

# **EDUCATION AND HEALTH STANDING COMMITTEE**

## **INQUIRY INTO GENERAL HEALTH SCREENING OF CHILDREN AT PRE-PRIMARY AND PRIMARY SCHOOL LEVEL**

**TRANSCRIPT OF EVIDENCE TAKEN  
AT PERTH  
WEDNESDAY, 18 JUNE 2008**

### **SESSION THREE**

#### **Members**

**Mr T.G. Stephens (Chairman)**

**Mr J.H.D. Day**

**Mr P. Papalia**

**Mr T.K. Waldron**

**Mr M.P. Whitely**

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**Hearing commenced at 10.51 am**

**WILLIAMS, DR CORI**

**Speech Pathologist, Speech Pathology Australia,  
examined:**

**McKENZIE, MR STUART NEVILLE**

**School Psychologist,  
President, School Psychologists' Association,  
examined:**

**McCUDDEN, MS GRANIA**

**Vice-President, School Psychologists' Association,  
examined:**

**VOGEL, MS LOUELLA KATE**

**Early Childhood Intervention Australia (WA Branch),  
examined:**

**DIX, MS LEIGH**

**Early Intervention Clinical Specialist,  
Early Childhood Intervention Australia (WA Branch),  
examined:**

**HYDE, MS FRANCINE**

**Orthoptist, Orthoptic Association of Western Australia,  
examined:**

**The CHAIRMAN:** Welcome to the hearing. Thank you very much for your submissions and for being here. I have the task, as well as welcoming you, to read the following to you in order to formalise the process. The committee hearing is a proceeding of Parliament and warrants the same respect as the proceedings in the house itself demand. Even though you are not required to give evidence on oath, any misleading of the committee may be regarded as a contempt of Parliament.

With a large group of witnesses, this can be quite messy. I will say for starters that we may have an opportunity or a need to have subsequent hearings with some of you. We will see how we go today and see where it takes us. I have the task of asking you the following four questions. I have got to get an audible answer for Hansard. We will go down the table from left to right as I get an answer to the first of the 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?

**The Witnesses:** Yes.

**The CHAIRMAN:** Did you receive and read an "Information for Witnesses" briefing sheet regarding giving evidence before parliamentary committees?

**The Witnesses:** Yes.

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

**The Witnesses:** No.

**The CHAIRMAN:** Finally, can I ask each of you in turn to state your full name and the capacity in which you appear before the committee?

**Dr Williams:** I am attending on behalf of Speech Pathology Australia.

**Mr McKenzie:** I am the president of the School Psychologists' Association.

**Ms McCudden:** I am the vice-president of the School Psychologists' Association.

**Ms Vogel:** I am a committee member of Early Childhood Intervention Australia (WA Branch).

**Ms Dix:** I am also a committee member of the Early Childhood Intervention Australia group.

**Ms Hyde:** I am the president of the Orthoptic Association of Western Australia.

[10.55 am]

**The CHAIRMAN:** I thank all of you very much for being here. I will run it this way, if I may: I will invite opening comments from each of you in reference to your submission—anything that you want to emphasise about your submission or any other detail that you think you might have missed out of your submission. That will then lead to committee members asking you questions, and then we will get a chance, hopefully, at the end, knowing that we have to be out of here no later than five to 12, to close off before we go. Stuart and Grania, for a range of reasons, I particularly attended to your submission, so I invite either of you to make an opening submission in reference to your written submission.

**Mr McKenzie:** I would like to mention that the School Psychologists' Association represents the interests of the government and non-government sectors, so we are representing both of those. I would also like to acknowledge the huge amount of work that Grania did in researching and writing that submission. I just wanted to mention that the sphere of influence of school psychologists is in the school age group; that is, when children enter school and when they leave, from the age of five to the age of 17. Research tells us that the critical years for intervention, especially in relation to sensory modalities—hearing, vision and speech, which are in the terms of reference—fall outside the sphere of influence of school psychologists. They are in the early years, from zero to three. Those are the critical years. Therefore, I suppose that is one point that we wanted to note.

We are probably not telling you anything new, but deficits in sensory and motor development skills are implicit in the later development of learning and behavioural problems. As school psychologists, that is when referrals come to the school psychologists' service. Therefore, there is no population-wide screening for the terms of reference in the early school years; there is only a targeted assessment, and that is done in terms of when a referral comes through to the psychologists' service. Then the psychologist will do some assessments on that student, and we will then do some brief intervention, and it is the conduit to a referral to other agencies. The current ratio of school psychologists to students is one to 2 000 in both the government and non-government sectors. Therefore, as you can see, it has to be a very brief assessment and intervention. I suppose, for me, the standard waiting list time, once we do make a referral, is between six and nine months in the metropolitan area, and longer in the country areas.

**The CHAIRMAN:** For what type of service?

**Mr McKenzie:** For referral through to not so much doctors and paediatricians, but to more specialised services like the State Child Development Centre and the more specialist services.

**Ms McCudden:** Allied health services—speech pathologists, for instance—in the public sector.

**Mr McKenzie:** Yes, and occupational therapists etc.

**The CHAIRMAN:** Grania, this is a two-person act, so —

**Mr McKenzie:** Yes, that is right.

**Ms McCudden:** I suppose I would just like to pick up on the point that Stuart made about the ratio of one to 2 000. We know that the WA child health survey was conducted in the early 1990s, which you might think is somewhat dated now. Nonetheless, the statistics still stand, and more recent surveys Australia-wide and statewide surveys of the health and wellbeing of young children from four to 16 show that one in five, one in six students—so up to 20 per cent of students—could be identified as what we would call students at educational risk. They might be at risk for any number of reasons but, in particular, speech and language problems, hearing and mental health problems, behavioural problems and social and emotional problems. If you have a ratio of one to 2 000 school psychologists, it means that approximately 400 students might be expected to be seen in any one year by a school psychologist. That is obviously unrealistic, and it means that the school psychologist is very reliant on being able to access other services, as are the families and the schools attended by these students.

