Corrected

REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO EARLY INTERVENTION INTO LEARNING DIFFICULTIES

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At Sydney on Thursday 2 August 2001

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The Committee met at 9.00 a.m.

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PRESENT

The Hon. Jan Burnswoods (Chair)

The Hon. Dr Arthur Chesterfield-Evans
The Hon. Douglas Moppett
The Hon. Ian West

LINDY LOUISE DANVERS, Child and Family Health Nurse, affirmed and examined:

CHAIR: We know you have received a summons, because we gave it to you. Would you like to commence by making a statement to the Committee explaining who you are and what you do, or would you prefer to go into our first question about the role of a child and family health nurse?

Ms DANVERS: I think probably going into the questions would be fine. I have brought along some documents that you may wish to have copied.

Motion by the Hon. Dr Arthur Chesterfield-Evans agreed to:

That the documents be accepted by the Committee.

Ms DANVERS: The documents I have brought along include the Child and Family Health Nurses Association submission to the Senate Community Affairs Committee into Nursing; the draft position paper on the scope of practice of the child and family health nurse, which answers a lot of your questions; the aims of the association; a brochure outlining for members the benefits of the association; the competency standards for child and family health nurses; and a copy of the journal that the association puts out on a regular basis. Those documents may answer some of your questions.

CHAIR: Would you like to advise the Committee on the role of a child and family health nurse, the qualifications you need and the settings you work in, and the aims of the association and its membership?

Ms DANVERS: I have taken some time to prepare answers to make sure that I am quite clear about giving you all the information. So if it is all right, I will simply read what I have written and then you can ask me about any further matters.

The Child and Family Health Nurses Association document on the scope of practice describes the nurse's role, context of practice, principles of nursing care, and education and preparation. That is one of the documents I have provided to you. I have taken out of that document some aspects of it.

The nurse's role is centred around a holistic approach to families through education, parenting support and counselling, and promotion of optimal social, emotional and physical development of the child. The nurse's role includes health surveillance of infants and children, along with educational and nutritional advice and role modelling for parents given age-appropriate activities, to encourage development. Primary care intervention is provided, along with nursing management of common health and behaviour problems in children. The nurse's role in the context of the wider community is important in defining the needs of the community in advocacy and planning appropriate services.

The principles of nursing care and child and family health are based on the principles of primary health care and health promotion. Its customary autonomy provides continuity of care with long-term involvement in a supportive and non-threatening environment.

Educational preparation for child and family health nurses, that is post-registration education, should be a formal, recognised educational qualification for child and family health nursing, at least at a graduate certificate level but preferably at graduate diploma or masters level.

CHAIR: When you say "should be", are you saying that at the moment it is not?

Ms DANVERS: That is correct; it is not a requirement. At the moment it is up to each individual area health authority to define what they did as an appropriate education level for the child and family health nurse.

CHAIR: Would every nurse have the fundamental nursing qualification?

Ms DANVERS: Yes.

CHAIR: Do you have any idea of what proportion of nurses might also have a graduate certificate for some other specific training?

Ms DANVERS: I do not know, but that information would be available through the New South Wales Nurses Association registration survey that is conducted each year.

CHAIR: Just off the top of your head, do you think that the majority of the people we are talking about would have specific qualifications, or would you think that their skills would come from more experience?

Ms DANVERS: A lot depends upon the manner in which the area health authority implements the program. I will read what I wrote about models of service delivery, which may help you.

Service delivery models are defined at area health level. Some area health authorities support a generalist model, where the nurse provides services from birth to aged care. In that case, the nurse may not necessarily have a qualification in early childhood. Other areas operate a specialist model where nurses focus on families with children.

Ideally, the child and family health nursing service would provide early childhood and school health services and be part of a multidisciplinary community-based child and family health team. In this way, the nurse provides the primary care service, with referral within the team to secondary level services such as occupational therapy, speech, physiotherapy, medical and counselling. This provides the client with accessible family-focused community-delivered services. This multidisciplinary team also provides professional support to the nurse and facilitates case conferencing, interagency liaison and continuity of care for the client.

In answer to your question whether every person would have the qualification, not every area health service would require that qualification. However, the opinion of CFHNA is that if a nurse is delivering a child and family health service, we believe she should have appropriate qualifications to do that. This point is outlined in our scope of practice document, which we have submitted to the Department of Health and to the Health Department's working group on health home visiting guidelines. As you would see, we had Judith Meppen, who is a senior nurse, endorse the competency document. However, competency and scope of practice documents are all documents that we as a professional organisation have put forward; it does not mean that area health authorities have to use them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there a problem of a shortage of nurses? Is there a problem that some area health authorities want to have this cradle-to-the-grave model? What percentage of nurses who are practising in early childhood have the qualifications that you would like them to have?

Ms DANVERS: We have 350 members in New South Wales. All of those 350 members have appropriate qualifications. Our association is part of the wider national organisation of 1,200 members, all of who have qualifications. In Victoria, it is a requirement set down by government that the nurse has a graduate diploma in childhood and family health or the equivalent. So government has put down that requirement. In New South Wales, that requirement is not put down. Therefore, as I have said, it is up to local area health authorities. Many nurses who work in a generalist model do not have child and family health qualifications. In fact, I would probably say that most nurses who work in a generalist model do not have child and family health qualifications.

CHAIR: Does the more generalist approach tend to be used by health services in rural and regional areas, and proportionately are there more specialists in the city?

Ms DANVERS: Yes.

CHAIR: As you know, the Committee has just returned from a visit to the Dubbo and Coonamble region. I recall that when we spoke to members of the Isolated Children's Parents Association they spoke about the cradle-to-grave model in the Hay and Rankin Springs area, and so on. I guess you can see why that may be the case. If there is a shortage of nurses, particularly in rural areas, I suppose the more general model would be favoured as providing at least some coverage. In the city area, would most of the people we are talking about have the qualifications?

Ms DANVERS: Yes. In metropolitan Sydney, it would be a requirement for nurses to be registered nurses with additional qualifications in child and family health, and many of them would also be midwives.

CHAIR: Most of your 350 members would be working in the Sydney metropolitan area, would they?

Ms DANVERS: All of our 350 members are qualified, yes, but not all of them would be in the Sydney metropolitan area. We gauge that there are about 450 to 500 nurses in that practice group and 350 are our members, so it would be a reasonable spread across New South Wales.

CHAIR: And your 350 members are in employment, are they?

Ms DANVERS: Yes. Many people talk about staff shortages but there are nurses out there who are qualified . There are available courses in the city but also as distance education. However, the issues surround incentives to join the work force and retention. CAFHNA members have identified the following issues. Incentive issues are the pay structure versus those in other careers. They are deciding that they can get better paid by working in a different career. Another issue is joining a work force that is stressed with heavy workloads. Those that are in the work force are dealing with anger and resentment from clients with problems who are unable to access services because of inadequate provision of services. There is underresourcing compared with other professionals. For example, there is a lack of what would currently be recognised as reasonable equipment such as computers and faxes. There is no secretarial support in these services. The funding priorities of the area health services are not focused on outreach community services. So the provisions of being in the modern age are not there. Communication is difficult, as Beverly would know.

CHAIR: Yes, we heard a bit about the telephone problems you are having. We are interested in that because our inquiry is about seeing what services exist. We are not really interested in lovely models on paper; we are interested in what really operates in various parts of New South Wales and also how each piece fits into the overall provision for children. Stuff on paper means nothing unless it is actually working.

Ms DANVERS: Some of the other retention issues that the nurses mention—this is very significant for them—include the lack of clinical career structure in community health. There are very few clinical nurse educators, clinical nurse specialists and clinical nurse consultant positions in community health. Yet these are recognised as part of the norm in a hospital environment. The need for clinical support and resources to provide clinical supervision in community health is not recognised. These nurses work in isolation. They are autonomous. They make an assessment of a child in a family and they make a referral. They develop a management plan, a review process, and they implement intervention, review the intervention and then make a referral. All of this is within an autonomous practice, often in an environment in which they are not supported by a multidisciplinary team and without a colleague to have any case discussion. So the issues of supervision and multidisciplinary support, case conferencing, are key to providing a standard of care and key to retaining the nurse in the work force. Many of the nurses you would have seen out west literally are hundreds of miles from someone else.

The Hon. DOUG MOPPETT: I think this cuts to the very heart of the matters that we are interested in in relation to where the medical model goes through a transition. You are starting to look at individuals and making these rather subjective assessments about their predisposition to learning difficulties later in life. It is easy to set up a system in which nurses feel confident weighing babies, talking about formulas and reflux and all this sort of thing, but then you get into this progressively more difficult area of assessing likely learning difficulties and developmental problems. Some people may say they will grow out of it and others will say that this is a precursor. The committee is interested in the point at which medically trained people, essentially, and with an administrative background that is health oriented, will have a cut-off and other people will take up the responsibility. Many children are just falling through the cracks and only show up when they arrive at school. Anything that you feel like suggesting to us is what we want to hear.

CHAIR: That is a big question.

Ms DANVERS: Yes, it is. To go back to the first question, the role of the child and family health nurse, I would see the role of the child and family health nurse as a primary care service deliverer within a supported team of multidisciplinary health professionals as the next level of care. That multidisciplinary team would include medical, speech, OT, physio—

CHAIR: Psychologists.

Ms DANVERS: Psychologists. The tertiary level of care would involve inpatient services, medical specialists. Those teams need to be part of each other or very closely linked. The secondary level of service may involve the GP or the GP may be at the primary care level, depending on the role that the GP takes. I would see the nurse's role as surveillance of the family, taking a holistic approach to the family, educating and supporting family to empower the parents to be aware of the normal processes of development. To take you through a nine months check with a baby, the nurse would sit on the floor and play with the baby. While she is doing that she is observing mother-child interaction. She is playing with the baby and assessing how well the baby performs, if you like, within normal developmental milestones. She is also role modelling for the mother. She would say, "He is doing this now and these are the sorts of things you can do next. You can play with him like this. These would be appropriate activities and these would be appropriate toys." She is watching mother-child interaction, she is observing the child's developmental milestones and she is role modelling for the mother the next step in encouraging development and play.

On top of that she talks to the mother about nutrition, solids, safety in the home, issues about the child getting up and crawling. I see that as a primary care role. Every visit should encompass assessment, education and role modelling. A nurse needs to be sufficiently educated to make a decision as to whether the family needs referral. Some of your questions are about screening tools. Screening tools should not be used in isolation as a yes-no answer. Our competencies say that screening tools should be used wherever available. They should be validated screening tools. As you would know, there are very few validated screening tools. The use of validated screening tools should always be in conjunction with observation, clinical practice, role modelling and all the things I have suggested.

A screening tool may be a component of your surveillance program but should never be used in isolation. For example, some areas use what is called a Woodside developmental screen, which has been validated in Australia. That tool can be used by an educated qualified nurse in a play environment with a parent to see where the child is at. It encourages the mother in play activities for the next stage of development. When I use it I will say to a mother, "You can see that Johnny is doing this. This is terrific. The next things that he will be doing are these. So the sorts of things you could do are getting down the floor and playing with him. You could use some balls, which would do this." That is how it should be used. The mother should not just be asked whether he is doing certain things that can be ticked off.

That is how I would describe the role of the child and family health nurse. That is a primary care service delivery. There need to be defined parameters in which the nurse is aware that a referral needs to be made. It is important that there is some defined parameter. Otherwise, as you say, children will fall through the cracks. My opinion on this may be different from the other person's opinion. That happens at every level of health care. The nurse may refer to the GP, who perhaps does not see a lot of children, who says to the mother that it is all right; do not worry about it. When the mother comes back to the nurse she will say that she is worried about it and that she thinks that the matter needs to be progressed further. Back at the primary care level the nurse does not have the parameters for referral and she may not make the referral. So we are talking about falling through the cracks at every level of service. To avoid that somehow we have to have agreed parameters on when we make that referral. There is current thought that parent concern is a good indicator and should always be taken seriously and acted on. However, some parents may not be in a position to be aware. For example, if a mother is depressed her interaction with her child will not be good and her concern would not be what it would be if she were well.

Some cultures may have different perceptions of opportunities for development. Some parents are not aware of what would be reasonable for children at that age. Parental concern should be taken seriously but balanced with health surveillance and education and support to empower the parents and to develop their knowledge. We can all see that. A parent with a first baby spends most of her time asking you whether something is normal. When she has a second baby she knows that it is fine. It is obvious that we need to give some input to the parent with the first baby. Society does not give that input today. If we had wider, extended broad families with very supportive communities mothers would learn to breast feed by watching someone else. They would learn how to play with children by watching. Currently, in our early childhood centres we have to have education groups on how to play with one's child, because parents have forgotten how to do that. Parents think that playing with their child is buying the latest toy on the market and giving it to their child.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When everyone knows that it is really doing what one is told.

Ms DANVERS: I am sorry, I am passionate about client health

The Hon. DOUG MOPPETT: Lindy, what you have said is valuable but it seems to me that if every child and mother could be exposed to an appropriate number of visits from one of your members, a great deal of the troubles that we are investigating would be over. I have not attempted to divide the number of children by 350 to determine the caseload that automatically suggests, but it seems to me that the problem is that fond aspiration you have described to the Committee is not the common experience of many parents. That may be because they are socioeconomically deprived, or in rural or remote areas, or there may be some other reason why that sort of support from such a well-trained, well-motivated and experienced person is not delivered.

What are your views about the lack of integrity in the network? What can be done to improve it? You have talked about a model that brings the mother and the child to a suitable point at which the learning process, through teachers, could take over with everything possible in place. The commission of this inquiry is to find out why that is not happening in so many cases.

Ms DANVERS: I do not know where to begin.

The Hon. DOUG MOPPETT: There are resources, including your people. Also there is a need for parent motivation on a voluntary basis to avail themselves of the service. Can you address that?

Ms DANVERS: I will walk you through a parent situation and the things that can or cannot happen. Once the diagnosis of pregnancy is made, the parents may visit and book in to a hospital at whatever time they choose. They may choose to be with their GP, with a hospital or with an obstetrician. Some obstetricians choose to not send their clients to booking-in services at a hospital, and therefore the client does not obtain the information. Antenatal care within a hospital framework is well provided and includes a lot of resources. Once the client is booked in, a monitoring process and an assessment of need can occur. At that stage there is an opportunity for the antenatal care program to be part of the eventual child's personal health record book; currently these are totally different.

Obviously privacy issues are involved; that is, the mother's record being combined with the child's record. Certainly, those two combined would begin a good record for the child. Once the baby is delivered, generally speaking most hospitals notify the community. However, there is not a requirement to do so. Therefore, that is an opportunity for parents to fall through the cracks. Generally speaking, parents who have at-risk criteria may be the parents who do not wish their information to be sent to the community.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it common that parents refuse to have their information sent from the hospital to the community?

Ms DANVERS: No, it is not common, but the next step is that in New South Wales there is no requirement for every family to be followed up, as there is in Victoria. If there is no requirement to notify, and no requirement to follow up, you are open to losing families. In Victoria there is a requirement that the labour floor notifies the community nurse and a requirement that the community nurse must follow up, as with a health visitor in England.

CHAIR: How does that work in a large specialist maternity hospital in Sydney? Does the Department of Health work out the nuts and bolts by simply looking up the mother's residential address? How does the notification get through to the services so that as many children as possible are picked up?

Ms DANVERS: Generally speaking the form is completed by a nurse or a clerk, but maybe not on a daily basis. Then, based on the mother's address, they advise the mother of the closest early childhood health centre and ask that she give permission for that to be sent. That information will be sent in the mail to the director of the centre. Some hospitals feel that that is not their responsibility and have said that they will not do that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In New South Wales?

Ms DANVERS: Yes.

CHAIR: Is that public or private hospitals?

Ms DANVERS: Mostly private hospitals.

CHAIR: So the public hospital system works the way that you have described?

Ms DANVERS: Generally speaking, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do the private hospitals refuse to do that?

Ms DANVERS: Yes. They give the discharge information to the mother. That means that the community nurse does not know that the mother exists. If the service does not know that the family exists, it cannot be responsible to follow up. Another reason that people fall through the cracks is because there is no concept within the community that attendance at such recommended visits is worthwhile. There is not a concept that "I am entitled to this", or "This is good for my child". Whereas Victoria has a community oriented program and its value is promoted by local government. In fact, it is proud of the service that it delivers. It has a 75 per cent attendance rate at 3½ years for vision. Recently I was in Victoria and saw wonderful posters asking whether the child had been vision tested. The council put up those posters.

There is a community framework that states that the parent is entitled to the visits and that they are beneficial for the child because they contain something that the parent can learn. So, there is a community framework, there is a health system issue, there is a legislation issue on a requirement to notify and a requirement for community health to follow up. Another issue is that if the community health services are required to follow up every parent, the services have to be funded. The Victorian Government has laid down a baseline program of visits to which every parent is entitled and has worked out how many hours nursing time it takes and has added issues of isolation and ethnicity. The program is loaded and is funded.

If the legislation states that a family has to be notified and requires a nurse to do a follow-up and report, and if there is a baseline service that is every parent's right, we are less likely to miss people. After that, we need appropriately qualified nurses, which Victoria has mandated, to visit the family and then we need defined parameters as to when the child is referred on.

CHAIR: Presumably you need a reasonably tight prescription of how often the child should see a nurse, say six months or 18 months or three years? That would have to be mandated within broad ranges?

Ms DANVERS: Yes. That would be the area of the developmental paediatrician of the State to decide what ages are appropriate.

CHAIR: The mandate would be, for example, four visits by the age of three years?

Ms DANVERS: Yes.

CHAIR: You would have a sense of what you wanted to achieve, and therefore what resources would be necessary?

Ms DANVERS: Generally speaking, there has been some agreement in the personal health record format across Australia, that that would occur at newborn, eight weeks, four to six months, seven to nine months, 18 months, 2½ years and preschool.

CHAIR: That is, even visits?

Ms DANVERS: Yes. Every parent has the right to access a series of new parent groups of eight sessions of two hours. On top of that you need to consider whether to build in the capacity to devote more time to the at-risk client, the client breastfeeding problems, the client with toddler behaviour problems, and other things. You need to build into the equation the fact that mothers with first babies will need more import and mothers with second and subsequent babies. While some people are critical that the Victorian model does not provide enough, it certainly provides every family with a baseline service.

CHAIR: What has gone wrong in New South Wales? Is the Health Department not interested? Does the department have priorities elsewhere?

Ms DANVERS: Yes, it has priorities elsewhere. In New South Wales funding for community health services has been historically on an ad hoc basis. It has never been a planned funding process. What you had last year you hope to have this year; what you had last year is probably what you had 20 years ago.

CHAIR: And you hope that the telephones work as well.

Ms DANVERS: Yes, it would be nice if my telephone worked. We are competing with large teaching hospitals which have the demands of purchasing more modern, expensive equipment.

CHAIR: So there is tension between preventative and community health and the usual big hospital, big equipment, high-tech approach?

Ms DANVERS: Yes, and with limited health resources every area health authority has to make its own judgment on its priorities.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It seems to me that at the moment we do not even have the resources to screen let alone fund a surveillance program. It might be one thing to stretch it to get a screening program to have a nurse to at least see all the babies, but it is another thing to have that within the framework of completely ongoing surveillance. To have uniform screening of everybody that is one resource level, but to get it within an entire surveillance program would need 10 times the resources again, would it not?

Ms DANVERS: No. There is ongoing discussion about what is screening and what is surveillance. Current research would suggest to us that sitting down and ticking off a screening tick box is not of value in isolation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It must be for the gross cases, though, some of which must still be missed?

Ms DANVERS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It may have some false positives and some false negatives for marginal cases. Presumably, the more marginal the case the greater false negatives and false positives you would get in the screening tool. The more gross cases the more reliable the screening tool will be.

Ms DANVERS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Obviously, the more support the nurse has the less false positives or false negatives, or mistakes if you want to call them that.

Ms DANVERS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have said that screening is not good if it is an isolated thing. I can see that that puts a loss of stress on the nurse to be right or for the child to display at the time of assessment whatever problem he or she has, which perhaps the child is not doing for whatever reason.

Ms DANVERS: And there is a need to have a validated screening tool.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sure. No-one would advocate using a screening tool that was not validated. That would be a bit gung-ho.

Ms DANVERS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably, validated screening tools are in existence, or at least every screening tool has a rating as to how valid it is. There is no absolute screening tool. There must be relative screening tools.

Ms DANVERS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: To what extent is it important to have, for example, universal access to childcare nurses as opposed to a more comprehensive surveillance program for screening? It seems to me that to have access to a nurse who is properly qualified would go a fair way, whether or not a screening tool is there. The next step in filling the cracks would be to make sure that the information is transferred from the hospital to the nurse to the school. Is that reasonable?

Ms DANVERS: Yes, it is reasonable.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Where should we put our emphasis?

CHAIR: The one thing we should do is get onto these questions about Families First and home visits.

Ms DANVERS: If I have not answered it, you might like to come back and I will think about it.

CHAIR: I am conscious of the time, as we always are. But, given that you have kindly prepared some written answer is for us, if we do not go through it now you can always hand your notes over to us.

Ms DANVERS: Yes, I would be most happy to do that.

CHAIR: We are not too worried about whether we get through it and tick everything off. I guess it is a bit like screening tools. We are very interested, particularly given what you have been saying about the deficiencies of the system in New South Wales compared to Victoria, in your view about what Families First strategy is talking about, particularly things like home visits by child and family health nurses. Do you see that as a step forward or a positive? Do you think it is not working and will not work unless the lack of resources you referred to earlier is addressed? We have three different questions about the implications for a member's training and resources, funding and so on. What do you want to tell us about Families First and home visits?

Ms DANVERS: I would like to put one other piece in the scenario in place first, which impacts upon the delivery by Families First of any service, and that is an aspect of the question you asked me of settings in which the nurse practices. As you may have seen, they vary from run-down isolated buildings and church halls to modern facilities. They are delivered in a variety of ways to meet client demand. Modern facilities should be able to provide home visits, drop-ins, appointments and groups, and should be within that framework of multidisciplinary child and family health teams. One needs to recognise that we are coming from a lot of services based in less-than-adequate buildings with less-than-adequate support systems. To implement Families First there is a lot of work to be done to bring the general standard up first of all, before you get to strategies of Families First. Question 5 would be the first one?

CHAIR: Yes.

Ms DANVERS: Implications for policy in terms of training and resources: In training, the implications are that safety and management of aggressive behaviour in clients will need to be addressed. Some nurses currently in practice may require additional training in the wider perspective of family and social functioning assessment and management within the home setting. However, current training programs are incorporating the Families First concepts. The Families First group, and I am on the implementation committee, met with training institutions sometime ago to discuss the concept. Training institutions were very happy to bring the concepts of Families First into the current training programs, and that was nursing, allied health and medical.

CHAIR: When you say "sometime ago", was that last year?

Ms DANVERS: Yes, last year and, fortuitously, the nursing educational institutions were in the process of reviewing the curriculum either this year or next year.

CHAIR: Are you talking about basic nursing qualifications or postgraduate diplomas and certificates?

Ms DANVERS: I am talking about postgraduate, although there is some incorporation into the basic training to try to get a more public health home-focused aspect to basic general nursing care. The resource implications, the baseline services for al families, which includes a first visit home visit, needs to be defined first and needs to be funded on a population basis. That is where you need to start. Caseloads for early childhood nurses currently vary from 140 newborn families cumulatively every year, which is the Victorian general baseline, to more than 250 in some areas.

