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 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 9.10 am

ASHWORTH, MS MELINDA
Teacher, Warnbro Primary School,
examined:

RIMMER, MS SHARON
Pastoral Care Coordinator, Warnbro Primary School,
examined:

GREGG, MRS CARMEN
Project Officer, Investing in our Youth Inc,
examined:

PHILIPPS, MRS CLAIRE
Community Nurse, Child Health, WA Country Health Service—South West,
examined:

The CHAIRMAN: Thank you for coming this morning. I have the task of reading some material to you, which is to formalise the hearing. It sounds a bit intimidating when I read it but I will read what I am told to read. It is just a formal process that we go through. Apart from welcoming you, I have the task of saying to you that the 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, any deliberate misleading of the committee may be regarded as a contempt of Parliament. I have the task of asking you the following four questions and I need a verbal answer from each of you so that it is recorded by the Hansard reporter. I will go down the table from my left to my right. 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 witness 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: We have the opportunity to try to cluster some of the school submissions together. Unfortunately, some people from the school committee who were going to be here were unable to make it but we may be able to get some other schools to appear before the committee before we finish. The committee has received a variety of submissions. Would anyone like to make an opening comment about the committee's terms of reference and any thoughts you want to put before the committee? I am not asking those of you who have provided a detailed submission to repeat it, but you might want to emphasise any major points that committee members could usefully hear about from any or all of you. Does anyone want to volunteer to start?

Mrs Gregg: The committee's terms of reference are for pre-primary schoolchildren. I would like to bring to the attention of members that our focus is earlier than pre-primary. We are promoting intervention in the zero to four years age group.

The CHAIRMAN: Are you promoting that because you see that as an opportunity for effective intervention?

Mrs Gregg: The research is telling us that early intervention is most effective because of a child's early brain development. There is a window of opportunity in that early age group.

The CHAIRMAN: Does anyone else want to emphasise any of their own thoughts on the terms of reference before the committee?

Mr P. PAPALIA: That might be confusing because we have disparate groups.

The CHAIRMAN: Can the member suggest a methodology of how we might extract from the witnesses any thoughts they want to put before us?

Mr J.H.D. DAY: We could follow up on what Mrs Gregg said. Mrs Gregg, can you elaborate on the program you are providing and the involvement that you get from government and non-government agencies? What is the status or condition of early childhood intervention services, which I agree are very important? How do you see their role the community at the moment? Are they as extensive as they need to be?

Mrs Gregg: I will include my colleague in this response. My colleague is a community health nurse. One of the benefits of our program is it is a great opportunity for the Department of Health and the Department of Education and Training to work together. The basic principles of our program are that it involves training teachers in a partnership approach so that they learn to work on the existing strengths of parents. The teachers do not operate from a professional position of power. Other main elements of the program are the home visiting and play cafes. Our play cafes provide an opportunity for visiting health professionals to visit and for the parents to ask questions of the health professionals. There are several opportunities for early intervention. Would you like to make any comments, Claire?

Mrs Philipps: Yes. This is a chance for the Department of Health to collaborate with the Department of Education and Training on matters relating to the zero to four-year-old age group in a way that has not happened previously, certainly in our area. The program came about because there is a kindergarten in the same street as my clinic. Although we had never met, through various conversations, Fiona Farren identified a cohort of children in the kindergarten who were not fully prepared for kindergarten because of speech delays and underdeveloped social interactions. We have worked together to see if we can improve that situation by doing something different. Fiona Farren came across the model of having a play group for the second and third terms, based at the school on the day that it is not being used. The children have an opportunity to play together before they enter kindergarten. The beauty of that program is that a teacher is there and is able to enhance the skills of the children and mothers before the children are even enrolled for kindergarten. The teacher is also able to pick up on children who have a speech delay or other social problem. In collaboration with the visiting nurse, the teacher is able to act on early referrals for speech therapy or for a child to have his eyesight checked or to facilitate a parenting group such as the PPP program or a community health nurse to look at aspects such as toilet training or preparedness issues for kindergarten.

