiality as well as accurate record keeping and coding for medical diagnoses.

In this era of medicine, accurate record keeping is required for the implementation and practice of evidence based medicine. A well set up database is a useful asset for evidence based medicine practice as it can provide accurate and comprehensive medical records for audit purposes.

**Otoacoustic Emissions as a Screening Test**

- for Hearing Impairment in Children recovering from Bacterial Meningitis

This paper was one of a few papers that discussed Otoacoustic screening. It is apparent that this is a highly sensitive screening test with a relatively high specificity. This makes it suitable for usage in high risk children for hearing impairment. The procedure is well tolerated, quick, objective and non-invasive. In this paper, screening of a high risk population with otoacoustic emissions had a 100% sensitivity for hearing loss and a 91% specificity.

**The Wessex Controlled trial of Universal Neonatal Screening**

for Hearing Impairment - Coverage, Failure Rate and Yield

This paper discussed the importance of Community Paediatricians as advocates for the implementation of universal neonatal hearing screening programmes using Otoacoustic emissions. The procedure is simple to use in this age group. The main problems with a universal hearing screening programme is that neonates who are discharged at a few hours of age and born over weekends when routine staffing is reduced, may miss the screening programme. This paper identified that 75% of neonates were screened by age 48 hours. In an aim to screen the remaining 25%, a recall clinic was available at 2 weeks a of age. Overall a total of 86% of neonates were screened. Further evaluation of population screening and other ways of increasing the population coverage are being investigated.
Multidisciplinary approaches to childhood learning disabilities