REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO EARLY INTERVENTION INTO LEARNING DIFFICULTIES

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At Sydney on Tuesday 20 March 2001

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The Committee met at 9.30 a.m.

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PRESENT

The Hon. Jan Burnswoods (Chair)

The Hon. Dr A. Chesterfield-Evans
The Hon. D. F. Moppett
The Hon. I. W. West
The Hon. Amanda Fazio

MEGAN LEANNE FAHEY, Acting Manager, Early Intervention and Co-ordination Unit, Ageing and Disability Department, Level 4, 83 Clarence Street, Sydney, affirmed, and

ELIZABETH MAY KNIGHT, Early Intervention Co-ordinator, Ageing and Disability Department, Level 4, 83 Clarence Street, Sydney, sworn and examined:

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

Ms FAHEY: Yes.

Ms KNIGHT: Yes, I did.

CHAIR: You have received the questions we prepared?

Ms FAHEY: Yes.

CHAIR: Do you want to say anything first? Question No. 1 is very brief, the statutory role of the Ageing and Disability Department's early childhood intervention services in New South Wales. I guess you can start with that.

Ms FAHEY: The Ageing and Disability Department's is responsible for funding and policy development in relation to support for people with disabilities and older people in New South Wales. The department's role in relation to support for children with disabilities is that we fund a specialist early childhood intervention program to the tune of approximately $8 million per annum.

Ms KNIGHT: We would fund a range of non-government organisations and government agencies to provide early childhood intervention services. Those kinds of services would include early childhood special education and integration support into mainstream settings for children with disabilities. Aged from nought to six is what we define as early childhood.

Ms FAHEY: We are also the leading agency for the early childhood intervention co-ordination program, which is referred in question No.2. Liz, as the co-ordinator of that program, can talk a bit more about that. It is a unique program jointly funded by the Department of Education and Training, New South Wales Health and ADD. It is cited by the New South Wales Department of Education and Training as an example of best practice in co-ordination for our particular target group.

Ms KNIGHT: The reason the co-ordination program had to be put in place is that a number of State and Commonwealth agencies are responsible for funding and providing early childhood intervention services. So, the service system was seen to be quite fragmented. The program was put in place to address those issues and to recommend ways in which planning and delivery of services could be improved and also to develop strategies to improve the effectiveness of those services for families. The underlying principles of the co-ordination program are effective interdepartmental and non-government partnerships, a family-centred approach to early childhood intervention, improved co-ordination services so they are easily accessible by families and cost-effective planning and provision of services.

CHAIR: When did the program formally commence?

Ms KNIGHT: It started as a project back in 1991 in three pilot areas, and it stayed in that form for about six years, A number of reviews were done over time. In 1997 it was reviewed again by David McRae, and the recommendation was made that the project have program status and be implemented statewide. That is when I came on board, to do that, and it is now across 16 local planning areas and there are about 73 local committees that support the co-odination program.

CHAIR: So, it has reached statewide coverage progressively or was it in 1997?

Ms KNIGHT: Progressively.

CHAIR: Do you still have more to go?

Ms KNIGHT: No, we have pretty effective coverage now. While the program is funded by the Department of Education and Training, ADD and Health, we have a management committee that has representation from Community Services, both disability and the office of child care, and we have representation from the Commonwealth Government through the Department of Family and Community Services, and we also have representation from Early Childhood Intervention Australia, New South Wales Chapter.

The Hon. D. F. MOPPETT: Could I just establish for my own edification, for you people to become involved, the child needs to have been identified as having a disability to start with? You would not be involved with children who were not otherwise seen as having a disability but were not identified as having a learning disability? They would just progress along with education. These are people who have been identified to you as having a disability?

Ms KNIGHT: Definitely. As far as ADD is concerned, because we fund under the Disability Services Act the child has to have a disability.

The Hon. D. F. MOPPETT: So you are making sure those people, like all other children who have learning difficulties, that is dealt with in the same manner, so to speak, so they are not steered out of the program if they have a disability in terms of addressing their learning difficulties rather than their learning difficulties? Do you see what I mean?

Ms FAHEY: No, can you say that again?

CHAIR: The next couple of questions address this to some extent. No. 3 is about defining and the question of children at risk. I guess we also have to talk about the age groups and where learning difficulties can be identified.

The Hon. D. F. MOPPETT: We have had some contact with disabilities in another inquiry. It seems as far as possible you want to see people with disabilities pursue a normal life in that they can access services, can go to ordinary schools, do ordinary things that everybody is doing, as far as possible. Are you sort of dealing with their learning difficulties in the same way?

Ms FAHEY: It is my understanding that the early childhood intervention programs that we fund and are provided through non-government and government services do identify educational outcomes as part of their service delivery. Children who would be accessing those services would be children with disabilities as identified under the terms of the Disability Services Act.

Ms KNIGHT: If a child that had a disability or a range of disabilities was accessing one of those services, they would be looking at the needs of the child as a whole and how to help that child reach its maximum potential in all areas of its development.

CHAIR: What age range does the program deal with?

Ms KNIGHT: It is nought to six. Six because that is the compulsory school age. So, nought up until they are enrolled in school.

The Hon. D. F. MOPPETT: We are having difficulties with these definitions. The question is how does the department define children who have a disability or a developmental delay?

Ms FAHEY: We use the definitions outlined in the Disability Services Act and we fund services to provide support to those people identified under the Disability Services Act.

CHAIR: Do you want to go on with this? I guess question No. 4 comes intro part of this. Partly because we are part-way through our inquiry into disability and we heard about how intervention helps children that have disabilities. I guess we are trying to see whether there is a group of children who get missed or who are not noticed and how they can be identified early. I suppose what we are about is how do we pick up the children who clearly need identification and help once they are at school or how do we go about identifying children at risk who may be only one, two or three?

Ms KNIGHT: I suppose, back to the terms of the definition, it is a grey area for children under the age of six because of their development and the timing. It can seem that children are either born with a diagnosed disability that is really quite obvious from birth, and those children will usually be given a quite straightforward diagnosis and their paediatrician or whatever would refer them on to early childhood intervention services. It may be that other children have a less discernible type of disability, and they would be diagnosed as having a disability because they were failing to meet their developmental milestones, and that in itself is enough for them to be referred to the childhood intervention service funded by ADD. At the same time they would have significant delays in their development to be seen to be not meeting their milestones. In itself that is a broad developmental range.

The Hon. I. W. WEST: How are they identified? I have a three-year-old, and there are hundreds of thousands of three-year-olds in this State. Is the identification made by the family?

Ms KNIGHT: It could be the family, it could be the child care centre, it could be the early childhood nurse or a friend of family who is concerned about the child's development and recommends that the parent take the child to the general practitioner or a paediatrician.

Ms FAHEY: It could be through the course of consulting about an ordinary childhood illness. The general practitioner might note something.

The Hon. I. W. WEST: If a parent came to you with an identification that their child had a problem.

Ms KNIGHT: If a parent was concerned, he or she would probably go to the GP and get a referral to a paediatrician and then be referred on to an early childhood intervention program. That is the normal course. It could be that a parent was concerned enough to contact the local early childhood intervention service and ask for help. The service would probably talk to the parents and refer them to a paediatrician, just to be sure.

The Hon. AMANDA FAZIO: What proportion would be picked up through the early childhood nurse? Children who do not meet early milestones are monitored by—I still refer to baby health centres, I cannot get used to the new terminology.

The Hon. Dr A. CHESTERFIELD-EVANS: Have they changed their name?

The Hon. AMANDA FAZIO: They always do. According to the blue book, kids are supposed to do things by a certain age. What percentage of kids are picked up there? Do they have the ability to refer children for checking only at the baby health centres?

Ms KNIGHT: I do not have the percentages with me. We have done some training with early childhood nurses to help them identify children who are at risk or probably have a disability, and with the processes for making appropriate referrals for the families. The Department of Health would have to give you that information.

The Hon. AMANDA FAZIO: They have the ability to refer people on?

Ms KNIGHT: Yes, and they definitely should refer.

The Hon. Dr A. CHESTERFIELD-EVANS: Professor Hays said he believed that kids should be screened at age three. He said that that was the optimal situation. The way you have described, it would be picked up by the GP. It all sounds a little terrifying; that if you get through this gate, and jump that style, and get to the next one, everything will turn out fine so you apply to the ADD and get the money. Bearing in mind that primary schoolteachers say that the amount of money kids get is proportional to their shoe size, do you think that ADD should have an outreach program to have universal identification? Just as we have universal vaccination for infectious diseases, we could have universal diagnosis for other problems through some screening program. What does the department think about that aim?

Ms FAHEY: Could you explain what you mean by a screening program?

The Hon. Dr A. CHESTERFIELD-EVANS: You would be screening for learning difficulties and for any problems in the child that were diagnosable by developmental delays, physical malformations or non-performance; things that are normal at that age. Professor Hays was of the opinion that three years was a good age to screen, because the child was old enough for problems to be manifest and young enough for something to be done. That would be the end point of the baby health program, if nothing was found. But if something were found, that would plug into other resources. That was his vision. What is the department's vision?

Ms FAHEY: It would be unlikely that the Ageing and Disability Department would be responsible for a universal screening program to identify the issues you have described.

CHAIR: We might ask the Department of Health about that.

The Hon. Dr A. CHESTERFIELD-EVANS: ADD might be of the view that it would be a good idea for the Department of Health to do that, would it not? The department could have the vision without necessarily being keen to do it themselves.

The Hon. AMANDA FAZIO: It would be a good planning tool for your department to have a feel for the numbers of potential clients.

Ms FAHEY: There are a number of ways we get information about the size, scope and type of need that comes through a joint memorandum of understanding that we have with New South Wales Health around population group planning. We also have a joint memorandum of understanding with the Commonwealth Department of Family and Community Services. We jointly get information about need. We have a number of ways of obtaining information. My response to your questions about what ADD would think about the introduction of a universal screening tool administered by another department is one I would have to take on notice.

The Hon. D. F. MOPPETT: We asked the learning difficulties people how they define learning difficulties, they said that they were all those things outside disability. They said that anyone with a disability goes in one category, and people with a learning ability goes in another category. You say that you look after people with learning difficulties, which means if that difficulty is different from their disability, but not directly associated, they qualified because they have a disability. Their disability might be physical.

Ms FAHEY: No, we need to be clear on this. The ADD is responsible for providing funding for disability services accessed by people with disabilities under the terms of the Act.

CHAIR: A lot of learning disabilities are not within your definition or ambit.

Ms KNIGHT: That is right. The services would provide for people who have disabilities. We assume that the learning difficulties they have are as a result of their disabilities.

