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## BRIEF

### Department of Families, Housing, Community Services and Indigenous Affairs

MaPS.Net PDR Id	BR10-001380
Due Date	8/11/2010
Critical Date	N/A
Consultation	Media No
	Group Manager Yes
	Deputy Secretary No
	State Manager No

To Senator the Hon Jan McLucas, Parliamentary Secretary for Disabilities and Carers  
For information

cc: the Hon Jenny Macklin MP, Minister for Families, Housing, Community Services  
and Indigenous Affairs

Subject: MN10-002086 Follow up - Better Start for Children with Disability initiative

**Issue:**

Following MN10-002086: Implementation Overview – Better Start for Children with Disability initiative,  
you requested further information on the Better Start for Children with Disability (Better Start) initiative.

Details of potential options for implementing the Better Start initiative are at **Attachment A**. Given the  
announcements made with the election commitment,

Information on the evidence base for the five identified disabilities (hearing and visual impairment, Down  
syndrome, cerebral palsy and Fragile X syndrome) is at **Attachment B**.

Given the association between Fragile X syndrome and Autism Spectrum Disorders, the Department will  
undertake consultations with key stakeholders to determine the appropriateness of including Fragile X  
syndrome under the current HCWA arrangements. Further information on this proposal is included in  
**Additional Information**.

As requested, the Department has investigated the evidence base for other disabilities that may benefit  
from an early intervention therapeutic approach.

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Decision Note – BR10-001380 Better Start

Recommendation:

1. Note the information provided in this brief
2. Agree to the fee for service funding model as per the HCWA package
3. Agree that the package include the five identified disabilities (hearing and vision impairment, Down syndrome, cerebral palsy and Fragile X syndrome) for commencement on 1 July 2011.

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Signed:

Janet Lucas

Date:

7.2.11.

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As there is no agreed definition for developmental disabilities there is a risk to Government that it will continually be exposed to criticism for any approach that it takes to include any additional disabilities.

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There are currently 42,000 children aged up to 6 years, who have been assessed using the Child Disability Assessment Tool in conjunction with the List of Recognised Disabilities (LORD), whose parents are eligible for Carer Allowance. There have been 11,000 children registered through the HCWA package and it is proposed through this package that a further 9,000 children will be assisted over four years.

Noting that the Government has committed to a 1 July 2011 implementation date, the decisions regarding the type of funding model and range of eligible disabilities to be included in the package need to be finalised as soon as possible as consultations with stakeholders and discussions to develop information technology requirements are required prior to the end of this calendar year.

**Recommendation:**

1. That you note the information in this brief and provide any comment on the components proposed. Noted / Please Discuss
2. That you note that any expansion in the list of identified disabilities within the package will require additional funding. Noted / Please Discuss
- 3.
4. That you agree to limit the package to the five originally identified disabilities, noting recommendation 3. Agreed / Not Agreed
- 5.

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Date: 9/11/10

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2.22 Irrelevant material  
2.22 Irrelevant material

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Comments (MO use)

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Signature: .....

Date: .....

**ADVISER TO ACTION:**

Local Member Advised	State Member Advised
Yes / No	Yes / No
Name of Member	Name of Member

Rating	Quality	Timeliness
Unsatisfactory		
Satisfactory		
Good		

**Additional Information**

This election commitment strategically aligns with the Helping Children with Autism (HCWA), National Disability Strategy, the Government's early childhood agenda, Government Hearing Service Program (HSP), Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative, and the National Framework for Action to Promote Eye Health and Reduce Avoidable Blindness and Vision Loss. It also aligns with commitments to education and social inclusion.

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### **Key elements and issues for the Better Start for Children with Disability initiative**

The election commitment announcement provided a considerable amount of detail about the adoption of a model similar to the Helping Children with Autism (HCWA) package being applied to this initiative. Based on the assumption that the Better Start initiative will be similar to the model used under HCWA, a number of issues are highlighted about the individual components that have been costed for the new initiative.

