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 ONE

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 9.50 am

RIDDEN, DR PHILLIP
School Head, St Stephen's School,
examined:

BENSON, MRS CHRISTINE
Teacher, St Stephen's School,
examined:

The CHAIRMAN: Welcome to the committee. I have to read to you the following as chairman. A committee hearing is a proceeding of Parliament and warrants the same respect that proceedings in the house itself demand. Even though you are not required to give evidence on oath, deliberately misleading the committee may be regarded as contempt of Parliament. I am required to ask you three questions, which you have got to give audible answers to. Have you completed the "Details of Witness" form?

Dr Ridden: Yes.

Mrs Benson: Yes.

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

Dr Ridden: Yes.

Mrs Benson: Yes.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet regarding giving evidence before parliamentary committees?

Dr Ridden: Yes.

Mrs Benson: Yes.

The CHAIRMAN: I am left with the task of asking you to state your full name, your professional address and capacity in which you appear before this committee.

Dr Ridden: I am Dr Phillip Ridden. My role is as head of primary school at St Stephen's School, Carramar campus. The address of that is St Stephen's Crescent in Tapping.

Mrs Benson: Mrs Christine Benson, deputy head of primary school, St Stephen's School in Carramar, St Stephen's Crescent, Tapping.

The CHAIRMAN: Thanks very much, firstly, for the submission and the opportunity to come back and have a discussion with the committee and being available for questions about your submission and your comment on the terms of reference of the inquiry. We have provided other witnesses with the opportunity to speak briefly to any points about their submission that they would like to make. Please free feel to give a brief opening statement and committee members will take it from there.

Dr Ridden: Thank you, sir. I will make it brief because you have got my submission. I appreciate your time and the opportunity to answer questions because the submission was brief and obviously raised a few issues. I asked Mrs Christine Benson to join me because she works very closely with families with whom we have intervention programs day by day and so she may be able to answer some questions better than I can. The first point I guess I wanted to make is that we believe early intervention is absolutely critical because problems that arise for kids have a lifelong impact both for them individually and for our society. The second is that the schools are mostly involved in

identifying these kids who have these early issues. Many parents miss the fact that their kids might have early developmental problems, especially if the child is very chatty, very articulate, if you like, or if the child is very like the parents were as a child, and sometimes they do not in that context see the difficulties that are there. Sometimes parents do know that their child is different but they do not necessarily know that that is a problem. They often just think that is their personality. So a lot of these issues are missed by parents prior to school. I believe we need some kind of a process whereby the community can screen kids early on, perhaps at preprimary level, perhaps at kindergarten level, but something like that, and to do comprehensive screening. As I said in my submission, there are some real issues with families having access to government services both to assess students and to provide ongoing treatment to them; problems in terms of availability and problems in terms of cost when private consultants are used. I guess schools have taken on this problem with various degrees of expertise, various degrees of success and various degrees of resources. That is the context in which I speak and I invite any questions you have.

The CHAIRMAN: I would not mind starting with one. I have asked other witnesses about the same area—it is developing as a strong personal preoccupation of mine. The figure of 26 per cent of students at risk, and that being supported by a number of submissions, and then suggestions that up to 25 per cent of students are not flourishing in the classrooms without external help from this range of specialists, that alarms me. I am also concerned about the pedagogy in the classrooms that responds to that. I ask this: is there enough mandatory structure to the pedagogy in the education system to secure progress for that 26 per cent inside the whole cohort?

Dr Ridden: That has always been a challenge for schools. Teachers are dealing with over 30 kids each, who have their own particular needs. We are focusing today on those children who are struggling in some way, but there are children right through that whole spectrum, including some who are absolutely brilliant, who equally need our attention and need to be challenged appropriately. So that always has been a difficulty. We put a huge amount of time and resources in our school into addressing these issues. From our point of view we do not adopt the policy with a teacher that, "This child is your child, you worry about them." As far as we are concerned, if there is a child who needs particular attention, we will bring all the knowledge that we can muster in the school to address that issue. We will use outside consultants to give us extra advice and we will together problem-solve and try to find solutions and ways of best addressing the needs of each child. Pedagogy is one part of addressing that, finding different ways of teaching the kids, different ways of structuring their environment for them, different ways of supporting them. All of those things we try to do, but we are trying to do that for a whole range of kids simultaneously.