**The CHAIRMAN:** I will pop in a quick question and then go to my colleagues. Do you have any comparison of your situation in Western Australia with that of your colleagues in the other states? Is it the same sort of ratio of psychologists to student population?

**Ms McCudden:** That is a very interesting question. I must admit that I would have to double-check. There was some recent data collected that indicates that WA is actually probably fairly well resourced in terms of school psychologists.

**The CHAIRMAN:** Comparatively.

**Ms McCudden:** Comparatively. However, our colleagues in Victoria have just had the announcement of a very substantial increase in their numbers, so that may change.

[11.00 am]

**Mr P. PAPALIA:** You illustrated, I guess, the relevant shortage of sites for that demand.

**Ms McCudden:** Yes.

**Mr P. PAPALIA:** But you also indicated that a lot of the conditions that result in children presenting to yourselves result from things like hearing problems.

**Ms McCudden:** Exactly.

**Mr P. PAPALIA:** Or other early childhood issues; psychological, I guess, and other issues.

**Ms McCudden:** Yes.

**Mr P. PAPALIA:** If the screening for those issues was enhanced and improved, in all likelihood the demand on your services would ultimately be reduced. I mean, that is the objective, is it not?

**Ms McCudden:** Absolutely.

**Mr P. PAPALIA:** So it is quite possible that by focusing on some other perhaps more urgent earlier screening we could end up with the result where some of your suggested need would be reduced altogether anyway.

**Ms McCudden:** Exactly. We could become unemployed, and what a wonderful reason to become unemployed, quite frankly.

**Mr M.P. WHITELY:** Is it that great?

**Ms McCudden:** Yes.

**Mr M.P. WHITELY:** I mean, my natural prejudices actually applaud what you are saying, but I just want to make sure I get this on the record that this is your evidence. Is it that great? If you are

saying that if we have adequate screening and intervention on things like health, hearing loss, vision etc that the majority of problems that you encounter will be addressed?

**Mr McKenzie:** There is a range of issues that school psychologists work with, including behaviour and mental health issues. So when you look at the influences of problems within childhood you are looking at the impacts of family, the impacts within child factors, factors like you have spoken about, and also various other disorders like attention deficit disorders etc which would not be corrected through that. You are also looking at trauma or abuse factors in a child's life. So as a school psychologist, the end result in working with the student in the system is a result of those factors, so those factors and the ecological model suggests those factors in relation to the other factors in the environment. So it is optimistic to think that we would be unemployed.

**Mr M.P. WHITELY:** Yes.

**Mr McKenzie:** But certainly we would see a reduction, particularly in terms of learning difficulties and behaviour problems. I will just give you a quote. Up to 57 per cent of children with language problems have been found to have behaviour problems and up to 86 per cent of students who are behaviourally disturbed have language problems, particularly in the area of —

**Mr M.P. WHITELY:** But the medical model to approach that is often a biochemical approach to the behavioural problems.

**Mr McKenzie:** Yes.

**Mr M.P. WHITELY:** Where it is considered co-morbid and somehow it is separate and needs separate treatments. What I take from your message is that you are saying there is an interconnectedness here that is not being dealt with. Kids have sensory deficits or they have something that has gone wrong—they might have had a trauma or something—that is in fact creating often mental health problems.

**Mr McKenzie:** Often in the mix is a precursor or a contributing factor, yes, definitely.

**Ms McCudden:** What we would advocate is that there is a complex interplay of genetic, biological and environmental factors that are playing themselves out on a moment-by-moment basis, and it is the accumulation of those experiences, if you like, and the risk factors that occur in each of those spheres plus the protective factors that occur within each of those spheres that really amount to an accumulation of factors that make it more likely a child will proceed down the risk pathway versus a healthy pathway.

**The CHAIRMAN:** I will interrupt and take Paul's advice to me, which is basically I am going to go back down the table now and I will start with you, Dr Williams, and just simply then come to each of you from left to right for some opening comments.

**Dr Williams:** I would like to open by letting you know that Western Australia is one of two states within the country which does not have an education-based speech pathology service. The other one is New South Wales. In all the other states and territories within Australia speech pathologists are employed within the education system or working within the education system. In the Northern Territory they are employed by the health department, but work within education to provide services to the large number of children that my psychologist colleagues have pointed out have speech and language problems which are associated with other difficulties.

It is true that the zero to three period is critical for development, but we do not have a magic wand and it is not possible to fix speech and language learning problems within that period. These difficulties persist across the lifespan and if children in Western Australia are missing out on services that will assist their speech and language development, as they are, then those children are going to be disadvantaged in the long term; and that has social implications for the children and economic implications for the society. There has been some recent research carried out in Victoria which showed that 50 per cent of the sample of boys who were on juvenile work orders had

underlying language problems which had not been addressed during their schooling. Language underpins literacy development. Literacy actually is a language skill. If you cannot make a sentence, you cannot write a sentence. We have got very strong evidence that tells us that children who have language learning problems early in their development go on to have literacy problems, and they will be performing less well than their peers and siblings at all stages. There is one study that looks at people through to the mid-30s, and those who had language learning problems are doing less well than their siblings on a range of social, educational and employment outcomes. So I think it is critical that services are supplied to these children. At the moment they fall into a big hole between health and education.