CHAIR: However, other children have disabilities which few people would describe as a disability. There is a spectrum from a profound disability through to a mild learning difficulty.

Ms KNIGHT: That is right.

CHAIR: Somewhere along that spectrum the role of the ADD stops. We are trying to find out where you stop. It has been put to the Committee that, as is often the case, it is the children with a milder, and therefore harder to diagnose, problem, that falls through the cracks. The more profound the disability the more people are set up to deal with it and a whole system comes into play. This inquiry is into children with probably much less severe problems and children who it is hoped with a certain amount of remedial work will progress. That remedial work may be medical, educational or some other work, and it is hoped that through their age cohorts they will progress through school in the ordinary way. The Committee has talked to representatives of the Department of Education, but not the Department of Health, but we certainly will do that.

We need you to help us. Some practical examples would be of assistance. It all comes back to screening. I presume the more severe the disability, the more overt, the easier it is to pick up. The people who talk about the advantages of screening are talking about how to pick up children with other difficulties. Can you comment on that? Although it is not your role, you may like to talk about the benefits and limitations.

Ms FAHEY: The difficulties for the Ageing and Disability Department are that we are very concerned to make sure that children with identifiable disabilities that meet the terms of the Disability Services Act are adequately and appropriately supported so that they can become as independent and as included in the communities as possible. To comment on other agencies' work and ability to service other children is outside the scope of what I can provide today.

CHAIR: For instance, what happens if a parent takes a child to a GP and the GP may be a specialist, or takes the child to the baby health centre? If the child is tested and it is decided that he does not really fall within the Disability Services Act, but no-one denies that there may be some difficulty, how does the early intervention program or any other departmental structure help? What support do you give to that child or family when there is obviously a problem and some people must be able to identify the problem, and where it is also clear by ordinary language that that child would not be identified as having a disability?

Ms KNIGHT: If that were the case, say the family took the child to the general practitioner or the early childhood nurse, they would probably be referred to their Area Health Service for assessment from a paediatrician who might think that the child would probably benefit from getting an assessment from a speech therapist or an occupational therapist, something like that. It would be through that process that they would decide that the child does not have significant developmental delay or a disability. My understanding is that the child would be eligible for some therapy through the Area Health Service. Hopefully the child would be enrolled in an early childhood service and would get additional support through professionals and early childhood services as well. So they would be looking at areas of need that the child has indeed development delay and they would be tailoring a program to meet that child's needs.

CHAIR: When you say that the child would be eligible does that also mean that some funding is available so that parents who could not afford it can still access the service?

Ms KNIGHT: I would think that therapy services provided by Area Health would be free.

The Hon. AMANDA FAZIO: Yes, I think they are.

CHAIR: There are long waiting lists?

Ms KNIGHT: There are very long waiting lists.

Ms FAHEY: And as you know priority setting for Area Health Services is undertaken within each Area Health Service. Whilst therapy for children might be prioritised high in one Area Health Service, it is not necessarily the case across all 17 Area Health Services.

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The Hon. I. W. WEST: Is there a link between those making an assessment and from where they get their money? If it is the medical profession making the assessment, their assessment will also determine what they get?

Ms KNIGHT: My understanding is that Area Health Services have their own budget and they determine how they will utilise those resources. So they set the priorities and the service provides them.

The Hon. D. F. MOPPETT: We have established that you identify clients, if I may call them that, and then it is proposed to you that one of those clients has a learning difficulty. How do you then pursue a remedy for that child? Is it simply the provision of money for people who provide programs? You do not actually organise programs, I would imagine, in the Ageing and Disability Department?

Ms FAHEY: If, say, a child has an identified disability that meets the criteria of the Disability Services Act the child would be eligible to access a service that is funded by the Ageing and Disability Department. As you know, we do not provide services directly: we fund them. Whatever is the process at a local level—the family might contact directly a service that we fund in their local area; they might be referred to a service in their local area after making contact with the early intervention line; they might be referred to that service by a paediatrician or a health worker in that local area; or they might be referred by the Department of Community Services.

The Hon. D. F. MOPPETT: Rather than describing the system, do you have difficulties with it? Does the system breakdown? Do you have requests for assistance from parents who are unable to find services?

Ms KNIGHT: Most families are able to access some level of service.

The Hon. D. F. MOPPETT: Finally they come to you and say that they have identified a service, we need some financial support—

Ms KNIGHT: No, we fund the service and the service then has to provide for families in that local area.

The Hon. I. W. WEST: We are now talking about people with disabilities, not people with learning difficulties?

The Hon. D. F. MOPPETT: Yes.

Ms KNIGHT: Say, a child in Dubbo is diagnosed with a disability. There is a non-government organisation that has an early childhood intervention service in Dubbo. They would be referred by their paediatrician or whoever to that service and that service would either see them immediately if they had capacity or they would put them on a waiting list but still invite in the parents and explain to them what they can offer and how the service operates and what the process is. At some stage that family would get a service.

The Hon. D. F. MOPPETT: Is your main function funding?

Ms KNIGHT: Yes, exactly.

The Hon. D. F. MOPPETT: Finally the bill comes to you and you say that you are happy with all the criteria but you are not the organisers of it?

Ms FAHEY: No. The specialist early intervention services for children with disabilities that we fund form part of a larger infrastructure of early childhood services. Other agencies provide early childhood-like services in the form of long day care centres, childcare centres, health clinics and other sorts of services for that same age group. It is a matter of working out which is the appropriate support option for you and your child, given their needs. So you know what our specialist early intervention services do—they provide support to families who have children with disabilities. It may not be the appropriate option for you, there might be something else that you need to access.

CHAIR: Coordination of all these different services does not mean that you have a decision-making role in the mix of services that should be provided?

Ms KNIGHT: When there are new resources the Ageing and Disability Department as a funder is able to target them quite specifically where we see geographical gaps in service provision but also components of service provision.

CHAIR: That is within your own definition of the disability?

Ms FAHEY: That is right.

CHAIR: As the co-ordinating agency do you play a role in saying, for instance, that we need more health services because we have got more children with a targeted disability?

Ms FAHEY: That is a useful forum from which we can gather information that we can provide to New South Wales Health that could inform their decision-making about priority setting within the Area Health Service or perhaps provide them with some anecdotal advice about the quality or otherwise of services for which they are responsible, and the same for the Department of Education and Training.

CHAIR: Does that work? Does that happen often?

Ms FAHEY: It is useful information that is received willingly by those agencies. How effective it is in influencing change, I could not say.

CHAIR: The Committee has received submissions from several early intervention service providers, about the impact of current eligibility criteria. One suggested that funding should be based on functional impairment and need rather than a specific diagnosis. What is your response to that suggestion?

Ms FAHEY: Is that question based on advice that you have received about a program of funding that is administered by the Department of Education and Training?

CHAIR: It is really from early intervention services that are concerned about kids falling through the gaps and the concern about pressure put on professionals to find a diagnosis because without the diagnoses the services cannot provide a service.

Ms KNIGHT: The reason services cannot provide a service without a diagnosed disability is that some of the services that the Ageing and Disability Department fund also get funding from the intervention support program managed by the New South Wales Department of Education and Training. It is Commonwealth funding that is administered at a State level. That funding is supplementary and nonrecurrent but has quite a resource-intensive accountability process. Part of that application process is it that services must list details about individual children and they must demonstrate a diagnosed disability. The Ageing and Disability Department does not expect that from the services that we fund to provide services to clients. We do not ask for that level of detail. If a child comes to a service with a disability we do not ask for documentation to prove that they have that.

However, the intervention support program does require that documentation. It is a significant issue because, for a range reasons, it can be quite difficult for a child under the age of six years to get a diagnosis of disability. So while it may be quite obvious that the child has a significant developmental delay, and is in need of early childhood intervention services, if they cannot provide the appropriate documentation they cannot get funding to provide a comprehensive service for that child.

The Hon. AMANDA FAZIO: That definition of a severe developmental delay is encountered in this program that you are talking about?

Ms KNIGHT: My understanding is that global developmental delay would be accepted but paediatricians are often loathe to give children a label if it is unclear about the kinds of disability the child may have. Intellectual disability is often not diagnosed until children are in their early school years. For a whole range of reasons that is an issue for some services applying for that funding.

Ms FAHEY: Hence my question about whether it was about a Department of Education and Training funded program and, as Liz has just identified, the intervention support program is a Department of Education and Training funded program

CHAIR: The Committee has already discovered a lot of this area is circular. A lot hinges on what exactly is meant by diagnosis?

Ms KNIGHT: Those children would be eligible for the Ageing and Disability Department funded services because they would be seen to have significant developmental delay.

CHAIR: The Department of Education and Training would be thinking of working with the children in the next group which is much more fuzzy and therefore they are much more likely to be lacking a diagnosis and hence funding.

The Hon. AMANDA FAZIO: Definitely. Is there any correlation between accepting that a child has a disability and the payment to the parents of that Commonwealth disability allowance in respect of the child?

Ms FAHEY: The carer allowance?

The Hon. AMANDA FAZIO: Whatever it is, the name is changed all that time.

Ms FAHEY: The carer allowance or family allowance?

The Hon. AMANDA FAZIO: I am not sure.

Ms KNIGHT: To be honest I could not say.

CHAIR: Did you suggest that may be a reason for undue strictness?

The Hon. AMANDA FAZIO: No, I was thinking that that allowance is based on the level of additional care a child requires in comparison to a child who is healthy and normal. They seem to have to go through the groups with the Commonwealth to actually get that payment. It seems to me that if you have gone through all those hoops, for example, a person with chronic asthma or one of those other medical conditions, the fact that you have been able to prove to the Commonwealth that the child needs that extra care and support, maybe should be enough to guarantee that they are eligible for assistance from other agencies.

CHAIR: The Committee will have to take up that matter. If funding were based on, to use the phrase suggested, functional impairment and need would that have significant funding implications if we use that kind of language rather than the specific diagnosis for Ageing Disability or any of the other players in the early intervention program?

Ms FAHEY: The definition of disability in the Disability Services Act also includes a functional reference so I think it says something like if you have a disability that is likely to be permanent or is permanent and it affects one or more of the following life areas—and it talks about communication and a number of other things—that is a reference to functional impairment-type approach to understanding people's needs. My observation, as Liz referred to, is many of our early intervention services also receive funding from the intervention support program. As Liz said, that funding is issued annually despite it coming from a recurrent source, and that recurrent source is Commonwealth, administered by the State Department Education and Training. That has some impact on services that we also fund because we provide those services with recurrent funding. It means that one organisation gets the funding which is recurrent, and they can plan into the future, recruit and retain staff based on that the current money.