Mr M.P. WHITELY: Picking up on something you said, you said that parents are missing problems with their kids where the kids are too similar to them, or they are too chatty, or whatever. Can you elaborate on what sort of problems you are talking about?

Dr Ridden: The sorts of problems we are talking about are that we get children who present with ASD—autistic spectrum disorder—or difficulties close to that, that might be missed. We have children who present with serious language delays but which the parents sometimes miss.

Mr M.P. WHITELY: If they are chatty —

[10.00 am]

Dr Ridden: We sometimes say to some parents, "Your child has some serious language difficulties that are impeding and going to impede their learning." They say, "What do you mean? My child at home goes babble, babble, babble all day long."

However, there is more to language development than the ability to simply babble words. Some kids do not have the structure of language ingrained in their heads, and therefore they are not able to learn language as they need to. Some of them do not have the ability to infer and interpret language. They do not pick up language cues. When you talk, you do not just listen to words; you pick up all

sorts of inferences and so on behind the words that are said. These are all skills that most people just learn. If you have young kids of your own, you know that sometimes you have to say very little for them to understand exactly what you are thinking. Some kids miss all that; they have none of that. They do not have the structures of language and so on, and so they have difficulties learning.

Mr M.P. WHITELY: Do you think that is a problem to do with the way kids are socialised these days? A lot of kids are in long-term day care. Are any trends coming out of that, either positive or negative, that you are seeing?

Dr Ridden: That will do for an inquiry on its own, that one, and anything I answer there will offend someone; but, yes, there —

Mr M.P. WHITELY: That means you are probably going to say something worthwhile, so please go for it.

Dr Ridden: There is research that is showing that kids who are spending a lot of time in day care are coming away with a lack of language structure and so on. There are people who can provide that research information for you. That is part of it. The time that parents are spending actually interacting with their children in terms of language is an issue, and there are other such things that are contributing to this too. Do you want to have a piece of that, Christine?

Mrs Benson: Yes. It is lack of communication as well that we find really problematic in some children, in the fact that they do not have the skills to be able to communicate with their teacher, for instance, so we then get behavioural problems, because their not being able to communicate effectively really frustrates them to the degree that the behaviour really just shows —

Mr M.P. WHITELY: I know that this might be terribly politically incorrect, but a classic example might be that mum and dad both have to work long hours to pay a mortgage. The kid is in long-term day care. Mum and dad come home and they are both really tired at the end of the day. They do not have a lot of time to spend with the kid, so the kid is not getting that sort of in-house socialisation and verbal skills. They are missing those cues. They go to school, and in kindergarten, preprimary and year 1 it is presenting as a problem, with missing visual cues in class etc. Is that the sort of thing we might be talking about?

Dr Ridden: That is part of it, yes. One piece of it that you are talking about is that area of development. There are other problems. There are problems for some kids in physical development. That includes such things as sight and hearing—sensory development, if you like—but it also includes simple muscle development and muscle tone. Kids do not go out playing on play equipment. They do not climb trees and things like that. We have kids who have great difficulty sitting at a desk and trying to write. Obviously, that is not something we make them do to a great degree at a very young age, but it is part of their whole development. There are children who —

Mr M.P. WHITELY: Can you elaborate on that? That is a really interesting point. You are basically saying that because kids do not have the rough and tumble of play, their physical coordination is not as good as it should be and it interferes with their ability to hold a pen and —

Dr Ridden: Absolutely. Holding a pen and sitting in a chair require certain bodily strengths. In a lot of families, kids do not do that. They lie on floors; they lie around on lounge chairs and so on watching television. There are other areas of development that concern us too, by the way: social development, emotional development, their understanding of boundaries. All those things impact on them when they come into an environment that is a school. We are very self-aware of our school environment and very critical of it, if you like. When kids are having problems, we say, “What is it that we are doing that might be exacerbating this? How can we restructure our environment? Is it our fault? Therefore, we are very aware of that, but you cannot have a school environment with hundreds of children who are all dependants and not have certain routines and certain structures and so on. That is the nature of a school. Some kids cannot cope with that environment, and they struggle in that setting.

