EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO ATTENTION DEFICIT DISORDER AND ATTENTION DEFICIT HYPERACTIVITY DISORDER IN WESTERN AUSTRALIA

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
ON WEDNESDAY, 29 OCTOBER 2003

Members

Mrs C.A. Martin (Chairman)
Mr M.F. Board (Deputy Chairman)
Mr R.A. Ainsworth
Mr P.W. Andrews
Mr S.R. Hill

Co-opted Member
Mr M.P. Whitely

Committee met at 11.15 am

ALBERT, MR PAUL
Director General,
Department of Education and Training,
examined:

BANKS, MS MARGARET
Acting Deputy Director General, Schools,
Department of Education and Training,
examined:

The DEPUTY CHAIRMAN (Mr M.F. Board): Welcome to our inquiry into ADD and ADHD. I do not need to go through our formal introduction because you know who we all are. However, I need to indicate to you that the committee hearing is a proceeding of the Parliament and warrants the same respect that proceedings in the House itself demand. Even though you are not required to give evidence on oath, any deliberate misleading of the committee may be regarded as a contempt of Parliament.

You have completed the witness forms and understand the information that was provided. For Hansard, will you state the capacity in which you appear before the committee?

Mr Albert: I am the Director General, Department of Education and Training.

Ms Banks: I am the Acting Deputy Director General, Schools.

The DEPUTY CHAIRMAN: Margaret, I recognise that you have been sitting there very patiently while we talked to Paul earlier. Obviously, you have read the terms of reference. I thank you for your submission and for taking the time to come and give us some additional verbal support for that today. We have an open mind about this inquiry. We have launched the inquiry primarily because we believe that there needs to be a stronger whole-of-government bipartisan state policy towards this, not only to assist parents in their judgment of where they should go, but also to try to give some direction to a whole range of people who are involved with this difficult disorder and, I guess, to clarify some of the misinformation that has grown over the past few years. With that, we invite you to speak to us for a while, Margaret. Then, if Paul wants to add anything, he can, and the committee can ask a few questions.

Ms Banks: As you have indicated, the challenge is that there are a range of perspectives, so the first thing from an educational perspective is that we acknowledge that medical diagnosis is part of this process. From an educational perspective, we do not enter into that side of the equation. We also acknowledge that there is a whole diverse range of perspectives about the condition, which can create challenges in terms of how we are expected to respond from a parent's perspective and from a community perspective in order to meet this diverse range of perspectives and viewpoints about the condition - whether it exists, whether it does not, whether medication is the answer or not. Therefore, we work within a framework of not a specific policy on ADD-ADHD, but a holistic health perspective where we use our student health policy as the framework in which we operate. Using the advice of the medical professionals and the advice from parents, the school is expected, under this policy, to work collaboratively in the interests of achieving the optimum health outcomes for the student. Then it is the role of the school to make whatever adjustments to the curriculum and the learning program in order to support the education outcomes for the students. We use the health care policy, so that if there is medication or other medical needs, they will be met under that

policy, which essentially says that students will access health care at school, and all parties at the school will do everything within their power to administer to those health needs.

We also regard all students who are at risk of not meeting their full educational potential to be at educational risk. We have a general policy that embraces the needs of a broad range of students. We do not have a specific policy for students with ADD or ADHD, but we have the students at educational risk umbrella, which means that there needs to be an individual education plan. Once again worked out collaboratively with all parties to devise that plan. For a number of students, it may also require the implementation of behaviour management, if behaviour happens to be an aspect of the student's needs, and there could also be a requirement for an individual behaviour plan, which fits under the umbrella of all schools being required to have behaviour management policies and to work within that framework.
[11.23 am]

Our role is to be responsive to professionals and parents to meet our brief of education provision. The collaborative approach is a very important element of that.

With respect to how we define attention deficit hyperactivity disorder, our policy for students with disabilities embraces about three and a half to four per cent of our student population and ADHD and attention deficit disorder are not defined as a disability. We have another large group of students who have particular learning difficulties.

The DEPUTY CHAIRMAN: Sorry, are ADD students in that three to four per cent?

Ms Banks: No.

The DEPUTY CHAIRMAN: So three to four per cent have disabilities. Do you have a handle on how many have ADD?

