EDUCATION AND HEALTH STANDING COMMITTEE

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

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
MONDAY, 31 AUGUST 2009

SESSION FOUR

Members

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

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Hearing commenced at 3.13 pm

HILLEN, MS GAYLE ANNE
Occupational Therapist,
Kidz OT Essentials
examined:

MIDDLETON, MS LYNNE
Speech Pathologist,
examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee, I thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering 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. I would like to introduce members of the committee and our research officers. And we have Hansard as well. This is a public hearing and Hansard are making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence it would assist Hansard if you would provide the full title. Before we proceed to the questions we have for you today I need to ask you a series of questions. Have you completed the "Details of Witness" form?

The Witnesses: Yes.

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

The Witnesses: I do.

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

The Witnesses: Yes.

The CHAIRMAN: Do you have any questions relating to your appearance before the committee today?

The Witnesses: No.
[3.15 pm]

The CHAIRMAN: Perhaps we will start with Gayle first. Would you like to state your full name and the capacity in which you appear before the committee today?

Ms Hillen: My name is Gayle Anne Hillen. I am appearing as a representative for DOT, which is the developmental OT group, which is an incorporated body as part of the WA Association of Occupational Therapists.

Ms Middleton: My name is Lynne Middleton. I am a speech pathologist. I am appearing on behalf of the Private Speech Pathologists Association.

The CHAIRMAN: Could you please forward our apologies on to Rosemary Candler, who we had hoped would also be here today. It seems that the invitation obviously did not arrive for Rosemary.

Unfortunately, the transcript will not be available for at least 10 days, but if there is anything that we do not cover that she feels would like to come in, then she could certainly send that to us by way of additional information. We will certainly have a look at that. Please pass on our apologies to her.

We will start with Gayle. Describe the picture, as it is now, the way you see it, in relation to the services that we have and the needs and the gaps in the services. If it is all right with you, as you are doing your presentation, committee members will just stop you for clarification. Then we will move to Lynne afterwards for her perspective.

Ms Hillen: At this point, there are quite a few gaps in the way children can access therapy. I am talking about occupational therapy and whatever is needed; if they need to do this via the public system. There are extensive waiting lists for child development services, anything ranging from three or four months for a child that is on a priority list—so those are children in the nought to three age bracket; up to 12 or 18 months if they are older. School-aged children are going on waiting lists but they are not receiving any intervention if they need it.

The CHAIRMAN: So they are going onto waiting lists but not receiving any intervention?

Ms Hillen: No; so they are going on the waiting list to be seen down the track. Often they have to wait 12 months before they are even assessed.

Mr P.B. WATSON: Is this in the metropolitan area, or is this statewide?

Ms Hillen: Yes; this is metropolitan I am talking about. That is in the Perth area.

What is happening is that a lot of those referrals are falling to the private sector, so the children are actually assessed and they are beginning to get some sort of intervention. But that is dependent on their family having the income or the private health cover to fund that. There is a system through Medicare called the Enhanced Primary Care program which is fulfilling some of the need, but there is a maximum of five sessions per annum allowed for children's intervention. That clearly is not enough if they have mild or moderate or severe needs, in terms of what they need. I am involved in a screening program, which I do in a private capacity, where I go into schools and screen children that are at kindy level or preprimary level—so that is your four-year-olds; 3.5-year old to 4.5-year-olds; or 4.5-year-old to 5.5-year-olds. I am looking at all the underlying skills that these children need in readiness for literacy in year one. As I say that is a privately funded thing that the schools have to pay for. That is something that I think is assisting in identifying the children earlier that need intervention and then they may go onto a public waiting list, via referral, having been identified as needing attention.

The CHAIRMAN: They are identified in the schools and then it is a case of whether their parents can afford private assistance; or, if not, they may go on a 12-month waitlist.

