

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, 30 JULY 2008**

SESSION TWO

Members

Mr T.G. Stephens (Chairman)
Mr J.H.D. Day
Mr P. Papalia
Mr T.K. Waldron
Mr M.P. Whitely

Hearing commenced at 10.47 am

McINNES, MRS SHIRLEY ANNE
Occupational Therapist/Resource Coordinator,
RUCSN,
examined:

HEWICK, MS CATHY
Inclusion, Disability and Community Services Manager,
RUCSN,
examined:

The CHAIRMAN: Welcome. I have the task of reading to you some formal words and I will ask you to respond to some questions. As well as welcoming you to the committee, I have task of telling you that it is a proceeding of the Parliament that warrants the same respect that proceedings in the house itself demand. Even though you are not required to give evidence on oath, any deliberate misleading of the committee may be regarded as contempt of Parliament. To each of you I put the following questions, for which I need audible answers for the purpose of them being recorded by Hansard. Have you completed the “Details of Witness” form?

The Witnesses: Yes.

The CHAIRMAN: Do you understand the notes attached to it?

The Witnesses: Yes.

The CHAIRMAN: Did you received and reading an information for witnesses briefing sheet regarding giving evidence before parliamentary committees?

The Witnesses: Yes.

The CHAIRMAN: The committee has received submission 7. We will be happy to hear from you any comments you would like to make about your submission. That would probably open up the opportunity then for questions. Would you like to proceed in that way? Would you like to highlight any aspects of your submission verbally?

Mrs McInnes: Yes. Everything we say is in the context that RUCSN as an organisation is absolutely committed to the importance of early intervention for young children. We are not going to dwell on that because I think that is evident is what we have presented already, but we recognise the importance of the early years and we strongly believe that children should have access to assessment and therapy services in the early years. Today we thought we would talk more about child care and how it might fit in with early intervention services and whether you need to know any more about child care. We are happy to talk about that and how it is provided. Cathy was going to do that and then I was going to talk more about the interplay that could happen between child care and health services, in particular child health nurses’ roles and therapists’ roles.

The CHAIRMAN: Please proceed.

Ms Hewick: As Shirley said, I was just going to talk a little bit about child care and early intervention within child care and my experience of working with many childcare staff. They have qualifications in early child development, both at diploma level and certificate 3, and can and do identify children through the simple developmental assessment that they do—children with developmental concerns at a very early age when they come to child care. We do see that as an important entry point for children and families. A lot of the time it is the first point of contact for a

family to realise that there is a developmental concern and then helping them progress towards “where do we go from here”. They also pick up any children who may have been to their GP, or may have been to a child health nurse even. Because they are in a larger social group or social context, their developmental concerns are more obvious and the childcare staff pick that up.

[10.50 am]

Mrs McInnes: What about inclusion facilitators?

Ms Hewick: Yes, we mention the inclusion facilitator in our paper. They support child care across the whole state and the whole of Australia. In Western Australia, RUCSN has five inclusion teams—one metro and the rest of them are rural or remote, so we have quite a good background in rural and remote regions and what is happening there. The inclusion support teams support childcare staff with any issue that the childcare staff feel that they need help with. Therefore, it might well be that childcare staff have identified a child as having additional needs and it might well be a disability—the child may already be diagnosed—and they will get help through the inclusion support agency to help that child participate in a childcare centre. However, the childcare staff will also get help if they identify through their assessments that a child may have developmental concerns that they are worried about, and then the inclusion support team will help them to liaise with the parents to help them take that next step.

Also, the inclusion support team’s role is really crucial to building the skills and capacity of the childcare staff to provide the highest quality care and learning environment that they can and it will help them in any way to achieve that and to improve that at all levels. We play that crucial role with the caregivers. At the moment, a lot of young inexperienced caregivers maybe do not have the life skills to deal with a difficult situation with a parent when they have to raise the topic that a child may have some developmental concerns. Therefore, we would help them to do that and hopefully it may be that the next time it is a bit easier for that caregiver. We help caregivers to recognise how important that parent relationship is first before they take the next step to early intervention and where they can go within their community then.

Mrs McInnes: Cathy, do you want to say something about the difficulty we have in accessing service once we have made a referral?

Ms Hewick: Yes, the timing is crucial and that is one thing I have written about. When a parent first hears—from whatever source—that there is a concern and that they might need to have an assessment done, parents are ready to do that. The GP sends a letter to the child development team or wherever and then they get put on a waiting list. I just cannot imagine the stress that not knowing—the uncertainty and the waiting time—would cause parents. Sometimes they maybe get a letter, but there is no time frame on that, which is an issue in itself.