Mr J.H.D. DAY: Do you try to educate or inform parents about how better to provide a home environment that is more conducive to these developments?

Dr Ridden: Absolutely.

Mr J.H.D. DAY: Do you get parents together and are they receptive?

Dr Ridden: Absolutely.

Mrs Benson: And some are more receptive than others, obviously, but that is becoming more and more a part of what we have to do in school. There has been a trend towards that, towards parenting the parent, over the past few years, which there was not 10, 12 or 15 years ago, I think.

Dr Ridden: And we work individually also. Chris Benson would probably spend about a quarter of her time—she can correct this if I am wrong—actually working with these children and their families and their teachers. When I say "these children", I am talking about those for whom we have particular interventions. In many cases, that does amount to helping parents and guiding parents in how to respond differently with their children, how to deal with them differently and so on. A parent came to see me the other morning with their child asking for some advice on how to deal with some issues this child was raising at home. We do a lot of that kind of thing on behalf of the community.

Mr J.H.D. DAY: To what extent do you think teachers are equipped to deal with or respond to these sorts of problems? Obviously, you are trying to do that at a senior level. Is the teaching profession in your school more widely or similarly equipped, or is a lot more needed there?

Dr Ridden: That is a very good question and it is a real issue. We personally have an issue with teachers who have one year of educational training. We talk about teachers being four-year trained. Many of them, especially secondary teachers, but also quite a few primary teachers, have three years of specialist knowledge training and one year of educational training.

Mr J.H.D. DAY: Doing a Dip. Ed.

Dr Ridden: The Dip. Ed. You cannot teach a teacher all they need to know about instruction, about assessment, about curriculum, about management of students, about dealing with parents—all this kind of thing—in one year. That is our personal view, and that is a little contentious too. However, that is our view. One of the things we do in our school is make sure that we train our teachers. Therefore, we work with our teachers. We involve them in meetings with parents and so on, and we train them by modelling, as well as by conversation, so that they have the understanding of what the issues are and how to deal with the students and how to deal with the parents—and by "deal with", I mean how to help them, and help them to work alongside us and with us, and us with them.

The CHAIRMAN: In your submission, on page 2, you have this line: teachers are experts in child or human development and in learning. To me, that jumps out in contradistinction to what you have just said about it; that is, for teachers, one year is the baseline of their involvement in this area. It worries me that there is not built into the systems very strong professional support to skill up teachers all the way through on the best methods of child development and teaching teachers about how students learn.

Dr Ridden: Absolutely. Teachers take almost as much criticism in the community as politicians do —

Mr P. PAPALIA: No, they do not.

Dr Ridden: — but we do have our areas of expertise.

Mr M.P. WHITELY: I have been one, and I can tell you they do not.

The CHAIRMAN: They digress!

Dr Ridden: I thought you might enjoy that. I refer in particular to primary school teachers. What we do know and are very good at are those things that are our focus: child development and how people learn, and also, of course, some expert knowledge in a particular field of learning. For a lot of primary teachers that is a more general knowledge; for a lot of secondary teachers it is a very focused area of knowledge. However, that is a lot to learn and a lot to know.

The CHAIRMAN: What is the experience in your school of the actual numbers who have some form of disability as opposed to students being at risk? You have used the figure of 26 per cent being at risk. What about diagnosed disabilities? Is there a percentage that —

[10.10 am]

Dr Ridden: There are very few.

Mrs Benson: With regard to central auditory processing disorder, we think that probably 20 per cent of each class has some sort of disorder. Central auditory processing disorder does not mean that one cannot hear; it means that one is not taking in and processing what one is hearing. We think that about 20 per cent of each class would be the figure. Of course, we do not get a diagnosis for all these children, so we are left with a bit of guesswork as well. Autism is definitely on the rise within our schools. Out of 56 children in our preprimary this year, we have assessments going on for four, possibly five of those children for autism disorder. That has a huge impact on our teachers, on the families and, of course, on the students themselves. When we come to developmental optometrists, we refer to them on a regular basis when we discover that a child cannot read and that in spite of every single thing that we have done for this child, he is still not focusing. We get the child to a developmental optometrist, who will tell us that the child cannot actually see the words on a page; the child is looking up and down and not tracking properly. We check the child's hearing and eyesight before we do anything else. That does not mean checking to find out whether a child can hear a dog bark, but checking to find out whether a child can hear spoken sounds and repeat them, and whether a child can track, rather than see, a picture in front of him and can look at the words and pictures on a page and make sense out of them. We can also look at the areas of ADHD and ADD.