Ms Banks: An additional 14 per cent of students have particular learning difficulties and this can embrace a whole range of learning difficulties. As you would be aware, often ADD and ADHD accompanies other learning difficulties, such as dyslexia, and a lot of other issues and conditions that require special support. We have used the definition that comes from the commonwealth standards. However, over the past two years we have been conducting a review of our services for students with disabilities. In that we have appreciated that whilst we categorise four per cent of students with disabilities and the 14 per cent are not given additional support, the whole range of 14 per cent do everything in their power to be categorised as part of the four per cent. Our longer-term plans and needs are to provide better for that whole range of students. However, it is a resource-intense approach and our whole thinking and way of supporting the four per cent of students has been built on a deficit model in which we give students a label and they get a package of supports that go with it. If students are not categorised in that way, they get nothing. We are trying to work towards a broader needs base. We have a number of support programs for the full range of students. The support is provided both at the school level and through our district office student services teams, which consist largely of school psychologists who assist in working through the individual educational programs and the adjustments that are needed to enable those students to best manage the curriculum. That means an individual case management approach for those particular students. That is a general introduction.

The DEPUTY CHAIRMAN: Thank you very much for that. We will open it up for questions until 11.45 am when we will need to conclude. The education department's awareness, knowledge base and individual programming for young people with ADHD has come a long way over the years. However, a set of parents were here on Monday and their experiences are not what I would call ideal; in fact, they are far from ideal. Generally speaking, I think they felt that although there is a knowledge base of the condition in theory, it breaks down greatly when it gets to a classroom situation. More often than not those young people are dealt with in a disciplinary sense and end up being suspended and treated in a way that is not subject to people understanding their condition,

particularly the health aspects. Hence, that has social consequences and other learning consequences that are inhibited by other factors, not ADHD. Apart from what you have said, and given the numbers you mentioned - we are talking about a large number of students - is there a stronger push in the department to educate teachers and to give them a knowledge base of how it works at the coalface and how, although some young people with ADHD are very bright, they have difficulties in being able to deal with retention levels?

Ms Banks: Certainly we have made some progress, but it is a very difficult area as we all know. I would like to talk about a couple of things we have instigated. As a result of our review of services for students with disabilities, one of the programs that we have built up is a program called building inclusive schools, which is about the professional development needs of both school leaders and classroom teachers so that, in the first instance, they have a better understanding of the issues you have identified and of their obligations by way of a legislative, moral and ethical response.

[11.30 am]

Leaders across our system are receiving this systematic professional development so that they will be better equipped as school leaders. Our long-term intention is to provide all classroom teachers with this information and professional development. In addition to that, we have a visiting teacher service. We have a centre for inclusive schooling which is located in Hale House. In a general sense there are 32 of those teachers. They are able to visit a classroom teacher with a particular student with a special need. They have a high level of expertise for working with the teacher and parents in case management and in giving information and additional support to the teacher. We therefore have a visiting teacher service as well as continuing to give specific training to all our student services teams in the districts to make sure that our school psychologists are kept fully up to date.

In addition to that, we are engaging as partners in some research in this field. We have not used our resources to assist research in the medical field. We do not think that is our domain. We have been assisting in supporting programs that would assist in the educational context. You may already be aware that we have support for the University of Western Australia child study centre. The early years screening project is looking at early identification and educational response. Another project is looking at students with reading difficulties. We are supporting a program at Curtin University of Technology involving executive functioning, gender, age and medication as predictors of developmental wellbeing amongst children with ADHD. We are trying to engage at a research level. The department is very strongly focused now on evidence-based response. Trying to get quality research with which to improve our practices is vital, and support for staff through professional development programs.

The DEPUTY CHAIRMAN: We need lots of short, sharp questions.

Mr S.R. HILL: You spoke about visiting teacher services. Were they going into the regional areas as well or were they particularly based in the metropolitan area?

Ms Banks: We have a rather large travel account. They are accessible. It is a statewide service. That statewide service is another area that we are wanting to build up. We are also looking at the potential of additional on-line support. We have some greenfield trial work going on to find out how that service can get to teachers, particularly by using our laptop or notebook program and the access that teachers now have.

Mr S.R. HILL: It can therefore be done through the classroom, can it?

Ms Banks: Yes. We are also training through our early intervention program that the director general mentioned earlier; that is, the getting it right program. We are giving teachers specific training in the building inclusive schools and behaviour management strategy so that they can support and work with teachers in the classroom. There will be up to 200 additional teachers next year.