The Hon. IAN WEST: That is 140 in Victoria?

Ms DANVERS: Yes.

CHAIR: And 250 in some parts of New South Wales.

Ms DANVERS: In many places in New South Wales. When you look at David Old's work in America, and that is focused on at-risk families, the nurses in his team have 50 families. If you try to replicate David Old's outcomes you would have to look at funding one nurse to 50 families.

CHAIR: Does that cover two or three visits in the first six months or just one initial visit?

Ms DANVERS: David Old's program looks at ongoing home visits. The Families First suggestion would be that first visit home visit is important, and at that stage one would do a family and social assessment and then, with the parent, develop a management plan to meet the needs, which may include ongoing home visits or service at the centre. It depends on the client needs.

CHAIR: And how that was done and what percentage you had in a particular region would have very different implications for resources and funding?

Ms DANVERS: Yes. The Victorian program model for funding has a weighting for first, ethnicity, rural isolation and at-risk client groups such as drug and alcohol. However, to know all of that you have to have the data and currently in New South Wales we do not have the database across areas that records even registration data for every child and family. The other issues you asked in regard to Families First, at point 6 you asked about universal home visits and is there a requirement. Yes is the answer to both of those questions.

CHAIR: As you said earlier, you more or less agree with the Victorian model?

Ms DANVERS: Yes. Question 7, feedback from CAFHNA members involved in Families First suggests that the health funding process is not clearly understood and that they have trouble in monitoring and tracking funding.

CHAIR: Can you be more specific about that?

Ms DANVERS: CAFHNA members involved in areas where Families First has been implemented have not understood how health money is allocated to them or how to apply for the money. When they hear that Health money is allocated to the area they have had difficulty in finding where that money has gone, in gaining that money to ensure that it is used for Families First activities and keeping that money for Families First activities.

The Hon. IAN WEST: You are talking about all those issues to do with ease of access to the funding?

Ms DANVERS: Yes, I suppose it is ease of access, but first is awareness. Some people never even know that the money is there.

The Hon. IAN WEST: Awareness and access?

Ms DANVERS: Yes.

CHAIR: When you say that they do not know, do they vaguely think that somewhere in Health there is a pot of money that they are not properly finding out about or do they think that somewhere or another there is this new body, Families First, run out of the Cabinet Office and somehow Health has to go and get a bit more out of the bucket of money, or is it a more general confusion that has not really worked its way through to the frontline?

Ms DANVERS: I would suggest probably general confusion in the grassroots management with people who are responsible; the managers who are responsible for delivering child and family health services. I do not mean the area director or the area executive. I mean Families First comes to your area and the manager who is directly responsible for delivering the child and family health service is having difficulties in knowing when that money arrives, how it arrives, what it is for and how to access it. There is then the ongoing problem of how to keep it and monitor it.

CHAIR: Is there a perception that the people you are talking about, your members and so on, are expected to do more, that is Families First with less or with the same?

Ms DANVERS: There is certainly feedback from our members that would suggest that there has not been an appropriate assessment of the current needs in child and family health nursing for resourcing, and then there has not been an appropriate review of resource implications for implementing Families First. I am saying that in one area they may have been given three additional nurses to implement Families First, but the baseline service that they are delivering is not of a good standard. We must first bring everyone to a standard that is agreed as a baseline service for parents and then fund additional activities.

CHAIR: While that is not happening what are those extra three nurses doing?

Ms DANVERS: They would be focused upon implementing Families First strategies. They would conduct home visits, outreach to community groups and support parents in accessing community groups.

CHAIR: So they are making a real difference?

Ms DANVERS: Yes.

CHAIR: But there is still a lack of knowledge of where we are going and how it will be planned and organised.

Ms DANVERS: Yes. There is a need to define every parent's baseline service. It differs in every area.

CHAIR: That gets back to the point you made earlier.

Ms DANVERS: Families First money comes in and it is allocated to the nurse to conduct home visits. But what else is happening? I understand that the health department does not take on the role of defining service delivery at area health level.

The Hon. IAN WEST: Did I understand you to say that baseline service is not one size fits all? The baseline service should have variables; it should be flexible.

Ms DANVERS: No. In Victoria there is a baseline service that every parent has the right to access. It involves a certain number of visits at age-appropriate times, with education, support and assessment. Each area, based on the risk categories of isolation, ethnicity and the number of first-time parents, receives enhancement funding to meet those additional needs.

The Hon. IAN WEST: That is where the flexibility comes in.

Ms DANVERS: Yes. The service delivery must be flexible so you need the resources to deliver a flexible service. That means you need a centre that is appropriate for groups and you need a car and a telephone. At present most community health nurses are required to use their own cars.

CHAIR: With provision for reimbursement for petrol at a kilometre rate?

Ms DANVERS: Yes. However, when they have an accident they carry the insurance and they must pay the excess.

CHAIR: Is it true to say that child and family health nurses are the poor relations of the health system, or is that going too far?

Ms DANVERS: No, that is not going too far. They are very well motivated, passionate—

CHAIR: I obviously do not mean individuals.

Ms DANVERS: As a group, they are very well motivated, passionate people who believe in high standards—as you can see from their practice guidelines—and who are working in isolation and under poor conditions.

CHAIR: Is it time to demolish or sell off the traditional, little health centres in various municipal areas and move your people into more multidisciplinary, modern centres with proper services? Is part of the problem the fact that we are dealing with a collection of 50- or 60-year-old buildings that have not been kept up?

Ms DANVERS: Yes. Traditionally the health department funded 75 per cent of capital costs to councils to build early childhood health centres. That position has been renegotiated by councils in recent years, and their involvement has decreased. Many current centres are dilapidated, suffer from a lack of maintenance and certainly do not have modern facilities such as faxes, computers, cars or mobile phones. There is a difficulty in that the responsibilities of Health traditionally included providing qualified staff, and councils were tasked with maintaining the buildings. However, that position has been renegotiated. There is certainly an opportunity to consider the concept of having fewer part-time, isolated centres and more centres that are part of a wider multidisciplinary team within a building that provides drop-in services, appointments and educational support for large groups, together with a referral to a multidisciplinary team. You must also provide cars and enable the nurses to visit parents.

CHAIR: In Melbourne we revisited a centre in Williamstown that was deliberately located in a purpose-built building that also contained quite a large childcare centre. The local government authorities did that deliberately because they felt that mix served parents and the collocation brought benefits to both groups—childcare workers and nurses might pick up something. It was removed completely from the health emphasis, which brought other benefits. Do you believe that is a good idea?

Ms DANVERS: Did it involve a childcare centre, an early childhood—

CHAIR: It was probably a fairly traditional early childhood centre with no other health professionals in the building or nearby. The council deliberately located it in a building purpose-built for a two-room, two-session-at-a-time childcare centre. It got away from the health services and focused it more on parents, families and children. It is an interesting approach—the isolation was certainly largely overcome—but it is not the multidisciplinary team that you are talking about.

Ms DANVERS: There are certainly opportunities to place services within either educational or childcare areas. Some of our members in schools are presented with a large room containing partitions. I do not think that is an ideal situation in terms of confidentiality or running a support group for parents. However, we certainly need to decrease the number of isolated, poorly repaired, half-a-day-a-week centres. I suggest that, ideally, the early childhood health centre service or the child and family health nursing service, as part of a multidisciplinary health team, would be a good structure. Appropriate facilities within an education facility would also be good.

It is important to have the facilities to meet client needs. That can be difficult in some environments. In the area where I worked we have initiated a conscious planning program to move from 13 part-time centres to six full-time, two-sister centres with group rooms that can hold 40 people and from which we can do home visits, et cetera. Those centres are not all based with a multidisciplinary team but they are part of a multidisciplinary team. I think you really need that. If you expect a nurse to be competent in assessing fine and gross motor skills, vision, speech and language the gold standard person must be a member of the team so that the nurse can learn from that person, have her skills monitored and discuss cases on an ongoing basis.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Should these centres be associated with schools, councils or hospitals as a general rule?

Ms DANVERS: They should certainly not be associated with hospitals. Some area health authorities have moved recently to save money by locating community health services on hospital campuses.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The shed down the back.

CHAIR: You could not possibly say that, but we can.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is what it would boil down to.

Ms DANVERS: I do not know what would be offered, but there has been a move in that direction.

The Hon. IAN WEST: It would not help isolated areas.

Ms DANVERS: It does not help anyone in the community. The concept of community health care is to deliver services where the client is—that is the important point—in a familiar, non-threatening environment. That is why large commercial buildings are not ideal for community health services. I suggest that that move would certainly not be appropriate. What was the other part of your question?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I also mentioned schools or councils. Councils are now running Meals on Wheels services and so on and have databases of where people are located. You are trying to get councils more involved.

Ms DANVERS: Yes, but councils have approached the health department in recent years to decrease their involvement in early childhood health centres. They have made their position clear.

CHAIR: This has been a fascinating and very useful session. May we have your notes on those issues that we did not address directly—mostly the questions about coordination? Do you have any difficulty with your written answers becoming part of the transcript together with your oral evidence?

Ms DANVERS: No.

CHAIR: It is so resolved.

Ms DANVERS: Thank you for the opportunity to appear before the Committee this morning.

(The witness withdrew)

JOHN ELKINS, Professor, School of Education, University of Queensland, sworn and examined:

CHAIR: Professor, I take it you are appearing as director.

Professor ELKINS: A former director. I am at the moment, in a sense, a professor without portfolio.

CHAIR: Did you receive a summons issued under my hand in accordance with the provisions of the Parliamentary Evidence Act 1901?

Professor ELKINS: I did.

CHAIR: Have you made a written submission to the Committee?

Professor ELKINS: I have not made a written submission.

CHAIR: Would you like to make an opening statement, or shall we go directly to the questions?

Professor ELKINS: Going to the questions would be fine.

CHAIR: Tell us what the Schonell Special Education Research Centre is.

Professor ELKINS: It is part of the School of Education and is approaching its fiftieth birthday. It was begun by Professor Fred Schonell when he returned from the United Kingdom to be the first Professor of Education at the University of Queensland. Initially, along with the research aspect, it was very much a clinic for students who were having problems. In about 1973, when colleges of advanced education mushroomed around the country, we gave up a large amount of clinical work and replaced it with the teaching of mostly masters degrees and post-graduate degrees in the area of special education. While we have some clinical activity, it probably ranks number three in what we do. It is a bit hard to say whether our teaching or our research comes first. We like to think it is our research.

We also assist in the training of educational psychologists. We have a centre, the Caroline Chisholm Centre, which is operated in co-operation with the Catholic Education Office in Brisbane. It provides field-based training and assists the Catholic Education Office. The building is situated inside the grounds of a Catholic primary school. In a way, to our mind, that is probably a better model of clinical operation than one in which the clinic is on campus—although at the moment we do have on campus a program for school leavers who have Down's syndrome. That is focused on literacy and information technology. Many of the families have Internet connections, and we help them to learn both to search the web generally and also to communicate with families and friends in that way. Universities these days are such busy and big places that they are not always the right places to run a campus-based clinic. Even parking, but so many other things also, make that difficult, although I think there is still a role for them. The one that you will hear about from Professor Wheldall at Macquarie is a very good example of a campus with such a role.

CHAIR: In a sense, the Catholic primary school that you mentioned provides your clinical work?

Professor ELKINS: It is one major part of our clinical work.

CHAIR: Do children at some other schools in the Catholic system come to the university?

Professor ELKINS: Yes. It is both for that, and it is a basis for training. The students in fact go to Catholic schools right across Brisbane for some aspects of education. Normally, they have four semesters of practicum. The first tends to be located in the Caroline Chisholm Centre as they acquire skills. Then they gradually move to doing most of their work in the wider set of schools.

CHAIR: Earlier the Committee, particularly in its first few days of sittings, had a lot of discussion about definitions. We know that some people do not worry too much about them, while others tend to think they matter a great deal, particularly if grappling with research literature and so on. From your point of view, what is the difference between learning difficulty and learning disability?

Professor ELKINS: I regard learning difficulties as experiences that are of difficulty, that is, in the learning of important things like literacy and numerousy. That, to my way of thinking, is an example of not, in a sense, blaming the child. The child may or may not be the major reason why he or she is experiencing difficulties. It could be the classroom program, or it could be outside stress that the child is suffering. So it is a much more ecological perspective. Within the group of children who experienced learning difficulties is a small subset of children whom I am quite happy to call learning disabled. The reason is, in my view, that a disability stems from an impairment. If you take the World Health Organisation definition, impairment is some constitutional fault which produces disability, and handicap is what is produced by, in a sense, society's failure to respond to that disability.

But I think there is an important element in the definition of learning disability that is used around the world. It is that the learning disability is not caused by any of the external factors, and there is a presumed neurological deficit. True it is that in recent years, with brain imaging and techniques of that kind, it has been possible to show that people who have severe literacy problems, for example, appear to have different brain activation. However, although that is an important piece of research, it certainly is not what we do when we are trying to diagnose someone with a learning disability. That would be, I think, extreme overkill unless MRI and such other expensive equipment were on every street corner. I think you simply cannot have a practical system of identification of the underlying impairment.

Furthermore, to a large degree neurologists do not really know what these different patterns of activation in the brain mean. So we cannot base our teaching on that data. But it certainly provides support for the belief that some children—the ones I am happy to call learning disabled—do have something different in their constitutional make-up. What has been emerging in the last few years in America, and in my thoughts and in those of a number of people around the world, is that we can regard the learning disability group as being made up of those students who have been given a fair chance of supportive intervention and have not responded to any degree. They are a small group. My best guess is that it is 2 per cent of all children. I think, in future, we may get a better estimate, but that is just based on experience.

CHAIR: Broadly speaking, do children with behavioural difficulties fit into that small group?

Professor ELKINS: They may. Behaviour difficulties occur as one aspect of the symptomatology of a lot of different circumstances and conditions that children might have, but other children who have no other obvious condition but have behaviour difficulties probably have inappropriate behaviours for reasons of, in a sense, the way that they are reinforced by teachers, peers, parents and so on. I think those children are amenable to interventions of behaviour management. So too are the others. But this is not really an aspect that I like to pull into the learning difficulties or learning disabilities area to any extent. Some people want to include everything within learning difficulties. I tend to take a somewhat opposite point of view. I tend to see it basically as in the academic learning area. Behaviour problems are important, and they exist, but in general most education systems respond by, first of all, helping regular class teachers managed their classrooms better; and, when that is not working with one or two children, they get in an expert in behaviour management to set up a program that will ameliorate the problem.

CHAIR: Where do you put ADHD children?

Professor ELKINS: ADHD is an issue in which I claim no great expertise. I am slightly sceptical.

CHAIR: That it exists?

Professor ELKINS: Not that it exists, but that the number of students who are labelled AD or ADHD is probably too high. Again, I think that quite a lot of the behaviour that they exhibit may not be constitutionally determined. It may well be much more environmentally based..

CHAIR: So it is the children's reaction to what happens to them at home and at school, and so on?

Professor ELKINS: That is right. I repeat, I claim no great expertise in this matter, but I would be cautious about labelling a child ADHD, and I would be very cautious about using medication as the primary intervention, though it would seem to me that there are some children for whom that is appropriate.

The Hon. DOUG MOPPETT: I have inferred from what you have been saying that you feel that most of these things may have a physiological basis, although it may not necessarily be understood at the present time.

Professor ELKINS: I am not quite sure that I would say "most". It seems to me, if we go back to reading difficulties, which is the major issue that comes up, depending on various factors, teachers tend to think that somewhere between 10 per cent and 15 per cent of students in their classes have problems in learning that they do not feel able to handle. The constitutionally-based ones, I suspect, are only a fifth of those, that something like 2 per cent of all children have a disability that is constitutionally based. We do not really know. The way that I approach it in a sort of pragmatic way is to start to answer the third question, that is, about first, second and third waves of teaching. This is a very educational perspective on the difference between learning difficulties and learning disabilities. The first wave basically is the regular classroom program. If the regular classroom program has faults in it, then there will be casualties of it. Probably, no regular classroom program is ideal for every child in that class.

Most children will learn to read, regardless of what the classroom program is like but there is probably an optimal way that classroom programs should run. Then there will be children who have difficulty learning to read with that program. They need some individual attention and that is where the second wave comes in. The second wave in several Australian States—New South Wales and Queensland at least—is partially addressed by reading recovery. But, certainly in Queensland and I understand in New South Wales, there are not enough reading recovery teachers to provide an intervention of that kind for all students. But there are other interventions that can be used.

The second wave, in a sense, takes into account that approximately 10 per cent or 15 per cent of students who are having difficulty even though we think there is a pretty good classroom program in operation. What we hope for there is a finite-type of intervention—a term, a semester, in some cases perhaps a year. At that point we have two outcomes. The majority of students are now regarded as being able to manage in the first wave and can go back into the regular classroom. Well, they are in the regular classroom all time. They do not lose their membership of the classroom when they get their second wave intervention. It is probably happening in another room, but it is only for perhaps half an hour per day or whatever the program involves.

The third wave involves the children who do not respond to the second wave. In the last two or three years there have been papers published, particularly in United States of America, referring to the "resistant children" or those who have not improved even though they had been given state-of-the-art intervention, particularly when they were young. At this point no-one is very clear about what their characteristics are or what will be the best way to help them. That is the new research challenge that people have.

The Hon. DOUG MOPPETT: If I might just interrupt you for a moment, one of your academic colleagues from Melbourne appeared before the Committee and gave us a rather sobering perspective based on American research. It described these people that we feel such a warm glow about, who lost their identification then came back into the first wave, but when looked at the end of high school were basically back where they started from.

Professor ELKINS: I think that the reality of classrooms anywhere is that there is a wide range of achievement. I am not sure that we should be trying to change that. I also worry a little when we conduct surveys of literacy and numeracy that we look at the average and where it is going: Is the average going up or down? That is important, but probably the top 80 percent of children are going to have sufficient literacy and numeracy skills to enable them to manage with their education and ultimately with their lives. We need to recognise that we cannot legislate out of existence that spread of ability. It exists in the children when they come to school; they are remarkably varied. I may be moving to the answer to another question, but it does not matter whether you start children at school on their fifth birthday—as they do in New Zealand—or once a year when they have attained a certain age by a given date, they are remarkably variable.

The Hon. DOUG MOPPETT: That is what I wanted to get back to. If it is a normal curve, that is inherent in people; it is a population issue that you cannot get away from. You are not going to be able to squeeze the bell curve into a narrow histogram that everyone is achieving.

Professor ELKINS: That is right, not to a marked extent. It may be possible to narrow the dispersion somewhat.

CHAIR: Some people have raised a slightly different but related question. Reading recovery, for instance, will sometimes produce a short-term improvement but if the child were to be tested, not at the end of high school but at the end of year two or year three, you may find continuing problems that could be helped by another program.

Professor ELKINS: Yes.

CHAIR: We are talking about whether programs that are designed to get children back to where they should be actually work.

Professor ELKINS: If you look what reading recovery or any of a number of other interventions are designed to do, they are focused on getting children reasonably fluent and reasonably accurate in dealing with text. Suppose this were to be offered in late grade one or early year two and the child has returned to the main group, what happens to that child now? It may well be that, although their reading skills have improved, the other children are moving ahead faster. It may not be easy for them to keep up. When children get to year three they typically begin to outstrip the classroom program in terms of their reading skills—it is less true for mathematics—because they begin to read Harry Potter and other books. They are reading them when they wake up in the morning and reading them when they go to sleep at night. They become very much better readers. It is not related to specifically what is happening in the classroom. Unless the children who are returned from reading recovery or some other program get caught up in this type of mass recreational reading, they do not practise nearly as much and they do not become people for whom reading is second nature.

The Hon. IAN WEST: Is it wrong to compare that analogy with physical activity?

Professor ELKINS: It is an analogy that I have used at times. If you give someone a fitness program and then say, "Okay, you are on your own", we all know what will happen. Some will continue but others will backslide. Indeed, one of the major problems in later school years is the existence of a group of children sometimes referred to as "alliterate"—that is, they just do not read. If they do not read they certainly do not improve in their ability to read. The nature of reading changes. Children keep narrative but they also add expository text, argumentative text and all sorts of things that they need to interact with the whole curriculum—science, history, geography and similar subjects. That is another thing. The word "reading" is deceptively simple when, in reality, it stands for a whole lot of different things at different times in a person's growth.

CHAIR: I have one of the question before we move onto your research projects about the importance of schools and teachers. You referred earlier to a rough figure of 10 per cent to 15 per cent of children having learning difficulties and being dealt with in the second stage. How would you describe the extent to which those percentages vary from school to school and place to place

Professor ELKINS: They vary enormously.

CHAIR: Are we talking about socioeconomic factors, for example, or ethnicity? Would you comment on the range?

Professor ELKINS: There are certainly issues such as socioeconomic and background-language factors, and to some extent gender—in the sense that some boys do not really regard reading as an important thing to do and they do not have the many role models. So, there is an effect there, too. If you have a school in a lower socioeconomic area and where, perhaps, many of the students have another language as their first language, teachers may consider that half of the children in the class are experiencing learning difficulties. Another way of saying that is that the teacher would like to be able to work with them one-to-one for a bit, but in a big class, or even the smaller class, that is not necessarily easy to do particularly if you think that half the children in the class need individual attention. It is one of the reasons why people have looked towards trained volunteer tutors. There is evidence that that has some positive benefits. It is a way of giving the teacher many hands.

CHAIR: What would the percentage come down to in a really fortunate school in a fortunate area?

Professor ELKINS: I have known people to say, and I believe them, that they do not have any such children in the class. There may be just one. There is a big range and that provides real problems for education systems in the allocation of resources, for example in regard to support teacher numbers. Education departments to try to put resources where they are most needed, but it would be hard to say to a school in a favourable situation, "You cannot have a support teacher." I think they would get cross about that.

CHAIR: Our next set of questions relate to the research about the difference that schools and teachers make. This is very close to the Hon. Doug Moppett's heart. He is forever trying to push us into considering what schools do.

Professor ELKINS: I think that is important. One study was undertaken by my colleague Krista Van Kraayenoord, who is now the Director of the Schonell Special Education Research Centre. We have done studies with colleagues from Western Australia, Victoria and South Australia on behalf of the Federal Department of Education, Training and Youth Affairs [DETYA] looking at students with learning difficulties in primary school. You may be aware of that. I have brought along a brochure that was sent to every school in Australia and I am happy to produce it to the Committee.

Brochure tabled.

That showed very much the sorts of things that I have said thus far. It was very much a broad brush approach. We looked at schools in which it was thought that good practice was happening. I would not say that all of the schools did things the same way, but in all cases of schools had it as a serious intent to have high-quality first wave programs—that is, really good classroom programs and really good intervention. Virtually none of them had a third wave intervention because none of them felt that they could offer what is effectively permanent support.

At the moment, unless we can learn more about these treatment-resistant children, we really are stuck with trying to support them throughout their school career. That may, in the extreme cases, mean less trying to make them better at reading and more trying to make the reading task easier for them by alternative text, tape-recording and a number of things which represent a way around the problem, rather than a solving of the problem.

There was one example that we looked at where a group of about 15 primary schools each contributed some of its funds to the employment of a support teacher with a very small group of about eight or 10 children on a full-time basis. The teacher was located in one of the schools. I am not arguing that this is necessarily the best approach. I think it was quite effective, but it was effective because the principals of those schools got together and said, "Individually, we are not able to do anything more for these really tough cases in our own schools. We cannot afford a full-time class for these children. We do not even have enough of these children to fill a class."