**Mr P. PAPALIA:** What do the speech pathologists that you are talking about that are operating in other states beyond New South Wales and WA entail and how do they differ from, say, our language development centres in primary schools?

**Dr Williams:** Our language development centres look at a very small number of the most severely language-disordered children. They exist only in the metropolitan area. Their services have been progressively whittled away over the last few years. Children now have to be exited from language development centres at the end of year 2.

**Mr P. PAPALIA:** Do those services, though, replicate what you are talking about, the education-based services?

**Dr Williams:** No. It varies a bit from state to state. Queensland probably has still what we would consider the best model. It has speech pathologists who belong to districts and it have schools that they are responsible for, and they go out to the schools and work within the schools to provide a service to the children. They are mostly in primary schools. Adolescents with language disorders get very little service anywhere in Australia.

**Mr P. PAPALIA:** Do you have any idea of the ratio of teachers to numbers in those areas in Queensland?

**Dr Williams:** I do not know but I will find out for you.

**Mr M.P. WHITELEY:** On page 3 of your submission you make a recommendation and I just want to get this on the record. As I read it, basically you are saying that on school entry we need to have screening of kids.

**Dr Williams:** There needs to be a mechanism for identifying students who have language learning problems. Some of them get picked up before they come to school. Sometimes the school knows, but the screening part is only the first step. Screening by itself does nothing.

**Mr M.P. WHITELEY:** No; true.

**Dr Williams:** And you actually mentioned intervention earlier, and I wanted to say that is what we need to be focusing on.

**Mr M.P. WHITELEY:** Yes, for sure, but at least we would be able to identify the problem.

**Dr Williams:** Yes.

**Mr M.P. WHITELEY:** It also says that it requires specialist training for child health workers and teachers conducting school assessments, so you are basically suggesting there that they can do that. With what level of training?

**Dr Williams:** It may be possible to develop a very broad screen that people could do. There has been research that looks at how good teachers are at identifying children who have underlying language problems which will lead to literacy problems.

**Mr M.P. WHITELEY:** Can you explain to me is whether it is a question of a teacher who has been trained sitting down having a 10-minute conversation with a child?

**Dr Williams:** No.

**Mr M.P. WHITELY:** How does it work?

**Dr Williams:** A speech pathologist would do that, and you are quite right that you cannot assess oral language skills unless you talk to the child and listen to him.

[11.10 am]

**Dr Williams:** There have been structured questionnaires that identify key evidence that there may be a language learning problem that teachers can tick. We actually have some of them available in the education system, but they are not widely used.

**Mr M.P. WHITELY:** Teachers might in fact use their first couple of months at school to use them? How would it work?

**Dr Williams:** Not in the first couple of months at school, because it takes kids a while to settle in and languages are complex things, so it would be difficult to make a judgement during the first couple of months.

**Mr M.P. WHITELY:** The emphasis is on screening before entering school. How would that work? Your submission says that there should be an emphasis on screening before entering school.

**Dr Williams:** It depends on how one defines “entering school”. In kindergarten, one could be starting to get an idea about the children who have problems. I do not know that population screening before children enter school is a possibility in the case of language. I do not think we could screen every child in Western Australia for language problems before they get into school.

**Mr M.P. WHITELY:** I am a bit confused, because your submission suggests that there should be an emphasis on screening children before they to school to minimise the impact of oral language difficulties. By screening, I mean “universal”.

**Mr McKenzie:** Pre-primary is the first compulsory year at school.

**Dr Williams:** Yes, so if we consider kindergarten to be prior to entering school, we could be looking at them in kindergarten.

**Mr M.P. WHITELY:** What does “looking at them” mean? I have a suspicion about anything that is ad hoc, fluid or whatever. If there is to be screening, it implies that there is a structured way of doing it. What would it look like?

**Dr Williams:** It obviously needs to be looked at in great detail, but I would probably envisage a two-stage process. The first stage might involve a teacher or a parent completing a checklist or a questionnaire that would identify areas that would start to ring alarm bells.

**Mr J.H.D. DAY:** At what age?

**Dr Williams:** You could do that at age four. If the parents were doing it, it could be done as the children go into kindergarten. Not all children go to kindergarten. Finding all of the children in the state before they go to school will be difficult. The first stage could be a really broad thing that says these are the kids that we need to find out more about. The second stage should involve specialists.

**Mr M.P. WHITELY:** Would the second stage be only for those children for whom some boxes have been ticked in the wrong place or would it be a generalised screening for all kids?

**Dr Williams:** I think it is more realistic to say that we would look at what the parents or teachers say, and only assess those children in detail.

**Mr M.P. WHITELY:** Who would do that assessment? Would it be a trained amateur?

**Dr Williams:** No, I think that is the job of a speech pathologist.

**Mr J.H.D. DAY:** Would that be around the age of four, or older?

**Dr Williams:** It could be done at age four. I think the idea of screening at one point is not reflective of what is likely to happen. One can miss kids at one point in the development, and they can show up at a later point of their development with difficulties.

**Mr M.P. WHITELEY:** If I can just play devil's advocate, my concern is by not having one point and a systematic approach to it, kids will also be missed.

**Dr Williams:** I agree. I think one point is a starting point, but if we say we are going to screen them all at four and we have got them so we are not going to bother anymore so we are not going to send anyone else to be looked at, we will not be doing the right thing.

**Mr M.P. WHITELEY:** I agree, but it is a good start though, is it not?

**Dr Williams:** To screen them all at one point? Absolutely.

**The CHAIRMAN:** My colleagues are trying to get me to give each witness an opening statement. I am sorry to interrupt you. Do you want to conclude your opening statement?

