

**COMMUNITY DEVELOPMENT AND JUSTICE  
STANDING COMMITTEE**

**INQUIRY INTO THE ADEQUACY OF SERVICES TO MEET THE  
DEVELOPMENTAL NEEDS OF WESTERN AUSTRALIA'S CHILDREN**

**TRANSCRIPT OF EVIDENCE TAKEN  
AT PERTH  
WEDNESDAY, 25 MARCH 2009**

**SESSION THREE**

**Members**

**Ms A.J.G. MacTiernan (Chairman)**

**Mr A.P. Jacob (Deputy Chairman)**

**Mr I.M. Britza**

**Mr A.P. O’Gorman**

**Mr T.G. Stephens**

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**Hearing commenced at 2.00 pm****WRAY, DR JOHN ALBERT****Doctor/Paediatrician,****examined:**

**The CHAIRMAN:** Dr Wray, you have read the terms of reference. You have asked to appear before the committee. We are a formal committee of the Parliament and we do not require witnesses to take either the oath or affirmation, but it is considered that your evidence is truthful. This is a public hearing and a transcript of proceedings will be made public. I understand that you are happy with that. You have completed the "Details of Witness" form. Did you understand it?

**Dr Wray:** Yes.

**The CHAIRMAN:** You have given a frank submission. Perhaps you could address it.

**Dr Wray:** I thank the committee for its interest in such an important matter. I appeared last year before the Education and Health Standing Committee's inquiry into development assessment and screening and this is a similarly related subject area of early childhood. I will bring your attention to the paragraphs in my written submission that address the specific matters before this inquiry. In my opinion existing government programs are adequately addressing the social and cognitive needs of most children. Excellent examples are available of good collaborate partnerships and innovative practices in the public and private sectors. Around 10 per cent to 20 per cent of all children need some additional supports and probably five per cent to 10 per cent of all children require a great deal more support.

**The CHAIRMAN:** What was the percentage requiring a great deal more support?

**Dr Wray:** Probably five per cent to 10 per cent. I commend to the committee the most recent survey of the health and wellbeing of children in Western Australia. It is a telephone survey of a broad cross-section of rural and urban Western Australia that is conducted from time to time by the Department of Health. The latest survey—July 2006-June 2007—indicates that 6.9 per cent of surveyed households reported quite a lot of trouble with the emotions of their children, while 0.8 per cent experienced very much trouble.

I turn now to some specific developmental problems. In that same survey the percentage of children from zero to four years old who were perceived as having a disability or long-term illness or pain that puts a significant burden on the family was assessed as being 5.1 per cent. Developmental problems in general for zero to four-year-olds may be around three per cent. If we turn specifically in that survey to the area of, for example, developmental language problems, late talking was found in 25 per cent of two-year-olds to four-year-olds and the percentage of children needing professional support was 11.8 per cent. You can get a feel for the breadth of the problem.

The concept in developmental services is to provide both universal and targeted programs. There is room for improvement in both areas, but at the moment there is a particular deficit in targeted programs and the most significantly underserved zero to three-year-olds specifically are Indigenous children; children from culturally and linguistically diverse environments, children with severe disorders of language development, children of substance abusing parents, children of intellectually handicapped parents, children of mentally unwell parents, and children from low socioeconomic areas and children with other significant risk factors such as early fire lighting, aggression, violence and cruelty to animals. These are regarded as significant red flags for a child heading down a slippery slope.

The second item is the identification of developmentally vulnerable children. An excellent service in Western Australia is available to all children through the community health nursing system. They now use standardised screening tools that have been available from January this year. Unfortunately, only about 10 per cent to 20 per cent of 12-month-old children access that service. Therefore, we are not picking up children through that service as we could. There are problems also with not enough community health nurses and not enough adequate funding to provide the intensity of services one would like to provide through the publicly-funded child development services.

**Mr A.P. O'GORMAN:** Did you say that at 10 to 12 months of age only 10 per cent of children access the system?

**Dr Wray:** My understanding is that about 10 per cent to 20 per cent of 12-month-olds access the child health nursing system. Typically there is a hiatus from around that time until when the child enters the school system at which stage they are picked up again by the school health nurse. Both school health nurses and child health nurses belong to the community health nursing structure.