Ms Hillen: Yes; four to 12 months. But the kids that we are dealing with in the four to six-year-old age group are anything from six to 12 months, if they are waiting for intervention. But because the first step is done in terms of a screening assessment, we have looked at what their needs are in terms of therapy. They are often then waitlisted for intervention. They do not have to wait for an assessment and then wait for therapy or input.

The CHAIRMAN: How does your assessment vary for occupational therapy? We were told that the index had been developed by child development services assessing children at various stages. How does what you are doing fit in with the measurement tools that are being used in the public arena to identify not just deficiencies in occupational therapy, it might be behavioural problems, it might be speech therapy, it might be visual problems?

[3.20 pm]

Ms Hillen: That has been upgraded. There is now an ages and stages questionnaire. Do you know anything about that?

Ms Middleton: I am not all that familiar with the index, but I remember a recent article in a paper in our area that said that in some disadvantaged areas, such as Bellevue, 30 per cent of children were at risk. So, yes, there is an index to say which particular areas are more at risk than others.

Ms Hillen: One of the schools that I work in is in Ballajura. I work quite closely with the school health nurse there, and she will often identify through her questionnaire which children might need occupational therapy screening, and also speech therapy, because that is also offered at that particular school. I think it is a questionnaire—if I understand correctly what you are talking about or referring to—that the parents have to complete, with the school health nurse, but there is still a need, then, for a professional to look at how the child is performing or not performing in that area of development.

The CHAIRMAN: So the service that you are providing to some schools is something that you or your organisation have negotiated on a private basis with those schools?

Ms Hillen: Yes. I have negotiated that on a private basis. There are a number of different occupational therapists around Perth that provide these services to different schools. I have seven Catholic schools, mainly in the northern suburbs of Perth, that are using our occupational therapy screening services. I also have one Anglican school that has taken our services on board.

The CHAIRMAN: Do you link in at all with child development services?

Ms Hillen: Hugely—absolutely.

The CHAIRMAN: How does the measurement or assessment tool that you are using fit in with their assessment procedures for different ages?

Ms Hillen: It is a screening tool, so it looks at developmental indexes of what the child would be expected to do in certain areas. Over the eight years that I have been doing this, I have selected the developmental norms that will be pertinent to the child mastering literacy skills. For example, we look at the motor skills that the child will need for reading and writing, as well as the visual-perceptual skills that the child will need for those tasks. That means that by the time the child gets to year 1—or even late pre-primary, now—the child will be ready to really take on board those skills that the child will need for year 1. Also, because I am at the school and working in the school, which is the child's environment—which I think is also really important—the other thing that we do quite extensively is that we work very closely with the teaching staff and the parents. We do a lot of parent education workshops—we call them forums—and they are fun situations where we will enlighten the parents about what sorts of developmental norms to look for and how to better those in their children in readiness for school. That is a part of the screening that has grown over the years. The screening was looking initially at testing the children, but the teachers were then saying that they needed assistance to help these children, because if they do not have good visual memory skills, for example, that could impact hugely on their reading, so we then had to look at what we should do with these results and how we could improve those skills in the children we have identified as having those difficulties.

The CHAIRMAN: So the assessment tool that you are using, and the support that you are giving, is very much with the endorsement of the Catholic Education Office? This is something that your association and other occupational therapists have organised with the Catholic sector. Is this applied in any way in government schools?

Ms Hillen: I do not think it is. It is something that we have looked at, and put proposals to the government schools, but it is a funding issue. It is hard to find the resources to fund something that is expensive in terms of testing and having a professional come in. We have looked a lot at trying to develop something that teachers can use, but they are already very burdened anyway with all the different testing that they have to do through the ages and stages of the children. Also, they all say that they do not have the clinical expertise to look at why the child is not using his or muscles effectively, for example, or other different aspects.

The CHAIRMAN: We are still to meet with child development services, but they will obviously have looked at the tools that you are using, and we will be able to ask them whether they have any plans in the future to use those tools. I know that they are very, very short of staff now but —

Ms Hillen: Yes, they are.

The CHAIRMAN: They are probably very pleased that you are offering a service that they are unable to provide at the moment.