Mr J.H.D. DAY: For the record, where are you operating from?

Mrs Philipps: From inner Bunbury.

Mr J.H.D. DAY: Is that at a school site?

Mrs Philipps: My clinic is 300 metres from the school so I can walk to it to attend the play cafe. We are located in separate buildings. The program is operating in five schools in Bunbury.

Mrs Gregg: It is actually operating at six schools in Bunbury and one in Harvey. Bunbury is our regional site and Harvey is our rural site. This is a pilot program.

Mr J.H.D. DAY: Is the program operating because it is being driven from a local initiative as opposed to a coordinated program being encouraged from a higher level in the state?

[9.20 am]

Mrs Gregg: The history of the program is that the Department of Education and Training provided some seeding funds to release a kindergarten teacher to address issues of school readiness. That is where the program developed. The kindergarten teacher was able to do some research and get community input into it. That is the background of the program.

I think an important part of the program is that teachers are often the first outside the family to recognise that there is an issue. Because this program works across agencies, including ourselves—a not-for-profit agency—we have been able to give teachers a family service list so that they have all the information at their fingertips of possible local referral sources. I was wondering if I could table this for the committee. I have got five or six copies.

The CHAIRMAN: That would be great.

Mr J.H.D. DAY: I will follow up on that. Can you comment on what you think is the adequacy of the services on a wider basis of the type that you are providing? Is there the degree of support from the health system and the education system in the state you think there needs to be, or is there room for improvement?

Mrs Gregg: Perhaps my colleague can better comment on health. From the education perspective, I think there is always room for more knowledge than what is available and better linking between services. The LEAP program facilitates those better linkages.

Mr M.P. WHITELY: I have not got a clear picture in my mind of your client base. Are these typically families that are struggling to deal with young kids?

Mrs Gregg: We take a whole-of-population approach. Anyone can come to play cafes. The people that receive home visiting are people that are enrolled for kindergarten. It is not targeting a specific risk group, it is targeting the whole population. Does that answer your question?

Mr M.P. WHITELY: You talked about intervening with parents and working with parents. That would indicate there is something in the parenting that is dysfunctional. I do not have a picture yet. I am asking you to be pretty blunt about who you see and what their problems are. Do not worry about being politically correct, just tell us, warts and all, what the problems are that you are encountering and what you need to do with them?

Mrs Philipps: As Carmen has said, it is a universal program, so anyone can come to play cafes. However, by their attendance the teacher is skilled then to pick out those children that are struggling or have some types of problems. We cannot say that every family at risk attends because some families, particularly at-risk families, do not always access those types of programs. I think the evaluation that we did showed that we were able to intervene with not just the children that were very at risk, but lots of children that had moderate levels of risk.

Mr M.P. WHITELY: When you say "at risk", what potential problems are you identifying? What are they at risk of?

Mrs Philipps: Things like behavioural problems, speech delay, children that are socially not ready to interact with their peers, children that have not had exposure to things like painting, play dough, being able to sit and attend to an activity, being able to sit on a mat, listen to a story, cooperate in a group, to do a song; things that they will need to be able to do once they enter kindergarten the following year.

Mr M.P. WHITELY: Describe to me a child that is struggling with those problems and where they would go through your pathway? What would be provided and what external services would be brought in? If there is a medical pathway, tell us about that. I know I am asking you to generalise but I need to get a picture.

Mrs Philipps: That is fine. There is a child that has come into play cafe, the mother speaks to the kindergarten teacher and says, "I am having trouble with toilet training. My child is soiling himself and wetting himself. What am I going to do?" Your kindergarten teacher would phone me and say, "Little Johnny and his mother need to have an appointment to see you." They would come to the child health clinic, we would do a consultation, looking at PPP strategies to enhance toileting.

Mr M.P. WHITELY: PPP is?