Mr M.P. WHITELY: You have an impossible job trying to manage this issue. I come from a particular perspective, so I am well aware of the divergence of opinions. One of the concerns I have got is that although schools are not involved in the diagnosis of ADHD, so much of the evidence they provide predetermines the diagnosis. We have hard evidence of particular children being diagnosed after a 10-minute consultation, after discussion with the parents and after reading information provided by schools. I think it is called the Connors checklist. They have even been retrospectively diagnosed, using school reports of adults from 20 years ago. I am an ex-teacher. A concern I have is that some teachers who are - I cannot find a better term - ADHD enthusiasts want to act as spotters for identifying children who may have ADHD and are often responsible for identifying behaviour, pointing out to the parents and then producing some of the information that paediatricians are using to diagnose. It is an incredibly difficult thing for you to check or control, but are there any controls in place to make sure how teachers are acting, because it is often not obvious?

Ms Banks: I am aware of what you are talking about, but our position goes back to the fact that it is a medical responsibility to diagnose the condition and it is a medical issue of what information they use. My understanding is that the intention is that that data collected from the classroom would be just one aspect of the data that medical practitioners should be bringing to bear when making that decision.

Mr M.P. WHITELY: We had evidence two days ago from parents that diagnosis was after a very brief consultation in which the child was asked to write one sentence and read one sentence. It was based on school reports and also what the parents said. I appreciate the difficulties you have in this area, but it is a concern that I at least want to flag.

Mr P.W. ANDREWS: To what extent is the crosschecking of information happening. For example, if there is a sole classroom teacher in years 1, 2 or 3, and, as you put in your submission, children experiencing stress, trauma, sudden psychiatric disorders and behaviour that might look like ADHD to some teachers, if that child has only one teacher, do we have a system in our schools for a crosschecking of observation? For example, if the five of us went into a classroom and observed a child, we would report it in different ways depending on our experience.

Ms Banks: I cannot say whether this is used all the time, but one checking mechanism available to the school goes back to the fact that we provide services that a classroom teacher can choose to use, depending on the need. Our school psychologists are among the best-trained staff we have. They all have six years of training, including a teaching qualification. They all train in psycho-metric analysis etc. They are available for all schools to use in the case management approach.

Mr P.W. ANDREWS: Do they go into the classroom?

Ms Banks: Yes, part of their role is to observe the child in the classroom. They spend a lot of time doing that to enable them to help the teacher to work the individual education plan.

I am not suggesting that it happens properly but it is there. We could do some further work on our quality assurance processes.

Mr R.A. AINSWORTH: Where parents do not have access to longer lasting medication which does not require a midday top-up, if I may put it that way, schools are required to deal with the storing and dispensing of the medication. Apart from the obvious time factor and everything else, is there a concern in the education system that it is not an appropriate thing for teachers to be required to do? Would your preference be for the longer lasting medication that did not require that?

Ms Banks: Going back to the dispensing of any medication, no teacher is required to do that under our policy. That is not just for this medication but medication for a number of conditions. It sometimes can be a big challenge for us to work through a process that is acceptable to the parents and the school in order to meet that obligation.

[11.40 am]

We will administer whatever medication is required, but, clearly, not all teachers feel comfortable with that and not all schools are happy about it. Certainly, in formulating a health care policy, we have spent a lot of time with the State School Teachers Union of WA discussing what is fair and reasonable for teachers, while of prime importance is the wellbeing of the student. Clearly, we welcome any way that reduces the workload and the responsibility at the school level. However, we work with whatever is in the student's best interest.

Mr M.P. WHITELY: Is there any centralised pool of statistical information that can tell us the numbers and percentages of children at particular schools that are diagnosed with attention deficit hyperactivity disorder?

Ms Banks: We do not routinely gather that data but individual schools would have it in their records.

Mr M.P. WHITELY: I know that a school does not play a role in the medical diagnosis but the information that it produces sometimes plays a role in identifying the children who may be exhibiting these behaviours. It would be interesting to see comparisons across schools because it may be that the way a school approaches the issue leads to differential rates of diagnosis.

The DEPUTY CHAIRMAN: We received evidence that the earlier these potential problems are picked up, the more likely a positive outcome or the situation will be at least managed that minimises or maximises potential. Are these programs that you have talked about based in high schools? Are there any primary or preprimary-type intervention programs? Is there an emphasis to look at this issue earlier rather than later?