Dr Ridden: I just want to add two things to Chris's comments. During the second year of our campus, which opened in 2001, we did a mass check on every child in the primary school—almost 500 children. We identified 150 out of approximately 480 kids who we felt needed a referral to find out what was going on with them. Of that 150, only four or five came back with the assessment that they were okay and that everything would be all right. Virtually every one of those kids was followed up with a course of therapy or something of that type. However, very few of those kids have a disability in the sense of having something that is diagnosable, especially funded, and especially provided for. The rest we just deal with.

Mr P. PAPALIA: My question relates, in a way, to what you have just stated. I have concerns that within the teaching profession, and more widely in the health professions, there is a desire to help as many people as possible and to try to do the right thing. As a result of that, we have spread the net so wide to try to identify things that are now termed conditions or disabilities, and I am concerned about the degree of objectivity in these assessments. How subjective is the determination about whether someone has—what did you call it, Christine?—

Mrs Benson: An auditory processing disorder.

Mr P. PAPALIA: An auditory processing disorder. Beyond that, I am very sceptical about some of the determinations with regard to ADHD. I know the determinations are completely subjective as far as the determination as to whether individuals have it; therefore, I am really questioning the extent of the problem, noting that whatever problems we identify, we will always have to prioritise effort and expenditure from government, because we cannot fund everything. What is the best thing to focus on?

Mrs Benson: Firstly, I would like to say that we do not make any diagnoses; we are teachers, and all that we can do is present a report to the consultants. We do not make a diagnosis. We say that the child is not learning. There is always a reason for a child not learning; no child sets out to fail. We present our professional reports to consultants, and the consultants take it from there. We never make a diagnosis. We are not trained to make a diagnosis. Sorry, I have lost track of the question.

Mr P. PAPALIA: There are two responses to sending 150 kids away and having three of them come back with the assessment that they have no problems. The consultants you send them to: the response is either, "Oh my God, it's so big and challenging; we will never solve this problem" or else the consultants are being so subjective that anybody could walk in there and get exactly the same diagnosis of having some sort of disorder. I am not saying there is not a problem, but the extent of it concerns me. The ways in which we derive these figures and arrive at the assessment of the problem is concerning.

Dr Ridden: With respect, I think the member is wrong. I think that the people making these diagnoses are trained and skilled in this area; it is what they do. I know that on this panel there are strong feelings about ADD, for example. I would be very happy to have a conversation about that at another time, because that in itself is a big issue and a big conversation. But we refer these children in the first place because they are not learning effectively at school. The member talked about a desire to help; that is the wrong word. It is a responsibility. We have no choice. If a child is not good at running, we say, "That's okay; you're not a good runner, son; you do something else." If a child cannot play the flute well, we say, "That's all right; don't learn the flute. Music isn't important." If a child is not learning to read, we cannot say, "That's okay, sonny; don't worry about reading; we'll do science with you instead." There is no choice. If children do not succeed in basic literacy and numeracy, then league tables declare to the world that our students are not succeeding. It is a requirement and a responsibility. We do not refer these kids in the first place unless we have reason to be concerned. My comment on page 2 was picked up by Mr Stephens. As teachers, we are very good at recognising when children are not developing appropriately and not learning appropriately. We do not always know what the cause is, although I have to say that in our school we have become very skilled at this. But we do not presume to make a diagnosis; it is not our call. However, we know when things are not right, and we are able to identify why it is not right and what the actual symptoms are that we think should be different, and then it is up to a speech pathologist or someone like that to actually make the determining call. The member talked about subjectivity. In fact, for these disabilities, there are international codes that define whether a child has ASD, for example, or ADD. It is not someone looking at them, listening to a teacher or parent and saying, "Fair enough." They have to fill out comprehensive lists. A diagnosis of ASD requires an assessment by a paediatrician, a speech pathologist and a psychologist. They have to follow particular guidelines, and unless a certain number of boxes are ticked, the child will not be diagnosed as having ASD. Interestingly, that poses some real problems. We are very concerned at the moment that we have a number of children who have received a diagnosis of PDDNOS. That stands for Pervasive Development Disorder Not Otherwise Specified. It basically means that the child presents with many of the symptoms of a child in the autism spectrum, but not quite enough boxes have been ticked to provide a formal diagnosis. The problem is that these children have all of the difficulties of an autistic child. They present that way and their ability to cope with the school environment is that of an autistic child. Schools have to deal with them, treat them and teach them that way, but as far as governments and health authorities are concerned, there is no support given at all because the child does not meet sufficient criteria to get a formal diagnosis for anything else.