Mrs Philipps: It is the positive parenting program. That is right across Western Australia; most nurses are trained in that, and other professionals. We would do a consult and then perhaps we would do a phone consult to see how that program had been followed to make sure that child then is able to achieve continence before they start school. That is looking at toileting. That is a big issue for kindergarten teachers. Another one may be a child who has got some delayed speech, the teacher has identified that. We can see them and give them some activities perhaps to work on and also do a referral through to speech therapy. So they have got something to work on while they are waiting for —

Mr M.P. WHITELY: Presumably most often for mum to work with the child?

Mrs Philipps: Yes.

Mr M.P. WHITELY: Toilet training problems or speech problems, the first instance is to give advice to mum on how to be an effective parent?

Mrs Philipps: Yes, and we have handouts and programs that our speech pathologists have done that we can easily give. If they are having problems with things like book sharing, problems with their first words, or with clarity of speech, we have got things they can do while they are waiting.

Mr M.P. WHITELY: So the genesis of the problems you are describing there are not medical, they are basically coming about because of their environmental, if you like, appearance?

Mrs Gregg: Occasionally you see medical problems, like food allergies, they get referred on. Issues for the dietician will get referred on. Issues for the speech pathologist will get referred on.

Mrs Philipps: Children with glue ear who need to see an audiologist. Also, at play cafe you are able to get the richness of a family situation. Perhaps mum has got PND, perhaps she has had a new baby, or there is a new parent who has just moved to the area with a child who is autistic. I am trying to think of one I spoke to last week. She does not know anybody. We were able to link her into services just through a conversation. It is looking at the social aspects of the child as well as medical problems; looking at the child as a whole.

Mr M.P. WHITELY: You touched on a point where you said that quite often families at risk do not engage; they are not functional enough to even get to that first step. One of the primary thrusts of this inquiry is looking at health screening—by that I mean eyesight etc. What you are identifying is a different set of problems that are nonetheless real. How do you generalise those services? Obviously you provide a good service, it is picking up a real need. This is not a criticism, but it is obviously fairly hit and miss because parents are not all accessing the service.

The CHAIRMAN: It is a voluntary service.

Mr M.P. WHITELY: How do we generalise without interfering too much in people's lives?

Mrs Gregg: Every parent that enrols their child at kindergarten is offered a home visit.

Mr M.P. WHITELY: Is that generalised or through you guys?

Mrs Gregg: This is part of our program. It is about them having an opportunity then to build a relationship with the teacher. I guess not every family will have issues. Maybe three-quarters of them are well adjusted and doing well, but it is still building the relationship. They feel they can then talk to the teacher if they have got anything that is concerning them. It leaves the path open for the teacher to make recommendations for them to feed into other services if necessary. That is offered to every kindergarten school child.

Mr J.H.D. DAY: What about pre-kindergarten? You mentioned you are concerned about zero to four years of age. I understand the theory of why that is important, but how do you capture those groups and are there many or any who are missing out who really do need assistance; and, if so, how could things be improved?

Mrs Gregg: We promote the play cafes. Play cafe makes use of the kindergarten space on a day when kindergarten is not operating. We encourage families with zero to four-year-olds to come to play cafe. You might have babes on hips and you might have two-year-olds. We find that those parents are really hungry for knowledge and really appreciate the opportunity to be able to interact with teachers and visiting health professionals like Claire.

Mr J.H.D. DAY: Would you say most families in your area who would benefit from that involvement actually are attending, or are there others who are missing out? It might be hard to tell, but you might have some feel for the situation.

Mrs Philipps: If I could comment on one of the schools, Withers, which is in a state housing area; perhaps a low socioeconomic area. The kindergartens there were having problems with lower enrolments and with the play cafe program over the past year to two years, they have noticed an increase in their enrolments in kindergarten because parents actually are aware of kindergarten, they are aware of the importance of it and they are going to play cafe in that particular area. The kindergarten teacher is tailoring her program for those parents of that lower socioeconomic group.

[9.30 am]

Mrs Gregg: I realise that that is a really good question, though. How do you get those people at risk? We have been talking to the Department for Communities, and we are encouraging the Department for Communities to refer people to play cafes.

Mrs Philipps: And DCP as well.

Mr J.H.D. DAY: And are they doing that?