**Mr A.P. O'GORMAN:** This morning we heard evidence that 97 per cent of children are seen within the first 10 days of leaving hospital. It appears that might be at the top level.

**Dr Wray:** That is right and then there is a significant attrition up to about 12 months of age. It is a rough phenomenon with firstborn children. The parents who have subsequent children barely present or do not present to their child health nurse. They do not avail themselves adequately of a free system. The uptake is extremely good in the very early period and that is why, appropriately, there is great interest also in developing prenatal and antenatal services—engagement with visiting nurse structures.

In my opinion the appropriate government service to coordination and resourcing responsibility for that identification and delivery of assistance to zero to three-year-olds is child and adolescent community health, but other governmental services, particularly the Department for Child Protection, Department for Communities, Department of Education and Training and the child and adolescent mental health service have very significant roles and there is significant opportunity for collaboration with other non-governmental and not-for-profit groups.

My opinion of what is the best model is a central governing group to help set various standards. That central governing group would be representative of the stakeholders with its operation occurring at regional levels so that regional communities can become involved. Best evidence shows that once the communities are involved there is greater ownership of the programs and greater responses to local needs.

On the subject of prioritisation, priorities have been developed in the child development service. Now there is uniformity in the way we agree with the prioritisation system, but in reality there are not enough resources to meet the needs of the most highly prioritised children. The relatively de-prioritised children do not obtain a highest level of service.

Program outcomes is a critical part that is often missing in government-funded programs; that is, the lack of outcomes in any program. This is critical and best achieved by the combination of standardised and non-standardised instruments that take into account factors in the program as well as outcomes for the child and outcomes for the family. Thank you again for listening to the matter and I am happy to take questions.

[2.10 pm]

**The CHAIRMAN:** It was interesting—it is the first time I have ever had those figures, instead of making guesses around those levels—to note here in your submission that the child development service, along with other health services is currently expected to find a three per cent saving. Is that right? What area of the CDS has been cut?

**Dr Wray:** We are obliged to find savings; the savings are not identified for us.

**The CHAIRMAN:** Let me understand the structure: you have the department, and what CDS within that department? I do not quite understand that.

**Dr Wray:** From the bottom up, it is the child development services' part of child and adolescent community health services and, in turn, part of child and adolescent health services—Princess Margaret and everybody else. There is a separate model of Princess Margaret as a hospital entity, along with King Edward, called women's and children's health services, and all of the community health structures for children were operated by the different regionalised health services. Now all the child development centres, community health nursing and policy have come together under child and adolescent community health, in turn part of child and adolescent health services standing apart from King Edward Hospital.

**The CHAIRMAN:** That is the reform that won awards; is that right?

**Dr Wray:** You might imagine there were elements of reform for all of that coming together, but the specific award was the reform of the child development services in which 19 centres scattered around Perth were brought together.

**The CHAIRMAN:** All right. You brought them together in an administrative sense?

**Dr Wray:** And in a clinical sense, in terms of having more equity to access the services, more uniformity about which children we will see and so on. Previously the system had been described as a postcode lottery; it depended on the postcode that the family lived in as to what type of services they would receive from their publicly funded child development centre.

**Mr I.M. BRITZA:** When you put that together what was the major problem? And I have a second question when you answer that. What was the main problem you had to overcome with this collaboration?

**Dr Wray:** It would really be about, mostly, entrenched ideas around ways of operating that had developed in each of the services. This has been described as an eclectic system in child development. There are one or two ways to take out an appendix, but in managing child development and behavioural issues there may be many approaches to that problem and many different senses of priorities around it. The different child development centres, to some extent, had developed slightly different systems, but also they had set different boundaries on their intake criteria. Some centres were not seeing children older than eight years of age, others were not seeing children older than 12 years, and some centres were seeing all children; those sorts of things. The coming together of that means there needs to be ground given on many sides by the clinicians. We had excellent support by administrative and managerial staff and we achieved it without any specific funding.

**Mr I.M. BRITZA:** We have found so far that one of the roads towards getting real answers is to get some genuine collaboration within the departments, and to stop rivalry with departments protecting their turf and funds. I asked the question because I see that for us to have a major effect—we have the same heart that you expressed here—these departments must collaborate, which is much the same principle as that which you have been able to do on a small scale.