Another source of funding is given annually, which is more difficult to plan into the future. There have been instances where the Ageing and Disability Department has been approached to provide additional recurrent funds to those services in order to enable them to claim into the future to provide additional services as populations have grown.

CHAIR: Has the department been able to provide additional funding?

Ms KNIGHT: We have. We have a current four-year Commonwealth-State agreement. We have made a significant impact in addressing service growth and viability issues for early childhood intervention services, particularly in regional and rural communities.

CHAIR: Is that agreement about to expire?

Ms KNIGHT: We have one year to go.

Ms FAHEY: In terms of making observations about what might be an administrative change that could be taken in another agency, that would have a significant impact on our ability and that of early intervention services to plan into the future and grow to meet local need.

CHAIR: Will any of these issues be discussed in formulating a new Commonwealth-State agreement?

Ms FAHEY: That source of funds we referred to earlier, the intervention support program, is administered by the Department of Education and Training [DET] from the Department of Education, Training and Youth Affairs [DETYA]. The Ageing and Disability Department [ADD] would be talking to the Commonwealth Government around the disability program and the Department of Family and Community Services.

The Hon. I. W. WEST: The Department of Education and Training has a different definition for learning difficulties as opposed to disabilities than the Department of Health, does it not?

Ms KNIGHT: Probably.

Ms FAHEY: We can advise you of what we used as the definition.

CHAIR: The funding from DETYA to State education departments is not within the ambit of the Commonwealth-State disability agreement?

Ms FAHEY: I would not think so.

Ms KNIGHT: No it is not.

The Hon. Dr A. CHESTERFIELD-EVANS: With the different definitions in different departments I suppose we are looking at unmet need. Are there many people that do not seem to fit into any programs or are you not able to comment on that?

Ms FAHEY: I would not be able to comment on that.

The Hon. Dr A. CHESTERFIELD-EVANS: We would have an interesting situation if each department came here and could not comment on that. We could only comment on what they were doing.

Ms FAHEY: I could comment on the fact that many families access our early childhood intervention services, like the service type that it is for them, and it provides a good level of support to them and it is responsive to the family's needs.

The Hon. Dr A. CHESTERFIELD-EVANS: Because you fund services that already exist? Effectively they negotiate the service and you fund it and they like doing things that way, is that what you are saying?

Ms FAHEY: No. It is my understanding that it is the type of service they like. It is very responsive to the family's needs; it is not responsive to a child with the disability outside its family context. That notion of a holistic approach to supporting and strengthening that family is something families like.

The Hon. Dr A. CHESTERFIELD-EVANS: Is that inherent in your funding method? Is that what they like about it?

Ms FAHEY: It is inherent in the approach we require our early intervention services to provide.

The Hon. Dr A. CHESTERFIELD-EVANS: So, we will fund you if you give holistic family support and we will not if you do not?

Ms FAHEY: Yes.

The Hon. I. W. WEST: If you have a family unit where one child had a disability and another child had a learning difficulty, you could not have a holistic approach because you could only fund disability, is that right?

Ms KNIGHT: We would be looking at the needs of the family as a whole unit. That is a difficult issue of accessing appropriate support for children that have learning difficulties. The services we provide would revolve around the fact that the family has identified needs because they have a child with a disability.

The Hon. I. W. WEST: But that may be through your funding for the child with the learning difficulty?

Ms KNIGHT: Families do not actually get an amount of money. They get access to resources.

Ms FAHEY: Through a service.

The Hon. AMANDA FAZIO: Did the Ageing and Disability Department representatives outline the services they fund?

CHAIR: Not specifically.

Ms KNIGHT: We would fund government or non-government agencies to provide early childhood intervention. So that is services for children with disabilities or developmental delay aged nought to six years. The kinds of things our funding would be used for is to employ early childhood special educators, therapists, and provide support into mainstream early childhood settings. The educators and therapists would be working with the child in the local preschool or child care centre. They would be supporting the family at home. They would be providing things like playgroups. They would have maybe some sibling support groups. They may have a family counsellor or social worker to provide support to the family.

The Hon. AMANDA FAZIO: Do they provide stand-alone services where the child would go during the day or do you try to ensure children are integrated into a learning centre?

Ms KNIGHT: It would depend on the age of the child, what we would say is what we think is appropriate. For a very young child it would be appropriate for the family to get support in the home. If it is an infant, they may have some problems like feeding difficulties or sleeping, those kinds of things; by working on communication, eye contact, really basic stuff if it is a very young child. For the child who is about three it would be appropriate for the family to be thinking about sending that child to preschool or child care if the parents are working. So they would get support in doing that. It may be that they go to a specialist disability type playgroup and get support on a weekly basis. It may be the child also goes to preschool and gets support in that centre as well. The families could also still access a support worker or father's group or those kinds of services. As the child grows and their needs change we would expect the service to change the types of support they have available to that family to reflect the changing needs of the child. Once they are four or five years old they would be planning towards transition to school and looking at the kinds of issues the families need to prepare for making decisions about school placement, what kinds of skills the child needs to ensure transition to school is going to be success. They would be focusing on that kind of thing.

CHAIR: In discussions with people during our inquiry for people with disabilities quite a number of people showered considerable praise on the early intervention program and all the kinds of work you have described, and then said for families the child going to school is often a difficult period because that holistic approach suddenly stops. I guess now we are putting on our disability hat, but it is also relevant to the early intervention inquiry. Should some of those services and co-ordination continue after the child starts school?

Ms FAHEY: ADD certainly recognises that that is a systemic issue. We would be very interested in making sure that family receive support they needed in order to make sure the school placement of their child was as successful as possible. I do not have anything specific I can say about that today, but it is an issue we acknowledge and we would be reviewing the situation carefully.

CHAIR: But, come what may, the sorts of services we are talking about stop when the child has its sixth birthday?

Ms FAHEY: It is my understanding that some services provide support well into school age for some families who have received early intervention support, but they do that using resources they have garnered themselves through fund raising or through a fee-for-service arrangement with some families. So, I cannot say categorically that every service does that or does not do that, but I am aware of some services that provide support well into school age.

CHAIR: Is there no State or Federal funding specifically earmarked for that purpose?

Ms FAHEY: No.

CHAIR: Should the early childhood intervention program be extended to assist children at risk of developmental delay or learning difficulties? If not, how else could the needs of children who are at risk be realised?

Ms FAHEY: Certainly ADD is the lead agency in the co-ordination program and would be very willing to work with both DET, health and any other government agency that provides mainstream support to children in the early childhood years to ensure that children at risk of developmental delay or learning difficulties receive the support they needed through those services. Whether or not the co-ordination program is the appropriate vehicle to take that forward, I could not say at this point.

CHAIR: Would you have any reason to think it is not? Say a bucket of money arrives and we all agree we will push the boundaries because we now have the money to widen the net. Is there any reason why the co-ordination program would not be the right vehicle?

Ms FAHEY: The co-ordination program has a number of priorities that were set as a result of the McRae evaluation. Some of those recommendations that remain outstanding we would see as a priority for the co-ordination program to focus on and achieve. One of them is about making sure that the system, such as it is, works effectively for people and their families. Obviously, there are a number of strategies you could use to make that attainable. Discussions about children with learning difficulties or children at risk of developmental delay could take place in that forum; it could take place in a number of other forums. I just am not in a position to say that co-ordination program is the most appropriate one.

CHAIR: But you cannot offer any specific reason why, on behalf of the department, you think it would not be most appropriate?

Ms FAHEY: Only that as far as ADD is concerned, we would see our lead in the co-ordination program as being probably focused on children with disabilities.

Ms KNIGHT: I agree that the legislative base for our funding would limit our role.

CHAIR: We have a couple of questions about recent Commonwealth and State Government reports, such as *Pathways to Prevention*, about the fragmentation of early intervention and family support programs. We addressed to a limited extent the shortage of therapy services. Do you have any further comments to make about the reports which draw attention to the fragmentation of services and programs?

Ms FAHEY: No.

CHAIR: Do you have any comments about shortage of therapy services?

Ms FAHEY: We recognise that therapy support is an extremely important issue for many families. The Ageing and Disability Department in the May 2000 budget statement given by the director-general announced $1.6 million for therapy support. That money will be distributed before the end of the financial year. That is part of our school-age therapy program for which we provide resources. We would see those resources being prioritised for children with disabilities who require quite complex levels of therapy intervention in schools in order to secure their placement in the school setting. There are many other children and families who have therapy needs that would need to access therapy support through their area health service and community health service. Access to those, as we mentioned earlier, is set by priorities within each area health service.

CHAIR: There seems to be a shortage of therapists in the field, which particularly hits regional and rural areas.

Ms FAHEY: That is right.

CHAIR: There is also, obviously, the funding question. Therapy services are very expensive for families who do not have access to funding.

Ms FAHEY: And that is part of the reason why we have had advice back from many families who view our early intervention services as very good, because they have therapists on staff or they are able to access therapists in a timely way. Although the total number of therapy hours might be limited, families know that in advance and they can make the necessary adjustments within the family so that they can rely on getting so many hours of therapy support over a period of time at the time they need it for the child's development. Into the school years that becomes more difficult, and the type of therapy might become more complex depending on the kind of situation the child is in. As you know, the more you move out of the Sydney metropolitan area the more difficult it is to attract experienced therapists in the range of therapy feels. We have gone some way towards addressing that by ensuring that the funding we have identified for school-age therapy is recurrent funding so that it is able to be relied on for future planning and service expansion purposes, but our contribution is only one among others that are made in that area.

CHAIR: Our original question 11 deals with what can be done to assist families with children at risk of learning difficulties who do not access early childhood services. Is that something you are dressing as part of delivering the intervention program?

Ms FAHEY: Yes, we certainly see access as an important part of making sure that families caring for children with disabilities can access the appropriate support services for which we provide funding. Where there are other families who require support, it is clear that there is a responsibility on all of us to make sure that people get the information they need so that they can go to the right place to get support. We can look at ways in which our information and support infrastructure around the co-ordination program can be delivered in a timely fashion to families. We have one vehicle in terms of the early information Infoline, which is a telephone service that can provide some timely information and support to those families but, again, this would not be seen as the priority target group that we would want to provide information and support to; it would be for families who are caring for children with disabilities.

CHAIR: Some people have suggested to us that one way to improve access for families would be to introduce universal preschools in New South Wales. Would that be helpful in ensuring that children from, say, four are at least in a setting where their problems can be identified?

Ms FAHEY: I do not think the Ageing and Disability Department would have a comment to make on that.

The Hon. D. F. MOPPETT: In accordance with the resolution of the Legislative Council of 11 October 1994, the Committee authorises the sound and television broadcasting, as appropriate, of its public proceedings unless otherwise ordered.