**Dr Williams:** The one thing I want to re-emphasise is the importance of language development for people across their lifespan. If one cannot communicate, one is in trouble. If one cannot communicate at an adequate level, one is in trouble again. If one's language and communication skills are not good enough to feed into one's literacy development, we all know what the outcome will be.

**The CHAIRMAN:** I will turn to each person in turn to make an opening statement.

**Ms Vogel:** I am here today on behalf of Early Childhood Intervention Australia, with my colleague Lee Dix. Early Childhood Intervention Australia, WA branch, is a committee that is made up of a group of early childhood intervention professionals, with professional discipline backgrounds primarily in therapies such as speech pathology, occupational therapy and physiotherapy. We are a group that is interested in advocacy for the families of children with developmental delay and disability. We provide professional development opportunities for professionals working in this area, and resources and support for the families of these children. We are very much interested in the inquiry, and our submission made a number of points to do with the screening tool that is presently being used and could potentially be used to enhance the universal screening process for the children we are talking about today. We also made some comments about the process following on from the identification of difficulties at the screening point, where those children go, and how effective the services at meeting the needs of children that have been identified as experiencing developmental delay or potential disability. Our group is made up of professionals from varying backgrounds. I come from a disability services background and Lee comes from a health background. We each have different backgrounds and experiences to share, so I would perhaps feel more comfortable talking to the committee today about the transfer of children with disabilities or known developmental delay into disability services and the follow-up stage of the inquiry. Perhaps Lee could talk about screening and access to child health development services.

**The CHAIRMAN:** Do you want to say something about that?

**Ms Vogel:** Primarily I would like to say that in Western Australia, some of the families of young children with known developmental delay and disabilities are experiencing significant wait times to access early intervention therapy services. My colleagues to the right have really explained well the importance of accessing early intervention services in the context of language. The school psychologists described very well the importance of accessing a range of professionals, such as speech pathologists, occupational therapists, physiotherapists and early mental health support for child and family, to prevent later problems. It is just so important that the children who are identified as having difficulties are actually getting a timely service. I wonder whether the committee is aware that families of young children with developmental difficulties are currently experiencing difficulties getting into an early intervention therapy service if they do not yet have a diagnosis. Some families are experiencing a wait of up to several months to have a diagnostic



appointment. When they receive a diagnosis, they may experience a further wait to access the disability service providers. They are waiting twice during their journey, and they are missing months of crucial therapy services time that cannot be made up. Dr Williams has explained the importance of getting in as early as possible.

**Mr J.H.D. DAY:** We heard earlier this morning that the wait for a speech therapist consultation is up to 18 months or so. Is that your experience?

**Ms Dix:** For older children it can be. It would not normally be that long in child development services for a younger child, but one would potentially be looking at six to nine months or possibly a year.

**Mr J.H.D. DAY:** That is a long time in any young child's life.

**Ms Dix:** The whole idea of early intervention is a misnomer, really. It is ridiculous.

**Mr J.H.D. DAY:** What should be the maximum waiting time for consultation, in your view?

**Ms Vogel:** Our group would recommend three months. We need to also be aware that initial appointments and initial assessment does not mean therapy, so one might experience a wait to have one's first appointment, during which one will meet one's developmental paediatrician or therapy team. The actual wait time before therapy and the service for the child and family begins needs to be recognised and recorded. The other question we raise is that if there are families—there are—in the community who have not had a diagnosis for their child and are not able to access services, what is the adequacy of the current community supports for those children and families? That is exactly why a group such as ours exists.

**Mr M.P. WHITELEY:** Can you give us an example of people without a diagnosis not being able to access services? What sort of problems do they present with?

**Ms Vogel:** First of all, if they do not have a diagnosis, they may have a situation in which they do not know what is wrong with their child. That can have all sorts of implications for the family not understanding what is wrong and how to help, and what services might be available in the community because they do not know where their starting point is. Of course the family is going through an intensely tumultuous time in their lives.

[11.20 am]

**Mr M.P. WHITELEY:** Can you give an example of the missing diagnosis that you are talking about?

**Ms Vogel:** Children with autism or global developmental delay who are waiting for the time when they can have an IQ test and then be assessed as to whether they are experiencing intellectual disability.

**Mr M.P. WHITELEY:** Is global developmental delay a diagnosis or a broad umbrella for a range of diagnoses?

**Ms Vogel:** It is a diagnosis that may be given by a developmental paediatrician for a child who is presenting with a broad range of developmental difficulties.

**Mr M.P. WHITELEY:** Is that a diagnosis to get them into the system?

**Ms Vogel:** Yes, it can be. The point we made in our submission is that different providers use different criteria to accept referrals into their service. We do not have a situation in WA whereby all early intervention service providers have the same criteria. Some have criteria that will accept children with certain diagnoses; they are a specialist service. Others have a broader acceptance of children. That is very confusing for families if they are not getting support at the time the child is identified as having difficulties.

**The CHAIRMAN:** Is that the completion of your opening comments?

**Ms Vogel:** I have one more point; that is, the importance of the effectiveness of the transition between health and disability services for children with known difficulties. There is a point at which a diagnosis is given, such as autism or global developmental delay, and that child needs to move from a health service provider into a disability service provider that can provide them with longer term support and therapy. In alluding to the notion of wait times, if there is a wait time to get into that health service provider and then another wait time to get into the disability service provider, that family is experiencing a double wait. I recommend that the inquiry take into account the experience of those families waiting for, firstly, the diagnostic assessment and, secondly, the beginning of long-term therapy in a disability service.