**Dr Wray:** We have come together quite well and there is good feeling among senior clinicians and also a fledgling management structure to help us go forward. It is mostly because we have a vision of having a single joined-up voice with regard to governmental services for child development.

**Mr I.M. BRITZA:** When did this award-winning program come into practice?

**Dr Wray:** It dates to a health reform initiative put in place around 2005, with a subsequent report and then subsequent work from 2006 to 2008; we began to operationalise in 2008. It is not until next month that we will see the rollout of a joined-up electronic database system —

**Mr I.M. BRITZA:** That was my next question.

**Dr Wray:** — which will be a critical part of our work. One of the frustrations in the past has been to generate a high quality business plan to convince funding authorities of the efficacy of our work, if you like. And because we were not joined up, we could not pursue those business plans as well as we would have liked. The State Child Development Centre in Rheola Street—the largest and the longest established centre—would vie for funding in competition with stakeholders that included emergency departments or children with cancer or other very significant and life threatening needs. We could understand in that scenario that child development issues would not be high on the priority list. In the case of colleagues in the other health regions, they were vying for funds in amongst adult needs because they were part of that system. I think that the coming together of children's health services in a focussed group and our centres joining up is a good solution.

**Mr A.P. O'GORMAN:** Do we have 19 child development centres around the metropolitan and rural and regional areas?

**Dr Wray:** No, "metro" in this case includes Mandurah.

**Mr A.P. O'GORMAN:** So 19, including Mandurah.

**Dr Wray:** Inclusive, yes. As far north as Joondalup, as far south as Mandurah; and as far east as Armadale.

**Mr A.P. O'GORMAN:** So who services the rest of the state?

**Dr Wray:** In the major centres there are small regional teams of therapists who are also health department funded, and by the nature of rural services you might understand that many times those clinicians are younger, less experienced and maybe transient. Typically, those younger therapists will turn to the senior therapists at the State Child Development Centre for professional support, and for specific medical input they may obtain the services of the visiting rural paediatric service or of the paediatricians in our centre. However, it is a separate system.

**Mr A.P. O'GORMAN:** But they are in the same situation of competing for funds in their particular regions?

**Dr Wray:** Yes, although in the case typically of the allied health professionals—occupational therapists, speech therapists, physiotherapists, psychologists and social workers—in the country scenario they also work for the hospital system.

**Mr A.P. O'GORMAN:** So they have a connection?

**Dr Wray:** That is right.

**The CHAIRMAN:** You say here, and in your oral presentation, that the child and adolescent community health service should have the coordinating and resourcing responsibility for the identification and delivery for children zero to three years of age, whereas what has happened is that a policy has been developed that early child development will be coordinated through the Office of Early Childhood Development, which is attached to the Education Department. Now, there are different models—their remit is still being worked out—but they are certainly charged with coordinating the COAG response, which will be significant. What is your comment on that and why do you see as —

**Dr Wray:** I am unaware of the details of the policy and the implications in terms of clinicians and other services that are currently there. Therefore, I do not know whether that model will include the notion that child development services come under such a department. I am not aware of that.

For me, to respond in a scientific way, it is about the evidence, whereas the precedents that established that such a system coming under education or some sort of educational banner, if you like, would make any difference is merely the shuffling of chairs on the *Titanic* and to decide whether there would necessarily be any other improvements coming under another department, I would want to know the evidence to support it.

**The CHAIRMAN:** There are a number of different issues here, one is the full Victorian model in which child health services are taken into an expanded education department, or a model in which there is some sort of coordination role—yet to be defined—that is given. You are proposing that health be given that role.

[2.20 pm]

**Dr Wray:** I do not understand the model of the Office of Education and Early Development.

**The CHAIRMAN:** It is a work in progress

**Dr Wray:** Ultimately, to whom does it report? Are there joint reporting lines? Is it all about education, in which case, ultimately, the agenda will drift into an education agenda, where there is input from mental health services and other childhood development services? The Victorian model is touted but, in the end, it is touted because it is fresh in everyone's mind, I think, because it is new. But there is still no evidence at this point that it is any more superior than existing systems.