(The witnesses withdrew.)

PAUL RAYMOND WHITING, President, Specific Learning Difficulties Association of New South Wales [SPELD], 64 Laurence Street, Pennant Hills,

PYE TWADDELL, Vice-President, ADDdult and Family Association and SPELD, Middle Cove, both affirmed:

CHAIR: In what capacity are you appearing before the Committee today?

Dr TWADDELL: I am appearing as a parent and teacher, and also as a representative of both associations.

CHAIR: Did you receive a summons issued under my hand?

Dr TWADDELL: Yes, I did.

CHAIR: You are conversant with the terms of reference of the inquiry?

Dr TWADDELL: Yes.

CHAIR: Do you wish your submission to be included as part of your sworn evidence?

Dr TWADDELL: Yes, indeed.

CHAIR: In what capacity are you appearing before the Committee?

Dr WHITING: I have a number of roles, but I am appearing before the Committee in role the President of SPELD and president of AUSPELD, the Australian Federation of SPELD associations. However, I am also involved in teacher education at the University of Sydney where I am the Associate Dean for Undergraduate Studies. My area of experience is learning disabilities in adults and children, and literacy areas in general.

CHAIR: You have received a summons?

Dr WHITING: Yes, I have.

CHAIR: You are familiar with the terms of reference?

Dr WHITING: Yes.

CHAIR: Do you have a joint submission?

Dr WHITING: Yes, we do.

CHAIR: We have already agreed that it will be included as part of the evidence. You have received the draft for the questions. Do you want to say anything before we move on to those. The first question is very general and asks you to outline the role of SPELD and the ADDult and Family Association. Do you want to say anything before we start?

Dr WHITING: We would like to table an opening statement. Also, we have some copies of the newsletters of both associations and the backgrounds of the two presidents so that the Committee has that available to them if they want to know more about the roles and functions of those two associations. We have eight copies of those to hand to you.

CHAIR: As you probably heard for the period you were here for the department's evidence, it sometimes makes sense to flow through our questions in order, but often it does not. If you would prefer to do it differently, or if you have thought of other things you want to tell us, please go ahead.

Dr TWADDELL: We consider the scope of the questions you submitted to our associations by the Committee are quite extensive, so we want to submit an opening statement that should help to place some of the issues into our perspective and, hopefully, get a lot of information across so that you can read it as may be.

CHAIR: Do you want to run through it or summarise it? Otherwise we will need some reading time.

Dr WHITING: Perhaps if we take the questions, then refer to the statement that is in front of you. We have numbered the paragraphs to make it easy to do that.

CHAIR: Otherwise we would have to take some time out to read it.

Dr TWADDELL: The first question regarding the role of the two associations, we were very grateful to the Minister for initiating the inquiry, because we have been trying to raise awareness about early intervention for learning difficulties for years. Most of our work continues to centre around helping parents and teachers to accommodate the learning difficulties of their children owing to the lack of early intervention. Although ADDult and Family includes attention deficit hyperactivity disorder as well as learning disability within the target population and SPELD refers to their specific learning difficulties, the main objective of the associations is to provide support, advocacy and information in response to the needs of children and adults within their target population and for those who care for, teach and work with them. Although the activities of the two associations may take different directions they are complementary in that they focus equally on the necessary aspects within the field of learning difficulties and, therefore, responsibly attend to the wide range of stakeholders needs. Beyond that this is why we felt it easier to table the newsletters and the background of the president of each to illustrate the scope of the current activities of each association and the scope of long-term commitment of the presidents.

The Hon. D. F. MOPPETT: Once again, we have a problem with definitions. I notice that in explaining the differentiation between your organisations you talk about ADD, which we know and which most people have a handle on, then you talk about learning disability; then you come on to specific learning difficulties. That will be one of the problems we have to overcome. Our definition is to early learning difficulties rather than disabilities and the specific learning difficulties.

Dr WHITING: Let me clarify that. There is a lot of misunderstanding about terms, because terms are used interchangeably and they differ, as you have heard before. Having read some of the transcripts of what has gone on in this Committee, terms are used differentially in different countries. America almost exclusively uses learning disabilities to refer to what Australia calls learning difficulties. The term "learning difficulties" is a broad term that encompasses any kind of difficulty for any kind of reason. For example, children who have gone to six different schools in 10 years could well have a learning difficulty because they have changed schools so many times and they have lost the thread of instruction. If they have just come from another country and they are having difficulty with the English language they will have a learning difficulty. I could go on.

Social and emotional reasons all cause learning difficulties. Another group of difficulties are intrinsic to the individual. Those are the ones that I prefer to characterise as learning disabilities, or which our organisation for the last 30 years has called specific learning difficulties. The word "specific" gives you the key to the difference. If you have a learning difficulty it may well be in every area of the curriculum. It may just be that you are a slower learner than other people, so you will have that kind of learning difficulty. If your learning difficulty is specific to one or two areas of the curriculum, but other areas are fine, something is intrinsically amiss and needs to be dealt with. That is usually a more intractable difficulty.

Actually, you may have seen a report in yesterday's *Sydney Morning Herald* that there has been a wonderful new breakthrough in dyslexia. It is always wonderful to the press because they have only just heard of it. It is all so new to them but, of course, it is not new at all. We have known for some time that there are differences in the brain structures of people who are dyslexic and who have the most common form of a specific learning difficulty and people who do not have that form of learning disability. That research, which goes back to Harvard University in 1991, was confirmed in 1994 by a second paper in the proceedings of the National Academy of Sciences in America. I will stop quoting things to you. I just want you to understand.

CHAIR: We have a copy of the article from yesterday's *Sydney Morning Herald*. Alongside that article is the article on ritalin at schools—another issue which has been raised.

Dr WHITING: We could talk about that at length, but that is not the issue now. When we talk about specific learning difficulties as distinct from just learning difficulties we are talking about something which is intrinsic to the individual. The definition of the National Joint Council on Learning Disability in America states, "presumed to be due to central nervous system dysfunction". That definition, which originates from 1981, has been revised a couple of times since. But on what we know now—10 or 20 years later—we would have to say that it is a central nervous system difference. This is an individual difference, just as you might be better at dancing than I am. I will never be as good as you are because I am just not wired that way. It does not matter how much I practice, I will not be as good as some other people. That is an individual difference.

There are millions of differences in our brains and in our bodies. You can have a difference in your ability to learn certain things because of the way your brain processes things. It is just unfortunate if it happens to be in the area of reading and spelling because we require you to do that, by law, five days a week, for 10 years of your life. You have to show your inability every day of your life. So it is a really serious issue for people who have that kind of disability. Teachers have not liked to come to terms with that issue. They prefer to talk about learning difficulties and they prefer to treat every child as an individual. In the past they have tended to say, "We should not worry about such things. Parents are overanxious because they will grow out of this."

But adults will tell you that they do not grow out of it. They still have it and they die with it if it is not addressed. But we know how to address it. That brings us to your issue: the earlier those things are addressed the better. That brings us to the whole question in which you are interested, which is: how do we best address that early on? The real difficulty is that it is hard to define this kind of a disability early on. It tends only to appear clearly in the early years of schooling.

Dr TWADDELL: Which is why we look at risk factors and not try to label. Labelling in itself really has no educational value. The learning difficulties-disabilities label debate really has more to do with political issues, funding and service provision than it does with educational provision or accommodation. One of the big problems with calling it learning disability is that if you assess the children and they exist you have to service them. The disability funding will then have to be divided into that many more sections. While a lot of the rhetoric of the Department of Education and Training regarding early intervention for learning difficulties and the accommodation of learning difficulties is really very good, the translation of policy into practice is not. We believe that the department will do what it can to keep learning difficulties, not learning disability, because that just opens a whole new political and funding can of worms.

CHAIR: Dr Whiting, when you describe SPELD and you talk about specific learning difficulties do you include ADHD, ADD and other sorts of areas which are clearly within the brief of the ADDult and Family Association? Do you cover those sorts of things, or are they labels with which you are uncomfortable?

Dr WHITING: Obviously we are comfortable with that sort of labelling.

Dr TWADDELL: But they co-exist a lot.

Dr WHITING: They are very rubbery figures, but 45 per cent of people who are attention deficit, hyperactivity disordered have a learning difficulty concomitantly with that disorder. Although everybody says that one does not cause the other, it is a mystery to me why a lack of attention would not cause a learning difficulty. I am sure that it does. But it does not cause a learning disability which, as I said before, would be intrinsic to a person. People are born with it. It is not their fault. They get blamed because they appear to be lazy, inattentive or whatever it might be, but it is not their fault. We need the recognition of the disability, as Pye said, not for any purpose other than to realise that a child needs specific, targeted assistance.

I think the department in its submission said that those are the people that it recognises will need some long-term support. That may be so. The figures are hard to come by because there are no good epidemiological studies for this. To use the department's terms, as many as 7 per cent of our whole school population may have a significant learning difficulty—I would say a learning disability—that could be identified and towards which we could target help. I come back to the issues in which you are interested. It is hard to identify that learning disability pre-school.

Dr TWADDELL: In actual fact, except for the political and the funding issues, there is really no need to identify a young child with a learning disability. What you are looking at are risk factors. If children have risk factors that may cause them to experience learning difficulties down the track, that is what early intervention is all about. That is why we make a distinction between prevention and accommodation.

Dr WHITING: I think this is your question 3.2, which refers to inclusive education.

CHAIR: It refers also to prevention and accommodation. We were struck by the distinction that you drew between the two.

Dr TWADDELL: The concept of inclusive education today is really an anomaly. It is really exclusive. The concept of inclusive education today generally refers only to those children with a label—those children with a manifest disability. It excludes all those students who are experiencing or who may experience learning difficulties. As I said earlier, I think that is the way a lot of people want to keep it, not because they do not want students to achieve at school, but because of funding and political issues.

The Hon. Dr A. CHESTERFIELD-EVANS: I refer to two points that you made earlier. You said that schooling is all-inclusive. Does that mean that we put them all into one school and we call that enlightenment? However, what is actually happening is that we are not catering for individual needs. Is that what you are saying?

Dr WHITING: Pye is saying that, first, we identify children with manifest difficulties. Then we say that we will include them in the mainstream. That is fine. But we have not targeted help to any children who are not identified as having specific manifest disabilities, in particular, learning disabilities, which are not manifest.

The Hon. Dr A. CHESTERFIELD-EVANS: You also said that children with this problem are in mainstream education and limited resources are available to them in that area.

Dr TWADDELL: That is a different issue.

Dr WHITING: That is an important issue.

The Hon. Dr A. CHESTERFIELD-EVANS: Many people have commented on that issue.