**Mr J.H.D. DAY:** In your view, why has there not been more attention given to trying to resolve these problems?

**Ms Vogel:** My view is that each of the services is working so hard to meet its waitlist for children. They are doing the best they can within their service. We put to you the need to bring together the groups, in particular, health and disability. I also recommend that child care be brought into that mix. Separate sectors of the community are providing very good services, but we need collaboration between those sectors and, of course, the early childhood education system as well so that there is a common understanding of what are the real wait times and how we can begin to reduce those wait times for families with children who are not only identified as having difficulties and need diagnostic assessment, but also need the early intervention therapy services. It is the bringing together of these services that would achieve that and develop an understanding of what resources are required.

**Mr J.H.D. DAY:** Do you need someone to be driving this to make it happen at a higher level than is the case at the moment?

**Ms Vogel:** I would believe so, yes. In fact, just before you called for submissions for this inquiry our group was looking at applying for Lotterywest or non-government support funding to appoint a project officer to look into this issue. The role of such a project officer would be to go to each of the early intervention services providers and ask for information about the real wait times experienced by families to get into their service for real therapy and not just for assessment; to draw together the expertise, knowledge and information from each service to begin to be able to present to people such as yourselves the situation as it is; and, perhaps, make some suggestions to improve services. It was with great satisfaction that we saw the call for an inquiry and we are happy to be here today.

**The CHAIRMAN:** Thank you. Leigh, do you wish to make a statement?

**Ms Dix:** Louella has done a wonderful job, as have the other panellists. I will not say very much, but I will give a practical example of a family that I have been working with to illustrate this process. I refer to a little boy who, at two, was not talking at all. The mother became concerned, perhaps having had concerns earlier, and thought that there was something wrong, but took a while to get there. She went to her GP, who said, "Don't worry, he'll talk soon enough. Boys are late in talking. Wait a few months". Finally, the boy was referred to our service. Because of the referral information, I was alarmed and, as I am flexible in my waitlist, was able to go out fairly quickly. As soon as I walked in the door, I pretty much suspected that this child had an autism spectrum disorder. I cannot diagnose that, but I told the mother that she must organise to see the paediatrician and that I would put her on the waitlist.

**Mr M.P. WHITELY:** What is your professional training?

**Ms Dix:** I am an early intervention clinical specialist. My background is in occupational therapy. I work specifically with children from zero to five.

It then took a number of months, even with me harassing and trying to find a spot to get this mother in to see the paediatrician. It took about four months before she saw the paediatrician. The paediatrician said, "Yes, I think you're right; there is something very wrong. We'll refer for an

autism assessment.” That took a further five months. I did my block of therapy with the child. The child is on other waiting lists at our centre. However, now we are waiting to see whether they get an autism diagnosis, because if they do we are hands off and we pass over to disability services. Really, the family is in no-man’s land and is just waiting. It waited for the assessment, which eventually did happen. I tried to get my speech pathologist to work with the child but the response was, “We don’t really want to start because they’ll probably be moving. We’d better wait to see what happens.” The autism assessment was done and the mother was told that she would need to wait six weeks before she would get the report. The mother rang me the other day to say, “Yes, we finally got the letter and he has autism. They have given me two service providers and they’re both full. I’ll probably be waiting now until the end of the year when some people exit those service providers before my child can get therapy.” The child will probably be three and a half by then.

**Mr M.P. WHITELY:** What does the kid need?

**Ms Dix:** He needs intense services and all the literature supports—occupational therapy, speech pathology and clinical psychology for his behaviour. He is very difficult to manage at home. He will run out the door or knock over the TV. He is an aggressive little boy who has no language skills whatsoever. A multidisciplinary team approach is required.

**Mr M.P. WHITELY:** I will play the devil’s advocate. This kid is obviously troubled. He cannot talk and has behavioural problems. That is his problem. Why do we need a diagnosis or a labelled approach to deal with this kid’s screaming need? How can we streamline it so that kids like him who have such obvious problems—he cannot talk. I know nothing, but that seems to represent a no-brainer.

**Ms Dix:** The difficulty lay in the wait times to access the assessment.

**Mr P. PAPALIA:** That is the point: Why do you need an assessment?

**Mr M.P. WHITELY:** If kids have such obvious needs, why do we need to say that we have a label for this and it will take X months to see the label and the label will guide the process? Surely the label is a barrier to effective treatment.

**Ms Dix:** It is.

**Dr Williams:** It is also the entree into coordinated, more intensive approaches to intervention.

**Mr M.P. WHITELY:** What about this kid? He cannot talk.

**Ms Dix:** I am happy with that. If a child who has autism does not have a diagnosis of autism, how could he access an autism specific service, such as the Autism Association of Western Australia? It is a specialist therapist for children with autism. We want him to be able to access such a service.

**Mr M.P. WHITELY:** I asked what the kid needs and you said occupational therapy, speech therapy and clinical psychology, which is the response to the label of autism. Would the response be any different if I said, “Here is a kid with severe behavioural problems and, I presume, has problems with motor skills and he can’t talk?”

**Ms Dix:** The treatment could be quite different.

**The CHAIRMAN:** I ask you to speak one at a time. Hansard will get cross with the chairman very soon. I know that four of you are ready to respond to Martin’s question, but please speak one at a time.

[11.30 am]

**Ms Dix:** No; I think the treatment could be quite different. Certainly, some people within the health department are not used to dealing with autism, which does require a specific level of training to know how to work with those children, as opposed to a child with a mild language delay, who are typically the children we see. People can feel out of their depth or feel that a child requires a specialist service. Then there is the problem of lack of coordination between the two service

providers, and Education. Part of the problem comes down to trying to get better coordination and better transfer between one service and another without these ridiculous long waits.

**Mr P. PAPALIA:** Part of the natural response to your complaint of delays in accessing services and diagnosis is to say, “We want lots more money and these people to do those things.” But, potentially, it could be resolved in another way through streamlining or changing the system.