**Mr A.P. O'GORMAN:** In your submission, are you dealing also specifically with children who are being identified with difficulties or, just in general, childhood development?

**Dr Wray:** My specific roles are in the identification and management of children with developmental disorders. But the universal systems that help promote child development are intimately of interest to me because they decrease the number of kids with conditions or the severity of the complaints the child has, so it would not make sense for me to separate my interests.

**Mr T.G. STEPHENS:** With your knowledge of the Victorian system, do you know where your counterparts in Victoria are now?

**Dr Wray:** Only some of them. Victoria has always had a slightly different system. We know our Victorian child development colleagues have, for example, been using the Medicare system, and returning funds to the health service, and the health service pays them a salary. That is completely different from any model in Western Australia.

**The CHAIRMAN:** How does that work?

**Dr Wray:** It is beyond me.

**The CHAIRMAN:** Doctors employed by the state government bill Medicare?

**Dr Wray:** Yes.

**Mr T.G. STEPHENS:** You are not quite sure exactly where the equivalent services ended up in the restructuring?

**Dr Wray:** Exactly. I am aware that the child health nursing system has come under the new ideas around education and early childhood development—doctors and allied health therapists. I am not sure where they are sitting at the moment. I know policy has come under the ideas around education and the super department.

**The CHAIRMAN:** I do not think doctors were transferred, were they?

**Dr Wray:** No. What are the tensions then between the employers of the doctor and the other systems? How can they be worked out? Ideally, a memorandum of understanding might make it all work. If a joined-up office assists with the voice of children, then that is a good thing. But you would want to know the evidence for the cost that would go into the restructuring.

**Mr T.G. STEPHENS:** Is there an equivalent in other jurisdictions to the Rheola Street thing in your network?

**Dr Wray:** Probably the most outspoken and most listened to group is the Centre for Community Child Health in Melbourne.

**Mr T.G. STEPHENS:** Which is led by whom?

**Dr Wray:** By Frank Oberklaid. Each state has a kind of specialist child development centre if you like. That might be the Rheola Street equivalent.

**Mr T.G. STEPHENS:** He clearly has not been brought under the education department's aegis.

**Dr Wray:** I am unsure of those relationships, but I follow it with interest.

**Mr T.G. STEPHENS:** Would the way people get to you often be via a child health nurse?

**Dr Wray:** Yes. Again, the database systems make it difficult for me to answer for all the centres at the moment. But, in relation to our own centre, a third of referrals come from the child health or community nursing system, third from general practitioners and a third from specialists and community therapists. Some of our centres have always taken direct referrals also from parents. That was one of the points we discussed in our coming together and we will, as a joined-up service, be taking direct referrals from parents as well, whereas previously there needed to be a professional in the middle. It is about a third, a third, a third at the moment.

**Mr T.G. STEPHENS:** Is there any suggestion of a way that the systems of early childhood support can systemically reform themselves to reduce the dependence upon your service? What would be happening out in the wider systems?

**Dr Wray:** I guess they are the notions around the broad-based preventive programs that help all parents and all children with their developmental, emotional and behavioural needs. There are aspects to them that can be improved. We should be doing more targeting of troubled families, teenage pregnant mums and substance abusers. There is so much more we could be doing in antenatal and immediate pre and post-natal periods to support those families. The best evidence comes from supporting those families and trying to reverse the trajectories of the families rather than waiting for the families to deteriorate and the child being taken into care at three or four years of age. That just does not work. Best evidence comes from putting in stuff early rather than providing rescue services at three or four years of age. In terms of children who have been identified as having developmental or behavioural problems, there is opportunity for closer collaboration with the private sector and with Medicare funded services. Here the federal sponsored system, as you know, has responded in latter years with a couple of Medicare programs. The enhanced primary care program allows general practitioners to refer for allied health services. But it is five therapy sessions a year—barely enough to touch the sides. You would know that most of the private health funds barely cover therapy services, typically to the tune of around \$500 a year, which is not much. There are ways those things could be addressed also to help enhance the use of private services. Another Medicare addition most recently—I am aware because I sit on the committee that the federal government is amazed at the uptake of this system—is the Better Access to Mental Health program for all Australians, a system that allows general practitioner and specialist referral to counselling colleagues: psychologists, social workers, occupational therapists and mental health nurses for 12 Medicare rebated sessions a year. That has been dramatic in its uptake by all Australians. We believe that around 15 per cent of the uptake has been for children less than 15 years of age.