Mr P.B. WATSON: It is not a service that is given to everyone, is it?

Ms Hillen: No.

Mr P. ABETZ: Would there any merit in having teachers, or even volunteers, do the preliminary screening—they would need to be trained up, obviously—because that would at least show whether the child had any issues at all that were presenting? That would then mean that those kids who desperately needed some help could be dealt with by—for want of a better word—the more expensive professional people. Would that be one way of spreading the screening dollars further to accomplish more, or is the problem that there is also a lack of occupational therapists and speech therapists actually available? If the government were to make the funding available to screen the kids in all state schools, would there be enough professional people out there to do that screening?

Ms Hillen: There would not be. I hear your point. I feel that there is a lot of merit in doing what I have done with the Anglican school that I am involved with this year—that is, I have helped it to develop a more comprehensive screening questionnaire that the teachers can use. The teachers fill that out for every child in their class level, and we look at that as occupational therapists and speech therapists and say these are the children who we think need to be screened. So out of a class of, say, 30 children there might be 10 or 12 who we feel warrant professional screening. That then minimises the dollars that they need to spend. They are then given strategies for the other kids. One child might not be holding his pencil correctly, for example, but that is the only thing that the child is having difficulty with. So we could give the teachers information on how to improve those skills without having to do the full screening. So, yes, I think that is probably one of the ways to really go with the whole screening process.

The CHAIRMAN: Could we ask you to provide by way of supplementary information a copy of the tool that you are using?

Ms Hillen: Sure. I have a copy here.

The CHAIRMAN: In addition to providing us with a copy of the tool, could you tell us a little about whether that tool was developed using evidence-based research? Has the assessment that you are undertaking with this tool been used in other states or other countries? We are all fairly new to this area. It is certainly a new assessment that I am hearing about. I would like to see how it fits in with the global picture.

[3.30 pm]

Ms Hillen: I am not sure that I can really comment on the global picture, but, certainly in Perth, this tool has been developed and refined over the eight years I have been using it. It was quite widely used initially by a child development team in Southwell, I think it was. They identified a couple of key areas they could look at among the preprimary population to see whether they were developing the skills they needed in readiness for year 1. We had in-service training regarding that screening test at that stage, which was nine years ago now. This tool has been based on that. It is a screening tool; it is not a standardised measure. It is based on developmental norms. For example, you would expect a child of this age to be able to use his or her shoulder muscles for this distance of time. It is based on developmental norms of what is seen in children's development, and that is pretty global. We rate the children on a 3, 2 or 1 scale. We say that 3 means they have the skill they need and are performing at an age-appropriate level. We are now seeing children who are sometimes three years old at kindy level, because the cut-off is the end of June, and you are seeing the older ones. We rate them according to their age level. If they get a 2 on the rating scale, that means they have some need for intervention or help to develop that skill further. If they score a 1, their skill is well below the age expectation. I will leave this copy of the letter that is handed out to the parents with you, as

testing is a partnership with the parents. The parents fill out a questionnaire about the child, because we see the child for only half an hour, and they indicate how the child is developing from their perspective—if they have any concern about the child and note their strengths. We do the test after that. I have consulted widely with the Catholic Education Office about this. Because it is a school initiative, the parents are invited to fill out the questionnaire but we do not need their permission to do the screening. Then we do the testing. This is a copy of the kindy-level test I do and the sheets I might use with the child.

The CHAIRMAN: Are you happy to provide them by supplementary information?

Ms Hillen: I am very happy to provide it.

The CHAIRMAN: When we have child development services back it will be interesting to hear their evidence. Obviously, in terms of children's development, we are looking for key performance indicators. This looks like it might be a key performance indicator to see whether a child is in need at that level. Maybe we will be able to ask them and they might know whether similar tools are being used in other states to assist children.

Ms Hillen: I would say there would be, but I cannot comment on that.