**Mr M.P. WHITELEY:** It seems to me to there is a silo-type approach.

**Mr P. PAPALIA:** It is though we have set up a system and it does not work very well when there are large numbers.

**Ms Vogel:** Yes. Part of the reason that collaboration may not be happening is because of, potentially, the under-resourcing. I cannot speak for all services, but it may be that the resources in each service is at a level where the workers in the organisation are struggling to keep up with their own wait list and their wait own times and provide an effective, quality service to the families they are seeing. Yes, I take your point; I think collaboration would be extremely helpful, but that takes time. As soon as you go off to a meeting—Leigh and I are clinicians—and spend time in a meeting collaborating with other agencies, we are denying children who are on a wait list who have needs now to access assessment in therapy services. Unfortunately, these services are not well resourced enough to let people walk freely out the door to spend time understanding the real issues and then working towards a solution. We absolutely agree with the need to do that. Improving resourcing would enable that to happen both by improving the services available and the people to effect this collaboration.

**The CHAIRMAN:** Is that the conclusion of your opening remarks?

**Ms Hyde:** I am representing the Orthoptic Association of Australia. Our concern is that the current provisions for vision screening in WA are such that they are cut off at age three and a half; that is, they are not being screened after that age. Children are not getting looked at again until they are at school and are aged six. If we are dealing only with amblyopia, which is traditionally called “lazy eye” we really need to see them before the age of six, because it is very difficult to get an eye to improve vision after that age. We are getting them, assuming the certain wait list times and what have you, by the time they are six and a half, seven, and we have already run out of vital time that we could have used from aged three and a half to six. So I am advocating that we make that screening time longer, as it was traditionally—I think it has been cut out only recently—so that the clinic sisters are in a position to keep screening them for past the age of three and a half and refer them. If a problem is picked up then, there is provision to refer to an orthoptist directly. It is impractical to always directly refer them to an ophthalmologist because an ophthalmologist, who we work in close proximity with, either on referral from or with them in the clinic situation, has six and 12-month waiting lists. I am advocating that the provision of the screening is too short. We need to be using those other two to three years in between so we can treat them. Unlike language difficulties, amblyopia is a silent problem; you do not know it is there until you have checked it. Of our two eyes, if one eye is seeing well and the other is not, you can live quite happily. However, in the long term, if you do not treat amblyopia, we know we will have epidemic proportions of macular degeneration and diabetic retinopathy in our ageing population. If you do not start off with two good healthy eyes, it will be a very big burden on society. When someone is sitting in front of you with a lazy eye and that eye can see only the top letter on the chart —

**Mr M.P. WHITELEY:** I have a technical question on amblyopia, of which I knew nothing until I —

**Ms Hyde:** It is lazy eye or turned eye.

**Mr M.P. WHITELEY:** Are you saying that you cannot always detect it at age three and a half?

**Ms Hyde:** You can. If you check their vision and there is a discrepancy in the vision or they are not getting at least to six over nine vision you can see there is a problem there.

**Mr M.P. WHITELY:** With a perfect screening system for age three and a half that screened for amblyopia, among other problems with vision, why would that not pick up everyone with a problem? Why then do you need later screening at age five?

**Ms Hyde:** At age three and half, if you are relying on a subjective vision test, you are relying on children being able to read; they do not necessarily have to know their letters but they must match up letters. At three and a half, some children are quite bright and they can do that very easily, and for other children you have to wait until they about four, if you are reliant on a vision screen only.

**Mr M.P. WHITELY:** The short answer to my question is you cannot determine amblyopia 100 per cent if screening occurs at three and a half, so there needs to be later screening to pick it up.

**Ms Hyde:** You would need to continue it. That is what I am advocating—it must be continued; do not cut it off at three and a half.

**Mr M.P. WHITELY:** Because kids of three and a half will be missed?

**Ms Hyde:** Yes, unless they have an obvious turn in their eye. The clinic sisters are pretty good at seeing that. It is not the only job they do. Orthoptists are trained in the detection of squint-lazy eye. That is our speciality, but we are underutilised.

**The CHAIRMAN:** On page 2 of your submission, you propose there should be a paid position ideally for an orthoptist, who specialises in the art of testing and treating amblyopia. Are you suggesting just one orthoptist be employed?

**Ms Hyde:** It depends on manpower. I have a shortage of orthoptists. If we had a position here, we could get someone from Melbourne and Sydney where the two schools of orthoptics are.

**The CHAIRMAN:** Just one for Perth, is what you want?

**Ms Hyde:** I am not sure that only one would be enough. About 10 years ago, when I was involved in some of these screenings, the Lions Eye Institute held voluntary screenings. We used to go and screen children, and we would get about an eight per cent referral rate from that, but there was not only lazy eye; there would be other refractive problems.

**Mr M.P. WHITELY:** Would an orthoptist be involved in the screening of that problem or is it something people can be trained to detect? What did the Lions Eye Institute do?

**Ms Hyde:** It used orthoptists to screen.

**Mr M.P. WHITELY:** Is there enough orthoptists to do it? If you have this screening at various ages—three and a half, five—are there enough orthoptists, people who can do this, to do the screening? It is not much point us recommending screening for —

**Ms Hyde:** No. I am advocating that we work in combination with the clinic sisters; that is, we continue the clinic sister but tell them they must screen right up to school age, and if there is a problem refer it to an orthoptist.

**Mr M.P. WHITELY:** Do you train up the clinic sisters to recognise amblyopia?

**Ms Hyde:** They are already trained in detecting a turned eye. They do a vision test.

**Mr M.P. WHITELY:** If there is screening at five and a half or six, or whatever the age group, by the clinic sister, could the clinic sister be trained to enough of a level to pick up those problems that are not being picked up at three and a half, or do you need an orthoptist there?