Mrs Philipps: We are just starting those discussions now with DCP.

Mrs Gregg: We cannot claim to be getting 100 per cent of families, but we think we have the best model at the moment to reach as many as we can.

The CHAIRMAN: Sharon, I wonder if I could just turn to you briefly. You mentioned the conference that you had been to. I think it was described as the Australian Health Promoting Schools Association National Conference. Following that experience at the conference, have you got some thoughts on how you see the health and wellbeing program assisting the health screening programs in primary schools? Do you have some thoughts that you want to share with us?

Ms Rimmer: Thank you, Tom, for asking me. What I would like to see happen in our Peel district, and obviously in all schools in WA, would be to have the title of a health promoting school. I have the whole protocol here in the outlines. If it is presented to each school, obviously it has to go through legislation that we set up these guidelines so that we are targeting the health and wellbeing of our students—mental health and obviously obesity, diabetes and what we are targeting. That is actually in the folder that I have for each one of you.

The CHAIRMAN: Do you have a copy that you want to give to us now?

Ms Rimmer: Would you like it now?

The CHAIRMAN: Yes.

Ms Rimmer: It is quite in depth. I have a copy of all the health and wellbeing programs that we run at school. If I may, I will refer to David's copy at the moment, because I have left mine in the car at Rockingham. I am sorry. There are quite in-depth protocols and guidelines for health promoting schools. However, what I would like to read to you is the role of our school nurse and what we wrote together to present to you. It is after the health promoting section. It is nearly at the end of the file. I will read it to you —

> The role of the school nurse has changed significantly over the past decade. Five to ten years ago the school nurse would visit a primary school weekly and be available to provide advice and services to children, including a full screen on every child, ie vision, hearing, weight, height, speech assessment, fine motor, gross motor including skeletal and feet assessment. There were also subsequent screening performed for vision in year 1 and year 6.
>
> In 2008 children are screened on school entry only for vision and hearing and other children deemed at risk are targeted for a full screen (eg refugee's, aboriginals, children with disabilities, foster children and children of parents with a mental illness.) While the population of many areas such as Rockingham has increased significantly, the FTE for school health nurses has not changed for a number of years.
>
> Much of the screening and referral for speech and fine motor/gross motor is now performed by the class teachers with nurses offering advice and support as required.
>
> As families are not offered a universal child health visit at 3 to 3 1/2 years any longer, there is often a gap in services and early detection of children from 18 months to school entry where many of the developmental issues are often first identified (in kindy). Also the wait lists for child development centres are extremely lengthy for allied health services such as speech and OT. This means that the intention of early intervention is not achieved as the therapy may not be able to start until the child is 5-6 years old. In particular for children with a suspected developmental delay the wait lists for paediatrician appointments is very lengthy, compounded by the medical officer position in Rockingham CDC not being filled for nearly 12 months.
>
> For older children, the screening and health promotion for scoliosis has also been phased out.
>
> School nurses are involved with a lot more health promotion in schools than ever before. Including Triple P, Rainbows, Nutrition information sessions with parents and children, Crunch and Sip Implementation and they work collaboratively with the Local Drug Action Group and other organisations to provide Education to year 7's at a conference annually.
>
> There are also new things in the pipeline such as the introduction of a developmental parent questionaire to be introduced in 2009 and assessment of BMI and addressing obesity issues to be introduced over the next 12 months.

That gives you an outline of what is happening.

Mr M.P. WHITELY: Is that something that you have written yourself?

Ms Rimmer: With our school nurse, Merilyn Dare, yes.

Mr M.P. WHITELY: And she has presumably worked for a long time in the field, has she?

Ms Rimmer: Yes.

Mr M.P. WHITELY: So these are her observations of what has happened.

Ms Rimmer: Yes, and that is sort of an overview of her role.

Mr M.P. WHITELY: That is very useful.

Ms Rimmer: Yes. Throughout my folder you will see lots of programs that we run at our school. We focus a lot on the mental health and wellbeing and security and safeness of our school. We were third last year in the pastoral care awards in the state for the programs that we are running. Our lengthy file will fill you in and hopefully give you lots of information on what happens at our school.