The CHAIRMAN: I cannot believe it is already 3.30 pm. Lynne, would you like to tell us a little bit about the identified needs and gaps in relation to speech therapy and children's services?

Ms Middleton: When we are looking at children probably at preschool age in Western Australia, we are looking at roughly 40 000 children, based on a study by McLeod and Threats in 2008 in the *International Journal of Speech Language Pathology* published by Speech Pathology Australia. Many of those 40 000 children come into kindy with oral language skills way below the levels we expect a child to be using.

The CHAIRMAN: Do you mean many of those 40 000 children?

Ms Middleton: Yes. Many of those 40 000 children probably could have been identified at maybe 18 months or two years so that we could have addressed some of the issues related to those children way earlier.

The CHAIRMAN: Did the paper you referred to earlier give a description of how they could be identified earlier or did it purely state 40 000 children?

Ms Middleton: It stated 40 000. It was just an incident study. The Private Speech Pathologists Association of WA has tried to address the early identification of those children by giving some indicators of what would constitute a child who may be at risk. We put them in a directory and then divided it into service providers and various areas. We know from the evidence that early intervention has a far better outcome. If we get these children at two, we may find we need only a few sessions, working with their parents in partnership. If we leave them until they are four or five, we have a great deal more sessions. The most significant predictor of how long a child will actually spend in therapy is how severe they are at the initial assessment. A child who has been left without any intervention until age four, or maybe six or eight, will spend far longer in therapy and probably have a far poorer outcome than children who are addressed earlier. One of the difficulties we have is actually communicating what is a problem and what is not a problem to people like GPs, nurses et cetera in the community. Because we are called speech pathologists, they see a child as having a speech or an articulation problem, or a lisp or an inability to say K, S or whatever. Speech pathology encompasses any aspect of communication such as how well children understand what is said to them, how well they process information or problem solve and how well they formulate their sentences in a reply. Those children who have difficulty following instructions are often misinterpreted as naughty children in the classroom. A classic example is a mother of a child I spoke with this morning who said, "Thanks for what you are doing." Her little girl is performing on the first percentile for her comprehension and language expression, but her performance scores on an IQ test are far greater than her verbal skills. She said, "On the weekend we had an incident when

Indy crashed heads with a two-year old". She said that everyone gave sympathy to the two-year old but it was clearly an accident because they did not see each other. She said that Indy ran off and hid because she has got so used to the fact that whenever anything happens, she is the one who gets into trouble. This is the sort of life a child with a communication impairment has from the time they get into a classroom.

Our Aboriginal children's oral language abilities are very poor. Many of them start school with language levels of two to three-year-olds and can be 10 000 or more words in their vocabulary short of those of their peers.

Mr P.B. WATSON: Do they have another language? Down our way, they speak the Nyoongah language but they do not speak English.

Ms Middleton: Many of the Aboriginal languages are not complete languages, simply because in the terrible dark ages they were punished for speaking their own language. If you ask many people in the community how they would say something in Nyoongah, they cannot give you the entire phrase. They can give you some of the words they would use. But they are not able to swap from our language to Nyoongah immediately. They can give vocabulary but they cannot speak it completely.

Mr P.B. WATSON: When I umpire basketball in Albany, some of the Nyoongah boys talk to me in Nyoongah. I am sure they are not saying very good things; they all laugh!

Ms Middleton: It is not so much the Nyoongah language—the second language versus the language of the classroom, it is the home talk and the school talk. The home talk is very short. A lot of articles, auxiliary verbs and verb endings go missing in their home talk. When we expect them to do their NAPLAN we expect appropriate grammar to be used. They use a lot of "Put that there" or just say "That one" and point or whatever. The job I have with the Nyoongah children I work with is always to say, "Use the words; you can't say 'put that there'. Say who is it you want to put it; what he is to do; what it should look like?" The rich language we expect in the curriculum they do not use as an everyday language with each other. That is one of the big challenges we have.