CHAIR: For how long were they taken out?

Professor ELKINS: They may have been there for three years. Inevitably, they went into the local school because they were by that stage so much members of that local school that they typically did not go back to the school from which they had come. But that did not seem to be a big problem. Plus, there was staged support: they would gradually increase the amount of time that they were in regular classes.

CHAIR: You seem to be suggesting that this kind of effective assistance intervention needs to occur well beyond the early years of school; you are speaking about primary in general?

Professor ELKINS: Yes, I am talking about primary in general. While in no way diminishing the importance of early action, I believe it is a mistake to believe that you can solve your problem.

CHAIR: You cannot fix up everyone by the age of 18?

Professor ELKINS: I do not think so, for two reasons. First, you cannot guarantee that children will go on to do that massive amount of recreational reading that I think is needed to make reading second nature, as distinct from a laborious task. Second, as I mentioned before, reading becomes much more complex than reading stories, which is predominantly what it is in kindergarten, year 1 and maybe year 2. I think systems have to provide some resources for students beyond year 2, because we cannot totally eliminate learning difficulties in the later phase.

CHAIR: With regard to the benefits that may come from recreational reading, are you essentially saying that that level of reading is necessary for what people might call functional literacy or for people eventually getting a decent job in the kind of society in which we live, or are you talking about going beyond that into something that obviously contributes to the quality of life but is not necessary for people to get by?

Professor ELKINS: As children get older, the challenges they face in learning are themselves enough for them to have to deal with. If part of their attention has to be given to laboriously working out what the words on the page are, they have much less of their cognitive resources available to work out the thinking challenge that they are meeting, whether it is in history, mathematics or whatever.

The analogy in mathematics is even easier to see. If the child does not know automatically that seven plus five is 12, if that child is trying to solve a problem in mathematics, regardless of whether it is in year 3 or year 12, they are going to be in difficulty because part of their thinking apparatus is already taken up with working out 7, 8, 9, 10, 11, 12, or however it is that they are still doing those things.

CHAIR: I suppose another problem is that those basic tasks become incredibly boring and unsatisfying for them?

Professor ELKINS: They can. That is the reason why I think recreational reading is so important, because there is such a wealth of enjoyable reading matter for children. It is much tougher to get, in a sense, non-school activity that develops the numeracy skills of children. There are card games and things you can do, or if you happen to work in a shop after school you can—but it is really hard. I think the teacher has a large responsibility to ensure that children are given a chance to practise particularly mental arithmetic.

The Hon. DOUG MOPPETT: There is almost a slavish adherence to the idea of the value of books and reading. People talk about the good old days, when kids sat down and read books, but now they have television. I sometimes wonder whether the human brain cannot adapt to receiving information in a number of different ways. It may seem that the only reason why we insist on reading is that certain functions in society, such as filling out the census form for example, require you to be able to read. But in terms of mental development, it does not matter whether you are reading for enjoyment or you are having information coming to you, both through your eyes and your ears, in some new form.

Professor ELKINS: There is no doubt that today we need to expand the definition of literacy beyond printed text. The ability to understand pictorial material, whether it is on television or in other forms, is increasingly important. But it is fairly difficult to foresee a time when we would not need to be able to read and write in order to be relatively independent. We do not yet know whether, for example, some students find some of these newer tasks difficult, in the way that some students find text reading difficult, because we have not really studied these new high-tech forms of literacy as much as we have studied traditional literacy. I guess I do not really know how to answer your question. I think that is something we will get to know in future.

The Hon. DOUG MOPPETT: I know some people who are avid readers, who carry on recreational reading into their adult lives; you just cannot give them enough books. There are others who read rarely, and only for specific reasons. Looking back, I find that people who read a lot do not have a wider vocabulary; they have the vocabulary that was imprinted in their minds when they were children, probably from their parents. You will not realise this, but people often say that I use unusual words. I think you will find them in the *Sydney Morning Herald* and other material. Most people narrow down their vocabulary to a very practical level and are not interested in developing their skills, no matter how much they read.

Professor ELKINS: I do not think it is terribly important to maintain recreational reading forever. I think that those who do, do so because they get reward from it. But I do think it serves an important function in primary school, in years 3, 4 and 5, because it enables children to build up a store of words in their heads that they can read without effort. The challenge of understanding what they are reading always remains: you have to think in order to be able to understand what you read. But to know what the words are is greatly assisted by going through a period when you do what I call overlearning.

It is a bit like learning to ride a bicycle, which is another analogy I use. Learning to ride a bicycle is pretty hard to do without some individual attention. It is hard for a young child to teach himself or herself to ride a bicycle with no help from anyone else. But, given some help from people, you can learn to ride a bike. Having learned to ride it, if you do not continue to do it, it becomes an effortful task every time you try to do it. As a child I rode a bicycle every day until I left high school, as well as for lots of recreational purposes. After 20 years, when I went to get on a bicycle again, I could ride. It was overlearned. I was not fit, but I had all of the components of the skill available. That is really the argument I am trying to present: that there is a point at which you have to overlearn, and then you have got it. You have your multiplication tables and your addition tables, and you have a reasonably good vocabulary of sight words. To me that seems to be really important, unless we can invent a society in which we will not ever need to read and write or do calculations.

The Hon. DOUG MOPPETT: We recently visited two country schools. If you were to say we need to encourage children to read recreationally, I think you would be talking about the elitist group only. In a country setting, in the afternoons the boys would go out and help dad with mustering, they would chase the chooks or the dogs, or something like that; the girls may do a bit of reading. A mother may say, "This boy is not going to go on the land; he is going to do a university course because he loves reading", but there are not many kids who do that.

Professor ELKINS: No. I think that if children do not go through that process, they are likely to find reading and writing effortful—not necessarily something they cannot do, but effortful. If something basic is effortful, there is less thinking capacity for the problems. I would argue that it is, generally speaking, better if you have that level of proficiency in these basic skills.

CHAIR: The following questions relate to, first, whether teachers are adequately prepared to assist children and, second, whether when we ceased to have specific infants teachers we may have lost something.

Professor ELKINS: In the study that we did on mapping the territory, we had a look at primary school, including early childhood teacher programs. It is really difficult to do that sort of research because every university has a different way of organising its program, together with different language and so on. But generally speaking, I think we would conclude a number of universities were doing a very good job in preservice and others doing less well in the aspect that relates to preparing teachers to be able to deal with students with learning difficulties and disabilities when they were out in the field.

It is quite difficult to bring pressure upon universities to change. One very effective thing that was done in New South Wales was the requirement to have a semester unit in some aspects of special education before they would be employed. I have actually used that argument in our own university, and said, "If you think one day you might be teaching in New South Wales, then you had better do this special education course." There are so many things that are fighting for a place in preservice education, so I think we will never be able to turn out teachers who are fully competent in every aspect of the job. To my mind, the greatest weakness is the limited extent to which professional development of teachers is required.

CHAIR: In all States?

Professor ELKINS: I could not speak for all States. Not all States have registration. If you do not have registration, I do not know how you would do this, except for the employer saying, "Part of your conditions of appointment are that in five years time you will have to show me the evidence of your professional development activities over these five years, otherwise you are out of the job." I do not know of any employer who does that, but the registration approach can. As far as I can see, in Queensland, South Australia, and I think the Australian Capital Territory, where registration of teachers is a separate function from employment, there is no requirement for ongoing professional development or you will lose your registration. That is not true of some parts of the United States, for example. You do have to show evidence of retraining, upskilling or however you would like to describe it.

CHAIR: Would that be your personal recommendation?

Professor ELKINS: It would. Having been director of teacher ed in our university for two years, I am not sure that it is possible to turn out a perfectly prepared teacher given the constraints that we have.

CHAIR: At the pre-service level?

Professor ELKINS: At the pre-service level. We have to expect that there will be some growth in skills and understanding and that that growth does not depend only upon experience but it also can be helped by appropriate forms of professional development. That was one aspect of pre-service. The other one you are asking about is whether we need specialist early childhood people. Employers are between a rock and hard place here. In schools of moderate size it is perfectly appropriate to have specialisation and to have early childhood teachers working up to age seven or eight and to have other teachers handling the upper primary school. In our university, along with a number of others, we are starting a middle school teacher ed program. It will focus on years 5 to 10. You do not have to have middle schools; you have to have an orientation to teaching children from pre-adolescence to the end of early adolescence. But in small schools in rural areas in New South Wales you need a person who will be able to operate from kindergarten to year 6. It is an awkward one.

CHAIR: Some people have put to us that maybe primary classes have benefited from gaining teachers with early childhood qualifications and experience but maybe the younger children have lost out by getting teachers who do not have that orientation.

Professor ELKINS: I do not know of any evidence that I could bring to bear upon that. It is one of those things whether you make judgments. But I think we should have early childhood teacher education programs. Maybe primary teacher education programs have to have enough early childhood material in them that if the teacher ends up in a small school—there may even be teacher composite classes at the schools—

CHAIR: It is anecdotal again but I know a teacher who spent years teaching year 4. Then he changed schools and for reasons—partly his choice—he surprisingly became a kindergarten teacher. Later he hopped back and taught year 6.

Professor ELKINS: Yes, individual teachers can do it but some teachers might find it difficult if they have never had any appropriate course work.

CHAIR: It was a great shock to the parents when this large male kindergarten teacher appeared. That brings us on to gender. You briefly mentioned the question about school starting age and whether parents should tend to hold boys back a bit.

Professor ELKINS: It is hard to get good research evidence on this. My intuition is that it does not hurt to start school late. That is especially true for boys.

CHAIR: When you say late you mean five and a half to six?

Professor ELKINS: Yes. We have some evidence from the Scandinavian countries, where school does not start until seven. There is no evidence that at the age of 12 or 13 there is any obvious difference.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But they have pretty impressive preschool activities. They may not define it as school but there is terrific child care from six months. The parents can mores go back to work and hand the kid over from any age. So to say that they do not start until seven does not mean anything in a Scandinavian context, does it?

Professor ELKINS: No. It is likely that the majority of the children coming into formal school are already reading. As I said, it is really hard to get good research evidence on this. The research evidence on repeating a grade is not very encouraging.

CHAIR: And on boys particularly starting late?

Professor ELKINS: I am not really aware. I am saying that this is my intuition, that if I were a parent of a boy who was not ready to go to school I would probably opt for a bit more preschool kindergarten-type experience but I would try to avoid it being a repeat in the same setting, try to arrange it so that the child felt that he or she was undergoing a normal set of progressions. That could be a challenge in some cases.

CHAIR: Is there much evidence on class size?

Professor ELKINS: Class size is interesting. There are relatively small benefits as you go from 30 down to 20. You do not get huge benefits until you are down to five, and that is obviously not practicable. What I think is important is that if you can reduce class size you also have to ensure that teachers know how to make maximum use of what they are being offered. The real goal in early classes—kindergarten and year 1 and year 2—is to have a teacher able to manage the full group and also at times work individually with every child. That is a little easier as the class size comes down, and that is where you will get the benefit. If the teacher does exactly the same as he or she did with 20 as with 30 the stress on the teacher is a bit less but there is no real likelihood that the children will benefit. But the children could benefit from smaller class size. There is an anecdote that relates to this. I am sure that you would never fall into this trap but in California a few years ago the Governor decreed that year 1 and year 2 classes would not exceed 20. But he did not ask where the teachers were to cope with the extra classes. The number of classes increased by 50 per cent and thus the number of teachers went up by 50 per cent. They now have untrained teachers in front classes.

The Hon. DOUG MOPPETT: So the effect could be inverse?

Professor ELKINS: Yes. You have to be careful. I have not seen that sort of bad planning happening in Australia but there is an enormous teacher shortage in the United States. We could see a drain of teachers to the United States. The State of Georgia just introduced a three-week training program for teachers.

The Hon. DOUG MOPPETT: Minute men.

Professor ELKINS: They have to do additional study for the next five years but they are in front of classes after three weeks, and that is worrying.

CHAIR: A more common practice which deals with the issue of numbers would be all sorts of variants of team teaching or parents as teachers or volunteers so that you cope with a range of differences in a class by having a teacher work with this group which seems to have difficulties while the volunteer or parent or somebody is working with a different group.

Professor ELKINS: Yes. You can make those sorts of things non-stigmatising if you are clever. In New Zealand children start school on their fifth birthday.

CHAIR: Regardless of what time of the year it is?

Professor ELKINS: Yes. The school's response is to have short-term group placements for children. The infants level—which they call the primmers—is sorted out relatively frequently. They see themselves as part of a larger group of several teachers and perhaps 100 or 150 children. Children could spend from 18 months to 2½ years in that infant phase before they would move into what the New Zealanders call the standard 1, 2, 3 and 4, which is the rest of primary school. I do not think that you have to start kids on their fifth birthday to do that. Because otherwise the teacher is halfway through the program and has to cope with a new student it was forced there. It is the way that they organise that makes the difference.

CHAIR: I guess that we keep answering question four: schools and teachers can make a huge difference.

Professor ELKINS: Yes. We have seen this. In this study, for example, we went to several schools where we saw substantial evidence that schools were really taking literacy seriously. Nothing else happens in the school for the first two hours of the day except literacy. In Victoria they have at least an hour a day. In Britain they have the literacy hour. It is clear that if you take it seriously you can be more efficient and effective. If you think that it will just happen then for some kids it certainly will not happen. Numeracy is very much a second cousin. That is worrying.

CHAIR: So we have all worried about literacy and forgotten to worry about numeracy?

Professor ELKINS: To some extent, although New South Wales has probably done better because people have developed courtesy programs in this State. Count Me In, Maths Recovery and a number of programs have been evidence that a serious attempt has been made to help in that area.

CHAIR: We have three questions we have not addressed. On Reading Recovery we have talked a little about differences between States but I would like your comments on Reading Recovery and the Community Literacy Clinic.

Professor ELKINS: A Community Literacy Clinic is a very small activity except for the group of Down's syndrome children. If possible we give lots of advice and maybe some materials to inquirers but we try to get the problem back into the school because in the long term that is where it has to be managed rather than do the school's job for it.

The Hon. DOUG MOPPETT: You are not a hospital.

Professor ELKINS: Yes, it is a community health model, which is not to say that the other is not useful. I am not critical of other forms of literacy clinic. Reading Recovery's greatest strength is its greatest weakness. Its greatest strength is that it is very tightly controlled and you can be reasonably confident that Reading Recovery is Reading Recovery. It is also its greatest weakness because where research shows that Reading Recovery could be more effective if it were changed in certain ways it is very difficult to get the organisation Reading Recovery to make that change.

CHAIR: And that is because of ownership, copyright, New Zealand origins, et cetera?

Professor ELKINS: A variety of reasons, but largely it is a consequence of the first thing. There are other programs that are probably equally effective. It is probably true that there are other programs that could be more efficient in the sense that they could deal with more children for the same number of dollars. Most of the research is done in New Zealand or in America. I brought a paper with me that has been accepted for publication by some New Zealand researchers. It contains recent research on Reading Recovery. I am happy to leave that with the Committee.

Document tabled.

CHAIR: Is Reading Recovery so widespread, organised and tight that it is relatively easy to train a large number of teachers to use it?

Professor ELKINS: It is a very good training program and very practical. You observe while you are teaching and then you have to explain and justify what you did in front of your peers and the tutor. It is a very powerful training model. I am not aware of any other program that takes as much trouble about training its practitioners.

CHAIR: Is it ageing? The Committee saw it in operation in a school and it seemed to contain some new text but some of the material used appeared to be a bit old fashioned.

Professor ELKINS: It can be used with any text. So your comment probably relates to the text that the school had rather than of reading recovery itself. It does not have a narrow set of reading material. Potentially it is usable with anything that is appropriate for the child's reading level and interests.

CHAIR: The school must have used a set a material that it had had for sometime.

Professor ELKINS: That is probably the case.

CHAIR: Do you have any further written material which you would like to provide to the Committee?

Professor ELKINS: No. I have only handwritten notes, to which I have referred. When I read the transcript I will tell you if it is inadequate in some respects.

CHAIR: If you wish, you can provide a letter which will be, in effect, an additional submission.

(The witness withdrew)

KEVIN WILLIAM WHELDALL, Professor of Education, Director, Macquarie University Special Education Centre, Macquarie University, North Ryde, and

CORAL RAE KEMP, Lecturer in Special Education, Macquarie University Special Education Centre, Macquarie University, North Ryde, affirmed and examined:

CHAIR: Did you each receive a summons to appear before this Committee?

Professor WHELDALL: Yes.

Ms KEMP: Yes.

CHAIR: Are you conversant with the terms of this inquiry?

Professor WHELDALL: Yes. I have not provided a submission to the Committee.

Ms KEMP: I am also the Academic Team Leader of the Early Years Initiative at the Special Education Centre.

CHAIR: Would you inform the Committee about the Macquarie University Special Education Centre.

Professor WHELDALL: The Macquarie University Special Education Centre, and we use the acronym MUSEC to save time, was established in 1975 to be a centre of excellence in special education. At that time the idea was to establish such a centre in every State. MUSEC was the only one that was fully implemented and continues to this day. We have three major functions: first, we are a research centre and carry out research programs into the educational problems facing children with disabilities and other special learning needs; second, we are a centre of excellence for teaching in special education. Currently all our teaching is post-graduate. Basically we train teachers and other relevant professionals to become special educators.

We have four post-graduate certificates in special education: behaviour problems, learning difficulties, early intervention and high support needs. We also have a post-graduate Diploma in Special Education and a Master of Special Education. Additional to that we supervise higher degrees by research at master and doctoral level in special education.

Our third major function is community outreach; service to the community and to act as appropriate models for the community. Our aim is to research and develop models for transmission to the wider community. One of the main ways in which we do that, and the way in which we are different from any other centre of excellence in special education in the country, is that we have our own independent school for students with special learning needs on site as an integral part of our centre.

Currently, we have 65 students and the school students are from kindergarten to year 6. Currently we have a small preschool. Our idea is to research effective instructional practice, implement it in the classroom, convey that information to our post-graduate students, and provide a model for the wider community of excellent instructional practice.

CHAIR: How long do the children stay at the school?

Professor WHELDALL: That varies. Under the current model, which is running for the first time this year, parents may choose for their children to be with us for as short or as long a time as they wish.

CHAIR: They may be there for their primary schooling?

Professor WHELDALL: No, virtually no-one does that. In some respects we are renegades in special education in that we are not totally convinced that "inclusion at all costs" is the best thing for all children at all times. We believe that there is a continuing role for special schools and special education facilities within schools. We do not believe that children should be consigned to those classes, or schools, for ever. At Macquarie we are modelling a new form of special school to which children can come for short periods to improve their academic skills and, equally importantly, academic and school survival skills, so that they can more meaningfully be included in mainstream schools.

It may be that at some point down the track they may need to come back, and that is possible too. They come to us for a minimum of two terms and typically do not stay for more than 18 months to two years.

Ms KEMP: There have been one or two exceptions to that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is this a sort of Bill Crews type of school?

Professor WHELDALL: Not at all, but I run the centre for Bill Crews in Ashfield. I provide the instructional model and teachers for that. I would be happy to talk about that if you wish.

CHAIR: You said that you have a new model for this year?

Professor WHELDALL: Yes.

CHAIR: Why did you change? What significant changes have you made to the previous model?

Professor WHELDALL: Partly pragmatic, partly political. We had to accept the fact that whereas in the past the Federal Government had been happy to interpret the criteria for disability funding generously in our case, over the past few years the sweetheart deals, if you like, have been more stringently applied. Funding is possible now only for children who strictly meet the documented disability criteria. I used the phrase "documented disability criteria" because that does not mean that the kids who do not meet it do not have disabilities; it is just that they cannot provide the necessary paperwork to substantiate the disability.

CHAIR: Earlier Professor Elkins spoke about children with disabilities as being approximately 2 per cent of the population.

Professor WHELDALL: That would be about right.

CHAIR: You are talking about the group that fits within that percentage?

Mr WHELDALL: I am saying that whereas previously we had children who in New South Wales one would say had learning difficulties and a small group of students with disabilities, we now have to focus primarily on children with documented disabilities. That is the move that is here, there will be about 75 to 80 per cent of kids in our school who will have documented disabilities, but we still want to retain a group of students with learning difficulties or learning disabilities.

Ms KEMP: We also have the clinics, which provide for students.

Mr WHELDALL: We also have a number of clinics at the centre, which provide services to parents and students.

CHAIR: How would you describe the difference between a learning difficulty and a learning disability? Is it important to you? Some people are worried about it and some people are not. When you have to deal with Federal governments becoming more restrictive in funding, you have to worry about it for that reason if for none other.

Mr WHELDALL: It depends with which hat you are asking the question. If you are asking me as an academic and whether from an instructional point of view it is important, I could mount a very cogent argument in favour of a non-categorical approach. But if you are asking me as the principal of a special school who has to consider funding, then these sorts of labels and categories are very important because they determine whether I get the money to teach the kids.

CHAIR: Are they very important in making the difference as to how you approach an individual child, or are they basically just labels?

Mr WHELDALL: They are just labels. It does not mean that there are not real differences. When we talk about the non-categorical approach to instruction, something that the Special Education Centre at Macquarie has been strongly identified with, it means that we do not subscribe to the view that there needs to be special programs of instruction for children according to the category of disability under which they fall. It is a very tempting, very seductive, view that if the child has Down Syndrome then he needs a special program for Down Syndrome children to help him to learn to read and function in the world. Similarly, other categories, some as real as Down syndrome and some a little more ill-defined, like ADHD and even dyslexia, you could argue that they, too, need specific programs of instruction due to the aetiology of the disabling condition. In fact, our reading of research suggests that that does not make conceptual sense: effective instruction is effective instruction is effective instruction regardless of the aetiology of the disabling condition. Would you like me to talk about what we see as the differences between disability and learning difficulty?

CHAIR: Only insofar as you think it is relevant, having said that.

Mr WHELDALL: I think it is. In New South Wales we use the term "learning difficulty" basically to mean any child who is struggling at school who does not have an apparent intellectual disability. In the United Kingdom they use the term "learning difficulty" to include everybody with learning problems, so you read articles about severe learning difficulties that are in fact about children who, we would say, have maybe a severe intellectual disability. The Americans might say that they have mental retardation. This terminology is very difficult and very confusing, especially for people outside the field.

CHAIR: What about phrases like "specific learning difficulty"? Is that very meaningful, or do you have your doubts about it?

Mr WHELDALL: If somebody used that phrase with me I would imagine the person was probably wanting to say something like dyslexia, by "specific learning difficulty". I am changing my view of it all. I am beginning to think that there is a useful categorisation to use the term "learning disability" for a very small group of children who are otherwise intellectually average or above average, but who have highly specific difficulties in a certain area, the most common of which is in reading and related skills. I am quite happy to admit publicly that over the past 10 years my view has changed so that I do now subscribe to the view that there is a very tiny proportion of students who have a highly specific difficulty, almost certainly biologically based, with learning to read. If people want to use the word "dyslexia" to refer to that small, very tiny group of children I no longer have a problem with that. I prefer the term "reading disability".

CHAIR: You spoke earlier about documented disabilities determining funding and so on. If we are talking about the broader group of children with learning difficulty, or even the group for whom you would use the term "learning disability", would they come into that Commonwealth definition?

Mr WHELDALL: No, not documented disabilities.

CHAIR: The funding we are talking about is for a group of children that everyone would—?

Mr WHELDALL: The definition is very carefully worded so that the funding does not reach more than about 2 or 3 per cent of the population. There is a very careful economic use of the normal distribution curve.