There has been a greater move recently to support some of the work. If we were a little better coordinated in the public system, we could look at other ways of helping to stream parents and families through the private system first or in parallel to being on waitlists through the public system. You might imagine that it requires quite a degree of counselling skills and other intake or triage-type resources to help direct families in other ways, that we try to do to the best of our abilities.

**Mr T.G. STEPHENS:** Are your people not intimately caught up in programs such as Best Beginnings type of collaboration?

**Dr Wray:** We seek to collaborate as much as possible. Best Beginnings is an example of a program that is targeted towards specific groups and trying to get in there early. Many of those children still

end up accessing our services. But we believe that, through the good work of the Best Beginnings folk, the needs of the children have been diminished. That is a great example of the way the primary programs and secondary and tertiary services can work. But, in the end, Best Beginnings is a targeted program in specific regions.

**The CHAIRMAN:** As a paediatrician, you obviously get to see the parents when they come with the children. If we are talking about those five to 10 per cent of people who have a great deal of need and we are not dealing with children with a genetic or purely medical disorder but a developmental problem, what are you finding with the parents? What would your overall observation be? Do the parents evidently lack parenting skills? Is nutritional knowledge an issue here?

**Dr Wray:** No. Developmental disorders affect all people, regardless of race, colour, creed or socioeconomic status. Many of our families include children of doctors, lawyers, politicians and everyone else who comes in. Developmental disorders are extremely common.

**The CHAIRMAN:** That is a disorder?

[2.30 pm]

**Dr Wray:** Yes. If we look at say a developmental language disorder, to the best of our current technology you will not detect, if you like, an anatomical problem in the brain or something being wrong with genetics in 99.5 per cent of those kids.

In that case, the brain development has usually undertaken some unusual pathways. Children with dyslexia are a classic example of that. They are otherwise extremely bright children who have difficulties learning literacy skills. In that case, the brain development has become unusual compared to their peers for reasons that are still not understood. It is only in research situations that a gene has been identified among 10 or 20 per cent of those children, and no development in gene identification has led to gene technology yet —

**The CHAIRMAN:** Obviously we are talking about a slightly different thing. The issue we raised with the previous doctor was that there is disorder and there is developmental delay. Developmental delay is obviously a broader concept that is more bunched at the lower socioeconomic levels.

**Dr Wray:** The term “delay” is sometimes used interchangeably. We might use the term “global developmental delay” to describe a child who is significantly behind compared to his peers in a couple of developmental domains such as language and fine motor skills. We use the term “developmental delay” because we use developmental tests. Some of those children make significant gains when learning so that by the time they reach school there are no major risk factors for them. A high percentage of children who have a global delay might do an IQ test when they reach school and be found to be intellectually handicapped. At that stage an intelligence test is done to diagnose the intellectual handicap. The concept is a continuum of developmental delay or disorders through to intellectual handicap or specific learning disorders.

**The CHAIRMAN:** I just make the point that although these language disorders can occur across classes, it is clear that when looking at the AEDI, language developmental vulnerability is bunched very heavily at the lower socioeconomic group. There is obviously something going on there.

**Dr Wray:** I understand your point. If there were an equal predisposition towards language delay among all classes, we would expect a much worse outcome from a child with a disability or an incapacity whose mother had poor educational levels and other socioeconomic stresses than for a child who came from a higher socioeconomic class and whose mother was highly educated. A coming together of the causations leads to certain outcomes for the child. Australia’s criminal past is a perfect example of how a changing environment can lead to great outcomes for individuals.

**The CHAIRMAN:** Any further questions?



**Mr I.M. BRITZA:** I think the question Tony asked the previous witnesses was a good one. You obviously had a couple of pertinent things to say. I do not want to call it a wish list, but are there two or three things that you would particularly like us to remember and consider implementing if you had your way in the perfect world? What are the initial things you would like us to do?