[3.40 pm]

The CHAIRMAN: Last week we heard from someone who teaches English as a second language in schools. I was quite surprised when we were informed that, for children for whom English is a second language, it could take up to seven years before they fully adjust to the language and fit in with everything in the school environment simply because of that initial language barrier.

If a child is starting school with speech and language difficulties and is given assistance, how long would it take, on average—particularly in the case of Indigenous children who may lack knowledge or have a limited number of words in their vocabulary—for the child to catch up? What support should be given to them in schools to enable them to catch up sooner rather than later?

Ms Middleton: I think that we need to address the early introduction of literacy in the education system as it is now. To be able to become literate, you have to be able to hear those sounds in words; you have to be able to follow directions; you have to have a good language base. Those children who are starting school with very poor speech and language skills need to have an oral language-rich program before they move into literacy skills. Ideally, for those children who are coming to school—

The CHAIRMAN: Tell me what an oral language-rich program is because I am—

Ms Middleton: Oral language is what we are doing now—it is talking. It is being able to talk, to understand what is being said and to be able to follow directions. It is to be able to problem solve by saying, "If this goes wrong, what will I do next?" It is being able to tell a story. You often find with these kids that when an altercation happens in the playground and you ask them what happened, they cannot go back to the beginning and tell a story with a beginning, middle and an end: they

cannot defend themselves, so they often get into trouble twice. They are punched and set up by the other kids who know that they will struggle to justify their actions to a teacher and so get into trouble again. For them, the world is a very unjust place. Many of them have behavioural difficulties in the classroom. For example, a little child that I was working with today has very poor oral language skills. If you go around the group, the other children will answer but this child will be the one to wiggle or change the topic or point to something else in the hope that he or she will not be shown up amongst their peers as not coping because they cannot answer the questions that you are asking of them. The services of our language units in Perth would be ideal for such children. The biggest problem with our language units is that we have so few places.

The CHAIRMAN: Are you talking about the ESL language units?

Ms Middleton: I am talking about the four language units that we have in the metropolitan area—the north east language development unit and the south east, north west and south west language development units.

The CHAIRMAN: These are in the metropolitan area?

Ms Middleton: Yes; in the metropolitan area.

The CHAIRMAN: We have four language units.

Ms Middleton: Yes; we have a north east language unit with two campuses—one in, I think, Balga and one in west Morley; however the catchment area is absolutely enormous. Last time I looked, we currently had about 30 places for children in my catchment area. If every child who required that language unit support were to be referred, we would need to multiply that service by at least 10 to 15 language units. In schools that have —

The CHAIRMAN: Who refers to those language units?

Ms Middleton: A speech pathologist.

The CHAIRMAN: If they are seen by a speech pathologist.

Ms Middleton: That is the difficulty.

Mr P. ABETZ: Are they run by the state education department?

Ms Middleton: They are education department run.

Mr P. ABETZ: So they are different from the intensive language centres?

Ms Middleton: They are the intensive language centres.

The CHAIRMAN: But I thought that the intensive language centres were for ESL students.

Ms Middleton: No; these ones are —

The CHAIRMAN: I am getting confused about the different centres!

Ms Middleton: These are for children who usually have English as their main language but who have difficulties with language processing.

The CHAIRMAN: Thus an intensive language centre, of which we have four in Perth, is for students who have English as a first language but who have been identified as having problems with their communication skills at school and have therefore been referred by a speech therapist—if they are lucky enough to see a speech therapist. If they have not seen a speech therapist privately, are they likely to be assessed by a therapist in school? For example, Gayle has told us that she has gone into schools and identified children who require occupational therapy assistance. Is there any mechanism by which—

Ms Middleton: It entirely depends upon the school—just as it does with occupational therapy. Some schools will pay for speech pathologists to screen some of their children. Some will —

The CHAIRMAN: Is that mainly the private schools?