CHAIR: Do we need to say more about the non-categorical approach you adopt, or should we move into our next questions about the range of early intervention programs that you have developed?

Ms KEMP: I do not know that we need to talk more about the non-categorical approach. Everyone seems clear on the non-categorical approach we take. You wanted to ask about the early intervention programs. That is probably my area. As you may or may not know, Macquarie University probably developed the first major early intervention program in this country, followed by the Clunies Ross program in Victoria. That was a program developed for children with Down syndrome. Not so much we believe that something different had to be done for kids with Down syndrome, but if we were going to research an area like early intervention we needed to have a cohort of children for whom there was no argument about disability. Most kids with intellectual disabilities have what we call "global delay of unknown aetiology". You cannot categorise them as autistic kids and kids with Down syndrome, et cetera.

The idea was to take this group of children for whom there could be no argument. If you made gains with those kids it could not be said that they did not have a disability after all; that we did not do anything because it was not a problem in the first place. That was the reason for having that group of students. Once the whole notion of early intervention became acceptable so that we were no longer arguing whether we should or should not have it, it became more important to provide programs to all kids. In about 1991 we changed the model to include not just kids with the Down syndrome but all children with disabilities. As a result of the view that was coming through the research we also decided that it was a little bit of a nonsense having kids with disabilities come in for five years for segregated programs when the hope for those children was that they would move into mainstream environments, and that was the hope for most families.

It was our view within that we should provide more inclusive programs, but provide programs that would address the needs of the kids with disabilities. We were looking at having a critical mass of kids with disabilities so that their needs were not forgotten. That is one of the problems with inclusion, you often have one child in a class. The view of inclusion, it is not really an inclusion view it is really an integration view, is that you have the child who is different and you make the child fit into what is already operating. When people try to do that it does not work because that child is always seen to be the child with a problem.

Our view was to try to get a program going that had enough kids with disabilities to make them a critical mass, and for the needs to be of paramount importance, but then to provide an environment in which they could interact and have normal social models and much more normal expectations. As a result of that we downplayed the early part of the program. We were encouraging parents to have the children in as normal services as possible, and then we thought that to prepare them for the next step into mainstream we would offer a preschool program, which was inclusive but which, again, had a particular provision for these kids.

CHAIR: Can you put some age groups on it?

Ms KEMP: The children we have had into that program have been four to six-year-olds.

CHAIR: This is the 1991 model?

Ms KEMP: That is probably more post 1995. We worked with a more inclusive group of children in terms of disability from 1991, and we played around with the programs. It seemed clearer and clearer to us that what we were doing was promoting disability, if you know what I mean. We had these kids come in, we tried to teach them in small groups and we would have them in play groups, but all they were seeing was what other children with disabilities were doing. I was trying to encourage those families into inclusive programs, but what I was hearing from the parents was, "But my children's needs are not being provided for in that mainstream preschool. It is very unstructured. My child is floundering." Up to the age of three or four we encouraged the children to be at home and go to generic services, such as play groups et cetera.

As they moved into preschool they would come into our preschool, which was an inclusive model but with a critical mass of children with disabilities. That has been supported by a fair bit of research in the United States. There are some programs. For instance Mark Wallery, who is quite a noted researcher in the area of early intervention in the States, has a similar model. He has 25 per cent of his children with disabilities and the rest without disability. Because of our funding we had to have a bigger proportion of kids with disabilities, because what was happening was that our kids with disabilities were funding the program for the kids without disabilities because we had to charge only a moderate preschool fee to encourage our kids without disabilities to come into the program. Because we had very highly qualified staff it meant that we needed even more money to fund the program so that it was an effective program.

The Hon. IAN WEST: That means your percentage was not 25 per cent?

Ms KEMP: No. It started off as eight kids with disabilities to 10 kids without, but in more recent times it has been eight to about 12. That was in response to parents saying that we needed more kids without disabilities in our program.

CHAIR: How do you recruit kids without disabilities?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Cheap child care.

Ms KEMP: It is not that cheap. It is probably equivalent to the fees charged by preschools in the area, nine to three preschools. We had some difficulty initially, but in recent years we have not had any difficulty at all. We have had visiting academics from the States saying, "How in the hell do you get parents of kids without disabilities wanting their kids in your program with all those kids with quite significant disabilities?" And we have had kids with severe intellectual disabilities in the program. We say, "The answer is simple: this is a good program. It is not just a good program for kids with disabilities, it is a good program for all kids." When parents realise that they are knocking on our door. They are lining up to get their kids in.

The other thing we did, which was quite smart, is that we did a little bit of research into the area of gifted children as well. We became well known for providing well for gifted children. Parents of children who are quite gifted were clamouring to get their children into the program. That encouraged other parents with kids who were fairly average to come into the program as well. We evolved into two programs. We had one program that was for three-year-olds without disabilities and four-year-olds with disabilities. We had various models running for two and three days. The focus in that program was social and communication skills, because they are important skills for all kids and we did not want a very academic program for the kids with or without disabilities at that stage. A program for older children was for five-year-olds with disabilities—they often came to our programs instead of going into school—and four-your-olds without disabilities and that became a year before they went to school. Our kids with disabilities came five days a week, and those without disabilities came two or three days a week. It became the transition program.

Apart from having good developmental programs for all the kids, we also had some academic programs specifically for kids without disabilities and some extension programs for gifted kids. We had a support program whereby kids with disabilities were supported to make the transition to mainstream classrooms. We had them in fourth term attending half a day a week with support from staff from the centre. In the final term all the children were involved in a transition program at the centre. We set up the classroom as a kindergarten class so the children had experience of how it works in kindergarten. We also followed those children into school. I followed one cohort of kids without disabilities and all the cohorts of kids with disabilities to find out how they survived in mainstream education, how long they were able to maintain their places in mainstream, and what their skills were like. That was an interesting exercise.

CHAIR: Do the children attend an enormous variety of schools when they leave you?

Ms KEMP: Yes. The kids with or without disabilities will go to State, private and Catholic schools. When I looked at the distribution of kids with disabilities I found that it was probably in normal proportion to what you would expect: about 30 per cent of the kids go to private schools and 70 per cent to State schools.

CHAIR: Do they come from a fairly wide geographical area?

Ms KEMP: Definitely. We have children from Doonside, Merrylands and all the way through to the eastern suburbs.

CHAIR: When you talk about a "transition program", I assume that that program is not oriented to the school; I assume that you are preparing children for what classrooms are like.

Ms KEMP: We also prepare kids with disabilities in their own schools. We visited their schools for half a day a week and worked with teachers. The teachers would visit us to see the child in the program and so on. That was an extremely expensive program. We held fees down so that children with or without disabilities were paying the same moderate preschool fees. However, we have been unable to keep that program going. There are two reasons for closing it—it will close at the end of this year. First, it was very expensive to keep the program running. Secondly, why should we have a program for a very small group of kids who happen to get into it? We want to move it into the community, as should occur with all good programs. We tried to get the State sector to take on the program—I have been trying to do that since 1997—but we now have a private preschool provider, a very dynamic woman who runs wonderful preschools, and we will trial a pilot program in the community next year if we can get the funding to do that. That is where we are at the moment.

CHAIR: Do you know whether that funding will be available?

Ms KEMP: We will probably have some version of the program next year with or without funding. If we get the funding it means that we will have a special educator to help get the program going and ensure that it is excellent. If not, we will have a special educator as a staff member, which will not be as good. The idea is to trial the program—by the way, these preschools are long day-care centres as well—and eventually provide services such as this for kids from birth. The services for kids with disabilities are very poor in child care and schools at present and many families are not willing to trust their kids to these kinds of services. If there is one child with a severe disability in the service you get some support through ad hoc funding. The person providing support is often not trained in special education and, as a result, you do not have good programs and services. We are looking to develop some exemplary programs in early childhood services across the board. Those programs will be inclusive because that is what parents want—and that is what they are entitled to. We intend to continue to research in that area. When the programs go out, we will continue to research the individual interventions and the model. That is where the early intervention services are at present.

CHAIR: In terms of the labels that we use, you have a mix of children with manifest disabilities and children who are basically regular. In this inquiry we have been asked to focus on children who one hopes will overcome their learning disabilities and have a fairly normal education. This program probably does not address the group that falls through the cracks.

Ms KEMP: In fact it does. Because of the orientation of our program, which looks at skills that are predictive of learning success, we have picked up kids whom, if one talked to them, one would think were bright little people who would have a wonderful future in education. However, because they have severe phonological problems we have been able to pick up the fact that they will have learning difficulties. We have told parents, "We have identified that your child has severe phonological problems and we suspect strongly that this will interfere with your child's ability to learn to read." In many cases, we have developed a program for a child in preschool, the child goes to school and the teacher says, "No, the child will be fine." By the end of year two, the parents return to us and say, "You were right; the school ignored it and our child has a reading problem." We have been picking up those children only because of the orientation of the program.

CHAIR: Why does the school ignore it?

Ms KEMP: Teachers, especially early childhood teachers, have a view that children develop at different rates—I am not denying that: they do—and that parents should not be alarmed if their child is not at the same level as everyone else. You should look at their strengths and allow them to develop and catch up. However, we know that that will not happen in certain areas of deficit without intervention. There is a fair bit of ignorance out there. There is also a bit of a hangover from the language movement, whereby you provided a wonderful learning environment for children who would then soak up literacy by osmosis. In some sectors in particular that is still a very strong view.

The Hon. IAN WEST: What is that area? I am confused as to why teachers say that a child is okay when you say that he or she is not.

Ms KEMP: We know that phonemic awareness is one of the best predictors of reading success. Phonemic awareness is a skill that children begin to develop before they start school: it involves the awareness of the sounds of speech and the ability to manipulate those sounds. It begins as phonological awareness, which is broader: it is being able to rhyme; knowing that "mat" rhymes with "sat". It is a bigger chunk of language than a phoneme, for example, which is an individual speech sound. As children move into school they become more and more phonemically aware; if they do not, they will have trouble learning to read. "Phonemically aware" means being aware of the individual phonemes in words and learning to play around with them or manipulate them in some way. For example, if the word is "cat" a child should be able to match the sounds to the letters. However, it is more than that: children must be able to blend those sounds orally.

Professor WHELDALL: We must be clear about this point because I think there is quite a bit of confusion in the community as to what phonemic awareness is. It is a precursor to reading; it is not about reading. It is not about being able to identify the sound of the letter "c" with the letter "c"; it is simply about sounds and being able to break up words into their component sounds. If a child has difficulty appreciating that you can break up the spoken word "cat" into the sounds of the letters "c", "a", "t", it is highly likely that that child will have difficulty learning to read. It is as simple as that.

CHAIR: When a teacher says that a child will be all right, do you identify that as a problem with individual teachers, with the system or with training?

Ms KEMP: It is definitely a problem with training.

CHAIR: Is it a problem with early childhood teacher training or the fact that teachers do not receive training in teaching reading?

Professor WHELDALL: All of the above.

Ms KEMP: I was teaching a class last night and one of the teachers who is with the Department of Education and Training and is being trained as a special educator said, "I don't know why we weren't taught these things in our initial training; all teachers should be taught these things but we have to wait until we attend a special education program for teachers before we learn about it." That is a real indictment.

CHAIR: Does that apply to all teachers or to teachers who will be teaching children from kindergarten to year two?

Ms KEMP: I think it is probably all primary-trained teachers.

Professor WHELDALL: Anyone who is going to teach a child to learn to read should be aware of the enormous advances made in scientific research over the past 20 to 30 years as to how reading works. This information has not got out there sufficiently.

CHAIR: In all universities? Does one university have a course?

Ms KEMP: We are not identifying any one university; it is a problem across the board. I must also mention—I am very concerned about this—the fact that the Department of Education, the AIS and the Catholic education sector released a kindergarten assessment document the year before last. As usual, university personnel were asked to attend the consultation meetings and to comment on the document. That assessment document was supposed to pick up children who were likely to have problems down the track, and I was horrified that it hardly addressed phonemic awareness. In fact, I would say that the document was fairly inappropriate in terms of identifying children who would have real problems learning to read. It did not matter how many times people—not just me—said, "But haven't you read the research; don't you know there is a huge body of research out there that supports this view? Why are you ignoring it? How can you do that?" It does not matter what you say, nothing happens because there is a group within the department—many of whom are literacy consultants—who have been brought up in the language method and who are still hanging onto it. They probably have not read a research article in the past 20 years. I do not know why they cannot have open minds, be flexible and take on board new knowledge. However, that is how it is. There is a political mindset in the department and many literacy consultants persist in holding this view. Special educators say, "Listen to me, haven't you heard about this?" It depends who speaks the loudest.

Professor WHELDALL: Perhaps I can clarify the issue. It is the small "p" politics of the education world—especially the academic education world.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It sounds like it.

Professor WHELDALL: For many years there was a prevailing view that the whole language approach to teaching children to read and to encouraging them to learn to read was the way to go. This was a reaction against what was regarded as the old-fashioned reactionary way of teaching children to read, which was largely phonics based. To clarify, I think the whole language approach has a lot to offer many kids. However, it has very little to offer kids who are struggling to learn to read. Kids who have come from a stimulating, middle-class, academic background who have been bathed in rhyme and story from the day they were born will likely flourish in a whole language environment—assuming they have no reading disability, which we will come to later. However, a large proportion of kids are not going to learn to read in that way. Perhaps 20 per cent to 25 per cent of kids will not learn to read effectively if you just use a whole language approach. These kids need highly systematic intensive instructional approaches—including a strong phonics approach—that are based on research. That is the point we have come to.

I think that there is some movement now to an appreciation that, yes, there is a role for whole language, but that, particularly with children who are having difficulties learning to read, whole language is not going to be anywhere near enough. I think that is where we have got to. Would that be a fair summary?

Ms KEMP: I do not think that has filtered through.

Professor WHELDALL: I agree with that.

CHAIR: Ms Kemp, you said that the first-year-out teacher is supposedly trained in all the latest concepts.

Ms KEMP: Can I tell you about an experience I had a couple of years ago, so it is fairly recent. I am interested in transition and the transition of children with problems into school. I was looking at a disadvantaged area in western Sydney. I got a grant to look at a group of children who probably had learning difficulties rather than disabilities, and how they work coping in the three classrooms. I looked at three teachers. One was probably my age, and probably taught the way I would teach because that is the way she was trained all the way back then; another teacher who probably had gone to a lot of in-service courses recently, and had a nice balance between whole language and phonics; and the first-year-out teacher, who had only just been trained. She was a lovely young woman with a difficult class of 14 children.

I was in the classroom, helping her to assist children as part of this research project. I said, "I would like to come and watch a reading lesson." She said, "I have three hour sessions a week. It is really great because I have the ESL teacher, the STLD teacher, besides me." Can you imagine, with 14 children, what a wonderful opportunity this was. She had one child who had probably a mild intellectual disability as well. That child had no letter sounds at all, had very poor phonemic awareness, and had no numeral recognition. This was a child destined to be very problematic. I came along to listen to this hour-long lesson.

The focus of this lesson was procedural text. She started off with a recipe, which was on a card that she held up. She went through the recipe and what they were going to do. The children then broke up into groups. They had a mixture of icing sugar, which they all had a little bit of a stir of, they had arrowroot biscuits which they iced, and then they made faces. That took an hour—with three highly qualified people working with those children, who could not identify letters, who had very poor phonemic awareness skills, and were probably destined to have huge literacy problem.! It is not a matter of resources only. That, to me, would illustrate that point very clearly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: She was wasting resources; she could have done that on her own?

Ms KEMP: I would not have bothered doing it at all.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It depends how old they were, does it not?

Ms KEMP: They were five-year-olds. I am not saying that children should not be taught text types. But one of the things we need to understand, especially in respect of children who are likely to have learning problems, is that there are two stages of reading. One is the stage that we call learning to read, and the other stage is called reading to learn. Once you get to the reading to learn stage, that is great; you can read anything. Then it is the job of the teacher to teach how to use that skill, how to analyse, how to synthesize, how to paraphrase, how to research. Those are important skills to have. But if a child cannot access print, that is a waste of time. If a child cannot read the sentence, who gives a damn what kind of text type the child is looking at? If the child cannot read a sentence, it is even worse.

I ask: Why are we doing this with these children? We are setting them up for failure. We know that by the time these children, especially the bright little buttons, the ones with normal or better intelligence, reach the end of their infant years they are totally non-motivated, they are very defensive, they are difficult to teach, and you have the beginnings of huge behavioural problems.

CHAIR: Where does reading recovery fit into that syndrome that you are talking about?

Professor WHELDALL: I was hoping you would ask, "What do you think of Reading Recovery?" Then I could say, "following Ghandi on western civilisation, I think that would be a good idea." Reading Recovery, potentially, is fantastic.

CHAIR: This is reading recovery with capital R's?

Professor WHELDALL: That we have a program like Reading Recovery in place at such an early stage to pick up children who are struggling is tremendous. I think that Reading Recovery has had an enormous success on many levels. In fact, reading recovery aims to attack the problem at many levels, ranging from that of the individual child, the teacher, the system, and a macro level of the political system. I believe Reading Recovery has been successful on almost every level, except the instructional level; that is, the instruction that the child receives. My centre was commissioned to do an evaluation of Reading Recovery in the early 1990s. We provided two reports to the Department which to this day have not been officially released by the Department. Luckily, within the contract for that research was a clause that allowed us to publish in academic journals. We have published an article in probably the most highly regarded reading journal in the world, the *Reading Research Quarterly*, entitled "Evaluation of Reading Recovery". May I table that?

Document tabled.

Let me tell you the results in a nutshell. We found that Reading Recovery was probably effective for one child in three. One child in every three did not recover, another child would have recovered anyway without Reading Recovery, and one child was recovered. Reading Recovery is an extremely expensive educational innovation. It would be worth it if it were having the same effect on every child admitted, but it is three times as expensive as it was thought to be because it is only effective for one child in three. We are not the only researchers to have reservations about the efficacy of Reading Recovery; many experts in the United States of America now also have major reservations about Reading Recovery. I not going to be political about this. Every New South Wales government since the early 1990s has supported, and increased funding for, Reading Recovery, in spite of the findings of our report that it was not nearly effective enough. Let us be clear about this. The evidence was there. It was commissioned. It was submitted.

CHAIR: Has it been adapted at all since the early 1990s?

Professor WHELDALL: No, it has not. Dame Professor Marie Clay's work I admire enormously. She has been a beacon in literacy research. But that work is now old. Reading Recovery is based on Marie Clay's work, which was carried out in the 1970s. There are at least 20 to 30 years of research that is not accommodated within the Reading Recovery model. If you were to ask me for advice on what you should do, I would say keep Reading Recovery. Politicians love the name, and are willing to give money to it. Systems love it, because they think it is effective. The only problem is that it is not effective enough on the ground. So, keep the name, keep everything, and change the instruction that happens in those half-hour sessions.

CHAIR: Why does Reading Recovery engender such passion in academia?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They are either for it or against it, that's for sure.

CHAIR: We are smiling slightly probably because we have heard the spectrum of views.

Professor WHELDALL: I am saying that I am for it, but I want it to be improved.

CHAIR: You are for the name.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are for the name in order to get the money! We know about you!

Professor WHELDALL: We have the system in place, and it works, but not as effectively as it should.

CHAIR: Why are people, including academics, so much in favour of it?

Professor WHELDALL: I think they love the idea of it. It appeals more to those in whole language, but if you have got to have remedial instruction then probably Marie Clay's reading recovery is the sort of remedial instruction you would go for. But it does not, for example, include overt, explicit training in phonemic awareness. You could easily insert a component of that. It is half an hour with the child every day. That half an hour could be better spent. That is all I am saying.

The Hon. DOUG MOPPETT: I want to ask you to comment on some other evidence that the Committee has from a medical practitioner who spoke about all these derivatives of the Greek word *phonos*, put them aside and said there was a medical basis to this: that the problem with these children was that they had a different central auditory processing system which meant that when I or anyone else was speaking to them they simply did not have the ability to distinguish quickly enough the changes in sounds. This meant to them that, unless you almost said, "C.A.T, cat"—not in teaching them to read, but in saying to them, "Go and sit over there"—it became a blur. They simply could not distinguish the changes in sounds in any simple word quickly enough. Although it is not one of these clearly recognised disabilities, the problem they have with their large nerves, small nerves or whatever, resulted in their being unable to distinguish the quick changes that we all take for granted. When you pronounce the letter "T" in a word it takes a thirtieth of a second, or perhaps some even shorter time, and they cannot distinguish it. Do you think that has anything to offer?

Professor WHELDALL: I would say there are probably a very, very, very tiny proportion of children who have the problem. I am peripherally involved with a research project investigating the link between central auditory processing and phonological awareness, to see whether there is any relationship between the two. We have a doctoral student working on that at the moment at Macquarie University as a joint project between the Department of Audiology and the Special Education Centre. I think the jury is out as to whether there is anything in that. What I would say is that it is not going to solve our problems. It is relevant to only a tiny proportion of children. Most children who are struggling to learn to read can understand language and instructions perfectly well, but they are still not able to learn to read. So it may account for a tiny proportion of the tiny proportion, but I do not believe it will turn out to be a major factor.

The Hon. DOUG MOPPETT: Suppose it is all self-selecting, but there was this reference to her wonderful success. But, then again, if you happen to be the central person, you talk about a large number of people, but it would still be a narrow segment.

Professor WHELDALL: That is right. If you want to talk about numbers, what the literature is saying is that 20 to 25 per cent of children in most western developed countries are struggling to learn to read. For the vast majority of those children, the problems are environmental: they are not in effective literacy learning environments, or the instruction that they received at school has been inadequate. These are the children sometimes glibly, and jokingly, referred to as the "children who were away the day they taught reading". That is another of the problems: not enough time is spent these days on explicit instruction in reading in the early years of the curriculum, because the primary curricula has become absolutely stuffed with curriculum content on absolutely every area. One cannot continue to expand schooling, so something has to give. In this case, less and less time has been spent on explicit teaching of reading.

I return to the important point that the vast majority of children with reading difficulties have problems that are environmental and can be fixed. However, in my view, there is a group of children whose reading difficulties are biologically based. I believe we should reserve the term dyslexia, if we want to use that term, or the term reading disability, for that tiny proportion of children within the 25 per cent. Maybe we are talking about 1 or 2 per cent of the population. The best way in which to identify those children — and this is another major topic in the literature — is not to go into batteries of tests and assessment, but to find out how they perform when they have the benefit of intensive systematic remedial instruction. If those children still do not pick up reading following a period of intensive instruction, one could be confident in saying that they have a reading disability, that something biological is making it very hard for them to learn to read. But I think we are talking about 1 or 2 per cent of the population. I would like, however—and I will take this opportunity to do so—to say that that small percentage I term as having a reading disability should be recognised, and should be recognised for funding. Those children are going to need help throughout their educational careers.

The Hon. IAN WEST: You indicated that the two approaches were not mutually exclusive—the language approach and the phonics-based approach—but that when it comes to getting a component into the teaching you encounter difficulties. Could you expand on that a little more?

Ms KEMP: The whole-language movement is more a philosophy than it is instructional. Sometimes it is really hard to pin down exactly what it is. It is a view that reading should be about enjoyment. It was based on work done in probably the early days of whole language. Goodmans in the United States of America and Frank Smith are the names that come to mind.

Professor WHELDALL: The 1960s.