Ms Ashworth: Just to back up Carmen and Claire, we have introduced a zero to four program at our school over the past—it would be close to—18 months. Last year, initially for six months we probably had only about 20 people. Again, coming from the early childhood teachers, there was the need for work on the nutrition issues, the social skills and the behavioural issues. Speech particularly was increasingly an area that we wanted to work on. We now run our zero to four program over two mornings at our school, based on the fact that we now have 72 children coming. A lot of those programs just answer the needs of the clientele that we are getting. I do not know whether we are fortunate that we have really focused on recruiting, I suppose. If the financially at-risk families have siblings within the school already, we try to again, I suppose, target them to get them in early, knowing that a lot of those families—this is generalising, I know—are at risk financially or have emotional issues within their homes. We have really gone out and made a point of trying to get them to come along, and I would say that a lot of the very young mums who are coming to our zero to four program particularly are from our at-risk families. I suppose we made a concerted effort to really target those families. They are open to anyone, but we certainly did target those families.

The CHAIRMAN: And you target them in what way?

Ms Ashworth: Just grabbing them while they are at school and encouraging them. I know that there are five particular mums that I worked with, and getting them along was then basically them getting to those other friends. That is a lot of the way in which we ended up doing it. We did just a general little letter—like an advertisement, I suppose—that we sent home to all the parents, but we posted it to a few families so that we knew that they specifically had it. Again, it was nothing forceful and nothing was expected of them. We have been fortunate in that we have a lot of those who come along.

The CHAIRMAN: Thanks very much for that. Reference was made to the child development centres. Which child development centre do you draw upon? Do you have one in your area?

Ms Rimmer: Actually, no. Merilyn works for the Kwinana community health centre. She is based there with the other school nurses. Otherwise we can access the early intervention service through CAMHS, which is the Child and Adolescent Mental Health Service, or the Kwinana adolescent mental health service, I think it is.

Mr J.H.D. DAY: What are the waiting times like for those two services?

Ms Rimmer: I know that one child waited 18 months for an appointment for speech therapy, which was referred through preprimary. You would be lucky to get in within six months. It would be fantastic if you ended up with an appointment within six months. Six to 18 months can be —

Ms Ashworth: I have two students in my year 2-3 class, and their appointment is not until July next year.

Mr J.H.D. DAY: How long have they been waiting?

Ms Ashworth: I put them in in February.

Ms Rimmer: At the start of this year.

Mr J.H.D. DAY: So that is 18 months.

Ms Ashworth: Yes.

Ms Rimmer: Eighteen months is about an average.

Mr P. PAPALIA: What service are they waiting for?

Ms Rimmer: Speech.

Mr J.H.D. DAY: You mentioned that, Sharon, in your comments. I was going to follow up about the adequacy of the therapy services, both for assessment and treatment. I guess you have just given some indication of that, but do you want to elaborate on that aspect?

Ms Rimmer: It is pretty cut and dried really. There is a lengthy wait. Sometimes when the appointment comes through, the parents say, "I'm over it." So there goes that waiting time, and then that child is not progressing, so it is a bit of a tricky —

[9.40 am]

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

Ms Rimmer: Maximum? I am sorry, what should it be?

Mr J.H.D. DAY: What should be the maximum for a good outcome?

Ms Rimmer: The maximum I would like would be six months and then you would be wanting a regular appointment. Even within six months, if that child has not progressed and at school, they are victims obviously if they are having problems.

The CHAIRMAN: On the same point, though, Sharon, are you aware that some schools buy in with their own resources the additional support of a professional like a speech therapist?

Ms Rimmer: Yes, very aware.

The CHAIRMAN: Has your school been able to utilise any of its own resources to harness all this —

Ms Rimmer: Access that?

Ms Ashworth: On that, last year in 2007 I was the learning support coordinator at Warnbro. I pushed very forcefully to have some of our FTE allocate an extra amount, I think it was only 0.2, which was a whole day a week where we had the Rockingham occupational health —

Ms Rimmer: Occupational therapist.