Mrs McInnes: As you have probably been told, we are facing waiting times of at least six to nine months to access services.

The CHAIRMAN: Do you have a sense of how that compares with the experience of, say, five years ago?

Mrs McInnes: As you can see, I am a bit older, so I can look back to when I started with RUCSN, for example, in 1992. At that stage I was working in child care as an inclusion support worker and it was quite easy to access a child health nurse to come to a childcare centre and assess a child. Therefore, we would go and the caregiver would have a few concerns and I would say that I think there is some sort of issue with language or coordination. My role there was not to assess a child but I could contact the local child health nurse and most childcare centres knew who their local child health nurse was. We could contact the child health nurse, with the parents’ permission, and she could come within a couple of weeks and say, “Yes, we have concerns”, and then refer the child on to a child development centre. I cannot say exactly how long we used to wait in those days, but it was certainly quicker to see a child getting into a child development centre. I have been involved in

the OT profession for a long time and when I talk to other OTs nowadays there are many concerns about how long it is taking for children to access services, and I cannot remember that discussion being so common 15 years ago. As Cathy said, there is a lot of anxiety on behalf of the parents but if you really believe in early intervention and the importance of the early years, you cannot sit back and have a child not able to access either a public service or private service.

The CHAIRMAN: What led to the change whereby you lost access to the visits by child health nurses?

Mrs McInnes: I am not sure. Reflecting on it, we think it was about 1996 or 1997 when we realised that the child health nurses were not so easily accessible in child care. I think, perhaps, their numbers did not increase at the same rate as the population increased and so they had to cut what they could do. They had to see the children in their local community but, in fact, it seemed quite an economical way of screening children and I guess this is what we want to come to. There is a population of children in child care where someone could go in and provide some sort of screening service—not all the children in our community are in child care but our figures suggest about 35 000 were and they are not all in child care full-time—in the same way that the AEDI was carried out in preschools, which did not identify particular children but identified populations of children. If that sort of screening can happen in schools, we suggest it might be able to happen in some form in child care. We have caregivers in child care who have some knowledge of child development or, ideally, you would have the health nurses come in and do some sort of screening. I cannot give dates and I cannot give numbers, but I guess the health department could.

Mr P. PAPALIA: What specific things are being screened for that you are identifying then having trouble getting through?

Mrs McInnes: The things I am aware that child health nurses screened for were vision and hearing, language development, cognitive development, motor skills and perhaps some self-help skills. They would be the same things that child caregivers are looking at in young children and that the inclusion support workers are looking at in young children. However, I guess there are also the more subtle aspects of child development that are related to children with autism spectrum disorder and about whom we have particular concerns because it might manifest around two years of age in that they are not talking or their behaviour has changed. If that group of children could be identified at about two years of age, it would have much better prognosis in that if services were available; you could get them into services. However, the AEDI screened in more or less the same area that we are talking about. I am not sure whether you know about the Australian Early Development Index?

Mr P. PAPALIA: I have heard of it in other submissions.

Another question for Cathy: in your clarification you were talking about the qualifications of childcare staff and you had caregivers and cert 3s, but you also said in the submission that there are people who are untrained as well.

[11.00 am]

Ms Hewick: Yes they are. I think the new regulations are aiming for all childcare staff to have, at least, certificate III, but I don't think that is ready to go yet.

Mr P. PAPALIA: Are you advocating that the people who do any screening be qualified?

Mrs McInnes: Yes.

Ms Hewick: I think they should be diploma qualified and upwards and maybe have some extra training. They do a pretty good job now identifying additional needs. I think it is an everyday thing that they do. They do not do a standardised screening or testing. It obviously has to fit within the accreditation quality assurance system. However, we have looked into that and they do not do a standardised assessment but rather a developmental checklist based on their observations.

Mr T.K. WALDRON: Is RUCSN funded by both the commonwealth —

Ms Hewick: Yes.

Mr T.K. WALDRON: — and the state?

Mrs McInnes: Mainly commonwealth—now through DEEWR—with a small amount of funding coming from the Department for Communities for some playgroups that we run in the mid-west Gascoyne and the Pilbara.

Mr T.K. WALDRON: I read in your submission that that includes support agencies across the regional areas—as referred to by Mrs Hewick. If you pick something up at that level, is the next step to get support or outside help?

