

EDUCATION AND HEALTH STANDING COMMITTEE

REVIEW OF WA'S CURRENT AND FUTURE HOSPITAL AND COMMUNITY HEALTH CARE SERVICES

**TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
TUESDAY, 1 SEPTEMBER 2009**

SESSION TWO

Members

Dr J.M. Woollard (Chairman)
Ms L.L. Baker (Deputy Chairman)
Mr P.B. Watson
Mr I.C. Blayney
Mr P. Abetz

Hearing commenced at 9.24 am**WILLIAMS, DR CORI****Speech Pathologist/Lecturer,****School of Psychology and Speech Pathology, Curtin University,****examined:**

The CHAIRMAN: On behalf of the Education and Health Standing Committee, I thank you for your interest and appearance before us today. The purpose of this hearing is to assist the committee to gather evidence for its inquiry into the review of Western Australia's current and future hospital and community healthcare services. You have been provided with a copy of the committee's specific terms of reference. This committee is a committee of the Assembly. It is a formal procedure of Parliament and therefore commands the same respect given to proceedings in the house itself. Even though the committee is not asking you to provide evidence either on oath or on affirmation, it is important to understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. As a public hearing, Hansard is making a transcript of the proceedings for the public record. If you refer to any documents during your evidence, it would assist Hansard if you could provide the full title for the record. Before we proceed to your submission and the questions we have for you today, I need to ask you a series of formal questions. Have you completed the "Details of Witness" form?

Dr Williams: I have.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

Dr Williams: Yes, I do.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

Dr Williams: Yes.

The CHAIRMAN: Do you have any questions about being a witness at today's hearing?

Dr Williams: No.

The CHAIRMAN: Would you please state the capacity in which you appear before the committee today.

Dr Williams: I am here as the National President of Speech Pathology Australia.

The CHAIRMAN: Thank you, Cori. You would be aware from one of the previous hearings when this committee was looking at screening for children that the committee has minimal knowledge about speech pathology. We became aware then that there was a big lag between children being assessed and when they received treatment, and that some children did not receive treatment. That was a very broad review. We would be quite happy for you to go right back to the basics, appreciating the fact that you have only 33 minutes to give your evidence. We are quite happy to listen to what you would like to put to us. We are specifically trying to identify the needs and the gaps in services. I will pass it over to you, and the committee members will interject if they need clarification.

Dr Williams: I will start by talking about speech pathology services for children and then about the speech pathology services that are needed in the adult population. Speech pathologists have the potential to work with children from the very earliest stages through to the time they leave school.

There are groups of children who need that support right through the educational process. Children have a range of difficulties with learning language. We know that some of them go hand in hand with other conditions that affect intellectual development, for example. Usually they are serviced by the Disability Services Commission. That is a whole other area of need that needs to be looked at.

The CHAIRMAN: I would be quite interested in hearing from you about the difficulties there might be because it is almost a shared service, is it not? It is a Department of Health budget and a Disability Services Commission budget. Although we are looking mainly at Health, you might want to make some recommendations about a budget that is under one hat that should come under another hat.

Dr Williams: It really needs to be under three hats because education is a very important area. You will have read in the findings of the other committee that language skills underpin literacy development. There is very strong research to support that suggestion. Realistically, in Western Australia, a child receives almost no services under the Department of Health past the age of between four and a half and five, and the education system does not have a speech pathology service. The statewide speech and language team employs some speech pathologists, but they work only with teachers and not with children. Although it is important to upskill teachers to work with this group of children, there is also a core group of children who have much more long-lasting and difficult problems that will affect them across their literacy learning. That group of children have what is called “specific language impairment”. We believe, as an association, that they need a targeted service to address their individual needs. That service is not available within the Western Australian public system. Parents who have the money can access private speech pathology services, and many of them do. However, as we know, many parents do not have the money to access those services. Therefore, those children essentially miss out. It is the association’s position that not addressing the language learning skills of these children has long-term costs to the community regarding the children’s vocational outcomes. There is very strong research to show that children with language learning difficulties have poorer employment and social behavioural outcomes. We also know that a significant number of not only children, but also adults in the justice system have very poor language and literacy levels.