Ms Ashworth: Yes, occupational therapist from our local health group came in with the kindys and preselection where she worked with those kids who had come out as being at risk in speech or OT. So we had her, as I said, and that came out of our FTE last year. I am not the LSC this year and I know that that has been cut, but I mean that was just a school decision.

Mr M.P. WHITELY: I hear what you are saying about a lack of access to speech therapists and long waiting lists. As I understand it, there are not enough speech therapists in any case.

Ms Ashworth: That is right.

Mr M.P. WHITELY: So, you know, let us be realistic, there are budgetary constraints. We could say, "Look, kids in every school should have a speech therapist and every child should have their needs met." You know, the chances of being met are probably fairly minimal. What can be done for the sorts of services; what can be done for these kids to provide perhaps from trained teachers or education aids, or what can be done to fill those gaps practically?

Ms Rimmer: You could still train your EAs, the education assistants, but then when you have special needs EAs—obviously there are some tricky kids they work with and most of their time is dedicated to that—but that would be good having someone trained. However, there are other things that you need to do in school and you cannot always say, "Right, this day because you're trained in speech therapy this is your role." It is impossible in a school because you are called to do this and called to do that.

Mr M.P. WHITELY: I guess I am asking you, as somebody who works with these kids, to put yourself on this side of the table.

Ms Rimmer: Yes.

Mr M.P. WHITELY: When I was a teacher we had budgetary constraints. What would you say we should be doing?

Mrs Gregg: Can I offer a suggestion?

Mr M.P. WHITELY: Yes.

Mrs Gregg: Getting back to the play café model, every now and then we are able to access a speech therapist who will come to the play café; so that is one speech therapist who is getting exposed to 20 to 25 zero to four-year-olds and there are opportunities for the parents to ask questions. There are opportunities for the speech therapist to set some plans in motion; would you say, Claire?

Mrs Philipps: Yes.

Mrs Gregg: And our colleagues in health think this is a very efficient and effective use of their time.

Mr M.P. WHITELY: So they are training mum typically?

Mrs Gregg: Yes.

Mr M.P. WHITELY: To actually work at home.

Mrs Gregg: Yes, and they always come with handouts and they leave leaflets.

The CHAIRMAN: Can I just put another proposition to you? I understand that a lot of the work of speech therapists is around phonemic awareness or phonological awareness, and that there is an argument that says that if you cannot get speech therapists, then the other way to do this is to make sure that the classrooms have got a teaching approach that is embedded into it, maybe mandated into it, a teaching phonemic awareness, or phonological awareness, depending which word you want to use. Do any of you have any sense of that, of the issue of whether your classrooms are set up in ways to avoid the need for people to be going off to these professionals by having a mandated style of teaching that picks up people with weaknesses?

Ms Ashworth: Yes, definitely, and coming from the learning support coordinator role, again, that role is within each school, and I know most schools now have them placed in there. I did it for the three years and I know that with the services that I was able to access through that role I was really able to then either train the teachers or offer them the programs that they needed to be running. I am just thinking of airrobics, for example, for the auditory process.

Mr M.P. WHITELY: Airrobics?

Ms Ashworth: Yes.

Mr M.P. WHITELY: How does that work?

Ms Ashworth: It is a computer program so that they are only focused on what they are listening to. It is phonological awareness, but it is also to follow instruction, the processing of what the story was about. So it is very literature based, but it is really focusing, though, on them to focus in on just what they need.

Ms Rimmer: Teaching themselves.

Mr M.P. WHITELY: So kids are sitting at a computer screen?

Ms Ashworth: Only for 15 minutes at a time for that session.

Mr M.P. WHITELY: There is a supervising teacher with a number of kids doing this, are there?