Ms KEMP: The 1960s and 1970s was when they did most of the work. It was based on looking at what adult readers did. When one looks at what adult readers do it looks effortless; it looks as though you do not have to look at every letter in every word, or every word in every sentence on the page. Linguists were really looking at what fluent readers did and attempting to extrapolate from that what ought to be happening to beginner readers. I think that is where they made their mistake. It almost allowed teachers not to worry about the children who were going to have problems, and therefore not to feel bad about them or to make them feel bad about having a problem.

CHAIR: When they were ready they would start to read.

Ms KEMP: It was almost ignoring the problem. We had all these wonderful literacy environments. We would read to the children and would allow them to read. That often meant learning the book by heart. Smart children who had a good memory could hide for years the fact that they could not read. Many have done that. It was all very pleasant for everybody. It is nice if everyone looks as though they are doing really well, enjoying school. This lovely sharing, caring environment is really nice. I think that what happened is that teachers were seduced by that kind of approach to teaching. What we have realised is that we still need to have good systematic instruction in phonics, but we also believe that there are some aspects of whole language that have been very beneficial. We want to encourage children to enjoy reading. We want to read to them and to give them a love of literature.

The Hon. IAN WEST: I appreciate that. Apparently I did not articulate that question very well. What I was getting out was what difficulties you have experienced with the department in implementing that?

Ms KEMP: There is a group of people who are still very wedded to whole language. It is a philosophy. You know how when you get a very extreme approach you get disciples of the cause that do not want to move an inch. You can have the same at the other end, by the way; you can have extreme phonics people.

The Hon. IAN WEST: Sorry, I understood that the two approaches were not mutually exclusive.

Ms KEMP: No, you can have elements of both and good teachers do both.

Professor WHELDALL: That is what we believe.

Ms KEMP: We believe it, but we still have the two extremes.

CHAIR: One other issue that leads into our teacher training question is even supposing the are zealots in the education department, or among the curriculum makers, I suppose if universities are still teaching teachers a more flexible approach—that you do not have to go all this way or all that way—then the zealots are not going to prevent new teachers from doing things that way. Or vice versa; the universities could be teaching something that people in the department are opposed to, who say, "we do not do it that way".

Professor WHELDALL: There is a resistance to take on board 30 years of scientific research into reading not feel-good philosophy. I am talking about controlled experimental studies that have been carried out over 30 years that clearly identify the building blocks of reading. It is a matter of people continuing to reject that. Basically, they have to because it is there. It is obvious. It is in front of them. They have to reject that and saying, "We are not interested in that." It is really an ideological matter. If you are into the whole-language movement you are into a progressive movement for liberation worldwide. If you believe in phonics you are a reactionary and would really be happy to stand next to Mussolini, I think. It is crazy. It is totally insane, but when you read some of the rhetoric, it reads like that.

CHAIR: Have you be involved in the teacher training area, for instance? Have you made sure that Macquarie University does not touch this Mussolini-type approach but goes all out for the libertarian view?

Professor WHELDALL: We do not have any say in what happens in teacher education at Macquarie University. There are other departments who deal with that. I do not want to blame merely government departments. I believe University teacher trainers are also complicitous with government departments, if you like, in perpetuating approaches to reading instruction that, in terms of today's evidence, are just plain wrong.

CHAIR: It is a fashion, but a very long-lived fashion.

Professor WHELDALL: A very dangerous one that has had enormous repercussions on the literacy levels of children in our country.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I think of the idea as being current. You do not know where these things come from. You get them as a sort of vibration or induction, if you like. You, conclude from reading the newspapers, that it has been political lack of commitment that has led to problems with literacy. You would say that it is this feel-good sloppiness and a progressive encroachment on the curriculum of other non-reading activities. They would be the two things you would say are the major factors. First of all, do you think that the literacy problem is real, in the sense that it is worse, or do you believe it is merely recognised? That is I always ask. Is it recognised that once if the child sat up the back and did not read, nobody ever noticed whereas now they do. They do because there are no menial jobs left for them whereas before there were. No-one really noticed that they could not read, so long as they filled out their timesheet or had someone else do it for them.

Professor WHELDALL: This business about how literacy levels have declined is a problem because there is very little hard data available that compares literacy levels then and now. There is some data that I will make the Committee aware of. Before I do that might I just point out that this is a crazy argument we are having, debating whether or not literacy levels have declined compared with 20 or 30 years ago. We should be celebrating the fact that literacy levels have improved enormously. What would we be saying about, say, childhood leukaemia? The prognosis for childhood leukaemia is something like an 80 per cent chance of full remission of symptoms now. Why are we not able to say that about reading after 30 years when all the research is in and we know how to do it?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But, is it?

Ms KEMP: Of course. It is very definitive in this area.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying it is 80 per cent better than it was or that it can be done?

Professor WHELDALL: No. I am asking why we are talking about whether reading standards have declined. We should be celebrating the fact that they are now much, much better. The fact that we are not suggests that there is a real problem.

CHAIR: We probably doomed that reading standards have increased.

Professor WHELDALL: No, we do not.

CHAIR: Over the last century, or since 30 or 50 years years ago.

Professor WHELDALL: There was a famous study carried out in the United Kingdom—I believe there are parallels between the two countries in regard to the education system and philosophies that have been dominant in those countries. It was called the "Oracle project" and it looked at children in classrooms 20 years ago and then looked at them today. That study found that the reading levels at the end of year three were similar to the reading levels at the beginning of year three 20 years ago. It is probably some of the most definitive evidence we have for a decline in reading standards by a very eminent team of educational researchers in the United Kingdom.

CHAIR: Would you not have to look at the reading levels in years five or seven?

Professor WHELDALL: I think they found it at both points that they looked at.

CHAIR: Earlier we spoke about children in Scandinavian countries starting school at age seven. Professor Elkins said it makes no measurable difference when they leave high school whether they started school at age seven or age five. Those kinds of issues cut across whether someone in year three 20 years ago could read better.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: He said that Scandinavian children could read before they went to school.

CHAIR: There are six questions we have not yet dealt with and we look like getting very bogged down. We certainly want to deal with some of them, for instance teacher training. Teacher training is an area that this Committee will want to make some recommendations about. We are anxious to know your opinion about whether whether teachers now or in recent years have been adequately prepared to assist children with learning difficulties. There is also a second question about specialist early childhood qualifications, which I presume includes the ability to teach children to learn to read. Have we lost something by training primary and early childhood teachers together, and so on? Would you care to give the Committee your opinion on those issues?

Professor WHELDALL: Yes. In the 1990s I was asked to be the Chair of the Ministerial Advisory Committee on Special Education, which around for a number of years. That was when

Virginia Chadwick was Minister for Education. One of the most significant things the committee achieved before it was wound up was to have established a requirement that there be a mandatory unit of study in special education for all teacher training students throughout the State. I believe that was a terrific achievement. I am not convinced that it has always been implemented as conscientiously and as effectively as it might have been, but it was a good start to make sure that at the very least all beginning teachers must have undertaken an awareness-raising course about the problems of children with special learning needs.

I think we could go further now. If we are committed to a policy of progressive inclusion of students with disabilities and special learning needs into regular schools, clearly regular schoolteachers need to have much more knowledge and, more importantly, far more skills in meeting the needs of children with disabilities and special learning needs. We need to move on. We pat ourselves on the back for the mandatory unit, but say that now we need more. I think that is happening.

CHAIR: What you do that in the preservice training or is it related more to professional development?

Professor WHELDALL: I think it should be happening preservice and, for those who have not had it, by way of professional development.

Ms KEMP: I believe that preservice training is really important because people tend to go back to their initial training. I would say you are not going to make a lot of difference unless—it is very difficult to attract people's initial training. They are the impressionable years. They have done nothing but whole language and when they come into the system we say, "That is all wrong. Forget all that and now do this." They become defensive about their training, as they should do. One would expect that. Unless we deal with this aspect in preservice training I believe we are fighting a losing battle.

CHAIR: When you talk about the special education unit you see that as, at least to some extent, familiarising teachers and enabling them to cope with those milder, more subtle learning difficulties? The unit covers the range between more profound disabilities and milder disabilities. What about the issue of specialist early childhood qualifications?

Ms KEMP: I do not think that would make any difference at all. I think all teachers ought to be training in how to teach basic literacy and numeracy skills. I run the literacy and numeracy units as part of the course and I am finding that teachers are coming back and they do not have the concepts in many cases. They do not know how to teach maths. I do not care whether they are early childhood trained—and some of them have been specifically early childhood trained—or K-6 trained. It does not seem to make any difference. They do not have any more or less skill.

I think it is not so much whether they are so-called specialist trained but whether they are covering what I consider to be the basics of primary education: teaching kids basic literacy and numeracy skills. If you have not achieved that by the end of primary school, then you have wasted your time totally. I am not against computer skills and all these other things, but the core business of teachers in primary schools should be to get kids to the stage where they can learn for themselves. We owe our kids that.

CHAIR: Some people who have spoken to us have put it more in terms of a familiarity with children's developmental stages, a little more specialisation in that sense—in other words, not so much looking at the knowledge of how to teach literacy or numeracy but a familiarity with an ability to pick up things.

Ms KEMP: I have a bit of the problem with developmental stages, because sometimes it is used as an excuse not to teach kids at all: "They are not ready yet. They are in this developmental stage, and we have to wait until we get to that developmental stage." They can only focus on developmental stages. In special education, if we worried about developmental stages, we would never teach anyone anything, because none of our kids would ever be ready to learn anything. We have to treat that with a fair bit of caution, I will put it that way.

Professor WHELDALL: In the same way, they say, "They will bloom in their own good time." That is a feel-good philosophy. Unfortunately, it is not founded in fact, but it is enormously resistant to any blandishments or persuasion or production of evidence. One of my clients a few years ago was 13 years old with a reading age of nine. She was attending an independent "progressive" school. When I went to speak with the school, at the parents' request, I was told, "Why are you worried about her? There are kids with far worse reading problems in her class. She will bloom in her own good time." We worked with her intensively for 18 months, so that her reading was massively improved following our intervention. We went back to the school, and I guess you can already predict what they said: "We told you she would bloom in her own good time."

CHAIR: What is MULTILIT?

Professor WHELDALL: I will table a full copy of the MULTILIT report and two copies of the executive summary.

Motion by the Hon. Ian West agreed to:

That the documents be accepted by the Committee.

The Hon. IAN WEST: With regard to the 18 months intervention, what periods of instruction did the person receive?

Professor WHELDALL: That particular person was having instruction for about an hour a day, which was privately provided by her parents. I arranged for a tutor; I think it was about an hour a day, three or four times a week.

The Hon. IAN WEST: At the parents' expense?

Professor WHELDALL: Yes. What I have tabled is an evaluation of MULTILIT commissioned by DETYA, which we carried out at MUSEC; it was released last year. MULTILIT is an acronym that stands for "Making Up Lost Time In Literacy". It targets older low-progress readers. It comes in at the very end of the remit of your inquiry, so eight-year-olds upwards really, who are at least two and usually three, four or five years behind their age peers in terms of reading and related skills. Typically, the kids we address are 12 and their reading skills are about the seven or eight year old level. These are kids who are reaching the end of primary school or the beginning of high school and they have basically stopped making any progress in learning to read. We have carried out studies that show that when kids reach the end of the primary years they make very little more progress; one or two months in two terms, if you are lucky.

For students who receive MULTILIT both in the Special Education Centre and in the Schoolwise program at Ashfield for the Exodus Foundation—and you asked me earlier about Reverend Bill Crews and his work—we provide a MULTILIT program called Schoolwise for the Exodus Foundation in Ashfield. Those sorts of students, who are very low-progress readers, typically receive two terms of instruction. In the case of Schoolwise, it was mornings only for two terms. The average gain was 15 months in reading accuracy in two terms. Two terms is about five months. So they put on 15 months in five months, on average. Some of them put on several years. A small proportion made very little gain. They are the ones that I think can reasonably be regarded as having a reading disability, because, in spite of intensive systematic instruction, they are still failing to learn to read. I am confident that they are the kids that we should be saying have, if you like, dyslexia or, in my terms, a reading disability. MULTILIT will help kids to make major gains. It has been replicated many, many times, as shown in the report, and that takes us to the end of 1998. Over the last 2½ years we have carried out many more replications, again showing that consistently we can help very low-progress readers to make significant gains in short periods of time.

CHAIR: Could it be applied to younger age groups?

Professor WHELDALL: I am confident that it could. There would not be a problem with seven or eight-year-olds. I would change it a little if I were talking about kindergarten and year 1 kids. But the same basic principles would apply. MULTILIT is based on three major things. First, there is a strong emphasis on phonics. There is also a strong emphasis on teaching students a basic set of sight words. We teach 300 words as sight words. Finally, there is regular, everyday practice in reading words in context, supported by a skilled other, whether that person is a teacher, a classroom assistant, a volunteer, or even a classroom peer tutor. Those are the fundamental building blocks from our point of view.

CHAIR: Is there a philosophical or practical basis for the age group that was chosen? Since we started this inquiry people have told us that once a child falls a little behind it is going to be harder and harder to make up, that programs such as reading recovery are based on assisting the child at the year 1 or year 2 level. I suppose commonsense tells you that there must be a fair amount of truth in that.

Professor WHELDALL: I agree that we should intervene as early as possible. My concern is that, in spite of all our interventions, a vast number of older children are low-progress readers. My particular interest at that particular time was to address that group of older low-progress readers, because they are always going to be with us.

CHAIR: Would it be true to say that MULTILIT addresses the one-third that reading recovery did not benefit?

Professor WHELDALL: It could be. Including the ones whom reading recovery initially benefited and who then fell behind again. I would love it if reading recovery put me out of business, but I do not think it is going to happen in the short term, unless we radically change it.

CHAIR: Because of the fact that Reading Recovery is a tightly organised program associated with copyright and so on, could some of the problems that you have addressed be fixed if it could be made more flexible or opened up for individual teachers or systems to change? In other words, are you making a fundamental criticism that the system should be tossed out and we should come up with something else, perhaps using the same name?

Professor WHELDALL: I think that so much work has been done, at the political level, the school level and the teacher level, that it is worth doing. I have changed my view. I now believe that we should stick with Reading Recovery and reform it from within.

CHAIR: But are we unable to do that, because of copyright and other issues?

Professor WHELDALL: I am not sure whether that is necessarily true. I did not know to what extent the copyright prevents you from providing additions to what Marie Clay says should be included. When I speak to Reading Recovery gurus, they tell me that they have made or are making these inclusions. I say, "Well, please point out to me in the literature an admission that it is time to revise it." So far, no-one has been able to point out to me where it says that we now believe Reading Recovery should include explicit teaching in phonological awareness, for example.

CHAIR: I must admit that when we were talking about this earlier, my knowledge was based on updating the materials, rather than changing the technique.

Professor WHELDALL: It would be such a shame to waste what has been achieved.

CHAIR: What would you like to see come out of this inquiry?

Ms KEMP: I would like to refer to our clinics here. Kevin has spoken about MULTILIT, which is operating as a clinic in the centre. I work with the younger children. We get four- to eight-year-olds in my clinic. A lot of the kids that come to my clinic are kids that parents identify and teachers are still saying it is okay in many cases. Parents are very aware of the problems that their children have. I get four-year-olds coming in, some of whom are from preschool, and they have fairly significant expressive language problems. I also get kids with mild intellectual disabilities. From kindergarten onwards, parents come to me and say, "I have had two other children, and it was noticeable that this child was having problems," or, "I was going along to hear my child's class read, and I could tell my child was having trouble." When I confronted the teacher, they said, "No, it is okay. He or she will be all right."

We have to charge a fee for that. I know that Kevin is in a different situation to me. In the first half of the year I actually made a loss in the clinic. These days universities are not being funded in the same way that they used to be. We have to pay for the facilities, et cetera, and we put a lot of work into these kids, who are often very difficult to work with, especially the little ones, and we have to do a lot of individual tailoring of programs, and so on.

Not only do these parents have to pay the fee, which is still substantial, but on top of that they pay GST. If they go to a speech pathologist—and speech pathologists are now teaching reading—not only do they not have to pay GST but they also get a rebate from their private health funds. I think that is a real problem. It is a problem for the teaching profession, too. That is what we are supposed to be good at doing: teaching reading. We are supposed to be professionals in that area. There is now another profession taking that over. And these are people who are falling into it, who are going to all these schemes, like the fast-forward scheme, the Spalding scheme, and taking all these little recipe programs that are being developed by teachers, linguists and so on, and so they are able to provide that service and parents are now being encouraged to go down that avenue.

CHAIR: Are they officially teaching reading?

Ms KEMP: They can call it anything. Reading is just printed language.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: With a huge shortage of them, they cannot be taking other professions, surely?

Ms KEMP: Some of them are doing our courses so that they can do it better. I have several speech pathologists doing my learning difficulties certificate. They are coming to learn from us so that they can work in their private practices.

Professor WHELDALL: In other words, the medical side is being subsidised to do the work of educators.

Ms KEMP: The fact is that many families out there cannot afford our services. We have often provided free services for families. I am in the position where I have made a loss and I am having to pay for that by some other work I am doing; I am moving money over to keep the service going. I am doing it for several reasons. I am doing it to provide the service that I think is needed; I am doing it to inform my teaching because I work in the clinic as well, and I believe that, as well as doing research, I need to keep my hands in there if I am going to have anything useful to teach my students, so it also serves that purpose.

Families ought to be able to afford this—families from all over Sydney, not just families who are earning good money. Even for those families that are earning good money, this is a fundamental skill that the kids need. It is not like violin or dancing lessons. We are talking about the basic skills needed to function in society that they are not learning in the schools.

Professor WHELDALL: So that is what you would like to see?

Ms KEMP: Yes. That is one thing. I would also like to see an improvement in the preparation of teachers, which is really important.

CHAIR: Is that in terms of methods of teaching reading or enlarging the special ed unit or both?

Ms KEMP: For me it is teaching literacy and numeracy. All teachers should have the skills to reach the full range of kids, including kids with disabilities. It should not be happening just with special ed units. I feel fairly strongly about that. I also believe that it is about time that people started to look at research in the area and to fund objective research. It may be teams of people working together across universities or whatever. Our practice needs to be informed by research. We should not be going with what is popular or trendy at the time and allowing the sorts of infights to be happening. We ought to be using scientific research to inform our practice.

CHAIR: Do the States vary in relation to the bias in favour of a whole language approach, for instance?

Ms KEMP: I think it is probably common across this country.

CHAIR: And other countries?

Ms KEMP: American no. The United States has a national organisation that looks at all research in the area of education. For instance, California has banned the use of whole language in its schools.

Professor WHELDALL: Typical Californian overreaction. That is equally insane.

CHAIR: In about 10 years someone will come along and—

Ms KEMP: We are against that swing of the pendulum. If you go extremely one way the chances are that the pendulum will always swing right back in the other direction. We want balanced, sensible, good eclectic practice, but we want people to have the full range of skills. We want them to be aware of what is happening in the area of reading and not just get one person's biased view. That is what I would like to see come out of it but Kevin may have other ideas.

Professor WHELDALL: My wish list is similar. The results of research into how reading works over the last 30 years should be implemented in teacher training programs now. More importantly, I would like to see teaching become a profession that is informed by scientific research; that teachers do not teach by the seat of their pants. They should teach from a professional knowledge base firmly rooted in scientific empirical evidence. Here we could make comparisons with the medical profession. We would not think much of medical practitioners who decided that today they feel like doing an operation this way just for a change to make it more interesting rather than adopt the acknowledged way to do it. Practice should be informed by research.

Here I am shooting this straight back to you. I did the research on Reading Recovery for the New South Wales education department, for the system if you like. Both the political parties that have been in government since have continued to spend money on Reading Recovery. So let us have political parties looking at the findings coming from scientific research too and take that on board and be prepared if necessary to fly in the face of fashion and public opinion and say that the evidence suggests that this is not effective enough, it is not a good use of public funds. I would like to see reading disability recognised as a real thing. I mean those kids who in spite of our best efforts at remediation are still left relatively untouched in terms of picking up on reading. It may be 1 or 2 per cent. They will need our help and support throughout their school careers. There should be funding available for those kids. Finally, I would like to see at least 95 per cent of kids in our State learn to read competently by the end of year 3.

CHAIR: If you both wanted one thing out of many initiatives could you choose, or is that a silly question at this stage?

Ms KEMP: I think the research informing practice.

Professor WHELDALL: Yes, everything follows from that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said that you would like to see at least 95 per cent of kids reading.

Professor WHELDALL: I would go as far as 98 per cent but I thought 95 per cent is a little more conservative. I would be happy with that as a first step.

CHAIR: I also raised this issue with Professor Elkins. Neither of you have mentioned ADHD behavioural difficulties, as symptom or cause or whatever. Is that because you focus much more on the intellectual, the neurological areas, because you see behavioural problems as a symptom rather than a cause, or just because we did not ask any questions that way?

Professor WHELDALL: My view of ADHD is similar to my view of reading disabilities. A tiny proportion of kids have behaviour that is so aberrant that we could, if we like, use the term ADHD. I also think that it is probably overdiagnosed by a factor of 10. Psychostimulant medication is probably overprescribed by a factor of 10. I am very concerned about the increased use of Ritalin.

CHAIR: People from the health department basically said that all the evidence was that it worked and they thought that perhaps more prescriptions could be picked up to address more problems. I do not think that I am exaggerating. I think that is pretty much what they said.

Professor WHELDALL: I think that the evidence suggests that it would be effective in making kids more compliant. It makes life easier in the classroom for teachers but there is no evidence to suggest that as a consequence the kids learn more effectively. If you want to sedate the kids so that teachers have an easier time in the classroom then be honest and say that is what you are doing. But do not claim that you are doing it for the child's benefit to help him learn better.

CHAIR: I think that evidence was from people from the mental health area of the health department. They certainly were not looking at it from a teacher's point of view or even perhaps from the parent's point of view. It struck all of us that they were so open-minded and expecting to see the numbers of doses go up.

Ms KEMP: We see a lot of kids who come into the centre who have been diagnosed with ADHD. They are often off task when they come in. We get some good instruction going in the classroom and those kids are so on task that when people come in and we tell them that they were diagnosed ADHD—

Professor WHELDALL: We have had parents come to us with their kids on Ritalin saying that they do not want the kids on Ritalin and asking whether we can see whether they can learn without it. That has happened many times over the last 10 years or so. When the kids are given appropriate instruction and appropriate classroom management using a technique called positive Teaching—which we do not have time for now—they do learn. At one point it was a bit like the equivalent of a Betty Ford clinic. It was like a detox unit for kids on Ritalin. It showed that many of them did not need it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You will be pleased to know that pharmacologists are marketing very thoroughly so that Ritalin does not have to be prescribed by specialists.

The Hon. IAN WEST: Without advocating medication, is not true that by making the child compliant and easier for the teachers in some percentage the environment then enables the child to advance in learning?

Ms KEMP: Only if there is good teaching going on.

Professor WHELDALL: Even then, I am not sure that there is evidence in the literature that suggests that Ritalin is associated with good academic gains.

The Hon. IAN WEST: No, it is associated with compliance. What I am getting at is whether on occasion it is of assistance in enabling learning because of the improved environment. I am not suggesting that it is a good thing but a consequence.

Ms KEMP: No, I would be surprised. Unless you change what you are doing in terms of instruction you are not going to change what happens in terms of progress in the areas of literacy and numeracy. There is no doubt about that.

The Hon. IAN WEST: I agree with trying to stop medication but I think that you are being a bit too clinical.