[9.30 am]

We believe that dealing with these problems earlier in life will save money in the long term. It is a really important issue for children. Disability Services offers public services up until the child enters school. Then children transfer to Therapy Focus, which is a non-government organisation, funded differently, and it works in different ways from the public system. At the moment there is not much communication or collaboration between Disability Services and the Department of Health in terms of these children, nor with the Department of Education and Training. If you are a child with a language disorder for whatever reason, you will be relying on parents to know the system, to know where to go to get some of the rather sparse services.

The CHAIRMAN: Should it be the role of the school nurse, or who at the school should have responsibility for coordinating the care for a child who requires assistance?

Dr Williams: There is nothing to coordinate, I think is the issue.

The CHAIRMAN: From 4.5, someone needs to make sure, when they move from primary level to high school, that if they have been receiving care or if they need care, they are getting the care.

Dr Williams: They have not been getting it in primary school—not from the public system.

The CHAIRMAN: None at all?

Dr Williams: No.

The CHAIRMAN: You just said that they might get some through Disability Services.

Dr Williams: Disability Services works differently, and Therapy Focus follows children through to the time they exit the school system, and then I believe they revert to Disability Services.

Mr P. ABETZ: A child who comes under the auspices of Disability Services has speech therapy available, but, for want of a better word, a perfectly normal child who has no physical or mental disabilities but who has some speech issues will not be picked up on?

Dr Williams: It may be picked up on.

Mr P. ABETZ: But there is no service provided as part of the education system?

Dr Williams: No.

Mr P. ABETZ: If the school nurse or the teacher picks up on that, where do they go with that?

Dr Williams: They may refer them to a child development centre, but the realistic picture is that they will sit on a waiting list for 12 to 24 months for an assessment, and they are likely to not get anything after that other than the assessment.

The CHAIRMAN: Because of the lack of staff to provide interventional treatment?

Dr Williams: Because there is not a service that is charged with providing a service.

The CHAIRMAN: Even if they are identified as being in need, there are no funds that can be tapped into?

Dr Williams: No. They are sent back to Health, but Health does not have the capacity to deal with school-age children. Even though its remit says that it will deal with children from zero to 18 years old, on the ground, realistically, it cannot do it.

The CHAIRMAN: So the committee should ask child development services what funds would be used to provide those services if a child was identified at school as requiring speech therapy, and you would expect that answer to be that there are no funds.

Dr Williams: They do not have any.

The CHAIRMAN: Child development services are coming back to meet with the committee in the next few weeks.

Dr Williams: I am sure they will tell you exactly that.

The CHAIRMAN: We will follow up on that.

Dr Williams: Schools have some devolved funding, which some of them use to buy in some services from private speech pathologists. The association's issue with that is that it is ad hoc. It depends on somebody in the school recognising the need, and the fact is that not all teachers, and particularly not all principals, understand the important role that language plays in underpinning literacy development. If you are a kid with a primary language disorder in a school where nobody recognises the fact that a service is needed, and your parents cannot afford to send you to private therapy, then you are left to struggle along in the classroom as best you can, taking whatever actions you take to cope with your difficulties. Sometimes that is acting out and behavioural problems, sometimes it is just disappearing into the woodwork and sitting there, not understanding and not being able to participate, and you exit school with not very good skills at all.

The CHAIRMAN: Do you think the appointment of 50 additional school psychologists, recently announced by the Minister for Education, is likely to make a difference to these children?

Dr Williams: They may well identify children with language disorders, but psychologists are not speech pathologists. Speech pathologists are specialists in the area of language and communication disorders. We spend four years training only in that area, and that is our area of expertise and passion. Speech pathologists are the people who can make a difference to these children in schools.

The CHAIRMAN: When should children be assessed for speech difficulties?

Dr Williams: Of course the earlier, the better, so the early intervention services available through Health are extremely important. But we also know from the research that there is a proportion of children who do not demonstrate language problems until the language learning demands change. There is a proportion of children who are not identified until four years of age, so that is too late for the health system, realistically.

The CHAIRMAN: But if they have not been identified early on, what mechanism do you say should be used to identify children at school who may have speech difficulties?

Dr Williams: There is a move for on-entry screening of children that should include language skills.

The CHAIRMAN: On entry to primary school?