Ms Middleton: Yes; it mainly is. However, some schools in the public education sector have trained their staff to use screening tools. The biggest problem in providing an adequate service for these children is that they should be identified before they get to kindy—not at kindy, before kindy. There is a huge problem in the community not only being aware of what is a speech and language problem, but also going to the wrong people for advice. If you go anywhere on the internet, it says go to your general practitioner or your doctor to ask for advice on speech and language. Doctors are given no training at all in speech and language identification. They have not got a clue! This is why we developed this tool. Unfortunately, some doctors will judge it purely and simply on whether the child has an articulation problem: if they sound okay, the doctors will say that they do not need a speech pathologist. Other health professionals will judge it purely and simply on whether the child can say their sounds or not. Sadly, this year the only screening referrals that I have had from school health nurses have been for children with articulation problems. There have been no referrals of the children with significant language delays and there should be at least two or three referrals for every kindy class across the state. As people who want to do the best by the children of this state, our job is to identify these children as soon as possible. That is probably at two years of age. We need to put a lot of resources into identifying these children. We need to put a lot of resources into working with parents so that they can understand and support their child's problem. We need to make sure that those children who have ongoing problems are referred to a language unit from kindy onwards and not have to fight for a place in preprimary. At the moment we have about 30 places in the north east language unit for kindy-age children and, do not quote me on it, I can get the exact figures, but we have about 15 places for—

Mr P.B. WATSON: Are they full?

Ms Middleton: Yes; the language units are full—well and truly full.

Mr P.B. WATSON: Are there any such units in the regional areas?

Ms Middleton: Not that I know of.

Mr P.B. WATSON: So we have to put up with this and just battle on up there, do we?

Ms Middleton: Absolutely.

Mr P.B. WATSON: It is terrible, is it not?

Ms Middleton: This is the best thing that we can be providing. The other day a policeman said to me that these kids do not have a chance. If they come into school without appropriate oral language, they are, from day one, behind the eight ball and some of them will never catch up.

The CHAIRMAN: You have the assessment tools to assess two-year olds, but who can conduct these assessments?

Ms Middleton: Speech pathologists can assess two-year-old children.

The CHAIRMAN: In view of the number of children who need to be assessed—given that speech pathologists will intervene to assist these children—who can screen them? Gayle has told us about a tool that she has developed for teachers to use in the identification of children who need referring on to occupational therapy assistance. Is this tool at a level such that enrolled nurses or other healthcare workers or level III carers and care assistants can administer it in order to identify those children who need assistance?

[3.50 pm]

Ms Middleton: It does not have to be as complicated as a tool. We have to lift our expectations in terms of what children should be doing and when. It is not okay for a child not to be talking until he is four. It is not okay to hear that Einstein did not start talking until he was four. Einstein was on the spectrum. Einstein had autism. Bill Gates has autism. It is not okay for a child not to be talking at four years of age. It does not have to be as complicated as a screening tool that everybody has to be trained in. We must have the idea that at two years of age children should be starting to put two

words together and they should be responding. Babies should be responding to and hearing somebody in the next room.

Private speech pathologists have tried to put together some speech indicators for doctors, knowing that they do not have time to give an elaborate test. All they have to ask is: what are the indicators to identify the children who might be at risk at birth? This comes from Teresa Anderson's study, which was a randomised control trial that was conducted in Liverpool in Sydney. She studied children from zero to 12 months to determine whether speech and language intervention was significant for children under 12 months. The answer was yes, it was. Another aspect of that study was who were the children who were most likely to have problems under 12 months. The study found that they are babies who are born before 34 weeks' gestation; premature babies with a low birth weight; infants with Apgar scores of less than five at one in five minutes; infants who suffered respiratory distress; and infants from lower stimulating environments. From those checklists we can pick them up as early as birth to 12 months. At 12 months we have another set of criteria. If the GPs had a checklist and had training while they were at undergraduate level in the fact that speech and language impacts significantly on adult health—Clive Herdsman was invited by Fiona Stanley to the Child Health Research Institute in 2003 and he said that the most important early years indicator for adult health over 30 is literacy. Good literacy skills depend on good oral language and communication skills. Speech and language is absolutely critical for the outcome of our children in this state.