Professor WHELDALL: There is a small proportion who need it. I have been persuaded by the evidence of the kids coming to me over the past 10 years that a small percentage of kids do need it, but not the vast numbers who are getting it. I think we are in agreement.

Ms KEMP: Kevin and I decided a long time ago that according to the behaviours that are supposed to be used to diagnose ADHD we obviously have it. We are really concerned that you are labelling kids with a pathology that is normal behaviour, especially for boys. It is normal exuberant behaviour. Are we trying to turn all our kids into little robots to—

CHAIR: Some people would say that the answer to that is yes.

Ms KEMP: That is a real worry.

Professor WHELDALL: I sometimes think that Ritalin is being used to stop boys being boys.

(The witnesses withdrew)

(Luncheon adjournment)

KERRY-LEE BUTLER, Director of Early Childhood Services, Learning Links, 12-14 Pindari Road, Peakhurst, and

TRACEY ANN WEBSTER, Acting Chief Executive Officer, Learning Links, 12-14 Pindari Road, Peakhurst, sworn and examined:

ACTING CHAIR (The Hon. Doug Moppett): Did you receive a summons to attend before this Committee?

Ms BUTLER: Yes.

Ms WEBSTER: Yes.

ACTING CHAIR: Have the terms of reference been made known to you?

Ms BUTLER: Yes.

Ms WEBSTER: Yes.

ACTING CHAIR: Do you have a submission which you wish to be incorporated as part of your sworn evidence?

Ms BUTLER: Yes.

ACTING CHAIR: Jointly or severally, do you wish to make an opening statement?

Ms BUTLER: Yes, I have prepared an opening statement. We are pleased that the Standing Committee on Social Issues has recognised the significance of learning difficulties in people's lives. This is a social issue, without quality and consistent intervention in the early years people with learning difficulties are vulnerable. The long-term impact of learning disabilities is not limited to academic performance. As children grow, if their learning disabilities are not addressed they are likely to experience long-term impact on their self-esteem, social life and resilience.

Up to one in every five school-age child struggles with a learning difficulty. This pervasive social problem equates to approximately five students in every classroom. Without appropriate educational support, research indicates that as the children approach adulthood they may experience a lack of self-confidence and esteem, future drug and alcohol abuse, unemployment and social and economic advantage, homelessness, and, very sadly, suicide.

Learning Links was formed by a group of parents 28 years ago to address the needs of children struggling at school. These children may not be at the bottom of the class. The Committee's response may well be that they are not the kids with the greatest need, and that other children who need more help and doing worse. But the reality is that children with learning difficulties have the potential to achieve and are aware of their struggle. They know that they are capable of more. This reality leads to frustration, anxiety, loathing of school, fear of trying, and a feeling of hopelessness and despair.

This issue is not always about a poor reading skill or lack of academic brilliance, it is also about the impact of being in a system in which the focus is continually on what is difficult. We acknowledge that some children survive the system, but often they are the children whose high levels of skill are in another area such as sport or drama, and is recognised. Learning difficulties consumes one's whole life, and the life of individuals and families. We feel privileged to present some of the experiences that the organisation has built up over the past 28 years. Obviously its history has been specifically in the area of learning difficulties.

ACTING CHAIR: Tracey, do you want to add anything at this point?

Ms WEBSTER: Not at this point.

ACTING CHAIR: Could you briefly outline the work of Learning Links?

Ms WEBSTER: Learning Links has three quite distinct programs. We cater for children who have experienced difficulty in learning from birth through to school exit. In that age continuum, we have an early childhood services program, of which Kerry is the director. That program caters for children with special needs in an inclusive preschool. It also provides early starters groups, and Kerry may add some information on that. A lot of this information is contained in our submission and I will not repeat the detail. We have Hanen programs—a communication program for parents of children with communicative learning disabilities.

We also have playgroups in the early childhood setting. We provide programs for children of school age. Quite a number of children who attended the early childhood setting come to us later for service in their school years because, unfortunately, they are not able to access the services that they still require on entry to school. In the school-age services program we provide a number of assessments which will identify the learning difficulties that a child may experience. We have a range of different types of assessments: psychometric assessments, which look at the IQ and cognitive ability; academic assessments, which look at achievement in relation to their peers and whether they are up with their literacy skills, whether they are above or behind the chronological age with reading, spelling and reading comprehension, and numeracy; and we provide speech and occupational therapy.

Learning Links provides a unique multidisciplinary service. Overriding the two programs I have explained, we have family services. That includes family counselling and support for the parents and provides parents with strategies to assist with their children and provides support for parents who have difficulty within their family. It provides parents with strategies to better support their child and assist with the relationship within the family. Some families breakdowns arise because of the difficulties that the child may bring into the family. That service is available to all families across both services.

We also provide statewide educational support so that parents, teachers and other interested parties will phone in and ask for assistance. We have a library available as well. We also provide another program called the Ronald McDonald House Charities Learners program, which is a funded program through Ronald McDonald House charities for children who have had serious illness and who, as a result of that illness, are behind in their academic skills. Most of the children in the program may have missed anything from six months to two or three years of school, and have no educational input in that time. We provide a catch-up service.

ACTING-CHAIR: In a moment we will move into a critical area of your submission about waiting lists and the excessive demand over supply. I come from the country and I note that you referred to the southern suburbs, the northern suburbs and the western suburbs. You do not have outreach into country areas. Would you comment on how applicable your activities would be to large regional centres or for country children when you talk about this area of unmet need? Before we get on to that, it seems quite remarkable that an organisation like yours would have to operate with waiting lists when it is the responsibility of the Department of Education and Training, the Department Health or someone to provide the services that you seem to provide. Would you care to comment on that? It is all in the context of unmet need.

Ms WEBSTER: In response to the area you were alluding to that we have waiting lists and large numbers of people waiting to access our service because of unmet needs from the Government, that arises on occasions because there are set criteria. Often those set criteria preclude children from accessing services. It is necessary to look at the individual needs of each child. That explains why perhaps there is sometimes that unmet need out there.

Ms BUTLER: I am also President of Early Childhood Intervention Australia, New South Wales Chapter, and I also sit on a statewide Early Childhood Intervention Co-ordination Program, which gives me the opportunity to meet quite a number of rural service providers. I am very fortunate. What I have learned is that from an early childhood intervention perspective, from the 0 to five-year-olds, is that a number of things impact on waiting lists. There are number of community-based organisations. Although the Department of Community Services, the Department of Health, the Department of Education and Training will provide a range of services, it is often the community-based family initiated community-based service that will take up the slack so to speak, take up the needs of children who do not meet any of those criteria in those other areas. Often they have to go to a range of different government bodies to attract funding. They would go to the Department of Education and Training Young Children with Disabilities Intervention Support program money, which is quite a complex funding document. I could probably talk at length about some of the difficulties that we find accessing, maintaining and completing accountability reports, et cetera.

DADHC has also had quite a bit of early intervention money going out to provide core services, but at the current level of funding it does not address all waiting lists. Again the Department of Health would be able to offer some services, but you end up with a very piecemeal effect and that is what I was talking about when I referred to lack of consistency across areas. In rural areas another big impact for services on chronic waiting lists is chronic shortage of staff. Recently I spoke to a member in a rural area who said that they have $85,000 sitting in the bank waiting to try to get therapists. It is a little bit like the doctors scenario and trying to get doctors out to country areas, but they cannot get the therapists out there, they cannot keep them out there and that is the difficulty. But it is not just in country areas. In the Sydney metropolitan area, for instance, we have a little trouble getting staff such as occupational therapists, physiotherapists, early special educators and early childhood teachers. Our training issues in New South Wales are impacting on service delivery. Does that answer your question about rural issues?

Ms WEBSTER: Certainly, our service would be valuable in rural areas if we could take it to them. What prohibits us from doing that is money and resources. In an ideal world if we took them there they would be welcomed.

ACTING-CHAIR: What provides you with your funds?

Ms WEBSTER: We are in a situation whereby the early childhood service receives government funding through DADHC and DOCS. That is purely for service. It does not provide funding for infrastructure. School-age services receive no government funding, so there is a fee for service there. However, with the fee for service we then raise funds and fundraise to have funding available for families who cannot afford the service. If the family can afford it we ask that the family pay. We try to keep that not competitive but affordable, I suppose, in relation to other services they may be able to access. If it is private speech therapy we try to keep it at a level below that. We also provide for any family who has a health care card a one-third reduction in fees. Then we have discretionary fees, so that if the family does not have a health care card but cannot afford fees, or even if the family has a health care card and cannot afford fees then we fund them down.

We try to make it as equitable as we possibly can. There will always be difficulties. It is very much based on an honesty system as well because if our families request or seek additional funding from us it is up to them to fill out a form. We get other funding from housie. Unfortunately, in our situation, changes to government policy is impacting on our funding that we can get from housie, and also the changes that were recently made to fringe benefits have had a huge impact on our organisation as well with the amount of money that we are getting. Money that we may have had available for services we now have to put towards trying to fund a fundraiser to bring in additional funds so that we can provide a service for the children. There are a lot of things that impact on our ability to provide a service.

ACTING-CHAIR: I keep diverting from our central plan, but I was wondering whether you would care to comment on the profile of the people who seek your service. We often hear about overcoming environmental problems to education, which are often socioeconomic, but the sad fact is that people who need it most are the least likely to access available services. Poor parent motivation and all those sorts of things have a history and acceptance that three generations of illiteracy will probably produce a fourth generation of illiteracy. People who seek out these alternatives to government services, whether it is coaching colleges or, in your case, more basic services, are the worried wealthy who used to revert to Dr Spok-type solutions.

Ms WEBSTER: In most cases our service is parent initiated. It is not something that is forced upon them. We do not say, "This is what you need." They come to us wanting the service. I acknowledge what you are saying, because it is very true. One of the programs we have been trying to fundraise is called Breaking the Cycle. We are looking to other organisations to donate to help break that cycle of illiteracy, which may be in families. We see a different clientele between our three city branches. For instance, Peakhurst and Dee Why are very much middle-class-type areas. We have a branch in the western suburbs, which has about 85 per cent of families not paying fees. We also have a bus available to the families because transport is also a problem. The bus will pick up the children to bring them to our service. Ms Butler is about to embark on a huge project of setting up early childhood intervention in south-western Sydney to meet the needs of those families. I believe families are becoming more aware of literacy. There has been a big literacy push and families are becoming more proactive in seeking services for their children.

Ms BUTLER: Definitely. We have an inclusive preschool in which 30 per cent of children have some disability. Those children with learning disabilities are not funded so we fund them ourselves. We see that those children whose families have poor communication skills but who might be doing okay—they have found jobs and so on—also have communication difficulties. Perhaps three or four kids in the family might have difficulties. When we are trying to place those children in the school system and find appropriate settings for them we know that they will not necessarily receive the full support they need to break that cycle. We can do a lot of early intervention but we cannot fix the problem. Those children need to continue with more ongoing support in those areas.

Ms WEBSTER: There is often no easy fix to that problem. It is an ongoing problem, so any services that are available in early childhood must be carried through the school system. Family councils help those families with poor communication skills to become advocates for their children. They support those families by going to the schools and helping them to seek the services that they want for their children.

The Hon. DOUG MOPPETT: Given your very impressive client list—in terms of unmet need you appear to have a mailing list that Coles Myer would be glad to get hold of—how are people referred to you? Why would someone knock on your door? Where do they hear about you?

Ms BUTLER: The Down syndrome association, for example, might refer parents of newborn babies. There is initial contact through baby health centres, early childhood settings or Families First. We met recently with Families First. It is situated in the Bankstown area and we are trying to network with Families First. It meets with nurses at the newborn stage to discover which families will require support, which is provided very early on. It is then able to refer to us. One concern is that, as we pick up these children at a very early stage, we must have enough services to provide ongoing support. As to early intervention, in the past the parents of premature babies, for example, might attend our early starters group and meet a physiotherapist who gave them some ideas about handling their baby and moving on to the next step. After several months, those parents might say, "I think I am doing okay so I will go to a normal playgroup; I know where you are if we need you." In those circumstances, the intervention might be quite short and specific. Whereas in other circumstances we might identify a child with significant difficulties who will require ongoing therapy. We do not want to put those children on a waiting list so that families become anxious and concerned and we cannot ameliorate their difficulties.

Paediatricians also refer to us. There is a lot of word-of-mouth referral. Parents at playgroups might say, "I've heard about that service." Families concerned about their child's communication skills might go to the local speech therapist who will say, "Why don't you put your name down at Learning Links because we know that is a good preschool that will keep an eye on your child?" Early childhood teachers telephone us to say, "We can't cope with this child any more. What should we do? Can you help?" School teachers will also say, "We've had another child involved in this program; why don't you try it?" There is no one current referral agency, but a network of people saying, "I know about that." However, if you are not in the network you will not find out about it. They are the families that we are trying to capture in early intervention. It is about developing links with different networks—for example, the Aboriginal network, the Arabic women's network or whatever. Families First has funded ethnic workers in Bankstown, for example, who will go a long way towards developing those links. It is a good initiative.

The Hon. DOUG MOPPETT: You are essentially word-of-mouth people: people have heard about you and various professionals are aware of you.

Ms WEBSTER: There is general awareness of where each branch is.

CHAIR: How are the 750 families divided between your three areas of activity?

Ms WEBSTER: Our head office at Peakhurst has approximately 300 to 400 families.

CHAIR: Is that where you started?

Ms WEBSTER: Yes. We cannot fit any more families in there. The western suburbs has about 120 to 130 families and Dee Why has about 100. Then we have assessments at the branches. About 50 families are involved with the Ronald McDonald House charity program at the three branches as well as Coffs Harbour, Newcastle and the South Coast and some of the western area of New South Wales.

The Hon. IAN WEST: What is the venue in the western suburbs?

Ms WEBSTER: Fairfield.

Ms BUTLER: The new funding that we have just received will cover the Fairfield, Liverpool and Bankstown areas. Early starters is covering basically the nought to threes. About 120 children come to the preschool each week and, of those, 30 children have additional needs. We visit services in the St George-Sutherland area and provide support for those children in their current childcare settings.

CHAIR: Did Families First come to you? Did you submit an expression of interest?

Ms BUTLER: It is not in St George-Sutherland.

CHAIR: What about the Fairfield area? How did Learning Links come to be the provider?

Ms BUTLER: We are not the provider for Families First. We have linked with Families First in the Bankstown area, as we will in Fairfield and Liverpool, but we did not apply for that funding. We do not see it as our core business at this time, but we will form strong links with those people.

CHAIR: So it is more of an inter-agency approach rather than Families First directing money your way?

Ms BUTLER: My big concern for Families First is that, while we are identifying these children very early on—I applaud the Families First initiative—we must ensure that we have enough physiotherapists and speech pathologist to look at early feeding and kids who are not rolling over, starting to crawl or reaching other milestones and provide good quality play-based early intervention that will offer support at a very early age. That is my big concern. I really do not want families to know that their child is having difficulties but not know what to do, and thus become shy of the system very early on and say, "They weren't there before so why should we worry about them now?"

CHAIR: Do early childhood nurses and home visits require more attention and funding?

Ms BUTLER: I suppose my concern—I do not know enough about Families First in well-established areas—is that we do not begin to prioritise just those families who are at risk. This initiative needs to occur across the board so that we pick up those families who are not seen initially as being at risk and provide good quality services to them. If a child is not eating well at nine months, for example, and developing good muscle control and good awareness of what his or her tongue and mouth can do we know that that child is more likely to develop speech and language problems later. If a speech pathologist is not able to be involved at that stage that problem will persist.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: From nine months?

Ms BUTLER: Yes. Think about a baby that has been fairly static for quite a number of months and is now starting to move his or her hands and arms and beginning to roll over. If that baby does not crawl and is left in that environment he or she will not find out about the texture of his or her environment or that something is hard or soft. Babies learn about body space because they can get under this and over that. Therefore, that baby will miss out on all the cognitive skills that are developed when children learn to crawl or pull to stand. Development is very much about genes, relationship with one's environment and the interaction that occurs. If we look at the early years study, we see that those children need to receive support along their developmental journey. We need to start early. If we look at speech and language, chewing and swallowing and the complex part of eating and then at producing sounds such as "m", "p", "b" and "d" and phonetic awareness, we can see that it moves on. Learning difficulties do not start suddenly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think you can pick that at nine months? Many witnesses have spoken about what can and cannot be diagnosed, whether there should be universal screening and the error rate of very early assessments. Could someone with your training pick a problem at nine months and say, "Get the speech pathologist down here"? If that occurred how many false positives would result and how many speech pathologists would you need—there seem to be about half as many as are required?

Ms BUTLER: Definitely.

Ms WEBSTER: Even if there were false positives it would do no harm.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, it would. What about the misapplication of resources and waste of money? That is a major harm.

Ms WEBSTER: I am saying that the long-term outcomes for that child would be only positive. I am not talking financially.

Ms BUTLER: I will give you an example. I was promoting our new service at Menai—we received some money, which is very exciting—at which our speech pathologist was present. A mother brought her twins to the stall to talk to us, and the speech pathologist picked immediately the difficulty that one child was having swallowing and eating. She said that she would like to see the child one or two times to provide some assistance. Help does not necessarily have to be long term: it can often be that sort of support. It is about that speech pathologist's expertise in picking up the problem and providing a small amount of intervention. If parents feel good about that intervention they will come back for more help as it is needed. I do not know that the cost will be so bad; we might have some real benefits.

Ms WEBSTER: As to speech pathology, one of my concerns within the school system is that many teachers have no general understanding of the role of a speech pathologist and how it impacts on children with learning difficulties. It is the same with occupational therapists. I think some special education teachers are fully aware of those roles, but that information needs to be introduced into teacher training so that teachers can identify children in their classrooms who might have a language or communication disorder and refer them to the appropriate people. All too often teachers assume that speech pathologists deal just with stuttering.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is the layman's approach. You said that you were concerned that there were not enough physiotherapists and speech pathologists involved with Families First. Do you mean that Families First was set up with no troops to run it?

Ms BUTLER: There will be no-one to refer to.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There are no troops to deliver the services that are identified as being needed.

Ms BUTLER: In some cases we can retrain nurses to be better, perhaps more developed and highly skilled in that area. They could receive support from physiotherapists in that way. It does not necessarily mean that we approach this issue from only one direction: there is thinking outside the box. Perhaps we could train some nurses and there could be an assessment by the physiotherapist, who could talk to the nurse about the next stage. Nurses could then keep that in mind as they conduct home visits.

The Hon. DOUG MOPPETT: We have established that you have a waiting list and so on, but could you talk to us about how you go about prioritising your services, whether that means that learning difficulties tend to go down and you really concentrate on people with pronounced and manifest disabilities in preference? Our inquiry is about learning difficulties. Then we might talk about equity of access, as raised in question 3.

Ms BUTLER: There are two sides to it. I will talk about early childhood services first. We are funded for children with disability. The Department of Education, Employment, Training and Youth Affairs does not fund for learning disability; the Department of Education and Training's intervention support program does not fund for learning disability. What we tend to do in the preschool and inclusive setting is take a child with high support needs, a child with medium support needs, then maybe four children with low support needs and try to find a balance, because you cannot have six children with high support needs in a classroom. So, yes, there tends to be a natural prioritising of who can receive the service.

Because we do not receive funding for children with learning disabilities there are barriers to those children accessing the service. However, because we are an organisation that was set up to service those children, we have always tried to find the dollars through fundraising. But that is difficult, and we are concerned that those children probably are not getting the full impact of the intervention that they rightly deserves.

Ms WEBSTER: The children that we service in school-age services are children in mainstream classrooms who are experiencing difficulty learning. So they may be children who have integration support in the classroom, or typical LD children who have attention problems or whatever. We try not to have a waiting list if we can avoid it. We try to get those children in as they ring up. It is a matter of matching children and supporting them. In regard to waiting lists, it can be simply that we have no space available. Then it is trying to match the child with an appropriate group, because we like the children to work in groups, rather than one-on-one, in an attempt to enhance their self-esteem. So that has to be done with their peers.

The Hon. DOUG MOPPETT: This all comes to the important point you raise in respect of question 3. Your submission states that you feel that there is neither equity of access to early intervention services nor consistent programs for all children. Would you can to expand on that?

Ms BUTLER: We talked earlier about the fact that access of services is a matter of word of mouth. There is also a very much wait-and-see approach by many paediatricians and general practitioners. That immediately makes a difference to who will get the service. It will depend on which paediatrician one went to see and whether or not that paediatrician believes in early intervention. Therefore equity in equal access to services and early identification is an issue. The quality of programs is very much influenced by the impact of the environment, funding and availability of staff.

Consistency is very much related to the quality of the staff. A long day care centre has maybe childcare worker trained staff, and a preschool maybe early childhood trained staff. If you are on the SUPS program you get a child care worker allocated to your program or to your child only when you are there. So people taking those positions are not necessarily well-trained and may not regard this as a career. It is a very minor point, but it makes a difference to who is offering the service and who is providing the support. So some children will get service from the Department of Community Services [DOCS] maybe once a fortnight, other children will get it once a month, and yet other children will be on the waiting list for up to six months. There is just no equity of access. There is not consistent programming, and the quality is very variable. That is just the reality at the present time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there any indexed fund-met need, or is there no data on that?

Ms BUTLER: There is no data. We are in fact looking at that in the south-eastern Sydney area and trying to work out whether or not a centralised intake system will look at that. We are unsure about that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And if it did, would there be one?

Ms BUTLER: Could there be centralised intake?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, and what would the intake point be administratively?

Ms BUTLER: Through the early childhood intervention co-ordination program, that is exactly what we are looking at, centralised intake, or at least monitoring how many children in that area are requesting a service. I have 30 children on my waiting list waiting to come to a preschool. They will not get a place this year, and maybe 10 of them will get a place next year. Where will those children go, and who will support them? What sort of program will they get if they are not getting our program? Those are real issues. We refer children to the Department of Community Services and are told that they have to have a psychometric assessment because they are over the age of three years, whereas I can tell you that those children have a developmental delay. Parents are being asked to jump through hoops in order to access services that are unrealistic.

I had a set of premature twins of 28 weeks, one of whom was blind and the other vision impaired. One little girl was in a wheelchair and hearing impaired. One little girl was totally dependent, and the other highly dependent. Those parents were told that the children had to have a psychometric assessment before they received services from DOCS. Children with learning disabilities will not receive services from DOCS because of the priority of access issues.

The Hon. DOUG MOPPETT: Quite a number of the dot points in question 4 have been covered in one way or another, but I would not pass on without asking you specifically the last question. Do you have any views on the role of child and family health nurses identifying and supporting families of children with learning difficulties? I think that question links with dot point 6, which talks about co-ordination between preschool and community health services, and then we come to schools. Our focus all the time, I have to keep reminding myself, is concerned with learning difficulties, not disabilities, largely as they manifest themselves in school and how people might deal with that problem earlier. We want to know what you think about the effectiveness of the health service nurses provided to monitor the development of the child, how effective that service is, how it is co-ordinated with other services provided by DOCS and maybe somebody else who has some knowledge of the family? Is that then effectively presented to the school when the child enrolls?

Ms WEBSTER: Is it effectively being catered for now?

The Hon. DOUG MOPPETT: Yes, under the current system.

Ms WEBSTER: I would have to say I do not believe it is. I am not overly confident in answering this question because I have not actually been there at the coalface in teaching kindergarten to enable me to know how that system is impacting on the school. I think there is a need overall for some sort of case management for these families, from the beginning right through. I know from our service that that is one of the things that works very well in that transition from preschool. It is the transition stage from one area to the other that is most important. It is ensuring that supports are met from one transition to the other. I believe there is a breakdown there. I believe that when children are heading off to school many of those supports fade away.