#### **Component 1 – Eligibility and Access Coordination**

There is no clear definition of developmental delay or of the conditions that would make up a category referred to as developmental disability. Without this definition there is a significant risk that the Government will receive ongoing criticism for an apparent inequity in providing support for one group of children and not others. Any extension of the current list of disabilities announced as eligible under the Better Start initiative may further increase criticism by those groups still not included under the package and increase expectations that other disabilities may be included in the future.

In terms of eligibility it is proposed to use the requirements for the Carer Allowance, along with the relevant diagnosis to access this package. The Child Disability Assessment Tool (CDAT) is used currently to assess eligibility for Carer Allowance (child). The questionnaire contains two parts – a treating health professional questionnaire and a carer questionnaire. A qualifying score must be achieved on the treating health professional questionnaire before the carer then completes the carer questionnaire. The two scores are then combined to determine if the carer qualifies for the allowance. The CDAT measures the severity of disability by assessing whether the child functions according to standards appropriate to their age. The child's ability is measured in a series of functional categories: language skills, self-care skills, social and community skills, and fine and gross motor skills. Additionally, behaviour is taken into account where it is significantly affected by the disability, along with special care needs. This is not currently a requirement through HCWA.

To access the early intervention funding a point of registration and information to parents about available service providers is required. Under HCWA this is achieved through Autism Advisors, located in existing Autism Associations. This current gateway for registration will not be suitable for the disabilities identified under the Better Start package. The Department has costed a gateway based on costs associated with HCWA (although these have been costed at a lower rate based on the assumption that diagnosis and assessment would generally occur earlier and with less contest for these disabilities than for autism).

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There are three potential options including identifying non government organisations, Centrelink and State/Territory Government services. The non-government organisations could possibly be sourced from the different peak bodies in each state and territory or through a disability services agency. This will require consultation to identify existing services that may be in a position to take on this role with available funds.

Given the strong association between Fragile X syndrome and Autism Spectrum Disorders (ASD) it may be possible to utilise the existing Autism Advisor gateway for the registration of these children. It is anticipated that some children with Fragile X are already accessing services through HCWA due to also having a diagnosis of ASD. The Department will undertake consultations with key stakeholders to determine the appropriateness of including Fragile X syndrome in the list of eligible disabilities under the current Helping Children with Autism package.

It will be critical to advise families that under the Early Intervention programs (HCWA and Better Start), that children will only be able to register and access early intervention funding once, regardless of multiple disability diagnoses. Therefore a child who has ASD and a sight impairment and who has already accessed early intervention funding under the HCWA package, will not be eligible for early intervention funding under the Better Start initiative.

#### **Component 2 – Panel Provider model and system requirements**

Considerable work is required to determine the way in which the Panel Provider model will operate under the Better Start initiative. Under the HCWA package, service providers apply to become members of an early intervention service provider panel.

Some existing HCWA panel providers have enquired about the new package. They have indicated that to service additional children they would require time to build up their capacity by recruiting additional staff. There are known workforce shortage issues for Allied Health Professionals and this may impact on

both the HCWA and Better Start initiatives. Waiting times for HCWA have reduced from 54 days to approximately 27 days in the last 12 months.

### Component 3 – Eligible Interventions

A reference list, at **Attachment F**, was used to develop the evidence base for the five identified disabilities (hearing and visual impairment, Down syndrome, cerebral palsy and Fragile X syndrome) and potential early interventions.

### Component 4 – Outer Regional and Remote Payment

The costing for the Better Start initiative included the provision of an Outer Regional and Remote (ORR) Payment. By applying the same eligibility under Better Start as the HCWA package, it is estimated that approximately 25 per cent of the eligible population would receive a one-off payment of \$2,000. This is particularly aimed at families living in areas where access to service providers is limited. For example, this funding may assist with costs associated with travel to services or outreach services.

The HCWA initial evaluation report found that the service model is working less well for people living in remote, rural and regional areas and for vulnerable groups, particularly Indigenous people. In these locations, many families have significantly fewer opportunities to access panel provider services because of a lack of providers and insufficient outreach services to meet all needs.