**Dr Wray:** Thank you for asking that question. I would ask you to consider the government's role in a number of ways such as the provision of services, which is a specific interest of the inquiry, and how they may be better run or better resourced. I would also like you to consider the other things that government does in terms of providing leadership, incentive systems, legislation, and community planning, and to consider the needs of children and childhood development in all those environments.

**Mr T.G. STEPHENS:** I refer to the risks of the new agency and educational department for your services. Is there a risk to your services as a result of this policy change?

**Dr Wray:** I am not au fait enough with the policy, Mr Stephens, so I cannot comment on the risks at the moment.

**Mr A.P. O'GORMAN:** How do we prevent children in the general population from winding up going to paediatricians, speech pathologists and occupational therapists? There seems to be a great surge in the number of children needing that type of treatment. Can we, as a society, do something to stem the flow of children into those professional services? Ideally, when we had children, we would speak to them, connect with them and do all those sorts of things, but that seems to be missing from certain parts of our society. What can be done to bring it back to being as perfect as we all imagine it should be?

**Dr Wray:** We need to return to the things that we can all do to support children and to be child aware, including in all matters involving government. While preventive strategies will decrease the burden of disability for the child and the child's family, children with disabilities remain inevitable. There will always be issues of disability. Children with Down syndrome were not recognised as being a distinct entity within childhood disability 150 years ago. All the children with intellectual handicaps were lumped together. What we have seen, particularly in the past 40 or 50 years, is an increased recognition of what has been referred to as the "new morbidity". The rate of childhood mortality and infant mortality is down and there is a greater emphasis on the developmental and behavioural trajectory of each child. A lot of that is due to the increased number of conditions that have been identified, but that is okay because we understand that identifying a condition earlier and trying to do something about it will change a child's trajectory. There are some interesting models in the United Kingdom and Canada involving innovative ideas at a community level to bring services together, such as community centres and parenting centres. You have probably heard about those. Planning for the community is more critical. We will never change the phenomenon of putting up big houses and big fences, except by legislation or other mechanisms, but they are the things that are critical to a neighbourhood.

**Mr A.P. O'GORMAN:** Have we, as a society, lost our basic parenting skills?

**Dr Wray:** No, the vast majority of parents have not lost their instinctive parenting skills; it is more a cycle of gradual deterioration in instinctive abilities. A mother and father who have some issues might have an effect on their child, who subsequently becomes a mother or father and some stage. If that child's skills have deteriorated, you can understand how the generation would be set up to deteriorate further. We all know of multiple generations of families who are unemployed, which sets up a subculture. In the end, those groups only account for a relatively small percentage of children with developmental disorders. Children from all walks of life can have developmental disorders, despite the best input from their family and the community. They will always be there but certain strategies can help.

**The CHAIRMAN:** You have raised an issue that we are concerned about. You described each centre as having its own system and said that clinicians usually furnish a lengthy waiting list response that is doctored on its way back up the bureaucratic chain. You said that the new system was supposed give more accurate answers but that the bureaucratic political doctoring of the figures was likely to continue.

What is your evidence of this, and what do you suggest we need to do to get some accurate figures?

[2.40 pm]

**Dr Wray:** I think the risk is always stating the rosy side. There are services out there, some great jobs are being done and, as I say, we meet the needs of the majority of children. Yes, there are wait lists. Let us speak frankly; the wait lists are there. What can we do to address them? Sometimes, the risk in parliamentary questions is that emphasis in the answer is given to the good stuff, and some of the not-so-good stuff is perhaps not taken up, and I guess everybody has experience of that. How do we overcome that? Only by ministerial direction to those who are under the minister.

**The CHAIRMAN:** You could seize the documents, I suppose. Are the wait lists that you refer to here all for paediatric services, as well as speech therapy? Is that the sort of thing you are talking about?

**Dr Wray:** Yes, that is right. Speech therapy has one of our longest wait lists in the public system.

I am sorry; that was a longwinded response. No single strategy would be the best thing. I have a quote that I looked up. It is from H.L. Mencken 100 years ago: for every complex problem, there is a simple solution and it is wrong. It will be multiplex strategies. They will have the best responses. I can see that maybe a separate office would help coordinate those strategies.