The Hon. DOUG MOPPETT: What about the identification of these children by the child and family health nurse? Do that come into your portfolio?

Ms BUTLER: We do not see them. I think it happens through early childhood settings—child care centres, preschools, long day-care centres. I think the Department of Education and Training needs to be applauded for its transition to school. Certainly, in our area, we have very good response from those early learning support co-ordinators. They have been very helpful. They have visited the preschool and looked at the child with difficulties—and it is not just children with disabilities, but children that we are concerned about. They are able to help those families go through the school process. They seem to be having an impact on principals' understanding of children with disabilities and learning difficulties as well their needs. So that is to be applauded. That has made a big difference to families.

For children with learning difficulties, we also are able to identify those children and know that the service and support systems are not necessarily in place. Often the child has to fit the school setting, as opposed to the school setting fitting the child, and that presents difficulties for families in that they have to accept a place that may feel is not quite right, or they had to put their child in a class of 30 children in the knowledge that their child will struggle, or in the knowledge that the child already is having difficulties and struggling in a classroom of 20 children with an additional aide. Because of poor organisational skills, they are very distractible, and they do not pay attention. So that child in a class of 30 you know will have difficulties, and the transition period will be difficult as well.

CHAIR: I return to the early childhood nurses, partly because the Committee heard from a witness from the association this morning. Many people, including me, assume that for a mother with a brand new baby that will be the point of contact. She either will go to that traditional kind of local centre, or else more frequently will get a home visit, with the hospital passing on information to the nurse in the community. The witness this morning was keen to see an expansion of the role by the health department in that respect. It is a bit worrying that you say you never see them. Is this because they are off in a health area, with walls around them, or is it because of a shortage of early childhood nurses performing that role, or have they become redundant or old-fashioned?

Ms BUTLER: I think many parents see the early childhood nurse as being important in those very early years. Then childcare becomes their focus, because that is where they are linked to that neighbourhood or playgroup setting, and then the child care setting, and that becomes their relationship. I do not know of many of my families who would still go and see their early childhood nurse.

CHAIR: At what age would they stop thinking that the early childhood nurse was needed?

Ms BUTLER: At 12 months or two years. The child care setting has great potential to be the hub that we send those people out from. It is a very natural and non-threatening environment for families and for the children. If you are putting an early childhood nurse in there visiting families who may not be accessing that service, at least there is a hub or a neighbourhood or a playgroup close by. Early childhood teachers have the child development knowledge and understanding. They have a range of children that they see, and therefore they have a good ability to monitor development. If you have well-trained staff in those settings—

CHAIR: Nurses would probably say it is a big "if". All of them are trained, even if there are not enough of them and perhaps they do not have the post-graduate training that they might have, whereas so many workers in child care, family day care and so on are untrained. If we are talking about a fairly scarce resource, that is trained people looking after children, if it works in child care it works. I guess that is going back to the past, to when the early childhood centres set out to be universal, or close to universal.

Ms BUTLER: I can see that point, but we need to ensure that a year before school children should be in early childhood settings, and our licensing should be such that we have trained early childhood teachers. The research has been quite significant, and it suggests that we will get good outcomes from that. Prior to those years, if children are in family day care or in playgroups, we need people who are trained to overlook that hub idea and look after those families. Family day care workers with well-trained support systems will identify children appropriately, because they are with the children all the time. It does not take long to pick out children who are having difficulty. If you can get good support and you know your family day care centre has that support, you can move on from there and ensure that the child and the family get the support that they need.

The Hon. DOUG MOPPETT: I tend to try to summarise these if I can. Seven and eight have a common denominator, that is, universal screening—trying to be less haphazard about it and trying to get some systemic identification of children—and a lead agency. Instead of not knowing when health drops off and someone else takes over, should someone be given the primary charge of this significant period when learning difficulties occur so that they can be identified and there can be successful intervention?

Ms BUTLER: I, and those I have spoken to, have really thought about this aspect. It is, as you said, a quite complex situation. I believe that the Early Childhood Intervention Co-ordination program has gone a long way. We are not going to have a simple solution to a complex issue; we need to acknowledge that health, the paediatrician, the speech pathologist, the physiotherapist, hearing and eye testing must be part of it. We need to acknowledge that the Department of Education and Training has a role to play in education and training on an ongoing basis. We also need to acknowledge the role of the Department of Community Services in regulating children's services; and the role of the Department of Ageing, Disability and Home Care [DADHC] in looking after children with disability, because disability and difficulty is quite a range as well.

The Early Childhood Intervention Co-ordination program has a philosophical way of bringing those people together. What we need is commitment from the Minister down, especially at management level, that that is an important process; and widening that from 0-5 to, say, 0-8 so that we can really look at those early developmental years. We have the system, we just need to enhance it. By those agencies working together and actually having some teeth so that they can look at issues such as funding and bringing that together for families; and looking at how each part of the spoke works. We have the basis there and I believe we could do something with it—with some teeth and funds.

CHAIR: What about a lead agency. Are you not concerned about that?

Ms BUTLER: I think it has more to do with their philosophy, a family-centred approach, and ability to work with other agencies; and identification of strong roles and responsibilities within the process. At the moment I probably see DADHC doing that. My concern about the Department of Education and Training is that it is not looking at all school environments for children. I would be concerned that this would be overlooked, considering some of the other needs that the department has within that bigger system.

The Hon. DOUG MOPPETT: The best answer to a difficult question is to pose a question in reply. This is a very difficult issue.

Ms BUTLER: It is difficult and we at acknowledge that difficulty. Learning difficulty is seen as a whole-of-life issue. It does not only relate to education; it relates to social skills, and the ability to get on with other people and be organised, and what that tells you about yourself.

The Hon. DOUG MOPPETT: You see those children that are referred to you; that is your core business. In your experience of those children do you consider that quite a number of them have been exposed to child care workers or other responsible people who have failed to diagnose the problem at a particular stage? Is that unusual, rare or often the case with the people who come to you?

Ms WEBSTER: Unfortunately, it is not unusual—if the service provider is not providing for the needs of the child, or if the child at that early age is not responding and working with them. Quite often it is a matter of having the right person working with that child and providing a program that suits the child. In the school age services we see teachers working with children, with a great program. It works beautifully for some children but it may not work for another child. It is very much a matter of trying to match the child with the right program. You may have a great program, but if the teacher or service provider is very boring it just does not work. There can be occasions when it fails.

Ms BUTLER: My comment on that would be certainly some learning difficulties are not seen until much later, possibly at the year one stage. That is my concern about universal screening. If we say we are going to screen the year before school, we will capture whole group of children, but there will be children who have had a good early childhood experiences that have made it. At year one, that is when their difficulties will be manifested, not earlier. There will be that group of children and I acknowledge that. For example, I have seen a child that was at another child care centre. His parents picked up the problem and decided to do something about it. He came to our centre and, because we have the trained staff, we could see those subtle difficulties. Learning difficulties are very, very subtle. They involve higher-order thinking and executive functioning.

We cannot assume that there is one time to screen and that you will pick up every child. I think we need to trust the professionals and have a place where families feel comfortable. We need to send a very strong message to health professionals, paediatricians and parents that, yes, we can make a difference if we act early—earlier is better; that there are places for them to go to and that has a good thing to be able to help the child in that way.

The Hon. DOUG MOPPETT: You see it as more important in a way that, however the awareness arises—whether it be the parent or a chance visit to a general practitioner or paediatrician, or a something more systemic, such as attending preschool—the most important in that earlier period is that the response will be effective. Then as you go on and the difficulty begins to manifest itself more clearly, perhaps when the child reaches school age, the important thing is to have a capacity to say, "Despite all that has gone before, we are the people who had this responsibility to identify and deal with the learning difficulty as it now becomes apparent."

CHAIR: Related to that is the difficulty you identified earlier and which other witnesses have also identified. That is, the way the Commonwealth funding works for the early intervention programs there has to be a documented disability.

Ms BUTLER: A diagnosed disability—by a doctor—and learning difficulty is not counted.

CHAIR: Should funding for those programs be extended to a broader definition? I suppose all the old questions relating to priority, definition and how far the net should extend, will arise.

Ms BUTLER: I consider that there will be a greater social impact if we do not help the children. They are the children who know they have difficulties, more so than many of the others. They are children clever enough to get themselves into mischief, so to speak. They are often disorganised and distractible, and have difficulty forming social relationships. The relationship between whether children feel good about themselves and their social interactions at school has a significant impact on school outcomes. We have to be looking at those issues. I am very concerned about that being the only pool of money that we have. What in fact happens is that you cannot get the support for that child and you have to force the parent into saying the child has a learning disability. The child then has a label. That is the only way they can access services.

You cannot be subtle. You cannot say to that family, "Your child is having some difficulty. Let us support the child." You have to give the child are label. You have to say, "For the rest of your life you will be like this." Parents do not want know about that. Many will say, "I don't want my child labelled because I do not want the department to think my child is stupid. My child is not stupid. My child is actually quite clever and can do all these things, but is having difficulty in this area." On the issue of labelling, while I can see that we need to have a definition I believe we could be more creative in the way that we deal with that, in order to help people to access services that they indeed to help them have better life outcomes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are very need prospective studies scheduled in respect of these children?

Ms BUTLER: Have you looked at the Early Years report from Canada?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No.

Ms BUTLER: I would suggest you have a look at that.

CHAIR: The Committee has that report.

Ms BUTLER: It is excellent. I was very impressed with Fraser Mustard from Canada and Graham Vimpani from Newcastle. I suggest you talk to them. They have done the research, and certainly the Early Years presentation was all that I have ever said about early childhood. They proved it, so that was really exciting.

The Hon. DOUG MOPPETT: It is almost like winning the lucky door prize. We ask this question of witnesses who appear before the Committee. If you had to choose just one initiative from the many related to children's learning difficulties, what would you choose?

Ms BUTLER: I am going to say much of what we said before. No single initiative is going to address this multifaceted problem. There is a variety of learning and social needs and these children have learning difficulties over a long and complex time of their lives. It manifests itself in the early years. I wish there was a simple answer to this complex problem. You obviously know how complex it is. I think we really have to look at a number of issues: co-ordination; family-centred practice—listening to families; smaller classrooms, perhaps with additional aides in those early years; funding to support children with learning disabilities; and really looking at some of that early years initiative research that was done in Canada, because I think that gives us some really good guidelines. If we could have that amount funding I think it would go along way towards addressing needs of those children in later life. I could not decide on one.

The Hon. DOUG MOPPETT: Tracey, would you care to add anything to the wish list?

Ms WEBSTER: Certainly therapy. More speech therapy funding. The research shows that something like 85 per cent to 90 per cent of children who experience learning difficulties have an underlying speech or language disorder. I would consider speech therapy in schools to be a great initiative.

The Hon. DOUG MOPPETT: I was going to comment on your casual remark, Kerry, about referral to local speech pathologist. Members of the Committee have just returned from the country where speech pathologists are as scarce as hen's teeth! The referral might be there but the speech pathologists are certainly not "local".

CHAIR: The Committee has had some complaints from academics that speech pathologists are beginning to teach reading because they can get a refund on Medicare.

Ms WEBSTER: Could I just say that one of the strategies we use is a transdisciplinary approach whereby how teachers work with speech pathologist's so that they can see how a program is documented, and the teachers then implement that program. The speech therapist acts as a consultant, comes back and oversees it. That is a way of getting across to all children. We do not have enough resources and there are children who require speech therapy as well.

The Hon. IAN WEST: I was about to ask a question along those lines. But I take it one step further and ask: Does that water-down its effectiveness? By having a parent, teacher, volunteer or a peer helper, whatever you want to call them, in terms of trying to spread the effectiveness of speech therapy into isolated areas.

Ms WEBSTER: I do not think it does, from our experience. Our teachers could probably go out there and work as speech pathologist at this stage, because they have taken on board those strategies and the program. They are not scared to work with the child for an hour and then have that child walk away without a piece of paper. They will do all the verbal work. Quite often teachers think it is only right if there is a nice piece of paper that goes back to the parents. I think our teachers are able to take on board speech pathology strategies and work with them.

The Hon. IAN WEST: Do you envisage some type of videoconferencing or train the trainer arrangement to try to assist in solving the difficulties in the isolated geographical areas?

Ms WEBSTER: I certainly would see it as a first step. If we are not able to provide the service and how to deal with the therapists out there, certainly it is a step in the right direction and I see it as being valuable.

Ms BUTLER: What has been good in our program has been the fact that from an inclusive setting I have three early childhood-trained teachers, two TAFE-trained staff, two untrained staff and four volunteers. I have a speech pathologist who only works in the service two days a week. But again, because she has been on site and she is collaborating and consulting with those staff, they have developed their skills and they need her less. The education does take some time, but when those staff move on to other services they are getting great staff and I will train up more staff, so you have a building-block effect I suppose.

Motion by the Hon. Ian West agreed to:

That the annual report of Learning Links be accepted by the Committee.

(The witnesses withdrew)

IAN GEORGE BAKER, Director, Education Policy and Programs, Catholic Education Commission, 276 Pitt Street, Sydney,

GERALDINE GRAY, Education Officer, Special Education, Catholic Education Commission, 276 Pitt Street, Sydney, and

ROSALIE MARY NOTT, Co-ordinator, Equity Policies and Programs, Catholic Education Commission, 276 Pitt Street, Sydney, sworn and examined:

CHAIR: Would any of you like to make an opening statement, or would you prefer that we commenced with our questions?

Mr BAKER: First of all, we appreciate the opportunity to be here. We have provided a submission, which we updated this morning. The early submission was a draft, and we have copies of the most recent submission if there is any confusion.

Firstly, the commission represents and co-ordinates Catholic schools, but we do not actually manage them. I think that is an important distinction, and it may become relevant to some of the questions as we go along. I would like to draw your attention to the last page of our submission, where we have some key recommendations, and to highlight perhaps two recommendations that we would like the opportunity to explore during the conversation. The first relates to access to Department of Health services, especially speech pathology. We are obviously aware that speech pathology has been raised by other groups.

The other recommendation deals with the related issue of ESL children, involving children coming into kindergarten—Australian-born children, I might emphasise—who do not have any facility or very minimum facility in English. I would like to cross-reference that to the third page of our submission where, for your information, we set out the percentages of students entering kindergarten who are ESL students by Commonwealth definition. For all New South Wales Catholic schools, it is 26 per cent of entrants to kindergarten, but you will notice in the Sydney Archdiocese that 50 per cent of the students entering kindergarten are ESL by Commonwealth definition. There are some issues related to this agenda that we think might be worth canvassing.

I will invite my colleague Rosalie Nott to make a few comments about the range of literacy and numeracy programs that operate in Catholic schools across New South Wales.

Ms NOTT: I will do that, because it is a fairly good example of the point Ian made in his opening comments, that is, the fact that we as an organisation do not manage schools but that the schools in New South Wales are conducted by 11 different dioceses systems and independent Catholic congregations.

In describing the range of programs—and this is the range of literacy and numeracy programs that you would commonly find in kindergarten to year 2 across the State—there are programs that are externally developed, for example, reading recovery, which I am sure you are fairly familiar with in terms of this inquiry; the First Steps program, which originates from Western Australia; Swell; and Count Me In, a numeracy program developed by the New South Wales Department of Education and Training. Not all of those programs would be implemented in every K-2 Catholic school across the State; it depends on the diocese.

There are some programs that are the result of cross-sectoral development. For example, the Department of Education and Training, the Association of Independent Schools and the Catholic Education Commission, the three school sectors, worked over a couple of years recently to develop a Starting With Assessment program, kindergarten to year 2, literacy and numeracy, with the whole idea of giving teachers at the very beginning of the school year a simple, classroom-based tool that they could use to help identify children who are having some difficulty in literacy and numeracy.

As a third example of the range of programs, there are some in place that are dioceses-developed programs. For example, there is a program in Wagga Wagga diocese called Numeracy for

All. Wollongong diocese runs a program called Good First Teaching for K-2 teachers. That gives you an idea of the diversity of programs that are in place across the State.

CHAIR: Does the commission or anyone else undertake a responsibility to say, "That is a great program operating in Wagga Wagga. We really should tell everyone else about that, and perhaps encourage them to undertake it themselves"?

Ms NOTT: Through the commission's main functions, on behalf of all the dioceses we have the capacity to do that, so that there is sharing and different project and committee structures that are in place. Whilst there certainly are boundaries around dioceses, those boundaries do not necessarily limit the sharing of ideas and programs.

With regard to resources, for example, we have a K-8 numeracy program under way at the moment, funded through the Commonwealth's Quality Teacher program, so it is a teacher professional development focus. It is being run by two dioceses together. Wollongong and Broken Bay are jointly running the program, and the outcomes of that will be shared with the other dioceses.

Ms GRAY: Just to add to that, if you are going to train in something like reading recovery, often the tutors are shared across dioceses. The First Steps program is certainly being shared across areas that have taken an interest in it and picked it up.

Just as the programs are diverse, extra specialist services are also diverse in the same way. So that if you recognise a student with a learning difficulty in kindergarten, year 1, or wherever year they are in at the school, you might decide at the school level to put in a teacher assistant, or in some dioceses you might have a specialist-trained teacher who goes across schools. So it varies, depending upon the area they are in, the priorities of the school and the resources available in that area to that school, so it is quite flexible.

Mr BAKER: And that flexibility allows schools and/or groups of schools to select a program that they think best suits their local needs. So that is the philosophy, but the local schools are in the best place to make a judgment as to the sort of intervention strategies that are most suitable, given their students, available resources in different areas, and experience of teachers.

CHAIR: Does that adequately explain the role of the Catholic Education Commission?

Mr BAKER: I think so. I am quite happy to answer questions in relation to the commission's role as they arise.

CHAIR: Do you or the dioceses systems have a working definition of learning difficulties? Do you worry about it? Or do you only worry about it because you receive funding from various people only if the definition is met?

Mr BAKER: May I make a comment and then perhaps defer to Gerry, who has expertise in the area. Other witnesses have obviously drawn to your attention the distinction between students with disabilities and students with learning needs. That is partly driven by legislation, partly by the Commonwealth Disability Discrimination Act, and partly by funding, but partly also—and I am a lay person in respect of this—by the fact that students with learning difficulties, by definition, generally do not have an identifiable clinical condition. If they had an identifiable clinical condition they would move to the next threshold. That is the only comment I would make.

Ms GRAY: Not that we want them to have that clinical definition. It is very difficult for the reasons other people have referred to. The estimates from the diocese would vary from 15 to around 23 per cent depending on what they are looking at. The definition is a problem. It is not related to a specific cognitive or physical or sensory disability but the student is still having a difficulty. That is one example. It is certainly not agreed to by all. Another one would be a discrepancy between performance children are expected to have and what they can actually do. It is quite varied.

CHAIR: I assume that you also find that because some of the socioeconomic factors and the one you have clearly identified about non-English speaking background the fitness statistics would presumably vary from region to region.

Mr BAKER: Yes.

Ms GRAY: And the conditions that we will talk about later such as early hearing difficulties that we are happy to bring up, particularly in some areas.

CHAIR: Obviously, this is a problem for the Committee and our inquiry because we have been asked to look at the group of children who are those hard to define ones who fall between the ordinary child who would progress through school without too much trouble and the children with manifest disabilities. We have been asked specifically to look at the group in between with problems of definition.

Ms GRAY: When I look at those with learning difficulties related to hearing it would be the students whose hearing could be corrected but because they have had a hearing problem early in life they will have ongoing learning difficulties unless they are supported and early intervention is put into place.

CHAIR: Perhaps we could move on to school starting age, class sizes, and gender. All sorts of people have spoken to us about their views or theories on the impacts of these sorts of things.

Mr BAKER: In paragraph 5 we have presented data on class size. This is ABS data. Class size is one of those very tricky things. It has been measured differently within States and between States. In our view the only comparable data is Australian Bureau of Statistics data. This is the student-teaching staff ratio. That includes both teachers and teachers aides, which is important particularly in this area of learning difficulties and disabilities. New South Wales Catholic primary schools have 19.6 students per teaching staff, government schools have 17.7, and the figure for the whole of New South Wales is 17.9. But like all averages it masks a great range on the ground. We are conscious of the fact that our class sizes tend to be larger. That is a concern. Obviously, we would like to be resourced to the point where we could bring those rates down.

Having said that, this is a very contentious area. The empirical research on class size internationally is somewhat ambiguous until you lower the class size to a very small ratio. That raises the question of what is a very small ratio, but the jury is out on that. Let me put it this way: you would have to make significant inroads before you get an effect. I am not saying that we would not like to lower the ratio. I am just saying that these are the facts. This is where we are and we are aware that the empirical evidence is ambiguous. We are also aware that you have to get significant decreases to get a statistically significant effect according to the research. On the identification and management of children with learning difficulties, there are issues with identification and access to services. That overlaps with the issue raised earlier about access to health department services. Often the schools see a preferred management strategy as being able to gain a teacher's aide. But then that brings us into the issues of funding and the boundary between a learning difficulty and a disability that can be funded. They are just general observations.

Ms GRAY: That is what we have. What we would like to have is specialist support and what we will talk about later again, the co-ordination and collaboration so that we can work with students. You would realise from our submission that we have an inclusive practice. We have very few specialist schools. All our students mostly across the State would be in the classroom together. We think that is a good thing but we realise that to do that we need specialist support. As far as resources make it possible, that is the way we would prefer to practice.

CHAIR: The eight special schools that you mention are a very small number out of the total.

Ms GRAY: There is one special school for students with an intellectual disability. Two of those schools are for students with a first disability of sensory hearing loss and then another two with the first disability of vision impairment. It is quite restrictive. All students with learning difficulties we would assume would be in our schools.

CHAIR: Do you have any comments about school starting age? Do you know whether the school starting age is roughly the same as in the government system?

Mr BAKER: Yes. Some years ago there was an inquiry into kindergarten entry age. Generally speaking, our schools take the departmental entry age as a benchmark and work off that. But it is not compulsory to follow that benchmark. Of course, the compulsory years at school begin at year 6. It would be typically around 4½. Our understanding of the empirical evidence is that closer to five is better but we would be very reluctant to set a mandatory entry age because many families cannot afford preschool services. We need to be frank about this. The intersection between the education imperative, which would stay close to five is better, and the social reality out there on the ground where a lot of families cannot afford preschool services—

CHAIR: School is cheaper.

Mr BAKER: Yes. Educationally, we have conceded problems with that but socially it becomes the lesser of the evils. Is it better to have the child in school or perhaps left at home with minimal supervision. I am not casting aspersions on the families but we are talking about families under economic pressure and there is an imperative to work. The commission's view on this is that educationally there is a persuasive, probably compelling, argument to say five but when you factor in other social issues we have said that it would be dysfunctional to mandate an entry age and the discretion should be left to principals basically and knowledge of the family and its circumstances.

CHAIR: So the diocese do not operate on the rule about turning five?

Mr BAKER: No, they are not bound by it but most use it as a benchmark.

Ms NOTT: That is my understanding.

Mr BAKER: In the Hunter area they are experimenting with a preschool exercise attached to—

Ms NOTT: I understand that there is an initiative in the Newcastle area. There is interest in schools in the Catholic sector in enrolling children quite a bit younger. I am not sure what age they are—certainly prior to 4½.

CHAIR: Is that in something designated a preschool?

Ms NOTT: No, it would be within the school.