### Component 5 – Resources

Preliminary research on the five identified disabilities indicates that many children with these disabilities require assistive aids and equipment as part of their early intervention. Under the HCWA package, families can access use up to 35% of their child's early intervention funding for resources that form part of the child's intervention plan to support therapy in the home environment. Resources that are eligible are determined by the professional undertaking intervention with the family based on the needs of the child.

As part of the National Disability Agreement, the Department is leading the Aids and Equipment Reform Working Group with state and territory officials to achieve more consistent access to aids and equipment by the end of 2012.

### Component 6 – Education, Information and Evaluation

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To support parents and carers to access information, the Better Start initiative includes an update to the Raising Children Website with relevant early intervention disability information. It is important to ensure families can access information that will help inform their decision making around the choices of intervention therapy that may be suitable for their child's needs. \$300,000 has been allocated for this activity.

Funding has been allocated to cover an external call centre to respond to queries about the Better Start initiative, with the function to be brought in-house in the third year of implementation. This is the approach used in the early implementation of HCWA and was found to be a cost effective way to deal with the large volume of inquiries received in the early phases of the package. Training and promotion is essential to this service offer.

Peak body and key stakeholder (for example, paediatricians) engagement is crucial to ensuring that information is understood and adequately distributed.

## ATTACHMENT A

## Options for implementing the Better Start for Children with Disabilities Initiative

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} Processes**Option 1: Fee for service funding – based on the current Helping Children with Autism package**

The HCWA package is based on a fee for service model that consists of a registered panel of service providers that deliver a suite of eligible interventions (based on best practice guidelines developed by Roberts and Prior 2006). Panel providers receive funds in arrears on a case claim basis for services delivered to eligible children. An eligible child is registered for HCWA early intervention funding on the FaHCSIA funding management system (by Autism Advisors) and claims for expenditure of up to \$6,000 per financial year (a maximum of \$12,000) can be made by panel providers (with family consent) against the child record. This model aims to meet the demand from families for control over how funding is used (based on the individual needs of the child) and choice in the service provider delivering the interventions. The registration of panel providers and payments on an individual case claim basis does carry some departmental overhead; however, the automated payment system which processes around 10,000 claims per month for HCWA is a relatively efficient payment method.

To access the funding there is the necessity for a point of registration and information giving to enable registration for the fee-for-service funding and to assist families to make choices about the eligible interventions. As noted in the Additional Information there are potentially 3 options for this gateway to access funds: Non-government organisations, Centrelink, or State/Territory Government services.

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An outline of current services and supports for children with disability provided by the state and territory governments is at **Attachment E**.

## ATTACHMENT B

## Evidence base for hearing and sight impairments, Down syndrome, cerebral palsy and Fragile X syndrome

A list of references used to support this information has been included at Attachment F.

### Vision impairment (Carer Allowance data Sept 2010 – 699 children<sup>1</sup>)

Vision impairment is defined as a limitation of one or more functions of the eye (or visual system). The most common vision impairments affect: the sharpness or clarity of vision (visual acuity); the normal range of what you can see (visual fields); and colour. There are numerous causes of vision impairment; including:

- genetic conditions;
- maternal infections experienced during pregnancy (e.g., rubella, cytomegalovirus, venereal diseases, toxoplasmosis);
- consequences of disease (e.g., diabetes, glaucoma, trachoma);
- complications associated with extreme prematurity;
- birth complications;
- trauma, poisoning, and tumours; and
- diabetic retinopathy;

### *Evidence for EI*

It is important to identify children with vision impairment and begin appropriate intervention as soon as possible because early identification and appropriate intervention may help speed the child's overall development and lead to better long-term functional outcomes (Clinical Practice Guideline: Vision Impairment).

### *Types of interventions*

For infants and young children with vision impairment, typical interventions generally involve the following approaches:

- correcting the child's vision to the extent possible;
- preventing or reducing the developmental problems that typically occur in children with limited vision; and
- providing family education and support.

