22 January 2020.

Dear Commissioner

Re: Draft Recommendation 17.2—Social and Emotional Development in Pre-School Children.

I am writing this submission to state my concerns concerning the ambiguity in Draft Recommendation 17.2, and the subsequent possibilities of harm which could come about as a result.

In the draft it states:

“The existing physical development checks of Australia’s 1.25 million 0 to 3 year olds in community health services can be expanded to incorporate social and emotional wellbeing aspects of development, so that any necessary assistance can be provided to both the child and parents/carers.”

“DRAFT RECOMMENDATION 17.2 — SOCIAL AND EMOTIONAL DEVELOPMENT IN PRESCHOOL

CHILDREN

Services for preschool children and their families should have the capacity to support and enhance social and emotional development.

In the short term (in the next 2 years)

State and Territory governments should use existing guidelines to expand early childhood health checks, such that they assess children’s social and emotional development before they enter preschool.”

My concerns are with the terms “Social and Emotional wellbeing aspects of development” and “assess children’s social and emotional development before they enter preschool”.

This is very arbitrary and is open to too much misinterpretation by practitioners. The assessment itself and the “diagnosis” by the practitioner could, by itself, be harmful to the child. It can create a stigma and retard the natural emotional and social development of the child.

All children are not the same. They all develop at a different pace. On any given day a child can run the full gamut of emotions. On some days he may be happy and energetic and extroverted, and on another day be not so happy, extroverted or energetic. Like all people, a young person goes through a range of emotions and levels of activity.

It is also well known that if the child is ill or injured, and the illness or injury is not properly attended to, then the child can display behaviour outside his norm which then can be misconstrued as social or development retardation.

There is a prevalence in society at this time to over-medicate anti-depressants and other psychiatric pharmaceuticals. This is NOT a solution for babies or young children.

As stated by the Centers for Disease Control and Prevention website:

“An adverse drug event (ADE) is when someone is harmed by a medicine. Approximately 200,000 children (17 years old or younger) visit emergency departments each year because of adverse drug events.

Children less than 5 years old are more likely than older children to visit the emergency department for an adverse drug event, and each year one in every 150 two-year-olds visits an emergency department for a medication poisoning.”

The following excerpts are from the Journal of Canadian Academy of Child and Adolescent Psychiatry published online 18 September 2014.

“There is much unknown about the use of psychotropic medications and their effects on children. Knowledge of the efficacy, specificity and adverse effects (AE) of psychotropic medications in pediatric populations lags behind what is known in adults (Wolraich, 2003). Despite this, physicians may generalize adult prescribing patterns to children (American Psychiatric Association, 2000).

Children can be more sensitive to AE than adults. In a study of antipsychotic medications, it was found that extrapyramidal AE occur more commonly in young people than adults (Sikich, Hamer, Bashford, Sheitman, & Lieberman, 2004

Despite limited information related to efficacy with children, psychotropic medications are a commonly prescribed first-line treatment for a range of psychiatric diagnoses in children in a variety of clinical settings. Approximately 85% of children diagnosed with attention deficit hyperactivity disorder (ADHD) are prescribed stimulant medications, 60% with bipolar disorder are prescribed mood stabilizers, and 57% of depressed outpatient pediatric clients are treated with antidepressant medications (Moreno et al., 2007; Olfson, Gameroff, Marcus, & Jensen, 2003; Olfson, Gameroff, Marcus, & Waslick, 2003).

The prescribing rate of psychotropic medications is increasing in children, as is the number of medication types prescribed per child (Comer, Olfson, & Mojtabai, 2010; Olfson, Marcus, Weissman, & Jensen, 2002). Over a 12-year period, multiclass psychotropic prescriptions rose in children from 14.3% to 20.2% (Comer et al., 2010

There is further uncertainty as to how children react to being treated with multiclass psychotropic regimens (Safer, Zito, & dosReis, 2003). The risks of AE (including those that are fatal) are potentially compounded by the simultaneous usage of multiple psychotropic medications (Safer et al., 2003), as many potential AE are shared across multiple medication types. A lack of evidence regarding concomitant psychotropic medication administration and its safety has been cited in the past as a concern for children in foster care (Zito et al., 2008). “

Rather than the erroneous current trend of over-prescription of babies, children and young adults, let us instead consider and implement a holistic program consisting of nutrition and diet, exercise, better education, improved communication and so on, as well as thorough physical examinations if required.

The children of today are tomorrow’s future hope. Let us explore all options to increase their potential and wellbeing.

Thank you for your consideration on this important matter.