**Mr T.G. STEPHENS:** Is there oversight of the profession, as in the health department's delivery of speech pathologists to children? Is that coordinated through you and your people, essentially?

**Dr Wray:** In the child development services, as a government-funded sector, we have a number of speech pathologists who deliver services, but there are a lot of speech pathologists in the private sector or with other not-for-profit groups.

**Mr T.G. STEPHENS:** Yes, but do the ones inside the health department who work with children come through your program?

**Dr Wray:** Not all of them, no. The child and adolescent mental health service also has them, for example.

**Mr T.G. STEPHENS:** I have this particular aversion to this issue; that is, the education department's need for speech pathology is, in my view, at least in part because of its failure to mandate a pedagogical approach to the acquisition of language. To think that it is coordinating early childhood development services before it has even got its own act together on the pedagogical approach is just a conundrum to me—watching the need for speech pathology emerge because of a failure in the education system.

**The CHAIRMAN:** Children are presenting with the problem as well, before the education department has got to them.

**Mr T.G. STEPHENS:** Yes, I agree; they are presenting plus compounding.

**Dr Wray:** The education system works great for the vast majority of kids. But for 10 or 15 per cent of kids—some people say 20 per cent—the system does not reach their educational needs. The truth about those kids is that they have often come from our child development services, they have had developmental language problems or issues and they drift on through the education system, so we have tried to help them as best we can. But they still have needs by the time they hit the education system.

**The CHAIRMAN:** One witness today suggested that we look at the New Zealand model, which has developmental therapists, to try to address this notion of all these different interrelated problems. Have you given any thought to that?

**Dr Wray:** One of our programs is a developmental playgroup. The playgroup is run by a highly trained person with a background in early childhood—in day care, if you like. Then our more specialist therapists come along and support the day-care worker with these children. That is a nice example of a generic therapist working with a family with minimal supervision and support by specialist therapists. Those models certainly are out there. The Disability Services Commission is currently experimenting with a similar model in its home-based therapy programs of a single clinician delivering services or, if you like, parental coaching and trying to represent the opinions of all the therapy colleagues by one therapist going in. They are interesting ideas. There are also United States models that use them. It is still not entirely clear which children do best with that model. Again, it is about establishing the evidence and understanding that not one size will fit all. Children with more complex developmental needs in a particular area will still require a specialist therapist in that area, but some children might fit well with a generic model. There are some generic therapists at Geraldton who go out and deliver therapy services and then check in with their specialist therapy colleagues about the progress of the child and other ideas.

**The CHAIRMAN:** It sounds good. In particular, if you are talking about building up bonds and trust —

**Dr Wray:** Yes, that is right. The opportunity to build a relationship with the family is favoured by that model.

**Mr A.P. JACOB:** You have spoken quite a lot about interagency and intergovernmental integration, as have all speakers. I do not know whether you are aware of the Canadian model, which the previous speaker raised with us, whereby Treasury allocates funds only when the service departments have agreed on their policy and funding priorities. I quite like that suggestion. I would like to hear your feedback or opinion on that kind of avenue.

**Dr Wray:** It sounds interesting.

**Mr A.P. JACOB:** Were you aware of it prior to this?

**Dr Wray:** No. If it involves new money, I think you would see a great degree of collaboration occurring quite quickly. But it is about new money.

**Mr A.P. JACOB:** It is sort of a carrot rather than a big stick approach.

**Dr Wray:** Yes. Again, we must have the outcomes in place. You are probably aware that the Australian Early Development Index has now got up through COAG. It will be very interesting to monitor different communities' push in the child development index. It would be great to tie any idea for services to outcomes to help understand what are the most successful programs. That is the real part that is missing. I think it would be an interesting model.

**The CHAIRMAN:** Thank you very much for coming in. You will be sent a copy of *Hansard* and you will have the opportunity to make any corrections that you want to make within the general intent and purpose of your comments. You will get a proper explanation of that when the document comes out. Thank you very much for taking the time to make your own submission and come in here to see us today.

**Dr Wray:** Thank you for your time and interest in the matter.

**Hearing concluded at 2.48 pm**