(Clinical Practice Guideline: Vision Impairment)

### *Interventions for vision impairment may include:*

- interventions focused on improving visual function (vision stimulation);
- orientation and mobility training interventions (sensory skills, spatial and concept development);
- developmental interventions (cognitive development);
- sensory and motor developmental interventions (gross and fine motor development);
- communication developmental interventions;
- adaptive/ self-help skills interventions;
- social and emotional developmental interventions;
- Resources/assistive technology (vision aids, premobility and mobility devices, play and learning aids, communication devices);

(Clinical Practice Guideline: Vision Impairment)

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<sup>1</sup> A further 70 children are listed under carer allowance categorised with Deaf/Blindness

*Early interventions programs should:*

- be individualised (based on an assessment of the specific strengths and needs of the child, and resources, priorities and concerns of the family);
- consider the child's health issues;
- select interventions with a consideration of the effectiveness of the intervention and the expectations for the intervention;
- define desired outcomes;
- ensure individual intervention components are compatible, coordinated and complementary;
- provide a baseline for ongoing assessment of the child's progress;
- determine the most appropriate setting for interventions;
- determine the frequency and intensity of the intervention; and
- allow for ongoing monitoring and modification.

(Clinical Practice Guideline: Vision Impairment).

**Hearing Impairment (Carer Allowance data Sept 2010 – 2032 children<sup>2</sup>)**

There are three types of hearing loss: conductive hearing loss, sensorineural hearing loss and mixed hearing loss.

- Conductive hearing loss: can be acquired or congenital and is caused by blockage or damage in the outer and/or middle ear. A conductive hearing loss leads to a loss of loudness and can often be helped by medical or surgical treatment.
- Sensorineural hearing loss - can be acquired or congenital and is caused by damage to, or malfunction of, the cochlea (sensory part) or the hearing nerve (neural part). Sensorineural hearing loss leads to a loss of loudness as well as a lack of clarity. In Australia, 20 children per 10,000 live births will be born with a congenital sensorineural hearing impairment. Causes include:
  - inherited hearing loss
  - premature birth, lack of oxygen at birth or other birth traumas
  - damage to the unborn baby from a virus such as rubella
  - jaundice
- Mixed hearing loss: results when there is a problem in both the conductive pathway (in the outer or middle ear) and in the nerve pathway (the inner ear). An example of a mixed hearing loss is a conductive loss due to a middle-ear infection combined with a sensorineural loss due to damage associated with ageing.

***Evidence for EI***

The recent Senate Inquiry into Hearing Loss in Australia found that children who are diagnosed with hearing loss within the first six months of life and who receive appropriate intervention and support will acquire good communication skills and be well equipped to engage with the world. At the conclusion of the inquiry, the committee noted they were convinced by the evidence that early intervention of people with a hearing loss will pay society back in the long term with higher workforce participation and the associated spin-off economic (Hear Us: Inquiry into Hearing Health in Australia, 2010).

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<sup>2</sup> A further 70 children are listed under carer allowance categorised with Deaf/Blindness

Evidence continues to accumulate that for those children who are identified early and provided with appropriate hearing technologies and early intervention have improved language development, increased academic success, and increased lifetime earnings (White, 2000).

There is also increasing evidence that infants acquire information about their native language at a very early age. For example, in hearing infants, exposure to a particular language during the first 6 months of life alters not only infants' listening preferences but also their actual perception of speech sounds. Therefore, for young children with hearing loss, early identification and early intervention is especially important. When possible, it is recommended that intervention begin within the first year, optimally by the age of 6 months. Beginning intervention before the age of 6 months may help the child to achieve developmental age appropriate linguistic milestones (Clinical Practice Guidelines: Hearing Impairment).

Specifically, children will benefit from early identification that is paired with comprehensive interventions that actively involve family members (Moeller 2000).

### *Types of interventions*

Interventions for most infants and young children with hearing loss primarily focus on the following goals:

- preventing or reducing communication problems that typically accompany early hearing loss;
- improving the child's ability to hear; and
- facilitating family support and confidence in parenting a child with a hearing loss.

(Clinical Practice Guidelines: Hearing Impairment).