CHAIR: Within the school but designated as a preschool class or essentially pushing the ordinary kindergarten class back to include children who are younger?

Ms NOTT: I am not sure what the demand was and how many children we would be talking about here. I am hesitating because there are quite a few things I do not know about it.

CHAIR: There is a bit of anecdotal evidence that for the reasons you mentioned the starting age is dropping. There is also a suggestion that that may apply more to non-government schools than to government schools and that in some areas schools are encouraging earlier enrolment. The evidence seems a bit patchy.

Mr BAKER: We do not have a definitive study on it but with respect to Catholic schools I would not say that we are encouraging it; I would say that we are responding to community pressures. Although there are no formal preschool services in the Catholic sector, a number of parishes are responding by establishing playgroups and like activities. This is going off on a bit of a tangent but there is some concern about how the yet to be proclaimed requirements under the Children and Young Persons (Care and Protection) Act might inadvertently close a lot of those down because they just will not be able to meet the requirements. Again there is that tension between setting community benchmarks, but if the service providers cannot reach those benchmarks it may be that instead of an incomplete service there is no service. That is the sort of dilemma that is in preschool provision, particularly in low socioeconomic suburbs and country areas.

CHAIR: Do your systems run transition classes and transition programs for children starting school more than, say, a day here or there? Is that common?

Ms NOTT: I do not know whether it would be common. Again, that would be a local initiative depending on school size, resourcing and other issues such as those. There could well be a situation in which a school, in enrolling kindergarten children, might have the younger or less mature children grouped together.

CHAIR: No, I meant transition in the sense of bringing children along before they enrolled to familiarise them with the school and the routine.

Ms NOTT: Yes, we have probably called it an orientation program. That is common and widespread. It would normally start around this time of the year or a bit earlier when enrolment procedures are well under way. Come October-November most schools would be welcoming children and their families. They conduct a range of orientation programs. It goes both ways. In some cases the schools go to the preschools as well.

Ms GRAY: If there is evidence of a student having a learning difficulty there are links to the preschools. Where they can they try to get the information so that there is a better transition to school. Going down the line of disability, depending on the needs of the child, a more intensive transition program would be part of the support to enable the child to enter school more easily. It really depends on information available and the links they have to their local preschools and services.

CHAIR: If the preschool pointed to something in that more amorphous learning difficulty area the school would be aware of it but unable to put in place much in the way of a program?

Ms GRAY: They would try to do the transitioning to school. They certainly look at it in the light of whether it would fit into a funding area but most of the learning difficulty areas do not. So they would look at support in the transition of the child to the school in the normal way. They would still open the possibility for extra days transitioning, and that sort of seeing. They would support more meetings to gather the information that might be needed to support the child.

CHAIR: We will move on to questions about teacher training. People have strong views about the adequacy of teacher preparation to handle children with learning difficulties and disabilities. Some people have said that they feel that modern teacher training prepares teachers less to deal with the early childhood area. Do you have any comment from the point of view of the Catholic system?

Ms GRAY: The Catholic system gathers teachers from all universities. Training for our teachers is just as it is with all other teachers. If teachers are given that ability, they are taught how to use explicit instructions and understand stages of development using the work aligned in the syllabus and the information we get from the Board of Studies. With the resources that come along with that and in developing that explicit instruction they should be able to teach a child across all stages.

In line with learning difficulties, it is important to keep up the level of quality in the special education core unit, the mandatory unit, in universities. In that way, through the general subjects, particularly the way in which the core mandatory unit is delivered, teachers come out with that understanding of identifying children with learning difficulties and the strategies that they can work with.

CHAIR: Do you strongly support the New South Wales system of having that mandatory special education unit?

Ms GRAY: Absolutely.

CHAIR: Earlier Professor Elkins from Queensland said that it was a good thing. He tells students that because they may want to teach in New South Wales they should do a special education unit.

Ms GRAY: That is a good thing.

CHAIR: How does professional development work for teachers in Catholic schools?

Ms NOTT: It does happen at a diocesan level, mostly. For example the range of programs I listed in my introductory comments, and some of them are specialist programs such as Reading Recovery, School Wide Early Literacy and Language [SWELL], First Steps, and Count me in, are initiatives that classroom teachers run. The commitments that diocesan officers make to professional development cover all those programs to ensure that they have trained Reading Recovery teachers to keep that strategy going.

There is a significant commitment for programs such as First Steps, SWELL, Count me in, and Numeracy for All are good first teaching. The program would have several components including the initial training of teachers, ongoing support for teachers, and whatever resources they may need.

CHAIR: Does that function by bringing one teacher from a school to a central place for intensive training and then that teacher retraining other teachers?

Ms NOTT: Again, that depends on the program and on the diocese. Some country dioceses have geographical challenges for the teachers, they may be remote or isolated. They have worked out strategies under which they might cluster training programs. Incidentally, it is a lot easier in the Sydney archdiocese to bring all the teachers into a central point, train them and send them off.

CHAIR: But it would be expensive.

Ms NOTT: Yes, in a couple of areas we are doing fairly solid work in the use of information technology as a means of supporting two functions; first, teachers and their development and having an in-service function, and, second, to assist teaching and learning. We use a range of methodologies for teacher development across those programs.

Ms GRAY: Because of this inclusive practice belief, a lot of dioceses run in-servicing and professional support alongside the training for those programs. Depending on where one is, they would be examples of aligning that to principals, executives and whole schools in different sorts of ways.

CHAIR: Do you have a view about teacher registration and the way in which it may boost the minimum qualifications for teachers in this area as well as other areas?

Mr BAKER: The commission is actively engaged in the discussion around the Ramsey review. The commission is not and has never been opposed in principle to teacher registration. Catholics school authorities in different parts of Australia operate on different models of registration, as they do across the world. However, to date we have not seen a model for application in this State which would tackle the hard-edged issues of increasing standards. Just registering everyone tomorrow will not improve anyone and, indeed, could actually make it harder to remove people from the profession—I will be frank about that.

Deregistration is the professional equivalent of capital punishment. As other professions know, it is almost impossible to deregister people, because that removes them from the profession. We are not opposed to teacher registration in principle. We are actively involved in the Ramsey review processes. We would like to see a system which actually defined standards and accredited teachers against standards.

This begs another issue: Given the perpetual problem of limited resources, should our focus be on new entrants into the profession or existing practitioners? We have 16,000-odd existing practitioners. Our submission states 14,000, but that is FTE. When you headcount teachers in Catholic schools there are about 16,000. The average age of teachers is 46, so the great bulk of our teaching force will be with us for the next 10 years. Mind you, there is a looming agenda, given the fact that it takes four years to train a teacher. Our annual intake is in the vicinity of 500.

If we are talking about teaching standards, the issue is not so much the entry into the profession over the next 10 years but what we do a bout people who are trained. I am over that 46 year level and I include myself in that. When I was trained this agenda did not exist. Retraining existing teachers, apart from anything else, is a huge resource use. To give a teacher a day's release to attend the course would necessitate employing a relief teacher at a cost of $223 a day. So you would need to spend $223 before anyone does anything or goes anywhere.

That begs another question: Who should be responsible for the continuing risk to the teachers? The employers, the teachers, or should it be a shared responsibility? When we are asked whether we support teacher registration, the issue is the model.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Surely that should happen in school holidays, should it not?

Mr BAKER: That is a very contentious, industrial issue.

CHAIR: Some of the same comments probably apply about the specialist early childhood qualifications, except that has been more of a pre-service issue than an in-service or professional development issue. Do you have any views that because of the move to generalist primary training, perhaps the generally trained teachers do not have the skills that older teachers had in dealing with K-2 classes? You are smiling, but saying nothing.

Ms GRAY: Earlier we said that if you learn the skills of teaching and understand the stages of development, you can teach those students and you can teach them very well. It is the way you look at the explicit instructions rather than how old you are.

CHAIR: I guess it is not so much a question of how good anyone is but the fact that in the past the training was broken up.

Ms GRAY: My initial training was in early childhood and later a degree and then another degree in my chosen specialist area. That is what often happens with teachers these days. Whilst accessing the support, it was the explicit instructions I have picked up along the way that allows me to look at all those students in the classroom. It is the individual needs of all the children, who operate at different stages, that one needs to be trained in.

Mr BAKER: The reason for my smile is that that there is a danger in us putting on rose-coloured glasses and looking back to the golden age of infants departments when all this was addressed. I think we can assert that these issues are more openly acknowledged now than they have ever been and there are more concerted attempts to address them than they have ever been. That is not to say that they are perfect, but I do not think that there was ever a golden age and I do not think that bringing back infants departments will solve it. That is my personal view.

CHAIR: I noticed that Geraldine is still smiling. As an infants trained teacher, she would remember the good old days.

Ms GRAY: Yes, and since then I have had quite extensive experience teaching kindergarten to year 12, and that is a very rich experience. My post-training passed when that initial early training involved the ability to do that.

CHAIR: It is obviously relevant that if the average age of the teaching force is 46, for most of them it is a long time since their pre-service training.

Mr BAKER: That is right.

CHAIR: What they have done since may well be more relevant. Earlier a witness said that pre-service training sets one's parameters, that one's mindset is determined and becomes an almost unconscious way in which some teachers work. Therefore, the initial training tends to set the way the teacher operates thereafter.

Ms GRAY: They are exciting programs when you are looking at new programs. I will go back and show my age again and look at the initial introduction of reading recovery. The way it is in-serviced, and the way it is delivered is really what is important to teachers in improving their techniques and moving forward. It is the professional development on the job that helps the children.

CHAIR: We have probably dealt with the next question because you started off by giving us quite a range of literacy and numerous programs that are offered. If we say, "Are they effective?" you would say "Yes", or "Yes, they need more resources" or "Yes, we hope so." Amongst some of our more academic witnesses we have had some quite passionate comments for and against the detail of reading recovery, for instance in relation to fashions about teaching reading. Some people commented on the flexibility of material and so on.

Ms GRAY: That is where we are lucky because we see through the flexibility that our schools are able to operate in with programs like reading recovery being used, as well as problems that involve phonemic awareness that might support or some academics might say will improve the workings of the programs. It is our schools being able to look at what they might take on board in relation to the needs of the child.

CHAIR: You are saying that in the Catholic schools or in the dioceses that do, for instance, reading recovery as such they are able to make it more flexible and take account of different strategies for teaching?

Ms GRAY: There are all different strategies going on. Yes and no. It is their choice. They do not have to run it to the initial way it was designed. I believe that there are different operations going on across the schools. For example, the tracking of students and the observation survey that is involved in reading recovery is being picked up later on down the track when the students are older to ensure that their literacy skills are developing. They are then looked at so that perhaps other strategies can be taken on board or aligned with it. I believe that those practices are out there.

CHAIR: Several witnesses, including those prior to you, referred to the shortage of speech pathology services. Others mentioned the difficulty of accessing all kinds of therapy services, waiting lists and the fact that you can get access if you can afford to pay for them but not if you cannot. Would you like to comment on the access to all those services for children in Catholic schools?

Ms GRAY: We would absolutely agree with the fact that there are nowhere near enough occupational therapy services available, particularly speech therapy services. That is the biggest area, I believe. Number one is lack of access. Once a child is entering into school, even when the child has had some therapy services, it appears to drop off. Therefore we agree with the comment that was made earlier. We also have concerns, and for different reasons, that it appears to drop off more quickly for students entering into Catholic schools. Whether that is due to cross-department arrangements that were historical or for whatever reason, we have received reports of the belief that if a student goes into the Catholic schools the student does not continue with the service. We are highly concerned about that.

Mr BAKER: Can I interpose here? The feedback to us suggests that there is a high degree of variability across area health services. They are highly autonomous. Some seemed to take the view that they will service students only in Government schools, which, frankly, we find offensive.

CHAIR: Most of what we have heard seems to suggest that once a child is in school the child has no automatic entitlement to the services. For instance, on Tuesday we were at Coonamble Public School, which is part of the Schools as Community Centres program. That service operates from the school and plays a role in ensuring that speech therapists come to Coonamble and that families get into them. But most of the families that get into them, the children seem to be of preschool age.

Mr BAKER: I acknowledge that students in Government schools do not have enough access, and we are not trying to get access at anyone else's expense. We acknowledge that there are limited resources and there will have to be priorities, but nevertheless there is evidence coming back to us that in some area health services there is a hard barrier that people in our schools cannot cross.

CHAIR: Is that explicit? Is a reason given?

Mr BAKER: There seems to be an issue in the Bathurst area.

CHAIR: Which is the Central West area?

Mr BAKER: Yes. As I say, this is evidence that comes back to us, but we would say that it occurs often enough for us to have concerns. But when we have made inquiries we run into the problem that each area health service seems to be totally autonomous and the issue has to be dealt with area health service by area health service.

CHAIR: For instance, earlier this week when we were in Dubbo and Coonamble, et cetera, we heard a great deal of praise for the Macquarie Area Health Service for the efforts it puts in and, by implication, criticism of other regions that are not as good. We have certainly heard a variation, but I do not know that we have heard anyone suggest a preference. I have been corrected; apparently a couple of submissions have been made on that the point.

Mr BAKER: It is an area in which there could be some greater collaboration across various service providers.

CHAIR: The report you are making about therapy applies to occupational therapy and physiotherapy, or does it relate specifically to speech therapy?

Ms GRAY: Yes, it applies to all areas of therapy, but the specific desperate need, the priority if we were going to have one, would be speech pathology. Related to that there was a review of therapy services in, I think, 1988 for school-age children by what is now known as DADHC, but was the Ageing and Disability Department. It was called a "Review of School-age Children in the Department of Education Schools" and there was almost this belief that all the school students in therapy were in the Department of Education schools. Obviously, they crossed over to disability and linked with those disability services, but out of that came a co-ordinated reference committee for the State, on which I sat.

It was a good move forward that the committee had a representative from the Catholic sector and that a representative from the independent schools sector was also invited to come onto the reference committee. Because of that they started to implement a co-ordinated, collaborative approach where we felt we might have a voice. But it seems to have fallen by the wayside in recent years, possibly due to a different structure or for whatever reason. These have not got off the ground. There is quite a difference across the regions as to what sort of support there has been. We would have a person from the Catholic office in Lismore sitting on the Northern Rivers committee co-ordinating a group that still meets, and there would be other examples in other health regions. But it seems to have drawn to a halt.

CHAIR: The central one that you were on?

Ms GRAY: We have not met, for whatever reason, for at least 18 months. It is very difficult to find out the new person who might kick that off again. That is part of the problem, obviously. Meanwhile, these services have not been improved. Aligned with that was the development of a package, which was going to be the training package, where you could look at that collaborative model of the central person taking responsibility, a bit of a case-management type of service, and training of a parent, a teacher and therapist that could go out and then train—train the trainer style—into each of the regions, but co-ordinated and supported from the central area. I have not heard what has happened there, either. That was actually being developed well over 18 months ago, but I do not know what has happened to it.

CHAIR: We should be able to look into some of these questions.

Ms GRAY: But I am sure there are reasons and, hopefully, it is sitting there ready to be kicked off. We would really like to see it go forward because it may be a way of working through some of these difficulties. Certainly, it was the beginning of hopeful links. Looking at that, and that is a good thing, it will not change the fact that we are desperate for more therapy support. That links itself to the other area of the earlier the better. Students who are coming into school with attention problems that may well be the cause of communication problem could have been worked on in their early years, and then they do not get those labels. None of us really wants to put a label on a student that goes with the student throughout schooling. The only way to improve on that is early intervention and support.

CHAIR: You have probably briefly answered question nine, unnecessarily labels—but you cannot access them unless you have a label. We spoke about that earlier.

Ms GRAY: We believe that you can do assessment and the support without having to put on a label which, as we all know, is necessary for funding, particularly for funding that comes from Commonwealth programs with which we are all aligned.

CHAIR: Are there any marked differences in the approach of Catholic schools, and we realise that it varies from diocese to diocese, to Government schools specifically related to children with learning difficulties?

Ms GRAY: We do not have STLDs, we do not have teachers for the difficulties as they state in the Department of Education, but we do have, again, that flexibility and depending on different areas, different schools, as to what sort of assistance is put into play. It could vary from a literary assistant, a special needs assistant, a specialist trained teacher in the school, a specialist trained teacher across schools, or an adviser across the diocese. There is a huge range.

CHAIR: You do not use that title, but you still use aids, specialist teachers, consultants and advisers? In that sense those three levels are similar to what is used in Government schools?

Ms GRAY: Yes, but there is a huge variation across schools. It is the flexibility, but it is also related to the availability of resources, of course.

CHAIR: Are any particular diocese doing anything particularly adventurous or different in catering for children with learning difficulties? Does your flexibility mean that you have pilots of interesting programs?

Ms GRAY: They would say that they have lots of exciting things going on and they are working at different programs all the time. The thing is, it is difficult for us to comment on that.

CHAIR: If any of you know from your knowledge or if discover in the next few weeks something that is particularly interesting it would be great if you could let us know. We could contact the diocese, the school or a cluster of schools. Perhaps you could send us something. It has to be specific. A couple of days earlier this week visiting various schools gave us a completely fresh perspective on what people are doing to address learning difficulties. If you come up with anything, that would be great.

Mr BAKER: I have two comments. With our emphasis on inclusion in regular classrooms and on skilling the teachers, we hope that this will be addressed as a teaching-learning issue—as all learning should be addressed. In that sense it will become a core business issue and part of the teaching-learning process. As far as identifiable programs are concerned, we return to where we started. The problem is that to attract funding we must cross the threshold and become a disability project. Funding is an issue. Projects are often created under the rubric of disability and not under learning needs because, as soon as they are created as learning needs, you are excluded from funding sources. That is the conundrum. We can point to many projects running in dioceses and schools for students with disabilities because, once you qualify for that, you qualify for what limited—I stress the word "limited"—funding is available. Once it is a learning difficulty program, it cannot be funded. We know that the Committee is aware of that dilemma.

CHAIR: What should come out of this inquiry? What is your wish list?

Mr BAKER: I return to where we began with what we called the key recommendations: the four dot points to which we have referred in the course of this discussion—which, by the way, we appreciate. I will reiterate them. All children should have guaranteed access to appropriate Department of Health services, especially speech pathology. We have discussed that point. Agreed mechanisms for transferring appropriate student information between service providers should be developed and implemented. We are particularly aware of the impact of recent privacy legislation in this area. We do not oppose privacy, but that is another infrastructure that must be developed, with its own costs. There is a danger with the railway track problem that we always face in Australia. State schools and State instrumentalities come under the recent State privacy legislation but we will be under the Federal privacy legislation, which will not come into force until December. I have looked at both of those pieces of legislation and there are differences. We cannot run disability services or learning difficulty services without interacting—we want to interact—with government schools, State departments of health and so on. But they will be under one privacy regime and we will be under another. That is one of the wonders of living in a federation. It might sound a bit left field but it will be a real-life issue from December.

CHAIR: Is the major issue school to school—government to Catholic school and vice versa—or is it about picking up children from childcare, preschool and early intervention services?

Mr BAKER: All of those things. It is about accessing information from the preschools and doctors. What are the criteria for exchanges? Who can give permission? There are some interesting consent issues: can parents give consent for their children or will children have to consent? The privacy legislation talks about "individuals " but makes no distinction on the basis of age. We are not against privacy but this is an area that you cannot run without exchanging sensitive information. That is another cost, to be frank. We will have to divert resources to put in place all sorts of privacy protections. I do not want to be misunderstood: I am not against privacy. However, like anything else, it will come with a cost. Like everyone else, we will have to create a privacy infrastructure. I think we all agree that this area is crying out for the exchange of more information between more people. Reconciling that with privacy legislation is an interesting conundrum.

Opportunities and resources for teacher professional development should be expanded, particularly for existing teachers. We have 16,000 teachers and we take in about 500 a year. If we are going to do things we will have do that with the teachers we have. My final point—which I would like to elaborate upon—is the issue of English as a second language [ESL] children. I will use the Sydney Archdiocese to illustrate this point as obviously most of the State's population is centred in Sydney. Some 50 per cent of students entering kindergarten are ESL according to the Commonwealth definition. That creates another dilemma in service delivery in this area because we can address students' learning needs only if we can identify them. Identifying them requires communication, and there is a communication issue.

There is also a funding issue. Those 50 per cent of students have varying levels of English—but a considerable percentage start school with minimal or no English. Students who were born in Australia who come to schools with no English do not qualify for intensive language support as Commonwealth intensive language support is aimed at new arrivals. There is an assumption—one can understand why—that children who were born in Australia will come to school speaking English. That is no longer a valid assumption for 50 per cent of students in Sydney. There is an intersection with service delivery. We must recognise that problem and address it. I do not think that information will come as a great shock. I am not making a criticism. This is a fact of life in modern Sydney. Catholic schools reflect modern Sydney—we want them to do that—but we can hardly assess those students coming from preschool to school if we cannot communicate with them in their preferred language. That is a serious issue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Surely ESL children starting kindergarten are a lesser problem than older ESL children starting school because they will have more time to catch up—as long as learning difficulties are not missed because of their lack of English. I attended Port Kembla infant school where 50 per cent of students who started could not speak English. However, I do not reckon that made any difference a couple of years later.

Mr BAKER: I take your point, which is well made. We are not saying that coming from an ESL background is a deficit in itself. However, it can mask a learning difficulty and compound the problem. Because of a lack of communication that learning difficulty will probably not be picked up at the point of entry. It makes it that much more difficult. This is not special pleading for Catholic schools; the issue is the same for government schools. Children starting kindergarten need access to interpreter services and materials in their languages. All schools, particularly schools in Sydney—and Wollongong and Newcastle to a lesser extent—need those support services.

Ms NOTT: If you are looking at a coordinated approach involving early intervention, community health and support in preschools, you must consider the fact that you will need to link with those mechanisms that will help parents with limited English and different cultural understandings and beliefs to understand the service needs of their children.

CHAIR: We have heard quite a lot of evidence from a number of witnesses about the rolling out of the Families First program in various regions of the State. Does that have any impact on Catholic schools or does it deal with too many areas that are too far removed from education or children who are still too young?

Mr BAKER: It had a bit of a slow start in our sector. To begin with there were a few echoes of the health department problem: in some areas there seemed to be a perception that it was a government schools program. However, the feedback to me is that we seem to be over those teething difficulties and our schools are starting to have an increased engagement with Families First. However, I think it still has some way to go before it becomes anything like a mainstream program for our schools. So it has suffered.

CHAIR: Is that more the case on the North Coast where Families First seems to be fairly well-established as compared with other areas where it has only just started?

Mr BAKER: I agree. It is like the Department of Health: our schools have been drawn in in some areas and there is less access in other areas. My impression is that it is becoming much more accessible but it still has some way to go.

The Hon. IAN WEST: Is the initiative coming from you? Are you approaching Families First or are you waiting for it to approach you?

Mr BAKER: It is coming from both directions. That raises an issue in schools because, as I am sure you are aware, many schools feel overburdened and some schools have difficulty identifying someone who has the time and expertise to become the liaison person for Families First and similar programs. I am not saying that all the difficulties and barriers exist on the Families First side; there are some institutional difficulties in our schools. Unfortunately, most of these issues come down to resources and time. We are certainly aware of Families First and we certainly see it as a positive program. However, I think it would be fair to say that, for various reasons, it has been a bit slow to move in our schools in various parts of the State.

CHAIR: Thank you for your attendance this afternoon. Please contact the Committee if you think of anything else that may be of interest to us. It is ordered that the evidence be published.

(The witnesses withdrew)

(The Committee adjourned at 3.56 p.m.)1