[10.20 am]

This is a big field here, and I do not claim to be an expert in all of this; I am not a researcher, I am a practitioner, but these are the issues we are dealing with. Chris mentioned the number of children in our preprimary class this year—which has shocked us—that we are really concerned about. You said, "Is this subjective?" I went into that class early in the year and was chatting to the kids and

mixing among the kids and so on, and I came out and said, "My hearing is getting worse because I can't understand half of these kids." I do have a hearing disorder. The teacher said, "No, it's not you, Phil, it is these kids." We have serious concerns about their basic articulation, let alone other issues.

Mr J.H.D. DAY: What proportion, just roughly?

Dr Ridden: I think it was 27 we referred out of 56—I think I put that in there—something like that. The speech pathologist has agreed that they need some treatment. That is basic articulation; that is before we even get to the business about language structure and so on. So, you know, these problems are not—yes, point made.

The CHAIRMAN: I think Dr Whitely may—Martin.

Mr M.P. WHITELY: I know we could have a long debate about it, and perhaps we should at some stage, but I do think that your statement that you do not diagnose is an oversimplification of the situation. The recent RACP national draft guidelines on ADHD, for instance, said that teachers' and parent confirmation—that is, the tick list confirmation—that a child exhibits the six inattentive behaviours, or the six hyperactive impulsive behaviours, is confirmation that the child has ADHD. Effectively, your tick lists coming out of schools, and that that is prepared by the parents, is the basis for diagnosis. That is the basis for DSM4; the diagnostic criteria. If you want to pare it down to what those diagnostic criteria are, you said that they were basically internationally accepted and they are based on science. They include things like failure to sit still in seat, fidgeting in seat, avoiding homework, failing to play quietly, running about as if driven by a motor; they are all incredibly subjective. The point that Mr Papalia made is absolutely correct. I have a huge concern when 150 kids are being sent away and only three kids are coming back as normal. I think the point that Mr Papalia is trying to make is broader than just ADHD; we are identifying problems with kids—and I think part of the conversation we were having earlier on, about a change in the way kids are brought up in those early years, and we are identifying problems coming out of that, their failure to actually thrive in a school environment, and we are pathologising it, we are dumbing it down, and we are coming up with short-term solutions. Obviously you care deeply about kids, but like it or not, when you identify problems like—it is not true for CAPD—ADHD and ADD, where do those kids end up? They end up, based on your tick lists and that of parents, in a paediatrician's office and they end up on amphetamines; that is the result of it. What we are doing is compounding the failure to actually help kids thrive in those early years, then dumbing down the response because of our desperation to do something. I think it needs to be viewed in that context, and you do have a responsibility. It is something that schools often say; "We do not diagnose and it goes off to experts", but it simply does not.

The CHAIRMAN: Are you seeking comment on that?

Mr M.P. WHITELY: I was participating in the debate —

Dr Ridden: I would like to make it anyway. I would like to make a comment anyway. There are two things: one comment is that the 150 is not a normal situation. When you start a new independent school, I can tell you now that every child in the neighbourhood of 15 kilometres who has been failing at school for the last six years comes to us so that we can fix it. That is a general attitude. I have commenced two primary schools at St Stephen's alone, on each campus, and each time in our first year we had brought in all of these kids, and many parents have said straight out, "My child's had a miserable life at school, everything always goes wrong, they are failing. I am bringing them to you to fix them." We try to say, "Give us at least six weeks, won't you?" That is part of the setting. So that was an unnatural situation. The point I wanted to make from that was that our identification that these kids had a problem was confirmed by the consultant. The other thing is; I would actually like to have a conversation with you about ADD at some point —

Mr M.P. WHITELY: I am very happy to.