### *Principles of effective early intervention for young children with hearing loss*

- recognition of individual difference – individualising the program to meet the specific needs of the child and family;
- development – providing services appropriate to the developmental level of the child;
- direct learning – providing services directly to the child as well as to the parent, who then works with the child;
- program breadth and flexibility – offering a broad spectrum of services that are flexible and multifaceted;
- program intensity – adjusting the amount of intervention, including the number of hours of intervention per week and the family's participation in the intervention, to meet the needs of the child and family; and
- family participation and environmental supports – supporting active participation of parents and other family members in the intervention, and facilitating other appropriate support systems.

(Clinical Practice Guidelines: Hearing Impairment).

### *Other comments/issues*

#### *Universal screening*

A universal newborn hearing screening is being implemented in late 2010 under the Council of Australian Governments.

#### *Cost of early intervention*

A recent submission to the then Parliamentary Secretary for Disabilities and Children Services, the Hon Bill Shorten MP for a Hearing Loss Early Intervention Support Package noted the cost of early

intervention for a child with a hearing impairment was \$15,000 per year. The submission also noted that State and Territory Governments currently fund 18% to 40% of this expense.

#### *Indigenous Australians*

The recent Senate inquiry into Hearing Health in Australia found there is a crisis in Indigenous ear and hearing health in Australia with Indigenous people suffering ear disease and hearing loss at up to ten times the rate of non-Indigenous Australians. The Inquiry noted that the rate of middle ear infection (otitis media) among Indigenous Australians far exceeds the level that the World Health Organisation describes as 'a massive public health problem...which needs urgent attention' (Hear Us: Inquiry into Hearing Health in Australia, 2010).

#### **Cerebral Palsy (Carer Allowance data Sept 2010 – 1462 children)**

Cerebral palsy refers to a chronic neurological condition of motor impairment. The term cerebral palsy refers to a combination of symptoms, not a specific disease. The symptoms of cerebral palsy are caused by a static (non-progressive) cerebral lesion (brain injury) that occurs before the brain is fully developed (Clinical Practice Guidelines: Motor Disorders).

Cerebral palsy, except in its mildest forms, can be seen in the first 12-18 months of life. It presents when children fail to reach movement milestones. Babies most at risk of cerebral palsy are those born prematurely or with low birth weight.

Although the cerebral lesion is static, the impact of the lesion on the child's motor development may change over time as the brain matures and as the child grows. Therefore, the functional impairments related to the cerebral palsy may change over time (Clinical Practice Guidelines: Motor Disorders).

Approximately 60% of people with CP find speaking difficult, as the muscles of the mouth and throat are affected.

#### *Evidence for EI*

In the past few decades the importance of early intervention on motor development has become widely recognised (Blauw-Hospers, 2005).

#### *Types of interventions*

There are many different types of intervention approaches and programs that might be considered for a young child who has a motor disorder. Some approaches (**such as physical therapy, occupational therapy, and speech/language therapy**) might be considered standard or traditional developmental therapies.

In addition to these traditional therapies, there is also a diverse collection of therapeutic models and techniques that are sometimes referred to as "complementary" or "alternative" (such as aquatic therapy or therapeutic horseback riding). These approaches vary greatly in how commonly they are used, the time commitment required (intensity), cost, availability, and potential benefits and harms (Clinical Practice Guidelines: Motor Disorders).

Types of intervention include:

- physical therapy
- occupational therapy
- speech therapy
- counselling and behavioural therapy
- braces and other orthotic devices
- mechanical aids
- communication aids

(Access Economics, 2008)

#### *Other comments/issues*

Other intervention approaches include:

- Specialised exercise intervention - hippotherapy (therapeutic horse riding) or aquatic therapy.

#### **Down Syndrome (Carer Allowance data Sept 2010 – 1537 children)**

Down syndrome, also known as Trisomy 21, is a chromosome abnormality. A person with Down syndrome has three instead of the usual two copies of chromosome 21.