Ms Ashworth: Yes, there are two or three. We have two kids at a time in our class that do it, because we have got six students who have auditory processing issues. That is just one of the programs that I can think of off the top of my head that we have now implemented into the whole school, because we do not have assistance for all of those different learning difficulties that they have, of course. Again we understand why, but for the speech and stuff, yes, we definitely are very aware of what we need to do as classroom teachers to make that part of their learning. Our IEPs—individual education programs—come into it where you are catering to those needs, no matter how varied they are in your class. You have to be accountable, that those kids need that style, whether they have a speech or hearing disorder or whatever it might be; and I believe in the past two years that we definitely try to target that and take it away from the fact that we cannot get to those outside agencies, you know, for whatever reason. I think definitely coming back to having the dental nurse, the health nurse, the speech pathologist at our zero to four programs, I mean that is a huge point that I think is the best way to get to these parents.

The CHAIRMAN: Melinda, can I just quickly finish my question?

Ms Ashworth: Yes, sure.

The CHAIRMAN: You, through the skill of your persuasion of the teachers, have been able to get them to adopt the approach in your school.

Ms Ashworth: I would say 70 per cent of the staff. There are always those resistant.

The CHAIRMAN: This is an optional teaching style in terms of this approach that is aimed at being inclusive, at picking up the learning difficulties of all the children in the class.

Ms Ashworth: Definitely.

Mr P. PAPALIA: I have a question that kind of follows on from that for Sharon. Does your position as the health and wellbeing coordinator exist because Kerry has decided that she wants that position funded and that she allocates her funds to you, or is it a standard position in schools?

Ms Rimmer: I am actually funded as a level 3 special needs EA and I am attached to a vision-impaired girl. Obviously the school and the class is set up; she does not need 100 per cent of my attention. She is made independent; however, I am there when I have to be there. So this role has come because we implemented a health and wellbeing program so I was able to fall into the role. However, at the end of this year the girl I work with goes to high school so my funding has come to a halt.

Mr P. PAPALIA: So that in effect it is just an —

Ms Rimmer: It is an in-school —

Mr P. PAPALIA: —opportunity that was taken.

Ms Rimmer: Yes, and to be able to promote and get our school up with more health and wellbeing and focus on the target of pastoral care.

Mr P. PAPALIA: Is it duplicated in any other schools that you know of?

Ms Rimmer: No. We actually, with our health and wellbeing program, set up a national read again in my file about our pastoral care room in the programs we have run. We have actually showcased our school to a couple of other schools in our area who want to set up the same but do not have the staffing or one particular person assigned to it. So in the way we have set it up we are very, very lucky, but after this year we do not know. We have to find funding or draw some funding from other—because obviously we want this program to be ongoing because of the results we have had with our students and community.

Ms Ashworth: That is right. Going on our achievements that we have had with the students and parents, I really think that the sustainability will be our priority for the future. Did I answer that right, Paul?

Mr P. PAPALIA: Yes. That is what I wanted to know, whether it was —

Ms Ashworth: So is it 0.4 of your FTE at the moment but then once the student goes it will basically have to go?

Ms Ashworth: Yes.

Mr P. PAPALIA: So then it will be up to Kerry and the principal to determine —

Ms Ashworth: It is up to the discretion of the school —

Mr P. PAPALIA: — whether or not it should be funded.

Ms Rimmer: We have started looking at it now, so —

The CHAIRMAN: I am sorry; the Hansard staff are trying to report it and it is difficult to have a conversation. I have to protect their workplace environment as well; so, one at a time.

[9.50 am]

Mr P. PAPALIA: I think the committee has the gist of the answer. There is no direct funding for that role; it is a management initiative of the principal.

Mr M.P. WHITELY: Can I ask a general question? It is open to all four of you to respond. I do not know whether this is a legitimate concern, but at the compulsory entry point for formal schooling in year 1 there is such a diversity of backgrounds, from children who were read to at the age of 18 months and were given picture books, through to kids whose parents are busy, have a huge mortgage and two jobs and probably do not have time to do that sort of stuff because they have five kids and it just has not happened. My concern is that we may be almost setting kids up with prerequisites for attending year 1. Having missed some of the experiences that the other kids have, they are actually gapped before they have even started their formal education. Is that a legitimate concern, or am I jumping at shadows?