Dr Ridden: — because where these kids end up is in fact not just in behavioural problems in class; where they end up, the research says, is in prisons and in hospital wards. That is where our ADD kids end up. That is a conversation for a later point.

Mr M.P. WHITELY: We will have that conversation at another time, and perhaps Mr Papalia might like to be party to that as well.

Dr Ridden: I come back to the fact that we are not flippant about this, and in fact only recently we were having a conversation when I was asking, "Is this us?" In fact, when we came up with these 27 kids that were referred this year, I actually said straight out to Chris and to others, "Are we being ridiculous? Are we wanting to refer kids for trivialities?" They said, "No, Phil, let us show you", and so they showed us and I endorsed it —

Mr M.P. WHITELY: Who said that?

Dr Ridden: The teachers —

Mrs Benson: The screening.

Dr Ridden: — and this person who oversees this process. We have a screening process; we use a speech pathologist, we use our own staff and so on. When I looked at those kids and when I listened to them —

The CHAIRMAN: This is preprimary screening, is it?

Mrs Benson: Yes.

Dr Ridden: — I identified that these kids really do need referral.

Mr M.P. WHITELY: I am not suggesting that kids do not have problems, but the response has to be more sophisticated. I am saying that when you pass them up the line, do not think they get passed to some level of great care, they get dumbed-down solutions in many cases. Anyway —

Dr Ridden: The problem is, Mr Whitely, if we do not do that and if we let them go and we say, "This child will be okay; let them grow up a little bit; they will learn to cope with school; they will learn etc" they get to year 3 and 4, and they are off the bottom of the benchmarks and we are under pressure and it is too late to address the problem.

The CHAIRMAN: I will go to Terry.

Mr T.K. WALDRON: When Tom asked that question—you mentioned before about sensory disabilities, and then you were talking about the social ones. Tom, were you after the actual percentage of those that are the problem kids?

The CHAIRMAN: I think you gave some stats, but —

Mrs Benson: We are not talking about problem kids here.

The CHAIRMAN: No.

Mrs Benson: It is not behavioural —

The CHAIRMAN: We are trying to distinguish between disabilities and learning difficulties. Do your stats do that?

Mrs Benson: Yes.

Dr Ridden: Yes, but as I said, very few actually come out with a diagnosis of a disability for which they get a disability pension, for which we get funding. In our primary school we are getting funding for kids with disabilities for, I think, about a dozen or 15; would that be right?

Mrs Benson: Yes.

Dr Ridden: About a dozen or 15 out of the 480. They are the only ones who are officially diagnosed as having a fundable disability.

The CHAIRMAN: Over and above those funds you get from government for the purposes of responding to those challenges, do you use your own school resources to —

Dr Ridden: Absolutely.

Mrs Benson: Yes.

The CHAIRMAN: Can you quantify the initial resources you acquire from your own resources to respond to these challenges?

Dr Ridden: I could start to do such a thing, but, look, if you add staff into it and so on, and funding for referrals, we are probably talking about, in our primary school of 500 kids—and we have four sectors to our school—$200 000 a year, with additional staff, with additional things. That is —

Mr T.K. WALDRON: I was going to change tack a bit here. You talked before about problems in early childhood and screening etc. Are you aware of programs that are around for early childhood before kids get to school like Smart Start, which has just had a review?

Dr Ridden: Yes.

Mr T.K. WALDRON: Are those programs helping? Should those programs be better coordinated? Because it seems to me that there are different programs all trying to do the same thing with a bit of commonwealth funding here, some state funding there, but they seem to be all over the place to me. Should coordinated programs—those early childhood programs with basic reading skills, not teaching them to read so much, but basic attention that will pick up those problems early—happen? Do you support those programs like Smart Start—if you know about Smart Start and those types? There are other ones out there as well.

Dr Ridden: I cannot say that I know a lot about Smart Start, so I do not really feel confident to respond.