The most common physical and developmental features of children with Down syndrome include:

- Physical characteristics
  - diminished rate of growth and physical development. Most people with Down syndrome do not reach average adult height;
  - an atypical head shape (the head may be smaller than average, with a flat area at the back);
  - eyes that slant upward toward the edge of the face and an excess fold of skin over the inner corner of the eyes;
  - white spots in the coloured part of the eyes;
  - small or overfolded ears, a flat nasal bridge, and a small mouth with low oral muscle tone and a protruding tongue;
  - short, broad hands with short fingers and a single crease spanning the width of the palm ; and
  - decreased muscle tone.
- Developmental characteristics
  - delayed cognitive development, usually within the mild to moderate range of mental retardation;
  - delayed and atypical speech and language development, with expressive language being more delayed than receptive language;
  - delayed development of social skills;
  - delayed motor skills; and
  - possible coexistence of other developmental disorders, mental health or behavioural conditions (such as attention deficit hyperactivity disorder oppositional defiant disorder, or **pervasive developmental disorders/autism**).

#### *Evidence for EI*

Children with Down syndrome are usually identified at birth, and it is recommended that the assessment and intervention process begin as soon as possible. Beginning intervention services early may help the child's overall development and lead to better long-term functional outcomes (Clinical Reference Guideline: Downs Syndrome).



*Types of interventions*

It is important that interventions for a child with Down syndrome be linked closely with the child's assessment as well as an assessment of the family's needs so that the intervention can be individualized. It is recommended that interventions for young children with Down syndrome include:

- multiple settings, as appropriate, such as home and/or community/centre-based services (such as child care setting, playgroups, and typical social environments);
- multiple modalities, such as using objects, pictures, sounds; and
- multiple opportunities to practice developmental skills with different persons (parents, therapists, peers) to meet the strengths and needs of the child and family (Quick Reference Guideline: Downs Syndrome).

Interventions should focus on specific developmental domains:

- Cognitive development
- Communication development
- Adaptive/Self Help skills

And can include:

- audiology
- family training, counselling, home visits, and parent support groups
- occupational therapy
- physical therapy
- psychological services
- social work services
- special instruction
- speech-language pathology
- vision services
- resource/ assistive technology services and devices

(Quick Reference Guideline: Downs Syndrome).

*Related conditions*

Both children with Down Syndrome and Fragile X syndrome evidence challenges with articulation/speech issues, expressive language delays, and strengths in some aspects of receptive language (Fiddler, 2007).

There is some overlap between the profiles observed in children with Down syndrome and Williams syndrome, in that both groups show delays in the onset of expressive language (Fiddler, 2007).

*Other comments/issues*

Other intervention approaches include:

- sensory integration therapy
- music and art therapy
- hippotherapy (therapeutic horseback riding)
- conductive education (focuses primarily on motor function and is based on the theory that abnormal motor patterns can be transformed into functional motor patterns by intensive "training".
- vitamin and mineral supplement therapy
- growth hormone therapy
- thyroid hormone therapy

(Quick Reference Guideline: Downs Syndrome)

### **Fragile X (Carer Allowance data Sept 2010 – 58 children)**

Fragile X Syndrome is the most common cause of inherited intellectual disability and the most common known genetic cause of autism. Typical features of Fragile X syndrome include:

- Developmental Disability: speech delay or disturbance; intellectual disability; learning disabilities; co-ordination and motor problems; low muscle tone;
- Behavioural and Emotional Characteristics: attention-deficit disorders, often with hyperactivity, distractibility, impulsiveness and poor concentration; Hand mannerisms – hand or wrist biting, hand flapping; speech pattern disturbances; shyness, social avoidance, poor eye contact; autistic-like stereotyped behaviours, pre-occupation with objects, echolalia; sensory defensiveness - aversion to touch, bright lights, loud noises, strong smells; emotional instability – outbursts of anger and aggression, especially in post-pubertal males; social anxiety, hyperarousal
- Physical Characteristics: large or prominent ears, long face and large testes, high broad forehead, high palate, prominent jaw
- Associated Medical conditions: epilepsy (up to 20% of patients) and elastin disorder resulting in heart, eye, ear, joint and bone problems in some individuals (Fragile X Association of Australia).

#### ***Types of interventions***

Most children make advances when they receive:

- speech and Language therapy;
- occupational therapy;
- behavioural therapy;
- physiotherapy;
- Autism Behavioural Intervention;
- Applied Behaviour Analysis; and
- sensory integration

(Fragile X Association of Australia).

