COMMUNITY INVOLVEMENT IN THE WESTERN METROPOLITAN HEALTH REGION

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As our theme is "Community Involvement" my paper is about the work we are doing for the Health Commission of N.S.W. in the Western Metropolitan Health Region.

The Western Metropolitan Health Region was established in August, 1973, with Dr. Gary Andrews as Regional Director. It contains fifteen local government areas in Sydney's Western suburbs with a population of 1.2 million.

The Western Region is staffed by "Community Health Nurses". Each nurse is based in a school and works in a small geographically defined area with a population of 3,000 to 5,000. Her many functions include a health screening programme for school children. This replaces the School Medical Service in this area.

All school children in New South Wales are health screened in kindergarten and again in 5th class.

Each community health nurse does a three months course. Dr. S. Sarks (consultant ophthalmologist for the Western Metropolitan Health Region) and I were asked to organise their training in ocular screening. We have been allocated a 3 hour lecture and a 1½ hour demonstration. The lecture basically covers medical eye conditions, refractive errors and strabismus. Also methods of testing are discussed.

The next day, in groups of six, the girls are given a practical demonstration. This is held at a school under the conditions in which they will be working. It is a 1½ hour demonstration with five main parts -

(1) vision testing,
(2) general anatomical features and positions of light reflections,
(3) cover test for near and distance
(4) muscle movements,
(5) convergence

Each child examined is given this series of tests. The nurses receive a comprehensive set of notes also. The lecture has been given by me, and the demonstrations by myself at Fairfield and Mrs. Wong at Mt. Druitt.

When the nurses have had time to settle into their schools, a follow-up visit is made to each girl by an orthoptist to see that she is screening correctly and so that she may discuss difficulties she is finding. All obvious ocular cases have already been referred by her for treatment. She presents the children of whose diagnosis she is unsure. The orthoptist writes a brief report on each positive case, and referral for treatment is arranged.

This follow-up visit has been the main role of the orthoptist. We are aiming to have an orthoptist visit each nurse once a term for half a day. We also suggest that all children with reading problems have an ocular examination.

In every school the equipment is standardised. There is a wooden test cabinet having a Snellen's test panel with internal lighting, set at twenty feet or with a mirror at ten feet, a Sheridan-Gardiner magnetic board with removable letters, a fixation torch,

an occluder, a fixation stick and squeaky toys. Also a set of Matsubara colour vision test plates for infants. Teachers are more and more often asking about colour blindness because of the use of cuisenaire rods for mathematics and reading by colour.

In New South Wales, many schools, particularly in the Western suburbs are having pre-school kindergartens built by the Government within the public schools. Children enter these one year earlier, that is at three years and nine months. It is good to be able to detect defects even one year earlier but, because of the earlier age, the easiest method of vision testing had to be adopted. It has been unanimously decided that Sheridan-Gardiner is the easiest because it does not involve eye-hand co-ordination to a fine degree or right versus left decisions. From the equipment point of view, it has meant that only the one Snellen's panel is needed. We have developed the Sheridan Gardiner Test further.

If you are on your own pointing to the chart, it is not possible to see which letter the child is pointing to on the Sheridan Gardiner cardboard sheet. Plastic letters which the child could lift from a frame were not practical as they were too easily dropped.

Mr. Harris (of Marsden Industries Sheltered Workshop, N.S,W.) and I then came up with the idea of a magnetic board with large removable letters. The children love this as it is a "matching" game and as the letters are printed on the back of the block, they can be easily seen by the tester at the end of the room. Even severely retarded children at Evandale School at Croydon with I.Q.'s between 30 and 60 can do Sheridan Gardiner by this method and certainly the three to four year child can cope easily.

Conclusion

The most important aspect of our programme to me is that it means that referrals will be made at a much earlier age. It has happened to all of us that a child of nine (i.e. the fifth class examination instead of the earlier one) has been referred with severe amblyopia. Beside the fact of the dramatically reduced chance of responding to treatment, the trauma of occlusion is great for this child personally, and the effect bad on the school progress. As these nurses will see the whole family in the scope of their work, we hope that they will detect defects from the baby stage on.

Mrs. Wong has been following-up in the Mt. Druitt area, and from the end of July, 1974 to the end of March, 1975 has confirmed 192 cases, doing only a few hours per week of follow-up screening. In the Fairfield area, I have in five weeks confirmed 29 cases. In one morning, I was asked to look at 11 children; 4 of them had no defect, (other than a large epicanthus in two), 1 had a large esophoria (and a behaviour problem); 1 had a "V" sign and intermittent divergent strabismus; 3 had convergence deficiency, and 2 had amblyopia only. I feel this programme is effective because screening is more thorough, and would like to see it implemented in other Regional Health Areas of New South Wales. Previous screening omitted cover test for distance, and convergence, and muscle movements were very crudely checked.

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