The CHAIRMAN: You are talking about the tools that should be given to general practitioners. In WA we are lucky that a great number of our GPs have practice nurses, particularly when they are working within a group. What discussions has your professional body had about the possibility of practice nurses administering the assessment? It could be linked to the GP provider number so that the nurse who is taken away from other duties is reimbursed by the government. It would perhaps ensure that more children receive these assessments.

Ms Middleton: We have made it so simple that if the parent has gone to their GP for advice about the speech development of their child, the GP should be able to ask them four questions applying to a particular age group. We are asking GPs to determine whether the child is 12 months, 18 months, two years, two and a half years or whatever. We are referring to the preschool years.

The CHAIRMAN: You are focusing on the parent who has gone to the GP asking whether there is a problem with their child's speech development. Should it be a program like that for Pap smears or a general program that maybe is run—Gayle spoke about a program whereby the teachers can assess for occupational therapy. Should this be part of the general immunisation program and, along with the occupational therapy assessment, there is a speech therapist assessment. If we were to capture all these things together, who is the appropriate person to do that assessment?

Ms Middleton: It would be ideal if every child who is seen by a GP went through the practice nurse afterwards and she went through the checklist. If the parent has gone to the GP and asked for his professional advice, the very least the GP could do is go through the checklist and ask the questions. GPs know that their advice is one of the most powerful tools they have in improving a patient's health. They report that regularly. Nothing will replace the image of the GP in the eye of the patient. We really need the GP to say to the parent that speech and language is important for their child's health. If he and not the practice nurse says that, they are far more likely to go to the speech pathologist. Screening everybody who goes into a GP's practice is a brilliant idea, but the bottom line is that it is the GP who has to say they have to deal with this problem.

There is another thing that as a state we could look at. Gayle mentioned that we have a plan called an enhanced primary care plan. It is a Medicare rebate that comes for five sessions. Five sessions is nowhere near enough for a child with significant speech and language delay. However, when Monash University did an audit last year, they found that under that enhanced primary care plan scheme $165 million was given to GPs to write the plan and $65 million Australia-wide was given

to allied health professionals to provide the therapy. If the state started to lobby Medicare and said, "Hang on a minute; yes, we want allied health professionals and GPs to work together. However, is it really necessary for the GPs to do the paperwork? Could the money that will provide an extra three sessions go directly to the allied health professional?" As we do now, the allied health professional would have to report back to the GP that they saw the child and outline what they found to be the difficulty. It could work better and it would not cost a cent more, but it would give that client another three sessions that would do significantly more than what we have to work with now.

The CHAIRMAN: Have your thoughts around those changes been formulated in a report?

Ms Middleton: The only report that has been done is the paper that reported on the outcomes of where the money was going under the enhanced primary care plan.

The CHAIRMAN: Do we have a copy of that?

Ms Middleton: I will try to get one for you. Speech Pathology Australia would be another resource to ask about that.

The CHAIRMAN: Could we have a copy of the resource directory as well?

Ms Middleton: Absolutely.

Mr P.B. WATSON: Is the fact that not enough people are seeing speech pathologists because there are not enough trained speech pathologists or references?

Ms Middleton: There are not enough trained speech pathologists. The number of students training in speech pathology has not increased in this state over the past 30 years.

Mr P.B. WATSON: My niece studies speech pathology at university and when she completed her course she could not get work and is now working in another field. I was interested in your comment.

Ms Middleton: I do not know what year it was, but there is plenty of work out there now.

The CHAIRMAN: I remember when I was at university the entrance requirement for students who wanted to undertake speech pathology was very high.

Ms Middleton: It has gone down significantly. It is much lower than it was earlier.

The CHAIRMAN: It required a TEE score of 95. What is it now?

Ms Middleton: I think it is 73. We have another school at Edith Cowan with not many students. If we were to provide the services that each child in this state who has a problem deserves, we would need to have significantly more speech pathologists. It would be lovely to see more working beside teachers in the early years units at the education department.