Dr WHITING: It is an important issue. We are aware of that issue.

The Hon. Dr A. CHESTERFIELD-EVANS: But you are making another distinction for people who are specifically disabled?

Dr WHITING: We are making another distinction for people in the learning area, yes.

CHAIR: Basically, when people talk about inclusive education they are thinking of a broad, mainstream group of 90 per cent or so of children in school. Then they have a group of children who are labelled as disabled in one form or another.

Dr WHITING: And they are included in the mainstream.

CHAIR: Then you act as though no specific learning difficulty is being experienced by that 90 per cent or so of children.

Dr WHITING: Exactly.

CHAIR: Where does that leave the programs about which the Department of Education and Training talked to us about—the Reading Recovery program, the role of testing and identifying learning difficulties, the support teachers' learning difficulties and so on? Are you saying that they are so thin on the ground that you do not really count them, or they are not performing the sort of role that you think they should be performing? What are you saying about that?

Dr TWADDELL: I was referring earlier to the rhetoric of policies such as Reading Recovery. If you read on paper the State Teachers Learning Difficulties [STLD] program it is very good. It is what ought to be happening. But, as you pointed out, on the ground it is not happening. For example, in the allotment of STLDs, there is no consistency of service across the State before additional STLD resources are apportioned to areas identified as having the greatest need. The first time there is State testing is the basic skills test in year 3 and then again in year 5. Then there is the English literature and language assessment [ELLA] test in year 7. They all have their place.

But the bottom line is the State allotment of STLDs is based on the number of children who fall into the lowest band of the year 3 basic skills test and the lowest two bands of the year 5 basic skills test, which may sound a better thing. But when you look at it you discover that there is an extra band in the year 5 results. So they have just moved the goal posts a bit. Then there is really no transfer between primary school and high school, which is a big problem. So there is rhetoric in relation to smooth transitions from preschool into formal school and from year six to high school. The rhetoric and the proposed processes are good, but it is just not happening. These are the people with whom we are dealing all the time.

The Hon. D. F. MOPPETT: Does it involve a question of resources? Are you suggesting that the programs are well thought out but the problem simply is that there is not enough money? Or are you saying that the programs sound good but, where they are applied, they are ineffective.

Dr TWADDELL: No, where they are applied, the programs are good. But then we are told that there is only x amount of money. One problem is that the Department of Education and Training is the perpetrator and the implementer of policies but it also does any sort of evaluation of the data regarding accountability. Our associations deal with the consequences of that all the time with parents, teachers and other professionals who are looking for help.

CHAIR: I guess we should return to the early intervention area because, to some extent, almost all of the things that we have talked about in schools are outside our terms of reference. There is general agreement that, if early intervention operates as successfully as we can make it operate, we may not need to concentrate so much on the primary and secondary years of schooling.

Dr TWADDELL: That would be the hope. Please do not get us wrong: the Department of Education and Training has initiated some very fine programs in the area of early intervention. Its Parents As Teachers program, which was initiated by the Early Learning Unit—we refer to it in our submission—and the Schools As Community Centres program is very good. The department has initiated preschools for four-year-olds, of which there are 78 across the State. These are fine and effectual programs. However, we get back to the question of fragmenting. I draw your attention to the Families First initiative, which is delivered by area health services, the Department of Community Services, the Ageing and Disability Department, the Department of Education and Training, the Department of Housing and non-government organisations. It has to do with the point that we mentioned in our submission: there are no overarching government policies and financial initiatives to pull it all together. Parents do not know what to do; they do not know where to go. They do not have a clue.

CHAIR: Families first is, by definition, an attempt to coordinate and bring agencies together.

Dr TWADDELL: That is true.

CHAIR: It is still has not spread across the State.

Dr TWADDELL: The funding is quite interesting, and it goes across a fair bit of the State. For the most part, we are hearing that families do not know where to go; they do not have a clue what to do. That is an old issue.

The Hon. D. F. MOPPETT: From a layman's point of view, for perhaps two decades we have seen extraordinary growth in this area. Twenty years ago, teachers working with parents might perhaps have identified a child, and that child and the parents might have travelled from a country area to Queenscliff. Many would look back at that as a turning point in their lives: a difficulty was identified, efforts were made by parents and others—probably without any extra resources—and primary school teaching staff probably supervised a recommended program. We now seem to have a proliferation of definitions and identified risk factors. You have not done this, but some people who appear before the committee think we should look at socioeconomic factors, parenting skills and so on. At the end of today, we go from a reasonably well-understood process of dealing with children during their education years to something that hopes to be all things to all men and women. I wonder whether we can do that.

Dr TWADDELL: The risk factors are not new; they have always been there. If you look in the literature even 30 years ago, you will find the same or similar risk factors. What has happened in the meantime is that contemporary research has well and truly defined which risk factors are more influential than others. Our point is that inclusive policies should look at learning first and the disability after that. Learning should be the main concern. If there are other disability factors, they can be addressed by the appropriate services.

CHAIR: When do you think the prevention of learning difficulties can feasibly begin? I am interested in the distinction you draw between prevention of difficulties and accommodating difficulties. How far back in a child's life can you go?

Dr TWADDELL: There is no magic step-over at which point you can say, "Right, this kid has learning difficulties". There is no magic at age at which you can conduct an assessment and say, "Yes, this child has learning difficulties". Look at what has been done in the American national educational goals 2000, which has been federally mandated since 1994 but which was commissioned in 1990. You ask what can be done at what age. One stellar example is what was done with prenatal care and getting mothers to visit the doctor. I think that intervention occurs early enough.

Dr WHITING: This is a significant issue. You can intervene at any point but, in practical terms, you really cannot—you are in the hands of what parents know and what they are prepared to do. That makes it very difficult. The only point at which you get control, so to speak, of the situation is school entry because that is when the law steps in and says, "The child has to be here". All children have to attend school at that point and, frankly, for my money the place to get results is at school entry. You can intervene at preschool, but it is patchy at best. It is very hard to administer because some children attend preschool all day, five days a week, and some children attend for two mornings a week. How does anyone running a preschool organise a coherent program for children who are coming and going the whole time? Some kids arrive at school having never attended a preschool, with no social skills and so on. The only time you get them all is at school entry.

CHAIR: Could you conceivably conduct some sort of universal screening at a much earlier age? Is that a practical policy?

Dr WHITING: Yes.

Dr TWADDELL: At preschool?

CHAIR: Even earlier.

Dr WHITING: You could if you had the kids.

CHAIR: Some people say that we should grab all the three-year-olds and screen them.

Dr WHITING: I would like to know how we could grab them.

The Hon. Dr A. CHESTERFIELD-EVANS: Are you saying that because we do not have a decent preschool program in Australia? Are you saying that, since there is no such program and the kids are all over the shop, we had better address the issue at school? If there were a decent preschool program and every kid attended preschool, would it not be a feasible proposition?

Dr WHITING: If every child attended preschool, you could economically intervene earlier. You would have all the children. However, you do not have all children at present—that is all I am saying. I am not saying that preschool programs are no good; I am simply saying that they do not cover all children.

The Hon. Dr A. CHESTERFIELD-EVANS: Can children be identified at that stage? You are saying that most of your organisations' resources are spent chasing lost opportunities, which is driving you crazy. Implicit in your comments—

Dr WHITING: Being able to help people would give us a good deal of satisfaction.

The Hon. Dr A. CHESTERFIELD-EVANS: It is taking resources from areas in which you would like to be more involved. Am I reading you correctly?

Dr WHITING: If early intervention were more effective, our associations would be out of business in due course. When SPELD was formed, it never thought that it would still exist 30 years down the track. It thought that it could bring sufficient logical weight to bear on governments to encourage them to do what needed to be done. It is only in recent years that the Department of Education and Training has done some of the things that SPELD has wanted done for 30 years.

CHAIR: Like what?

Dr WHITING: For example, having an increased number of support teachers for learning difficulties or having a Reading Recovery program—which is patchy; that is the problem. You asked earlier about resources. We have talked to ministerial advisers about this and, when it comes down to the wire, what they have done is pretty good. However, they are hamstrung because they do not have any more resources to allocate. They look at the basic skills test and say, "Here is a school in a low socioeconomic area that has a lot of needs and no support teacher and there is a school that is doing a lot better. We will take the support teacher away from that school and give him or her to the first school. That is very logical". However, they ignore the fact that the better school used not to have very good results and will not achieve good results in the next five years because the kids who need ongoing support will not receive it. The bottom line is that there are not enough teachers to go around.

The Hon. I. W. WEST: Has there been any research into what resources are needed as opposed to the fact that there are not enough?

Dr WHITING: I do not know how you would conduct that kind of research except to base it on what we know about the incidence of learning disabilities among school-age children. We must reckon that about 7 per cent of children need some kind of longer-term intervention that is probably more intensive than the assistance that a support teacher can provide under the current model.

The Hon. I. W. WEST: Are we currently getting to about 1 per cent?

Dr WHITING: We are probably running at about 2 per cent?

The Hon. I. W. WEST: What is that 2 per cent costing in terms of yearly funding?

Dr WHITING: I do not know.

The Hon. I. W. WEST: So many millions of dollars?

Dr WHITING: Yes.

The Hon. I. W. WEST: You are saying that we need five-sevenths more—whatever that means.

Dr WHITING: Yes. As you see in the submissions from America and in our submission, legislators are realising increasingly that it is not a luxury down that end; you have to wait for the cost benefit, which comes when you get a reduced incidence of juvenile delinquency and incarceration. I think McRae made the point that you have a huge illiteracy level among our prison population that far exceeds the illiteracy level in the rest of the population. You must see that evidence as persuasive; there is a connection between the two. I am not saying that all children become criminals: some of them become brain surgeons. There is no risk about that. But all the other factors that you have heard about—the social, economic, personality factors, family dynamics and so on—also impinge and lead to there being a significant difference between the socially unsuccessful population that is costing us a lot of money and the population that is unsuccessful at school.

The Hon. I. W. WEST: Would I be somewhere near the mark if I said that we are funding about 25 per cent of what is needed?

Dr WHITING: That would be a guess. Even if we increased funding by 25 per cent, there would be a marked increase in effectiveness. There is no question about that. We hear from the schools, teachers and parents that needs are not been met. Where programs are in place, needs are being met. Where they are not in place, needs are not being met. There are no resources.

CHAIR: On the point about needs being met, if the resources are there and schools have Reading Recovery programs and reasonable staffing levels in terms of support teachers and so on, is there any evidence—research based or otherwise—about the number of children whose difficulties are resolved by age eight or whatever? How do we measure what allocation of resources and programs resolve the problems of the children whom we are talking about?