Dr Williams: On entry to preprimary, I think, or during preprimary. I would recommend that they are assessed before they hit year 1, so that some support can be put in place.

The CHAIRMAN: Do you know if that happens in any of the other states or internationally?

Dr Williams: I believe it happens in Great Britain. I would need to go back and check to see exactly what happens with this. I know that there is certainly a federal government push for children to have on-entry screening, but I am not quite sure how far the down the track other states have gone with that.

[9.40 am]

The CHAIRMAN: We would very much appreciate any evidence that you can provide to the committee by way of supplementary information because, as you are aware, we are undertaking a very big review and it might be easier for you to hit on the appropriate articles and evidence-based research than for our research officers, who have a wider area to cover.

Dr Williams: I am happy to do that for you.

The CHAIRMAN: In that case, we will come back because I am very interested—not that the other committee members are not interested—in what you said about funding coming under three hats. We have been looking at the health budget. I still am not quite sure whether there is funding through the educational sector for preprimary assessment. Are you saying there is education funding for children who are identified later during their school life as needing assistance?

Dr Williams: The issue is that there is no funding in education.

The CHAIRMAN: So there should be?

Dr Williams: There should be an integrated service for these children.

The CHAIRMAN: The Child and Adolescent Health Service covers children from antenatal to the age of 18, and so it should have a sum of money in its budget. I do not know that would necessarily need to come through the education budget.

You then said that if a child with a disability is picked up, then the Disability Services Commission follows that child through from zero to 18.

Dr Williams: With a change into the organisation called Therapy Focus, which provides therapy services, not just speech pathology but occupational therapy, physiotherapy and psychology in a team-based approach. Therapy Focus supply services to children with disabilities while they are at school.

The CHAIRMAN: If a child at school was having problems and there was not a pocket of funding, then having a child labelled with a disability might enable them to tap into some of that funding?

Dr Williams: Yes, it might. But the criteria are quite strict to access that funding, and children with primary language disorders do not meet the requirements for funding under Therapy Focus.

The CHAIRMAN: So the three hats are disability, education and health. We will be meeting with the Department of Health's child development services agency. Again, if you come across research elsewhere that shows when assessments are being made and whether there are any sums of money being used in this area during a child's life up to the age of 18, the committee would obviously be interested in learning more about the model.

Dr Williams: Are you talking about Western Australia or models outside?

The CHAIRMAN: Even models outside Western Australia. If there is a best-practice model in another state or country, we can ask child development services whether they have reviewed this model and, if not, will they review it. Or it might be something we can put to the minister for consideration.

Dr Williams: I can tell you that in the United States there are more speech pathologists employed in schools than in any other sector of the community. Thousands and thousands are employed in US schools. It is a requirement under their legislation that children have access to any support service they need. Speech pathologists in the US are employed within school districts to work with children who have identified language learning problems.

The CHAIRMAN: Again, if you have a reference to that, that will be helpful to the committee.

Dr Williams: I do not believe it matters where the funding sits. If there is funding that sits under the health umbrella for services to school-age children, all the better. I believe very strongly though that the service needs to be located within the education system. It is no good pulling kids out of classrooms to take them to a child development centre for intervention. The intervention, to have the greatest effect, needs to take place within the context of where the child is learning.

The CHAIRMAN: It might be something required within the schools; for example, for children whose second language is English, someone within the school assists those children. Maybe if children with a speech disorder are identified within schools, if as you say it is associated with a district educational office, then maybe a speech therapist can be attached to so many schools depending on needs.

Dr Williams: That is the way the models typically work. Queensland has as model that works that way. Their speech pathologists are employed by the education system, but they are based regionally and have responsibility for a number of schools.

The CHAIRMAN: So that happens in Queensland?

Dr Williams: Yes, that happens in Queensland and in Tasmania. The Northern Territory has speech pathologists who work in schools, but they are funded under health; and I believe that they are based regionally in health sites but they work out into schools. South Australia at the moment is looking at their paediatric speech pathologist services to school-age children. They have speech pathologists who are employed in their department of education and children services who are located in schools. South Australia is currently reviewing the model of service for those children. I am back in Adelaide next week for the second part of the planning of that review.