Ms Banks: Most of what I talked about applies from kindergarten through to year 12. Our whole policy is aimed towards early intervention and significant additional resources in the earlier years - such as smaller class sizes and the getting it right strategy that I spoke about. We also give our support to, for example, the research that I mentioned in the zero to eight years with the early screening and we are a very active participant in the zero to eight joined up government strategy that is being implemented. I have a strategic early childhood group within the department bringing various sections together. The fundamental question we are trying to ask is how can we, in the very early years of kindergarten and primary school, help make up for any areas of deficiency for children at risk in the zero to four range. It is not just dependent on what has happened in the home setting. Actively, on all fronts, we acknowledge the importance of early intervention.

The DEPUTY CHAIRMAN: One of the things that I am particularly interested in is the difficulties that ADHD kids have in social experiences such as sport. We have heard from parents that in some cases they have not gone out with their children for four or five years because their behaviour is socially unacceptable. Some of those kids have gone through the whole of primary school without an invitation to a birthday party because of that. Do these programs make a conscious effort to bridge the knowledge gap of other parents about these kids? It is not leprosy we are talking about here. It is an attention deficit and it often has nothing to do with IQ - I am not a doctor, I am just talking about the evidence we have taken. Is there an effort from the department or a policy within schools to bridge those gaps because parents cannot do it on their own. Many letters have been written to me by parents of children with ADHD who have had the P&C pass a motion against them because they are perceived as bad parents because they are administering drugs at school. They feel socially alienated for having tried to do the right thing by their child. Does this policy go beyond the interface of the child and address the whole school environment?

Ms Banks: We acknowledge the importance of working with the parent community. We have not got the specific, broader information to all parents. Part of our building inclusive schools concept, which has come out of the review of services for students with disabilities, has plans for parental information. It is about community attitudes. The school can play part of a role in assisting with the changing of community attitudes but some of these are difficult. I am aware of what you are talking about with regard to ADHD. We also have it with regard to parents who are having

difficulties with students with disabilities who are being integrated into a main stream classroom. It well and truly adds to the burden of the parents of a child with special needs. Schools do quite a bit on a one-to-one basis. We feel that the leadership of the school principal is a vital influence and that he or she has the capacity on the ground to influence the community perspective. Our major strategy is assisting school principals to have a better understanding of the condition. However, as you have raised and as we know, we are not saying that we have done all that can be done in that area. It is an area in which we can continue to improve.

Mr P.W. ANDREWS: Margaret, do you see the school principal as a key player in -

Ms Banks: Absolutely, he or she sets the culture of the school and the environment at the school so that parents feel welcomed. In the building inclusive schools strategy, the fundamental questions for the school leader are: what students come to my school, what students do not come and why do they not come, and, when they are at my school, what is it like for them at my school and does it feel good for every student? Then we can ask what the students are achieving or what should they be achieving.

Mr P.W. ANDREWS: If a principal has an anti-ADHD slant is it quite possible that that school will not diagnose?

Ms Banks: I am sure that the personal perspectives of school leaders permeate in all sorts of -

The DEPUTY CHAIRMAN: This is a difficult question for you to answer: would you allow people to cross school boundaries based on a particular school's reputation for having a very progressive and enlightened policy on ADHD kids?

Ms Banks: Certainly, and that actually happens. The only limitation we have is that in some schools there is a policy of a local intake simply because of the high demand. We have to set a boundary around that school to determine who can attend there. However, if it is not a local intake school there is that flexibility for parents and we encourage parents to make choices.

Mr R.A. AINSWORTH: Are you aware of any schools encountering specific problems with diversion of the ADHD medication? In other words, the kid is not taking the medication but is using it in other ways.

Ms Banks: I could not be sure from our complaints unit whether that has happened. I am sure it has happened at all schools - government and non-government schools. There are, as you would be aware, specific issues around adolescents, their medication and their lack of willingness to take it when they need it or their willingness to misuse it or pass it on. Those are issues that are dealt with at the school level through a whole school health policy trying to help students with their personal choices.

The DEPUTY CHAIRMAN: We could talk to you for hours because your information is very enlightening and very valuable to us. I am hoping that before we conclude our inquiry we will get the opportunity to talk to you again as we look into making the recommendations and so forth. Thank you for coming in today. You will get a copy of the transcript and you will have 10 working days in which to make any corrections. If you want you can add something by way of supplementary information on the return of that transcript. I thank you for the valuable information you provided today that will certainly help us with our inquiry.

Committee adjourned at 11.50 am