Dr WHITING: I have not done any work in that area. I can say only that, of those schools with Reading Recovery programs that have been evaluated, about 90 per cent of children appear to benefit from the program to the point of not needing further intervention. But a group of children will continue to need intervention.

If you ask how many children need intervention, Margot Pryor's study, the Australian Temperament Study, which was referred to in one of your earliest hearings, did look at the number of children who are significantly behind, say, in reading in second grade. I think it came up with 16 per cent. Those children do not all have learning disabilities. They may be children of any non-English-speaking backgrounds and had emotional problems or whatever, but it found there was that number who were behind at second grade. On the other hand, they found that the children who were behind at the beginning of first grade and you do not do anything, you do not intervene at all, at the end of second grade 30 per cent of those children are normal, they do not have problems any more, they just got better.

So, of all those we intervened with, reading recovery will speed up some who would have, in any case, been okay with normal teaching, but with others we will bridge the gap—there are still two-thirds for whom there would have been a widening gap. Once you get to the end of second grade, the prognosis is really pretty poor. Research evidence there is if you are having serious difficulties at the end of second grade, you will probably have more serious difficulties at the end of fourth grade, and so on.

CHAIR: Has anyone effectively measured the percentage of children for whom the programs are not going to achieve anything? I suppose there must be a group at the end of second grade for whom the prognosis is poor, regardless of the resources provided.

Dr WHITING: I do not believe there is anyone who we cannot teach to read and spell, at least to a functional level. For many years we have operated on the view that even with intellectually disabled people with an IQ of 55 we could teach that person to read at some kind of functional level. We know how to do it, but that does not mean every teacher knows how to do it or is capable of managing a class of 30 that has within it a group of two or three children who have serious difficulties. That is why the support teacher program is such an excellent program, if you can get it in place everywhere.

CHAIR: Because you must withdraw the children from their ordinary classes?

Dr WHITING: The support teacher program does not withdraw children but brings them in to work with them in the classroom. There are children, of course, who need intensive one to one, and that is why in Britain and in America there are schools just for dyslexic children. There are not huge numbers of such schools but some of them are state schools and some are private schools. We do not need to go into that, but it is very interesting to hear what the parents, the children and the staff say about that situation. We ideologically tend to say that is terrible, to withdraw children from their normal school and put them in a special school, but it is not like that when you have a learning disability. There is a serious issue here. We do not have any problem with withdrawing people and putting them into hospital to help them get better if we cannot help them get better at home. We would like to help them at home but we cannot always. It is the same with a learning disability. It is not an insignificant issue and is life threatening in some cases. I have met numbers of people who have attempted suicide because of a learning disability, especially if it was not recognised, nobody could put a name to it and nobody could say anything other than, "if you just tried harder you would do better".

Dr Twaddell, in her PhD research, looked into whether we can identify, say, in the first months of school, risk factors and then intervene in the classroom without additional support, just the classroom teacher making curriculum modifications, and whether that will make a difference to the prognosis of these children. I think the answer was clearly yes, we can do that. The classroom teacher can do the assessment with the whole class. He does not have had to pull them out, take them into a separate room will use a specialist. You can do that using the normal activities that kids do when they arrive at school and then you can modify their curriculum to assist those who do not have the ball handling skills, the visual motor co-ordination skills and the language skills and personal, social skills—all those things which are signs that this child is going to have difficulties later. If I go back to the 1970s, I can remember Dennis Stott from Canada saying that if we recognised in the first six weeks of school the learning styles of children and accommodated them, we would have many fewer children labelled as intellectually disabled or, in those days, they called them mentally retarded. I believe that is right.

Dr TWADDELL: That is touted as a new idea today.

Dr WHITING: Yes. This is back in the 1970s, I am talking about.

Dr TWADDELL: It has come full circle again. To answer one of your questions about the efficacy of our programs, by the department's own admission the STLD program is so wonderful it will point to the advances in the BST, of children in schools that had very good STLD programs. Unfortunately, as we said, they took the STLDs out of those schools and put them in schools that were considered to have greater needs. What is going to happen I do not know. You mentioned the preschool programs. It is not a matter of having a good preschool program. That whole issue gets into quality childcare and quality preschool education, which is a whole other kettle of fish. But one of the easiest and best ways to identify children at risk is to look at typical developmental milestones and then look at the child—is there an atypical pattern, which would be an internal factor, and are there external risk factors for that child—and put together a profile and then adjust their curriculum or the education program to help them. So, it is not a matter of handing a document over, and saying, "This is the year 3 preschool program".

I would add, from my research, as has been mentioned, the identification of children at risk when they walk through the door, so to speak, these children were assessed in five different domains—outside motor or language. It is called outside motor instead of gross motor because when we think of ball skills as being a gross motor sport, the information processing that has to happen to catch a ball is far more complex, if you will, than just having muscles. You have to visually process and it is also very task specific, depending on the speed of the ball, the ground you are standing on, the size of the ball, et cetera. What was interesting was high and low target scores were identified within this research as well as mean scores and the usual descriptive scores. There were 692 children in 15 schools, and three separate samples, so they were different children but at the same selection.

CHAIR: How old were they?

Dr TWADDELL: They were just legal age to be in kindergarten, which begins at 4.6 and goes up till age six, but not too many six year olds. So, the only criterion for being in the research was just being of an age and in school on the day. So, efforts were made to cover different geographic and socio-economic areas, and there were city and suburbs, and five schools in and around Dubbo, so there was a country population also. But for the lower target scores we identified 13 per cent of children, out of 692 children, who had an overall target score, which I found very interesting because I notice in your first day's testimony 12.5 per cent of children were identified at the end of kindergarten as being in need of reading recovery. That is not to say they could all access reading recovery because reading recovery is also somewhat of an exclusive program, it is not a universal program. So, the anticipation would be that if you identified those children when they came to school first up, that by adjusting instruction to accommodate the developmental and learning needs, you would thereby have greater opportunities for more positive outcomes. It would be anticipated you would lessen the number of children identified at the end of kindergarten as being in need of reading recovery and open up places for other children, as there always will be some children who are in need of it.

Dr WHITING: In fairness, there will always be some children at the end of reading recovery who will still need ongoing support, because they have these learning disabilities.

CHAIR: The other thing you were reasonably confident of it is that a large percentage of those children could be assisted successfully by the normal classroom teacher, kindergarten teacher, for instance?

Dr TWADDELL: Yes, but I think those teachers need a great deal of in-service help. The inclusive program is part of the reason these classroom teachers have had to cope with and teach a much wider range of difficulties and disabilities in the classroom than they ever did before, and they are not properly resourced to do so.

CHAIR: The Teachers Federation has put to us that kindergarten class sizes should be reduced to enable the sorts of things you are talking about to be addressed.

Dr TWADDELL: They have been reduced probably down to about 27, and is still possible with those children to assess a lot.

Dr WHITING: In my experience, kindergarten classes were at one stage reduced to about 22. Every school I went into about 10 or 15 years ago had 22 in kindergarten. The research evidence on class sizes I am a little bit out of date on, but it used to be that you do not achieve much effect on individuals when you reduce class sizes until you get below 20. It does not make a huge difference in that intervening band. Mind you, when I taught 44 I was pretty pleased when it came down to 30. But I think they are ridiculous numbers. But from 30 to 20 does not make a huge difference, except it feels better when you are teacher and it makes it a lot easier to administer. You get the learning differences when you get under 20. A kindergarten class that is getting near 20 will have a lot more potential for effective teaching.

The other problem that has been raised somewhere in your submissions is that your brief is from nought to eight, as the early childhood does. We have a strange anomaly in the teacher training system that you train early childhood teachers and they can be employed by the State Department of Education and Training to teach sixth grade while they are only trained from nought to eight. On the other hand, we train primary teachers and they are trained to teach kindergarten up to year 6. They cannot teach preschool, whereas your early childhood teachers can get a job teaching sixth grade with no training for it. It is much more serious, I believe, to have regularly trained teachers teaching children at school entry when they have no very good training in early childhood teaching. So many children are not at the typical five-year level in all their milestones and all the demands that Dr Twaddell was referring to. They are still back at the early childhood area and they may or may not have had experienced, trained-in-early-childhood teachers in their preschools—there are plenty without them. So, they will come to these teachers and, as Dr Twaddell pointed out in our submission, the teacher may have been teaching sixth grade last year and maybe for the past 15 years has been teaching sixth grade and now they had decided to put the teacher in kindergarten.

CHAIR: Is there something to be said for the old infants department?

Dr WHITING: There is something to be said for it but you have to be very careful, because in the years when we were doing that I once asked the infants group, "Why did you choose infants teaching?" I am sorry to tell you that their answer was, "Because we don't have to read anything". Of course, that is absolutely not true. My point is that the kindergarten teacher is the most important teacher in the hierarchy of education, because the kindergarten teacher is responsible for laying that groundwork. Earlier I said that if the teacher is not successful by the end of year 2, research shows that the teacher will be even less successful in year 4and worse in year 6. It does not get better after the infants school years.

Dr TWADDELL: Dr Kemp's document "Teachers for the 21st Century: Making a Difference" stated that a lot of money is proffered for quality teaching. It points out that in teacher development they are going to lift the skills of practising teachers in key priority areas of literacy, numeracy, mathematics, science, information technology and specialist skills. The only specialist skills that are mentioned are the teaching of indigenous students, students in rural or remote locations and those in disadvantaged schools. The first thing that implies is that children in one of those subgroups are in big trouble, because they need specialist teaching, no matter what. The biggest omission is that there is no mention anywhere in the document of teachers with specialist skills for learning difficulties or early childhood teachers.

Dr WHITING: We need to make the point that learning difficulties and learning disabilities are no respecters of socioeconomic status or anything else. They occur just as prevalently with people of high socioeconomic status as those of low socioeconomic status, and vice versa. Because someone is in a low socioeconomic status area or family does not mean that that person will have a learning difficulty or learning disability. There may not be any trouble at all. While it is true that those children do not do as well, and the research of the past 20 years has shown that, those are purely social issues that need to be addressed by social measures.

The Hon. Dr A. CHESTERFIELD-EVANS: You said that there was a report on antenatal care carried out in 1994. You are saying that there is no socioeconomic difference. In terms of birth weight, nutrition and so on we understand that all problems are worse in lower socioeconomic areas. Are you saying that that is not true.

Dr TWADDELL: Of course it is not true. It is so upsetting when funding is painted across a whole group regardless of learning needs, which is why we say that the current concept of inclusive education needs a paradigm shift to make it, because it is currently exclusive.

The Hon. Dr A. CHESTERFIELD-EVANS: Do you say that antenatal care is not important?