The CHAIRMAN: That is four states that you have identified that have speech pathologists as part of the educational support core.

Dr Williams: New South Wales and Western Australia are the only states that do not have this.

The CHAIRMAN: Thank you very much. We will hopefully be able to contact each of those state departments to find out about the model that they use, and if there is a funding formula that they use. However, because you know about these models and may have been to conferences where there have been presentations or you have at your fingertips a description of each of those services, I again ask if you could provide the committee with those details as supplementary information.

Mr P. ABETZ: Has your organisation done any cost estimates for providing adequate screening to give those kids the help they need? What sort of money would the education department need to provide such a service?

Dr Williams: We have not done that at this stage. The issues are quite difficult and complex, and we have not had the resources to address that. Certainly it should be possible to gain information from the other states about what sort of investment they have.

Mr P. ABETZ: The motivation for my question relates to the social implications for kids who have poor educational outcomes, work outcomes, social skills outcomes and so on, which so often leads to other problems in life. In terms of investing at that very early stage of life perhaps a business case could be made that by investing, say, \$100 million a year in speech pathology, or whatever, we might save that amount in the penal and court systems and so on. We should be looking at the long-term costs.

Dr Williams: I have a vague memory, which I could probably track down, of a paper with such a cost benefit analysis in Britain, so I will look for that.

The CHAIRMAN: That would be very useful. There was some mention yesterday, when we spoke with both occupational and speech therapists, of assessment tools that would be appropriate for ascertaining whether children have difficulties. Do you have a tool that you are able to recommend to the committee for that preprimary level, and in recommending that tool does it have to be administered by a speech pathologist to identify the problem or could it be identified by a teacher in the classroom or by a volunteer mum who is supervising the class or assisting the classroom teacher?

When my children were at primary school level we were on a roster, because that also would then maybe save some of the time rather than intervention being used. Could you elaborate a little bit on that?

[9.50 am]

Dr Williams: One area that needs to be assessed for children when they are entering school, and is relatively simple to do, is the area of phonemic awareness—also sometimes called phonological awareness. There are a number of fairly simple screening tools that could be used to do that. The Sutherland phonemic awareness test, SPAT, is one that could be used, and teachers could work with that. They would need to be appropriately trained. We have had feedback from teachers that they found that time consuming and difficult, but, on looking at what they are doing, it turns out they are not using it correctly. It is a test that has “discontinue” rules. The teachers have not been aware of how you use a discontinue rule, which essentially says: if you get this many wrong, stop here. Teachers have been putting kids through the whole thing. It has taken them a long time. The kids have not been succeeding and it has not been nice.

The CHAIRMAN: Could someone at the level of a teacher’s aide use that and go from school to school doing those assessments? I am looking at the funding for both conducting the assessments and then for the actual intervention.

Dr Williams: I think with appropriate training from a speech pathologist—yes, they could do that sort of thing. That is one area. Phonemic awareness is the area that underpins entry into literacy. It is the skill that allows children to focus on sounds in words and to relate that to the graphemes—the letters that you use to represent those sounds. That is really important for access into literacy—learning to decode. The whole area of language—expression, being able to use language to get your message across, being able to understand language—is a bit more complicated. However, there exists already within the education department a tool called “Time for Talk”, which I actually helped develop. It was published in 1999. It was sent out to all schools; no training provided. It sits on shelves in libraries. It was even found in the music room in one school! It is a screening tool that

has a standard task associated with it. It was developed for use by teachers. It will give a first pass identification.

The CHAIRMAN: That is for what level?

Dr Williams: That is aimed at preprimary. That is a possibility. The thing with all assessment of language is —

The CHAIRMAN: Could we also ask for a copy of “Time for Talk”?

Dr Williams: It is available to download from the Department of Education and Training website. It is actually in the Aboriginal education branch section. It is there because we developed a parallel task for Indigenous kids. It is based on a picture sequence around which the teacher asks some questions and then gets the child to tell a story about the pictures. We developed an Aboriginal picture set, which the kids really enjoy. Aboriginal kids like that set of pictures. It does take an investment of time. You can only assess a child’s language development if you have the time to talk to them one-to-one. You cannot do it in a group situation. There are some parts of the “Time for Talk” profile that are based on observation and there are some parts that are based on this task. It has been used in a number of schools. Forest Crescent Primary School picked it up and used it across their school. It was one of the things that helped them to win a national literacy award in 2001. I cannot remember the date; but that was one of the things that helped them. They still use that as a regular part of their preprimary screening. It comes along with a manual of activities that can be used in the classroom by teachers and parents, and whatever. It is a good first pass. It will pick up the children who need more detailed assessment.