Mrs Gregg: In education we talk about "school readiness"; that term is used a lot. That is why we think it is important to concentrate on the zero to four group, so that when kids come to school, they can make the most of the opportunities that are offered there.

Mr M.P. WHITELY: Is there not a danger in that? There will always be a couple who get left behind. I have not talked about the cohort whose parents simply do not have time because they are working to pay the mortgage and feed the kids.

Mrs Gregg: We do not accept that there should always be a cohort that will be left behind. We think that if we can get in there with early intervention—the earlier the intervention the better—that will set kids off on a better trajectory.

Mrs Philipps: It also saves money in the long run. If we can put speech therapy in place at the age of three, it is far better than for them to be trying to get into a long list at the age of seven.

Mr M.P. WHITELY: What should kids be able to do from day one of year 1? That is the question I am asking. They are obviously not a blank page.

Ms Ashworth: Basically, I think for ages zero to four, if there is an intervention to get those services involved—in this case, there is—the main focus is the social skills that we would want any child to have. I know that our focus is not academic. It is all about play and social and emotional development. That is our only focus.

Mr M.P. WHITELY: Is it good or bad for kids to be in intensive day care? I do not have any experience of that. My own kids did not go through that.

Ms Ashworth: It is a real mix. If I were to generalise, yes, those children have social skills exposed to them, but sometimes there are definitely emotional challenges that come out.

The CHAIRMAN: My task here is to intervene, because we have other witnesses coming. I thank you all. If there are any points you wish to emphasise before you leave, what would you like to say?

Mr J.H.D. DAY: Before you do, following on from what the Chairman said, can I ask you to reiterate or elaborate on what you think is the adequacy or otherwise of both early intervention services and therapy services, and what you think needs to be done to improve the situation, if it needs to be improved?

Mrs Philipps: I did not really get a chance to talk about the pilot program that we looked at—the three and a half-year-old parent assessment of development that we did at South Bunbury last year. At the kindergarten orientation, every parent who came with their child was asked to complete a set of health questionnaires on arrival; it took them about five minutes to complete. We were able to get a good health history for all of those children before they actually started kindergarten the following year. This took place during term four. In the community, I see very few three and a half-year-olds who have had a health screening. It is available; it can be accessed, but we just do not see them. It is a very mobile population. We had a captive audience of mums and dads. We had an afternoon session and an evening session to cater for working parents. The parents filled out questionnaires about their child's development, looking at speech, hearing, social development and the whole aspect that we currently use. Next year it will be parent evaluation of development—PEDS—so it will actually be a validated tool. Parents will have the opportunity to speak to me, and from that we actually had children referred, before they even started kindergarten, for speech therapy, behaviour management through PPP, and toileting. The kindergarten teacher had a profile of her whole student population and their health needs before they had even started kindy. The other great thing about that was working with the teacher. She was able to actually do the developmental questions for the children that I did not see because I was not there at the time. At that session we were also able to provide information about immunisation, nutrition before school, general behaviour management and things like sleep and breakfast—real basics that for some families are very difficult. That program will be rolled out to the other five schools in Bunbury this year, so we will actually be doing a health developmental screening of children before they even get to kindy.

Mrs Gregg: I urge the committee to look at early intervention because research tells us that that is the most effective tool. We think we have a model that is very cost-effective, and resources are shared across health and education. We are thinking of different build-ons to add to that model all the time. It is very exciting.

Ms Rimmer: I reiterate my point about budgets and the importance of resource allocation within the schools to achieve our sustainability. That is the most important thing. It is really good to see guidelines for health being promoted in schools, to promote health and wellbeing in our schools. I hope that I will get some feedback from the committee.

The CHAIRMAN: Thank you very much. We have one minute before our next witnesses arrive. I think we have a job to do for you. A transcript of your evidence will be sent to you. If it has to be corrected in minor detail for the purposes of accuracy, please send it back to the committee within 10 days. Thank you very much.

Hearing concluded at 9.56 am