Ms Hewick: Yes.

Mr T.K. WALDRON: Okay; is that more difficult to get in those country areas?

Ms Hewick: It is much more difficult to get help in the country areas. The Pilbara team has mentioned the case of a child with autism—that is, he does not have a diagnosis for autism at the moment but it looks as if the diagnosis will head in that direction—who is waiting for assessment. The team reckons it will be nine months to a year before the child has an initial assessment, and he is almost three-years-old now. The chances are that he will start school without a diagnosis—although one would hope not. Some of the regional areas rely on a fly in, fly out paediatrician, and if there is not one, what then?

Mr T.K. WALDRON: Yes. In those childcare centres, do you work with other groups such as—I mention these all the time—the Smart Start groups and other early childhood programs? Do they work in with you at all or are they separate?

Mrs McInnes: It depends. We would collaborate with them to provide a service if that were the most appropriate thing to do and they were in the area. We certainly work with whoever is in the area. Smart Start would be in some areas; Best Beginnings in others —

Mr T.K. WALDRON: Best Beginnings is the program I had in mind.

Mrs McInnes: — Let's Read will be somewhere else. So, wherever there are services in the community for young children, particularly if they are applicable to childcare, then one of the roles of the early inclusion support worker is liaison to ensure that all those groups in the community are being accessed —

Mr T.K. WALDRON: So, are those groups getting outcomes? Do you think those groups generally are doing a good job?

Mrs McInnes: I think any intervention services work for families and young children if they are projects that have been well researched. Those mentioned would have to be well researched in order to get government funding. I have some examples of services that have been provided in childcare that I thought just might be relevant to understanding how the community could work in partnership with childcare. One of the programs that RUCSN has run at different times is called PALS; that is, Play and Learning to Socialise. I am not sure if it has been mentioned before. However, that is a program where you work with the caregivers on children's social skills. It seems very basic, but a lot of kids do not have the opportunity to learn those basic skills of sharing and waiting for turns, which will be important for their success when they get to school.

Mr M.P. WHITELEY: A different tangent: I am interested in asking for your professional opinion as an OT. Generalised screening: what sort of things should we be putting in; that is, how can we test for deficits in fine motor skills and gross motor skills and whatever else we need to build into an adequate screening process?

Mrs McInnes: I think with vision and hearing there are probably standardised tests that can be used. From my recollection of when my children were young, the child health nurse was looking for

the squint; she was looking for the short sighted and the long sighted; and she was checking the child's hearing—probably in a rudimentary way. However, that is something that caregivers pick up. They say, “He doesn't notice what we say to him” and often they will say “He is not concentrating”, but we do ask parents to think if the child can hear what is being said. In the case of a child with autism, the caregiver might say, “Oh, he must have a hearing problem because he is not talking and he is not responding.” It is necessary to observe as well as have an assessment. I guess we are saying it has to be put into context. For fine and gross motor skills we look to the basics such as stacking blocks, threading, bilateral coordination skills, balance ability and all those things.

Mr M.P. WHITELEY: So, would that be something that would be easy to train a community health nurse or even a —

Mrs McInnes: I think community health nurses would be aware of those screening tools.

Mr M.P. WHITELEY: Would it be possible to train somebody else with a lower skill set to perform those assessments? I guess we are trying to find ways of practically and economically generalising this. If there is a relatively easy test such that you just have to sit down with a kid and get them to play with blocks and do a few things —

Mrs McInnes: Yes.

Ms Hewick: I think if you just look at the childcare qualification. Using the skills and knowledge they have learnt at TAFE or uni, qualified persons can, without using a screening tool, identify and pick up on issues of fine or gross motor skills etc at that level. There probably could be an in between —

Mr M.P. WHITELEY: Okay.

Mrs McInnes: If I could, I will just make reference to a couple of the other programs that we have seen operating in childcare. The Peel and Rockingham-Kwinana Park community child development centre has just run a program—unfortunately, all these programs are always pilot programs because they always get a bucket of funding that has just become available—working in childcare services with care givers to explain children's developmental levels and what to look for; how to talk to parents; how to make a referral to a child development service; and how to enrich the programs that they offered to make sure that they were targeting the needs of a universal group of children—that is, their programs were not targeted at any one child—by ensuring that there is a good language component in their program and good gross motor opportunities for children. So, these sorts of things have happened. Also, the Disabilities Service Commission offers Skills for Kids, which is a childcare program that is targeted at children with disabilities. So, there are examples of where it has happened, but it is not happening all day every day because it is all pilot projects.