Dr TWADDELL: It is very important. I have mentioned that as one area within the risk factors. It is referred to in our submission. The document "American National Educational Goals 2000" stated that the first goal is that all children will enter school ready to learn. That sounds a bit grandiose, but they have been working on this for a dozen years and there are tried and true programs that have been evaluated and show that they make a difference later on.

CHAIR: I refer to questions six and seven about the importance of early assessment. What strategies do you recommend to improve assessment prior to school entry? You have said that one was to make preschool compulsory. Can you comment on the effectiveness of identification and management of learning difficulties during the early years of schooling? Can you comment on the ways that assessments of children entering kindergarten in the first month are effective in the assessment, identification and management of learning difficulties with the five-, six- and seven-year-old children?

Dr TWADDELL: Currently there is no consistent service provision assessment.

CHAIR: Do teachers routinely do that anyway?

Dr TWADDELL: The older infants teachers do, the older and better trained ones. I was interested to discover during my research that children were assessed early in the year and late in the year. Across the board the scores of the country children were below those of the city children early in the year but well above by the end of the year. One of the reasons that that was put down to was the fact that there are still rural teachers with infants training who do what they need to do for systemic policies and they go into the classroom and take account of the individual differences of the children and adjust instruction accordingly.

The Hon. Dr A. CHESTERFIELD-EVANS: Are you saying that infants teaching standards have gone down?

Dr TWADDELL: In the State of New South Wales there is no longer certification of infants teachers. Teachers are certified as either a primary teacher or a secondary teacher. There is no longer specific early childhood certification in this State.

CHAIR: If the New South Wales has lost some expertise in the contribution made teaching?

Dr TWADDELL: Yes, especially in light of all the contemporary research that has gone on. It really seems quite unconscionable not to be specifically training early childhood teachers. Some are, and they go into child care and preschools, but the K2 teachers in the State school system are not specifically trained.

The Hon. D. F. MOPPETT: What do you define as our credo in this? What are we aiming to do? You have identified a group of children who, as a result of basic skills testing, subsequent testing, and finally the ELLA testing, will be identified as having failed. What do we want to do? Do we want to turn that around so everyone gets through?

Dr TWADDELL: No.

Dr WHITING: No, we want to give everyone the basic functional levels of literacy and numeracy that they need to function effectively in society. That is the essential aim. The norm for any test will be based on a population and will have an average score of 50 percent. The fuss that is made about the number of kids who fall below 50 per cent is nonsense, because that is how the test was constructed. It was constructed so that half the population will fall below 50 per cent. I am not worried about that. What I am worried about is functional literacy.

Everyone is empowered to be what you have the potential to be. I am not to say what one's potential is. As a teacher I have to assume that the child's potential is limitless and I have to open the doors for the child to fulfil whatever it is that his dream might be or that his potential might lead to. Very few people have dreams that come from nowhere, usually they have some innate ability for something. As a teacher that is what I have to do. I am not looking at everyone becoming a rocket scientist. I am looking at everybody to find something in which they can make a contribution to society. I believe everybody can do that.

That means that I have to assume unlimited potential in all children. Of course, that is the danger in labelling. The moment you label someone, people will say that that is the limit of their potential. So what do you expect me as a teacher to do about it? That is quite wrong. The usefulness of labels is that I can understand someone's needs a little better and I can meet that need while recognising the enormous potential that is not affected by that label. That is a restrictive theme and I want help the child get free of that label. That is the vision I would like our teachers to have.

In order to empower teachers to do that we need to have the in-service work that Pye talked about with early childhood, kindergarten and infants teachers, so that they can do those very simple assessments which are based on understanding of child development. That can enable them to say, "Look at the way that that child is walking across the playground. We need to do a little more motor work with that class, because the children are not skilful in that area, and that will hold them back in one area." That is a small example.

Dr TWADDELL: Simply, we know what typical child development is. If the information regarding typical child development is disseminated to teachers and parents they can see what is atypical. It is only against the typical that the atypical can be recognised. If the atypical is recognised or there is a concern by a parent or a preschool teacher or in the child-care area we can move on to get specialist assessment after that. I bring to your attention a comment in the Australian Early Childhood

Association newsletter which states that there is a tendency in the current climate to rescue the bottom end and let the rest scramble for anything that is left. That sums up a few things very well.

CHAIR: We have not covered the importance of the parental involvement in the identification and management of learning difficulties and the types of support structures are required to help parents of children who are at risk. Can you comment briefly on that?

Dr WHITING: The reference in the submission to the Families First program has clearly identified the number of programs that we see as very good for involving parents. But it is always a question of contacting parents, how to get to the parents. The schools are great once the kids get there, but because so many things are hereditary very often the very parents you need to contact do not come near a school, because they had a poor experience with school and were hurt by that. The thing that parents want most, according to the research done in that area, is understanding. They do not expect schools to work miracles with their children. They expect schools to understand when the child has a difficulty and attempt to do something.

Parents allege, at least, that they would be really happy if we could reach that stage. Our frustrated parents are the ones who have been told that it is their fault or are asked, "Are you sure your relationship with your husband is all right?", and those types of insulting remarks which are sometimes made by teachers to parents. They imply that it is either the child's fault, the home's fault or the family's fault, or the parenting, and sometimes it is. I do not deny that for one minute. Mostly when we are talking about learning disabilities it is something that no-one has control over. We need to have the humility, and teach teachers to have the humility, to say that.

Dr TWADDELL: And then do something about it.

Dr WHITING: If they do not know what to do they should admit that. I love the doctor who says, "I have done everything I know and you are still no better", as one recently said to my daughter. She greatly appreciated her medical practitioner being honest with her and not pretending that she was able to do something that she could not do. Teachers need to be in the same situation and to deal with parents with appropriate humility. We have to train teachers to do that, we have to in-service them with the whole business of learning difficulties and learning disabilities, on which there has been too little emphasis in general teacher in-service. There are plenty of targeted programs, specific programs, quite a lot in training support teachers.

In the early days there was not much training, they were mostly untrained. Still some are untrained, but there are big efforts going on in that area, but not in training the general classroom teacher. It is the general classroom teacher who needs to understand those things and to be able to communicate effectively with parents. That is the frustration we hear on the telephone all the time. That is what needs to be addressed for parents.

(The witnesses withdrew)

ANN BURTON, Speech Pathologist, of 44 Boomerang Road, St Lucia, Queensland, affirmed and examined:

JANET ELIZABETH DENT, Speech Pathologist, 114 High Street, Lismore Heights, sworn and examined:

CHAIR: Have you received a summons?

Ms BURTON: Yes.

Ms DENT: Yes.

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

Ms BURTON: Yes.

Ms DENT: Yes.

CHAIR: Do you wish your submission to be included as part of your sworn evidence?

Ms BURTON: Yes.

Ms DENT: Yes.

CHAIR: In what capacity do you appear before the Committee?

Ms BURTON: I am a speech pathologist currently in private practice and I represent Speech Pathology Australia which is a professional association of speech pathologists.

Ms DENT: I am a member of Speech Pathology Australia and I am also a member of the New South Wales Department of Health, Speech Pathology Advisers Group. I am here representing the speech pathology advisers group in the Department of Health.

CHAIR: What is a speech pathologist?

Ms BURTON: In the information that was provided to you there is actually a facts sheet from the association detailing what is a speech pathologist to which you may like to refer. We have been trained to assess, identify, diagnose, treat and work with people with a communication disability. To help with that notion I will pass around a model that was developed in Education Queensland which helps to explain the different sorts of problems and the scope of services with individuals. We have read the transcript of the hearing of the Committee of the previous day, and listened this morning, and there still seems to be some confusion about the disability difficulty issue. That was quite well explained by Dr Whiting in the previous session but I had already prepared this model and I thought it fits quite well.

Document tabled.

CHAIR: The Committee still wants you to explain because it bedevils so much that we hear from people unless they make it clear how they define the terms, and where they place themselves.

Ms BURTON: You will see on the model there is a certain section of—we are talking children—students who have special needs in communication. The expanded box underneath it is split in half horizontally with communication difficulty at the top and communication disability at the bottom. As Dr Whiting said, the communication difficulty we regard as being caused by extrinsic factors, many of which are very similar to the extrinsic factors that Dr Whiting was talking about whereas the disability is in the hard wiring. That is the intrinsic factors that will be there with the individual no matter what opportunities are there. However, along the bottom you will see there is a line that goes from mild to severe so it is perfectly possible that someone with a mild intrinsic disability is actually going to have less trouble in the education area than someone with a severe extrinsic difficulty. The two areas are not mutually exclusive. You can certainly have people who have got a hard wiring intrinsic problem who have got all the other overlying extrinsic problems as well. Speech pathologists work with all the individuals in that area not only with those who have a disability. We work with any individuals who have got any sort of difficulty in communication.

CHAIR: The Committee is on a learning curve and that is very useful and much clearer. Despite your formal definition which I think referred to a communication disability, you do deal with children who may have communication difficulties?

Ms BURTON: A pathologist will work with anyone with special needs in communication.

CHAIR: As a rule of thumb how do speech pathologists prioritise whether a child needs your assistance or perhaps, with guidance from someone else, might be helped through their communication difficulties by their parents, school or whoever? What tools do you use?

Ms BURTON: Speech pathologists have the luxury of working individually with children and, in the young years, with their families because after all the mother or carer has to bring them there as well. I do not think a speech pathologist would start to work with a child without attempting some sort of assessment. It depends how young is the child, and if the child is very young it may not be a formal assessment done with the child—it might be observation of the child and a detailed checklist done with the mother. We certainly aim to get the individual profile of that child and, as I say, that is the luxury we have because we work with individuals. We are always a little disconcerted when children are perhaps in the school setting and this same individual profile is perhaps not gained for each child.

I suppose we see our role as informing people who are involved in the very early education of children, whether it is in the special education unit, in a preschool or in grade one. The role of speech pathologist is very much to educate the other educators as well as perhaps to work specifically with the child if they have a serious language disability. I have a past hat—I worked in Education Queensland as a speech pathologist. I suppose that the flavour of the speech pathology service in Education Queensland is that first of all they are educators and secondly speech pathologist. While we do not take classes because we are not trained teachers mostly, the focus is very much on what can we provide to facilitate the best education of this child at whatever level.

CHAIR: What is the typical age a child first sees a speech pathologist? What is the earliest age? What is the normal range?

Ms BURTON: It depends perhaps on the education of the mother, the grandmother or the lady next-door. Jan works in very early childhood so she might like to answer.