**Ms Hyde:** They are trained well enough now to pick up whether there is a discrepancy in vision and if there is an obvious turn in the eye. They already do that.

**Mr M.P. WHITELY:** You were saying, though, that some times it is not obvious and, if I understood you, that sometimes these kids are missed and we need test them again at age four or five. Will we get the educated amateur approach whereby they do a good job picking up the obvious

but miss the kids? It is not much point our recommending screening for something if we cannot practically do the screening.

**Ms Hyde:** When I said that it should continue past three and a half, it relies on the reliability of the child to be able to do a vision test. It is not that a clinic sister will miss it again. If that child consistently does not do the vision test properly, alarm bells should ring that the child is obviously intelligent enough to do the test, but there is a problem so they should be referred, and generally that would be to an ophthalmologist or an orthoptist.

**Mr M.P. WHITELY:** The clinic sister would have enough knowledge to say that a child needs to be referred on up the chain—the two per cent or five per cent or whatever—to be examined by a specialist and that is the way we can meet that need.

**Ms Hyde:** Yes.

**The CHAIRMAN:** We have heard about the wait for speech pathologists. Are there lots of vacancies for speech pathologists that are not filled?

[11.40 am]

**Dr Williams:** There are always unfilled vacancies. Speech pathologists are usually women. Women are in and out of the workforce. That is part of it. The positions that remain unfilled for long periods of time tend to be in the rural and remote areas. That is a real issue for those areas. I cannot give you figures because it changes from month to month.

**The CHAIRMAN:** It is often referred to as such a critical area.

**Dr Williams:** Yes, it is.

**The CHAIRMAN:** From my quick observation of the advertisements for those positions in rural and regional areas, they are very modestly paid.

**Dr Williams:** Oh, yes.

**The CHAIRMAN:** For an area of such critical importance, can you guide me as to —

**Dr Williams:** We are paid on the same level as OTs, physios—it is allied health.

**The CHAIRMAN:** The other issue for me really probably goes to the school psychologist. I cannot get a sense of a seamless service working for the non-government school sector. Am I missing something here? I can sense programs seem to be available for government schools. In my own particular area I have these large independent school systems: the independent Aboriginal school and the Catholic school system that has a very large Aboriginal clientele. Do people who are in the non-government school sector find just as easy a pathway, do you know, as an association? You say you represent school psychologists from both the government and the non-government field. Is it a comparable experience?

**Ms McCudden:** Many of our colleagues who work in the independent and Catholic education sectors will bemoan the fact that they do not have access to the same level of resources, internally and externally to the education system, as do we.

**The CHAIRMAN:** You guys have been bemoaning about the level of your service and others are actually envying the level of your service.

**Ms McCudden:** Absolutely. In the large independent schools, and if you do not mind, I will cite—

**The CHAIRMAN:** The elite schools?

**Ms McCudden:** Yes, the elite schools. That perhaps is a somewhat different picture because they typically have people accessing those schools that have access to large financial resources, so, therefore, they can afford to purchase privately services that their children may need. That can often paint a somewhat different picture in terms of wait times and so on, although paediatricians obviously are typically working the private sector as well as perhaps in hospitals, and there will be

wait times there, but people may be able to go to a private speech pathologist, for instance, as opposed to accessing a speech pathologist working at a child and adolescent community health centre.

**The CHAIRMAN:** I have experience, not of the elite independent schools, but the independent —

**Dr Williams:** Yes.

**The CHAIRMAN:** They are independent schools, but they seem to not have clear pathways from the problems that are diagnosed of kids with speech difficulties.

**Mr McKenzie:** The government sector in terms of resourcing through Schools Plus, which is education assistance, and also the school psychology services—however, we are doing a lot of referral outside in terms of our access to allied health services. There used to be school age therapy services, which they turned into Therapy Focus, I think, but that service was available not just to students who had identified disabilities but for that group of students above who were having difficulties but they were not in that disability category; whereas, I think that Therapy Focus has a specific focus on disabilities. You are advocating for students with disabilities who then can access a range of services; it is that next level above of students that do not quite reach those criteria where we have real difficulties, not just in the non-government sector but real difficulties in the government sector, finding referral pathways.

**The CHAIRMAN:** If I may finish off my question; in terms of the shortage of resources that is out there, the opportunity for school psychologists or speech pathologists to influence the pedagogical style of the classroom, it seems to me that language development is so critical—do I use the word correctly when I say phonological awareness or phonemic awareness?

**Dr Williams:** Phonemic awareness is one aspect; it is not the be-all and end-all.

**The CHAIRMAN:** If it was deployed as a mandated pedagogical style in the classrooms of Western Australia, would the language development opportunities for many kids be enhanced very significantly?

**Dr Williams:** It would address some difficulties. Phonemic awareness contributes primarily to learning how to decode print, so how to make sounds out of the black marks that you see on the paper. The contribution is there very early in schooling. What it does not do is contribute further to an understanding of what you are reading, which is the crucial thing. Reading is about understanding more than about decoding. The switch between learning to decode and being able to understand happens at about year 3, so phonemic awareness will support children in that early stage but not provide them with —

**Mr M.P. WHITELY:** There is—

**The CHAIRMAN:** Before Martin interrupts, I want an answer to my question. Can you remember my question?

**Dr Williams:** Yes, it would provide benefits for some children in the early years as far as learning how to decode print, and there is also some evidence to show that it does make a contribution to spelling.