One thing I did not mention is a study by Ron Gillham. He undertook a study that was a randomised control trial in the USA. His report was published last year, and I will provide the reference. Basically, he looked at the effect of intensive language intervention versus long term, once a week or twice a week. They gave a group of children daily speech therapy for one hour and 40 minutes and then compared those results with the results of children who were getting sessions once or twice a week.
[4.00 pm]

The children who had the daily intensive therapy improved significantly. I do not know if you can see it, but this shows the children who actually had the daily speech and language intervention and these are the children who had the same amount of intervention but over a two-year period. So the children who have intensive therapy respond significantly better but continue to achieve gains even after therapy has ceased, compared with those children who do not. In the government sector traditionally we offer children a block of five weeks and then another child is cycled through, to try

to give everybody a little slice of the cake. This would suggest that really in those five weeks those children should be seen every day, not once a week, if we are going to actually do something significant.

The CHAIRMAN: Has anyone conducted any research on speech difficulties from kindy through to grade 7, as a pilot in several schools?

Ms Middleton: Looking at intensive versus non-intensive?

The CHAIRMAN: Looking at, number one, if it is a school of 300, how many children in each year might benefit from speech therapy and how that varies in different areas. What picture do we have of the identified need?

Ms Middleton: The study by McLeod was very significant, and it is an Australian study. It is McLeod and Threats and the journal was published by Speech Pathology Australia, but it is the *International Journal of Speech-Language Pathology*, and I will email you that—the address. Basically, they had quite a significant number of children. They had almost 5 000 preschool children in Australia and they found that one child in four is likely to have some degree of communication impairment. In WA, looking at children up to 16, we are looking at about 90 000.

The CHAIRMAN: Who might be in need.

Ms Middleton: Who might be in need.

The CHAIRMAN: So 90 000 in our primary and secondary schools who might be in need of assistance with speech therapy.

Ms Middleton: Some sort of communication impairment, so whether it is stuttering or articulation or language or literacy or whatever, but some sort of communication impairment.

Mr P. ABETZ: That is for all of Australia, is it?

Ms Middleton: That is for Western Australia.

Mr P. ABETZ: That is for Western Australia?

Ms Middleton: That is for Western Australia. We are not touching it.

The CHAIRMAN: We have been fortunate in that schools now have additional psychologists to help them, but it looks like we need a lot more than school psychologists going into schools.

Mr P. ABETZ: Perhaps a few more speech therapists could actually reduce the need for psychologists in terms of the problems. I have worked a lot with chaplains in high schools in Rossmoyne, Leeming and so on. That is why we want to bring chaplains into primary schools, because if we can deal with the issues early, they do not become so big at that point. I think that often school psychologists are dealing with psychological issues that, had a speech therapist dealt with them, would not be there.

Ms Middleton: If you have a child with significant speech and language impairment, it does not matter how much counselling you do, if that child cannot understand what you are trying tell them, they are not going to respond.

Mr P. ABETZ: The brick-wall syndrome. What do you see as the overall solution?

Ms Middleton: The overall solution is getting them early; it is getting children as early as possible. We can identify these children from birth and start just putting in a public awareness program for parents on what constitutes a speech and language problem, what the effects are and what this is likely to do. Tell them that, yes, playing in front of a play station and watching lots of television and playing outside and just being a boy; if they are not hearing language, that is putting them at risk. They need to be talking to them, encouraging them, asking them certain sorts of questions. So really doing a campaign to say that speech and language really will equip your child for school, that is basically what we need to say.

The CHAIRMAN: I am afraid we will have to finish now. Please pass on that message to Rosemary. I would like to thank you both for the evidence you have given 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 of 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 introduced via these corrections and the sense of your evidence cannot be altered. However, should you wish to provide additional information or elaborate on particular points that we have discussed today, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. Thank you both once again for coming along today.

Ms Middleton: Thank you.

Hearing concluded at 4.05 pm