Mr T.K. WALDRON: Smart Start is a program whereby parents are contacted when their children are babies and they are sent a book, then they have meetings with other parents and they have tests; they have the speech therapist there and that type of thing. They are trying to pick these kids up as early as three years old. They are actually teaching them the basic things, and then if they pick it up then, they get treatment before they get to you guys, so they are under —

Dr Ridden: Then, yes, that is a good thing. The problem is that you are only touching a select group that way.

Mr T.K. WALDRON: My point is that you talked before about overall screening. If those programs were coordinated so that all young kids were tested—I do not know whether it is possible, but the majority of young kids—is that going to help the very situations that you have been talking about, which are really interesting?

Dr Ridden: Probably so. We, in fact, are planning to do the screening of our next year's preprimary intake this term; in fact, later next month. We will be trying to then identify those kids this year and get some programs in place for them before they get into preprimary classes.

[10.30 am]

Mr T.K. WALDRON: Are you aware of the different Canadian programs in schools that teach children phonetics from computers? Do you have any comment to make on those? Are they good? Should the Department of Education and Training say that you should be using four of those, for example? I am a country member and we do not get a lot of the services. I have noticed that schools are picking up these things and doing them independently.

Dr Ridden: If you are talking about programs like Earobics and so on, yes, those things have a place in supporting children.

Mr T.K. WALDRON: Should they be better coordinated through the Department of Education and Training?

Dr Ridden: Possibly. I think that the question is too big. We need to explore it and tease it out more before I can really say that we should do this or that.

Mr T.K. WALDRON: Thanks.

Mr J.H.D. DAY: In relation to your referrals of children to speech pathology assessments and occupational therapy assessments etc, there are problems with families accessing those services. It seems to be a little better in your school because you subsidise that and go to an effort to make those services available. Can you elaborate on the degree of the problem from your school's perspective and from the wider community's perspective and on what you think must be done to improve the situation?

Dr Ridden: There is definitely a significant issue regarding accessing government services. I said that it takes nine months to get an initial assessment and then, when a course of therapy is recommended, it takes another six months for something to happen. They are not fantastic figures; they are normal figures and they have been confirmed by parents who have told me that. All the research says that if a child has a developmental problem the sooner it is dealt with the better chance there is of correcting it. In addition, if a child begins by failing in school, we all know that that is very difficult to overcome later. Therefore, we try to make sure that a child succeeds from the start. To wait for a year to get something done is just unacceptable. I am not critical of the people who are working in those government services; the problem is that there simply are not enough of them. Our school is committed to making sure that children do not miss out because of their parents' finances. We have a budget to allow those people to get private services but that can be very expensive. Interestingly, nowadays people will not even write reports without charging extra. A speech therapist might charge $250 for an assessment and another $150 to write the report; that is a $400 assessment. What use is the assessment unless we and the parents can get a report on exactly what the problem is and what we might do about it? These are expensive services. Very few of those services are supported by medical funds. I am aware, of course, that Medicare is a federal matter but support is given for paediatricians, some speech therapy and some counselling from educational psychologists, but not for testing and so on. That is about the sum of it. People must pay for everything else, and that is it.

Mr J.H.D. DAY: Unless they can get access to the state government funds services but, as you said, the waiting time is very long. Do you believe that additional people would be available if more resources were made available for those services? Would the professionals be available?

Dr Ridden: Are you asking whether there would be consultants to employ?

Mr J.H.D. DAY: Yes.

Dr Ridden: I have no idea. You would need to talk to the appropriate health professionals about that.

Mr M.P. WHITELY: I have two question related to the conversation that we had earlier. You said that you have disability funding for 15 children. Do you get it as a pool of funding or is it tailored to those specific children?

Dr Ridden: We apply to the Association of Independent Schools, which disperses the money on behalf of the commonwealth and state governments. Each child is ranked on a point score as to how serious the disability is and how that affects the funding.

Mr M.P. WHITELY: I am familiar with that. What I really want to know is what you do with the money. Does it go into general funding or is it used specifically for delivering a teacher's aid for particular children?

Dr Ridden: It is targeted to the children, but in all sorts of different ways. We might buy resources with it, we might pool the money to buy resources or we might sometimes pool the money to buy a teacher's aid. We sometimes also use the money for a particular child to target a particular program. Those children benefit and we must be accountable to make sure that those children benefit from that funding.