**The CHAIRMAN:** Are you supporting then the concept of mandated —

**Dr Williams:** Mandated phonemic awareness?

**The CHAIRMAN:** In terms of the pedagogy of the classroom.

**Dr Williams:** You mean as opposed to whole-language-type approaching?

**The CHAIRMAN:** Yes.

**Dr Williams:** Absolutely.

**The CHAIRMAN:** Thank you.

**Dr Williams:** But I would not like to see it left just as that.

**Mr M.P. WHITELY:** The message is that you are saying that it is a building block, is it not?

**Dr Williams:** It is a building block.

**Mr M.P. WHITELY:** You cannot build little bits of it or you cannot build the whole of it, and there are some kids that are gapping. This is consistent with stuff we had from the education department.

**The CHAIRMAN:** Grania, do you have any comments on that same point?

**Ms McCudden:** I would agree. I think that speech pathologists have a lot to offer in terms of pedagogical advice to our teaching colleagues. I think the whole language approach is an approach that should not be left on its own. It needs to be added to and strengthened quite significantly with things like phonetic awareness. One of the things that I think the whole language approach does, though, is help to build that comprehension that you have mentioned. It helps children to understand and better interpret the text that they are reading, so, having gone beyond the mechanics of decoding the word, to actually understand and contextualise the print that they are reading.

**Mr M.P. WHITELY:** If you use the whole language approach from day one, year 1 in school, you are actually asking kids almost to come to school with prerequisites, are you not?

**Mr McKenzie:** If you use that approach exclusively.

**Mr M.P. WHITELY:** This was the sort of stuff that was coming out of the education department. That sort of thing was coming out last week.

**Mr McKenzie:** You would need to be aware of a developmental context, the appropriateness or the timing actually of that phonological approach, rather than a —

**The CHAIRMAN:** We have got about five minutes to wrap this up. I was going to propose that we go back down the table from left to right, if we can, just to see whether people have got some emphasis or underlining of what they wanted us to hear.

**Dr Williams:** I just want to add one thing. We were talking about access to private services. Private speech pathology services in Perth also have waiting lists. Yesterday a colleague of mine and I had phone calls from people saying, “We can’t get our child into a private service anywhere. Can you help us?” One of them involved a two and a half year old and one of them involved a 14-year-old. There are no services. They cannot even get straight into a private speech pathologist service. The other thing, just again, is the gaping hole for school aged children in services as far as speech and language go in Western Australia, because the health department cuts it out at the end of year 1 and the education department does nothing about it.

**Mr P. PAPALIA:** There are not enough language development centres in the —

**Dr Williams:** There are language development centres for a very small number of children. They are cut out at the end of year 2 as well.

**Mr McKenzie:** I think the notion of having universal screening at certain points, certainly for hearing and vision, on entering the school system, so they are there earlier, and then screening points for language development, early screening points that start to funnel students with difficulties towards therapy, would be a huge contribution.

The second part is to effectively provide not only an assessment of, but also intervention for those identified students so that it is not done on a disability or label basis but is outcomes based. It would be enormously helpful to have therapy services, particularly in the pre-primary years 1, 2 and 3, that are school-focused and are able to work with the school system.

[11.50 am]



**Ms Vogel:** A slightly different point that has not been raised today that is worth mentioning is the importance of parenting capacity building programs in the early years. I do not know whether members are familiar with the Best Beginnings program. That is targeted at specific areas of the community. We feel that those sorts of programs are integral to helping parents have the skill mix, knowledge and understanding of childhood development and for knowing how to support childhood development. Those programs also add to the parents' general knowledge of community supports. Expanding those programs would be a good preventive measure to enhance the availability of supports for parents and children of young families. Otherwise, I reiterate what I have said about the opportunity to enhance collaboration between the health, disability, childcare and education sectors to reduce wait times for families accessing early intervention.

**Ms Dix:** I note the importance of the lack of resources, which is contributing to the incredibly long wait lists, particularly for very young children. I know there are problems with schoolchildren also. However, the early brain development and critical developmental period of children is from birth to three years of age. Children should not come into the system and be identified as having problems before they are two years old and then have to wait until they are three years old before they are provided with the appropriate services. We must do something about that.

I will make a quick point about education. Some members sound interested in literacy rates in particular. If members do not already have it, I can provide them with the study into the European early education models that was released about three years ago. That is a very interesting study because the country with the best literacy rate is Finland, which does not begin a formal reading and writing program until the children are seven years old. Prior to that, the children are taught a very strong language-based and play-based education model so that the language foundations are built before beginning on working on formal reading and writing.

**Mr M.P. WHITELEY:** Lower the prerequisites.

**Ms Dix:** All of that is done before we hammer into the children how to write the letter "b" and how to read the word "cat". It is all about rhyming words such as cat, hat and mat and the usual early playful things that are done with a small child.

**The CHAIRMAN:** I am more than happy for you to feed that into us through David.

**Ms Hyde:** I reiterate that we should think of a way to close the gap between three-and-a-half year old to six-year-old children and continue to provide them with vision screening in collusion with a clinic sister. We should also provide a referral system to an orthoptist or two, who have a paid, full-time position and who are available all the time for people who are concerned that their children are not meeting the required visual standards.

**The CHAIRMAN:** Thank you. I have a formal task to complete, which is to read to you that you will be sent the Hansard transcript of your evidence for you to correct any minor errors. After you have made the corrections, please return the transcript within 10 days of receipt. If the transcript is not returned within that period, your evidence will be deemed to have been recorded correctly.

I hope you have found the opportunity of making oral submissions helpful. I guess the proof, perhaps, will be in the quality of the report, which will be enhanced by any additional comments that you want to make. We hope to be able to report by August or September. Thank you for coming.

**The Witnesses:** Thank you.

**Hearing concluded at 11.55 am**