The CHAIRMAN: Do you have a sense of the actual percentages of parents that you described there as a bit reluctant to have their children presented for screening? Any sense of that?

Ms Hewick: Sorry; any sense of their reluctance to what?

The CHAIRMAN: To have their children presenting for screening. In the submission, at page four, you talk about child health screening for children between nine months of age —

Mrs McInnes: It is probably hard to come up with a percentage figure. You might say it is one in 10, but sometimes I think the parents' reluctance is that they do not want to investigate their own concerns—very often they will say, “Oh, dad was just like that”—or they do not have the time to investigate them. These are people who are working fulltime. It would be hard, I think, to give a percentage. However —

The CHAIRMAN: At page 8 of the submission—sorry, Cathy, did you have anything further to say?

Ms Hewick: I was just thinking—further to Shirley’s comments—that it also depends on where the family is at, at a point in time. I heard a parent talking on the radio who had a child who was diagnosed with autism but for a whole six-month period the family did not see anything happen for that child because they had a new baby who cried for six months. It depends on where parents are at in their space and in time as to what they can see and what they cannot see.

The CHAIRMAN: At page 8 of the submission you make reference to WILSTAR and CHAT assessment tools. Are these tools no longer used; and, if so, has something replaced them?

Mrs McInnes: The CHAT was an autism assessment and our understanding is that it is not used. It used to be done in the 18-month screening by the child health nurse. It was a very parent-friendly little 10-question assessment. Cathy, would you like to speak about the WILSTAR?

Ms Hewick: The WILSTAR program was run out of the State Child Development Centre and was for babies who had been identified by the child health nurse as having—that is, the child health nurse had concerns—communication difficulties. Obviously we are talking about very basic communication skills because the child was less than nine months old. The child health nurse recommended such children for the WILSTAR program, which involved two speechies or a speechie and an OT visiting the parents at home over four sessions. Based on what a speech therapist has told me, after four intervention sessions designed to help parents understand their relationship and to bond with their child and communicate with a baby, the child’s communication development was on par—after the fourth session—in, I think, 90 per cent of cases.

That was when they ran the WILSTAR through the State Child Development Centre, and they are not doing that any more either.

[11.10 am]

The CHAIRMAN: Has it been replaced by anything else?

Ms Hewick: I do not think so.

The CHAIRMAN: On the same issue?

Mr P. PAPALIA: It is segueing into one of those and it is mainly to Shirley, probably as an OT but not necessarily limited to Shirley. Did you attach that Ross Gittins’ article from *The Sydney Morning Herald* to your submission?

Mrs McInnes: I attached —

Mr P. PAPALIA: I found that incredibly interesting, his observations of the references that he made to studies by James Heckman, and also the Perry program and the results of that Perry program, which seem to me—and I am not widely read on this—but I would suspect that everyone we meet acknowledges that early intervention is great; everyone will use that. No matter what their specialisation is and no matter where they come from within the system, they say that early intervention, the earlier the better.

Mrs McInnes: Yes.

Mr P. PAPALIA: I think a lot of it might be hung off this study. The findings of this study indicate that within our system we concentrate so much on cognitive intelligence that we overlook the importance of emotional intelligence. Everyone who advocates early intervention from within the normal state system or the independent school system are focused totally on cognitive intelligence almost; they are talking about the WALNAs and the NAPLANs and all those sorts of things. Yet the suggestion is—and from your comments too you could easily infer—that the intervention relating to assisting parents to know how to help their children is far more important and far more effective than any amount of other specialist intervention; and I would like your comment on that, Shirley in particular as an OT and also Cathy from your own experience that you just referred to, because I have a suspicion that we are almost focusing on the wrong thing in a lot of areas.

Mrs McInnes: I would say there are two things, and from the other articles that I attached from RUCSN about brain development, we are very aware of the importance of attachment and communication and knowing your child, and not only between a parent and a child but between a caregiver in childcare and a child; that you have got to be constantly alert: what is that child trying to tell me; am I alert to that child? So that, I think, ties in with that attachment and the importance of it for a child's self-esteem and success. However, because I am an OT, I cannot ignore the fact that the child who has poor language development and poor motor skills is going to enter a school system where they are completely inadequately catered for. You know, we have missed the most important years in making sure they have got those skills so that when they start school they are in with a good chance. When I read in the paper of the problems children are having in schools now and in high schools and I think back, yes, I remember when screening was almost universal for young children, when I thought the health services were more responsive to identifying kids early, and I think we have lost it over the last 10 years or so. So kids are going to school ill-prepared, and if you start school ill-prepared, it is not going to be easy for the next 20 years, and it is to do with both your emotional development and your skill development.