Mr M.P. WHITELY: My second question relates specifically to page 4 of your submission. You say that the hearing and sight tests that have been conducted in schools in the past have been inadequate because of their superficiality. You say also that the tests identified only students with obvious impairment of the senses, adding little to the observations that the parents or teachers have made. You might want to prepare some documentation on this. I would like some real detail about what is missing; in other words, other than whether a child can hear a sound or can read eye chart.

Dr Ridden: That is basically what is done.

Mr M.P. WHITELY: Can you tell us what is missing? We are really interested in what specifically we should be testing for beyond that.

Dr Ridden: I think I indicated some of those things, if only in summary form.

Mr M.P. WHITELY: I would really value the detail of what you think is missing.

Mrs Benson: The tests done in the schools take only between two and five minutes. The tests we are talking about with an audiologist might take an hour or an hour and a half.

Dr Ridden: Prior to that piece of the submission you just mentioned, I suggested that speech and language screening was needed to identify both articulation problems and language development problems and that there needs to be screening for physical development, which includes gross and fine motor skills, audiology and vision testing. They would seem to me to be the key areas. We are talking about screening. The difference between a screening and an assessment is that a screening is, if you like, the first dab or superficial assessment that identifies whether one child is fine and another child has some problems. A complete assessment delves deeply into the sources of the problem. The screening simply identifies that there are genuine problems.

Mr M.P. WHITELY: I would still like to get further detail from you. Your submission says that the detail is missing. What we want to know what that is so that we can make practical recommendations about the things that we should be doing in the screening and testing processes. It may concern peripheral vision; I do not know. That is the question—we do not know. What do you think is missing, specifically?

The CHAIRMAN: Do you have any numbers you can give us on the number of parents who have reported to have been turned away from PMH recently?

Dr Ridden: That was a particular response to a particular child who, at the age of six, attacked people and the child had to be disarmed and so on. The family was both physically and emotionally in tatters and I told them that if they turned up at Princess Margaret, the hospital was obliged to deal with them. The mother came howling to me on the following Monday morning and said that they would not take her; they just turned her away. I have been told since that that is true. I am talking about idiosyncratic information.

The CHAIRMAN: We have to wrap up the hearing. Do you have a quick comment on the following proposition; that is, in the screening of the students you have coming in, you have described that there are a large number of students at risk and that a large number of people are being screened who need external consultants. Does it also challenge you to explore your classroom pedagogy and to have an evidence-based approach to responding to the global cohort of students that are there so that they have a rich and successful educational experience as the first task you have as educators to challenge your current educational environment for that cohort?

Dr Ridden: That is where we start and where we are all the time. I am being presumptuous, but we are a good school. That is our bread and butter. We look every day at exactly what we are doing and how we are doing it. Chris, my other deputy and I spend a lot of our time talking to teachers about what they are doing and how they might do it differently and how we might address these issues differently. That is what we do. We even have a group of curriculum leaders, who are elevated members of the teaching staff, who work with teachers to help them to do what they do better. That is the initial focus for us. We will continue to deal with whatever students arrive at our door and we will continue to educate them in the best possible ways we can.

Every year we do a battery of standardised testing, which includes now the NAPLAN testing, but we were doing standardised testing long before WALNA ever came in to tell us we needed to. Every year we do that sort of testing. We sit down as a whole staff. We display all the results. We go through them all and we say, "What does this tell us? What are we doing well? What are we not doing well? Why are we not doing it well? What could we be doing better?" This is all the basic bread and butter of our job. It is beyond that that we are struggling to provide all that is necessary for all students who come into our school, and that is not our desire, that is our responsibility, and we take it very seriously. We work at every level to address it.

The CHAIRMAN: Thanks for that. I will wrap up by reminding you that your evidence before the committee today will come to you as transcripts for correction of minor errors. Please make any corrections and return the transcript within 10 days of receipt. If they have not been returned within that time, you are deemed to have agreed to whatever is recorded in the transcript. New material is not to be introduced and the sense of the evidence cannot be altered. Should you wish to provide additional information or elaboration on particular points, please include a supplementary submission when you return your corrected transcript of evidence. Thank you very much.

Dr Ridden: Thank you very much for your time. We appreciate it.

Hearing concluded at 10.40 am