#### ***Related conditions***

The evidence clearly supports the contention that autism is associated with Fragile X syndrome (Cohen et al, 1991).

Both children with Down syndrome and Fragile X syndrome evidence challenges with articulation/speech issues, expressive language delays, and strengths in some aspects of receptive language (Fiddler, 2007) There is overlap between children with Williams syndrome and fragile X syndrome, specifically in the area of pragmatics (Fiddler, 2007).

#### ***Other comments/issues***

Newborns can be screened for a number of genetic conditions, including Fragile X syndrome. Tests are carried out by taking a small sample of blood via a heel-prick, and the blood is stored on blotting paper cards. This is not done as a matter of routine in all states and territories.

Physiotherapy is not currently a recognised intervention type under the HCWA package.

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## ATTACHMENT E

**Existing State and Territory Services for identified disabilities (hearing and sight impairment, Downs syndrome, cerebral palsy and Fragile X syndrome)***New South Wales*

- EarlyStart – Early Childhood Intervention (Department of Ageing, Disability and Home Care)
- EarlyStart – Diagnosis Support (Department of Ageing, Disability and Home Care)
- Early Childhood Intervention Coordination (Department of Ageing, Disability and Home Care)
- Early Childhood Intervention Telephone Information Service (Department of Ageing, Disability and Home Care)
- Extended Family Support Program (Department of Ageing, Disability and Home Care)
- Family Assistance Fund (Department of Ageing, Disability and Home Care)
- Transition Support to pre-school, childcare and school settings (Department of Education and Training)

*Victoria*

- Early Childhood Intervention Services (Department of Education and Early Childhood Development)
- The Kindergarten Inclusion Support Service (Department of Education and Early Childhood Development)
- Individual Support Packages (Department of Human Services)
- Aids and Equipment Program (Department of Human Services)

*Western Australia (Disability Services Commission)*

- Disability Professional Services
- The Community Aids and Equipment Program
- Intensive Family Support Services

*Queensland (Disability and Community Care Services)*

- Family and Early Childhood Services
- Aids and Equipment Initiative
- Family Support Program

*South Australia*

- Therapy and Family Support services (Disability SA)
- Inclusion Support Program (Disability SA)
- Early Childhood Service (Department of Education and Children's Services)
- Support for people with sensory disability (Disability SA)

*Northern Territory (Department of Health and Families)*

- Respite services
- Carer support
- Disability services

*Tasmania*

- Early Identification and Intervention or Developmental Programs (Department of Education)
- Children's Therapy Services (Department of Health and Human Services)

- Early Childhood Intervention Services (Department of Education)

*Australian Capital Territory (Department of Disability, Housing and Community Services)*

- Therapy Programs for children with disabilities and developmental delays
- Early Intervention programs
- Individual Support Services
- Children with Sensory Impairment

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## ATTACHMENT F

## Reference List

- Access Economics. The Economic Impact of Cerebral Palsy in Australia in 2007. April 2008.
- Angelman Syndrome Association - <http://www.angelmansyndrome.org/info.html>
- Better Health Channel, Victorian Government, 2010.  
[http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Angelman\\_syndrome](http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Angelman_syndrome)
- Brain Foundation <http://brainfoundation.org.au/a-z-of-disorders/48-prader-willi-syndrome>
- Clinical Practice Guideline: Quick Reference Guide for Parents and Professionals – Down syndrome Assessment and Early Intervention for Young Children (aged 0-3 years). New York State Department of Health, Division of Family Health, Bureau of Early Intervention.
- Clinical Practice Guideline Report of the Recommendations: Hearing Impairment. – assessment and early intervention for young children (aged 0-3 years ). New York State Department of Health, Division of Family Health, Bureau of Early Intervention.
- Clinical Practice Guideline Report of the Recommendations: Motor Disorders – assessment and early intervention for young children (aged 0-3 years ). New York State Department of Health, Division of Family Health, Bureau of Early Intervention.
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