The CHAIRMAN: Shirley, have you considered that also in schools, over not necessarily the same period, that pedagogy has changed in the schools to a different fashion of teaching?

Mrs McInnes: Yes, and for me that is the difficulty because I come from the old school, and so I can only comment —

The CHAIRMAN: At a time which did not produce the same level of failure to thrive in the education environment?

Mrs McInnes: No, I do not want to condemn the education environment. I am just saying it is different to what I experienced; it is even different to what my own children experienced. I find structure is very important for some children, and that is perhaps less important today than it was, but I have done no research in education, so it is a personal view.

The CHAIRMAN: I think there is a risk that the teachers have not either.

Mrs McInnes: Yes.

Mr M.P. WHITELEY: I just want to make a specific reference to your submission. You talk about the voluntary nature of screening after nine months. I mean, it is always voluntary, but after nine months, it is particularly difficult to engage them, again before you get to —

Mrs McInnes: Preschool.

Mr M.P. WHITELEY: Preschool. How do you think that can be addressed at a policy level, given that it is difficult to make things compulsory? I hear your message about perhaps offering it in childcare. That is perhaps one practical strategy.

Mrs McInnes: Yes.

Mr M.P. WHITELEY: Any other ideas?

Mrs McInnes: Once again, old school. The co-location in the past of the child health nurse and the kindy or the child health nurse and the childcare—you know, I drop the kid at kindy and think, “So and so hasn't had their two-year-old check; we will pop in a get that done.” A bit like immunisation, it was just something you thought, “I must do that”, because it was kind of schooled into you. But there were different pressures on young mothers in those days to what there are now. But whether some sort of screening could be introduced through childcare—and, as I say, it does not reach all the population—whether the playgroups could be made more aware of where their child health nurse is or whether she could come in and give a talk to the playgroup mums, just even that sort of information.

Mr M.P. WHITELEY: We took some evidence from people previously, and I do not want to put words in their mouths, but they identified that children in childcare may be missing out on some of

those opportunities that traditionally kids have had whereby they have had intensive, one-on-one language development, rather than hanging around—politically incorrect to say it—mum’s ankles all day.

Mrs McInnes: Yes.

Mr M.P. WHITELEY: So perhaps by having them in childcare, it seems to me that you are suggesting that we may in fact be hitting that percentage of the population that is most at risk.

Mrs McInnes: It could well be, yes.

Ms Hewick: Just on that, the mums or dads taking their children to a child health nurse, I have quite a few friends with young kids and they do not seem to see the importance in it. Once the baby is born and the baby is fine and the child health nurse gives them the okay, it is like, “They are fine now; I don’t need to do any follow-up.” I do not know whether the importance of going to see a child health nurse or having some development checks along the way is just not fashionable or just not highlighted enough in our community, or how we could make that a bit more fashionable. I think there is also fear for parents going to the child health nurse because it is seen as now you only go if there is something wrong, which is not —

Mr T.K. WALDRON: There is a stigma attached to it, just about.

Ms Hewick: I think there is a little bit, yes.

Mr M.P. WHITELEY: Yes, rather than it being automatic.

Ms Hewick: Yes, rather than, “I really must do that because that’s really important”, it seems to me.

Mr M.P. WHITELEY: You do all these things at the start when you have got your babies.

Ms Hewick: Yes.

Mr M.P. WHITELEY: Then all the pressures of mortgage and life and everything go on and you do not have time and also it is something you deal with when there is a problem.

Ms Hewick: Yes.

Mrs McInnes: Yes, and some problems are subtle and parents will not pick them up. It is not until you see a child in a group situation or with an experienced pair of eyes that some of those issues are picked up. Something that is referred to in our paper that I will just draw your attention to is that RUCSN, as well as providing inclusion support, is the professional support coordinator for childcare across WA; so it is a vehicle through which information can be channelled to all childcare services, and training can be coordinated. I guess it is a bit like the education department admin part; the PSC is the conduit for information going to childcare, so that things can be implemented through a central body.

The CHAIRMAN: In that submission you have at page 8 a reference to the northern corridor speech pathologists. Have you got a sense of whether there are any speech pathologists in that northern corridor taking on new clients?