The CHAIRMAN: That can be administered by a classroom teacher or by a volunteer?

Dr Williams: Yes, it can. I believe at Forest Crescent they have used some teaching assistants on occasions to do it. Yes; it was written for use by teachers, so the instructions in it are fairly detailed.

The CHAIRMAN: You have to leave in a few minutes. As we are specifically looking at needs and gaps, are there any points that had you had more time that maybe you can flag?

Dr Williams: I need to stay here for a week! We have only talked about primary school. There are no services to children in secondary schools in Western Australia. That is on a par with most of the rest of the country, from what I understand. Maybe a complete service is not realistic, but at points of transition where the language demands of the classroom change, then there is a place to actually provide some support. If I had all the money in the world, I would like to see a transition service for children going into high school. It is not just the kids that we already know about.

The CHAIRMAN: Is that because children are coming from different schools with different levels?

Dr Williams: It is partly but it is also because of what is expected in the classroom in terms of language. If you think about classrooms, they run on language. High school teachers talk at a different level to primary school teachers and expect that the children will understand. There is a whole issue that comes into play in high school about subject-specific terminology. If you have difficulty learning vocabulary just from what you hear around you, you are going to have extra problems in high school. If primary school teachers do not know a lot about language, high school teachers know even less. That is it for the children. You might have guessed that that is my area of expertise and passion.

I also talk to speech pathologists working with the adult population. Their feeling again is that there is a focus on medical and nursing within the health system at the moment, and this is at the expense of allied health. We know that stroke is very common in our older citizens. Two things come out of many strokes that speech pathologists work with: one is the swallowing issue, dysphagia, which is a life-threatening issue. Speech pathologists and other specialists work in that area in collaboration with ear, nose and throat people and dieticians to make sure that the swallowing process is safe for

people. That is acute, and so I guess there are not quite as many issues around that area; although the people who work in the area would say that there is still a need for more support.

The CHAIRMAN: There is still a need for dedicated stroke units to ensure that those patients recover?

Dr Williams: Yes; absolutely. The other arm is rehabilitation, because many people who have a stroke end up with their language and communication impaired, sometimes gone completely. We all know how important communication and language is to our social and emotional well-being. That is no less true for adults than it is for children. Rehabilitation services within Western Australia are not meeting the needs.

The CHAIRMAN: If a patient has had a stroke, and is in hospital, when they go back to their GP, is their GP able to refer them off for speech therapy?

Dr Williams: They could refer them to a private speech pathologist if the person has the funds to do it, and if they can find a private speech pathologist who works with adults. There are far fewer of them.

The CHAIRMAN: There is no funding under Medicare for patients who cannot afford to have private?

[10.00 am]

Dr Williams: Under primary health care perhaps; but, no. It is relying on private. It is expensive and there are not that many speech pathologists who work in private practice with adults. The rehabilitation services through Royal Perth at Shenton Park also have to provide rehabilitation services for people with brain injuries—all the young men who come off their motorbikes. Many of them end up with language problems and learning problems that go along with brain injury problems.

One person who I spoke to said that part of the issue for those people is that the amount available through the insurance system in Western Australia to deal with problems arising out of motor vehicle injuries is much less than it is in the eastern states. That is to do with the cost of third party motor vehicle insurance within the state, she believes. I guess that across the board there are gaps—across the lifespan, really.

The CHAIRMAN: I appreciate that your students are waiting for you. I apologise for the fact that you had to wait. Thank you very much for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added by these corrections, and the sense of your evidence cannot be altered. Should you wish to provide additional information—in addition to all the additional information that we have asked for—or to elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript. Thank you again very much for coming along today.

Dr Williams: My pleasure, and if you think of any other questions, please contact me; I would be more than happy to help.

Hearing concluded at 10.01 am