Ms Hewick: I just checked on that yesterday, the case in the example. The child that we were referring to in there—I cannot remember what we said—has speech delays around pronunciation and stuttering, and he has just turned four. He was referred at the beginning of the year to a child development team in the northern corridor and he was seen, I think, two weeks ago for his first appointment and then put on another waiting list.

[11.20 am]

They have told her that they will not be able to see him until the middle of next year. While she was waiting, she went to her GP to go through the enhanced primary care, through Medicare, and he said, “Yeah, your child definitely needs some private speech.” She got a list of the private speech

therapists in the north corridor, but all of them, their waiting lists are now closed and they would not even put her on the waiting list for private speech through the enhanced program. Now she has an appointment in two weeks' time with another private speech therapist, which she has to pay \$85 for a three-quarters-of-an-hour assessment. She can afford to do that, but as we know there are many families who cannot do that. She was hoping that enhanced primary care would at least give her four free sessions, but she cannot get into that.

The CHAIRMAN: Do you have a professional view as to what number of children in child care you think have speech and language delay—this is in reference to page 9 of the submission?

Mrs McInnes: I do not have a number, but it is surprising how often I am in the three-year-old room in child care and I am thinking, "I can't understand what that child is telling me." Unfortunately, we do not have a number.

Ms Hewick: It is big enough for us to have put a submission in to get some funding for the Peel region to have a speech therapist work with the child care staff on the floor over a year, for a project with the inclusion support facilitator. In that region, it was a big enough issue and the inclusion support agencies which we have got are contracting the role of the ISF—the target group, I should say. Children with speech delay do not really fall into that unless they have got a disability. We do support staff as much as we can and give them resources to help around speech and language, if that is the only issue, a developmental concern, but it was a big enough issue coming to us through the inclusion team that we put that submission in. We are looking to work with Therapy Focus probably in Kalgoorlie and in the far northern corridor on a similar theme. We do not have the numbers, but it is a growing issue.

The CHAIRMAN: I finish with the observation that there might be some correlation between the presence in child care facilities and speech and learning —

Mrs McInnes: That is always mentioned as a possibility because I think statistics do show—and I do not have the statistics—that there are more colds and flu and blocked ears —

Mr P. PAPALIA: Anecdotal evidence to support that.

Focussing on the suggestion that RUCSN is a good conduit to potentially target a great number of children, but also those ones that may even be the ones that we really need to focus on, you note that you do not run three of the inclusion support agencies in the state. Do you have relationships with them and your own ability to liaise and coordinate if there were another responsibility like screening or something?

Ms Hewick: The PSC supports all the inclusion teams for our own PD etc, and information, but we also meet regularly with DEEWR as a group. So we do that and we do PD together as well, so we do have relationships with them.

Mr T.K. WALDRON: That issue has been raised a couple of times here and before, regarding language problems in day care. Is there a difference between long day care and family day care? Is there something that shows you that if you are in family day care it is better because of the smaller numbers?

Ms Hewick: I used family day care. Personally, from my experience as a parent, not only for my child, you are just dealing with one person the whole time. For me, that is very helpful, and also for the children. Because it is a smaller group, it is an ideal environment as one caregiver is working with four children. A lot of times the four children are the same children every day. In my experience, that is what I had. So for the children to form social relationships, it was very easy to happen, as well as a relationship with the carer. It depended on the skill of the carer as to what they provide. I have to say it was a challenge to find the right one for me. I suppose they can meet the needs of children with developmental issues a lot easier because it is a smaller group, so they do not need our involvement as much. We are not maybe up to speed with that as much as we would child

care, because of the higher ratios where staff need more support because small issues are a lot bigger.

Mr P. PAPALIA: It would be an interesting study to do.

The CHAIRMAN: We have got to wrap up with the advice to you. We have got other witnesses waiting, that is what the appearance through the back door was. Your transcript of this hearing will arrive and you will get a period of 10 days of receipt to correct any minor errors. You are not to alter the sense of your evidence, but correct any minor errors otherwise the transcript as it appears is taken to be what you have said. If you wish to add, elaborate or add particular points, please include a supplementary submission in response and we will have the opportunity then of considering the corrected transcript and anything else that you provide to us within that time line. My final task is to thank you for your submission and thank you for being with us today. Hopefully we will produce something of value out of not only your own submission but the work of the committee.

Mrs McInnes: Thank you for the opportunity because it is something close to our hearts that we think it has got to be resolved and addressed.

Hearing concluded at 11.26 am