Ms DENT: I work in New South Wales Health and typically we see children approximately three years of age. That is shifting with an emphasis that the Families First initiative has provided and also just general international and national trends to early intervention. We are now getting children referred at much younger ages which is terrific, but typically it is approximately three years of age that you will find a parent acts on their feeling that something is not right with the child, and overcomes the message from the general practitioner that he will grow out of it, or the mother-in-law saying "Don't worry, your husband did not talk until he was six." We typically see children approximately three years of age.

Research of patterns in Australia shows that three years of age is about what happens when the children with a speech problem are referred. They are children that are having difficulties with the actual motor process of talking and making themselves understood. Sadly in the age at which we are referred children with a severe language problem, these children might speak clearly but that is the end of the communication competence. Their understanding of language is poor and their capacity to express themselves using good vocabulary and providing specific information to people is very reduced, that is at about seven years of age and that is when they hit the wall at school. Those sorts of children are referred late.

CHAIR: When you say "sadly", you mean from your point of view they could be identified a great deal earlier?

Ms DENT: Much earlier.

CHAIR: At what age?

Ms DENT: I think we have put in our submission an example of some work that has been done in Canada by Fraser Mustard looking at the first three years of life. It is really the flavour of the month with a lot of the scientists. It is terrific because they are recognising that the first three years of life are so vital in the brain being elastic at that stage and being able to learn all things that children need to learn. I am going to give the Committee a document, which is the *First Birthday Report of the First Words* project by American speech pathologists and scientists into when you can identify patterns of behaviour in children that are going to indicate they may have a severe learning difficulty. They have developed a check list for parents to fill out and provide back to speech pathologists looking at behaviours in children aged 6 to 24 months. They are saying that at around 12 months they can discriminate, based upon the range of behaviours the child is displaying, those children that will go on to have significant difficulties in some areas. They can discriminate between children with hearing impairment at that age—a child that has a mild speech problem, communicating in every other aspect but their sound patterns are behind—and the children with the full range of behaviours that indicate communicative competence is not there, that is, eye contact, emotional expression, how they communicate with objects, how they use communication to regulate their environment. These are not children that can talk. By looking at communication behaviours children are displaying at an early age, they are saying we can start intervening at that stage. It is a bit different to some of the information. I would like to keep this for now and then provide it to the Committee later.

The Hon. AMANDA FAZIO: How is that used, in Canada is it?

Ms DENT: The first words project is based in Florida.

The Hon. AMANDA FAZIO: How do the parents get it?

Ms DENT: It is a funded project. They have a project team that works in a county in Florida. They disseminate the checklist to paediatricians, early childhood nurses, childcare workers, any person that a young family will come in contact with if they expressed concern about their child's development. They are trying to catch as many children as they can, but obviously, as other presenters have said, it is difficult to have a universal method. They are catching more children than waiting until they hit school. They are asked to fill out the questionnaire and that is sent back into the speech pathologists who work on the team and do the scoring. Then they determine what intervention is suggested as a result of that.

The Hon. AMANDA FAZIO: Does that report have any information on, say, the number of questionnaires distributed and the number of families who participated?

Ms DENT: Yes. It has all of that sort of demographic information.

The Hon. AMANDA FAZIO: Do you know off hand what that is? It is not really a compliance rate because it is a voluntary program.

Ms DENT: Yes. Well, they are getting more children than they did. Why they brought this in is that the American Government has recognised, they say in here that spending a dollar on early intervention programs saves $7.16 in special education and crime programs later down the track.

CHAIR: That is very precise!

Ms DENT: Yes, it is in here. I know that there are issues that have come before this Committee. I think Professor Hayes said that we spend 50 times more on our gaols than we do on early childhood programs. They are finding at school they are picking up about four per cent of children that have learning difficulties, or 12 per cent but only four per cent had some early intervention. They are saying, "Let's try to increase this access to individual programs before children hit school." I don't know the exact figures, I am sure they are in here, but it is looking favourable for a whole-of-community response.

The Hon. D. F. MOPPETT: Returning to our definition problem, a pathologist will identify and diagnose the difficulty and then a therapist will deal with it, is that correct?

Ms BURTON: Same animal.

Ms DENT: Used to just be told by a medical specialist, "Treat this child so that after his cleft palate operation he can speak well." But as we broadened our range of conditions that we looked at, pathology does the diagnosis as well as planning and treatment. But we are the same.

CHAIR: A speech pathologists does the lot, is that right?

Ms DENT: Yes. The speech pathologist is a bad name for the range of jobs we do. We look at all aspects of human communication and swallowing.

Ms BURTON: When I am in-servicing people I tell them to think of languages being brain level. While you are listening to me you are doing receptive language and I am obviously doing expressive language. But you can also do expressive language without saying anything. So, if I said to you, "Put the word "umbrella" into a sentence", then you are doing expressive language and it is all up here in your brain. Speech level is when you get your cognitive stuff into the series of noises that we have all been trained to understand as representing what is going on here and then voice level is here. If you can think of those three areas. As far as education goes, obviously it is much more serious if you have a language problem than if you have a speech problem. And it is much more serious if you have a receptive language problem than if you just have an expressive language problem. Sometimes people have just expressive language problems and their understanding of language is perfectly good, and sometimes people have both, that is, they have trouble with receptive language and expressive language. There is a sort of hierarchy in the conditions that speech pathologists work with that are most dangerous to least dangerous for their educational outcomes.

CHAIR: Where would there be a dividing line? We started today with witnesses from the Ageing and Disability Department and if you were present you probably heard us trying to determine its boundaries. Can you give us any indication, from what you have just explained, whether that department would include children as having a disability or whether it would regard them as outside the brief? Or is that an impossible question to answer?

Ms DENT: Do you mean the Ageing and Disability Department in New South Wales?

CHAIR: Yes.

Ms DENT: I was a bit confused and they were talking about the funding arrangements for early intervention services, but as the coalface clinician I see the efforts other professionals are going through to meet funding requirements to get children into their early intervention programs and into support programs in schools. Both the Department of Education and Training and the Ageing and Disability Department, or its Commonwealth equivalent, have set language levels at very low, very severe end of the spectrum in getting into early intervention programs and language programs at school. They have set a language score of about 70 with 100 being average. So it is about 1.5 per cent of the population.

The Hon. Dr A. CHESTERFIELD-EVANS: Would you argue similarly to Dr Whiting that in fact it has been defined at a minimum cost level almost? A lot of people are defined out of help?

Ms DENT: Yes.

Ms BURTON: Could I perhaps share with you something that happened in education in Queensland. They have early intervention units known as Special Education Developmental Units [SEDU]. There is still a limited number of places there. There is an ascertainment process in Queensland education.

The Hon. Dr A. CHESTERFIELD-EVANS: Is that an assessment program?

Ms BURTON: An ascertainment for high-level low-incidence disability. This is not for learning disabilities. That is much too big for that. We have another word out there for that—appraisement. This is "ascertainment" and these are for the low-incidence disabilities of hearing, vision, intellect, physical, and in the last three years we have added autistic spectrum disorders and speech language impairment, which is now recognised as a specific disability. Even though I absolutely agree that it is very difficult with a three-year-old to say "This child is speech language impaired [SLI] intellectually impaired [II]", it is a really difficult thing to do because they have to have this label to get Commonwealth funding to get in. They actually put them on what I call level one. So you can say, "All right, we will have a guess, we will put this child as II1", which means they can access the Special Education Developmental Unit or they might say with another child, "We will put this child on SLI1." But before they go into school the actual ascertainment process has to take place and maybe someone who is on SLI1 is going to be ascertained as intellectually impaired, and maybe someone who is SLI1 will go the other way. But it is a way of getting around having to have a diagnosis. You have your best guess at the diagnosis, but it does not stop the child from getting into the facility.

I do not totally understand New South Wales departments. I can understand the hesitation of the representatives of ADD—an unfortunate name for a government department—their reticence about moving up into the real education area. This is just my personal opinion. I think it is more appropriate if the educators move down because the educators have to take carriage of all of those children. It does not matter whether they are disabled or they have difficulties or whatever label you want to put on them. So, rather than trying to get the very encased disability services to spread across, it might be functionally better if you could get the education services to go down into that area so that there is a seamless carriage of children from, say, three right up into their school years rather than suddenly there is this hand over at school level. I know some of the students who access the SEDUs if they had an identified intellectual impairment. They are also supported by the disability services, but they are in an education framework already.

CHAIR: What age range are we talking about in Queensland?

Ms BURTON: From three years on. They can get into an SEDU from three years of age.

Ms DENT: They are probably like early intervention centres in New South Wales but more formal.

CHAIR: And run by the education department?

Ms BURTON: Yes, and it has qualified teachers.

Ms DENT: And speech pathologists.

Ms BURTON: Yes, and it has qualified teachers.

CHAIR: Do children get into it free, provided they reach the level of the classification, even though people may not be sure of exactly what the diagnosis is?

Ms BURTON: Yes.

CHAIR: They are then assessed again when they start school?

Ms BURTON: Because they can access therapy services they will probably be assessed before they start school, but they have to go through this informal ascertainment process before they start school.

The Hon. Dr A. CHESTERFIELD-EVANS: Is that another word for assessment program?

Ms BURTON: It is more than that. The point of ascertainment is to enable you to gather enough data to develop an individual education plan for that child. It is very much an education focus. The point is that all the educators involved with the child have to know what the problems are and they have to modify the curriculum to provide the child with an alternative curriculum that fits the child's disability—if we are talking ascertainment, we are talking disability.

CHAIR: How are these children found? Who decides to test them in case they have a problem?

Ms BURTON: A lot of referrals come from community health. Someone will have taken the child to a speech pathologist in community health or privately. Often, speech pathologists are one of the first ports of call because it is very obvious if the child next door who is the same age as your child is talking, but your child is not. I do not know if this is the case in New South Wales, but there is an enormous backlog, so the child could be on a waiting list to go to a hospital department for 12 months.

The Hon. Dr A. CHESTERFIELD-EVANS: New South Wales or Queensland?

Ms BURTON: The same.

Ms DENT: New South Wales also has long waiting lists.

The Hon. AMANDA FAZIO: Do the children go to the SEDUs sessionally?

Ms BURTON: Yes, they usually go there two sessions a week. Usually when they are of the right age they are also in a regular preschool. The theory is that the specialised teacher in the special education developmental unit can offer some support to the regular preschool teacher who is dealing with the child for the other three half days.

The Hon. AMANDA FAZIO: Do they get transport as well?

Ms BURTON: Yes, they do.

The Hon. I. W. WEST: And they are accessing Federal funds?

Ms BURTON: No, it is the Queensland Education Department.

Ms DENT: The ascertainment process is called statementing in England. It is almost where labels work, because it means that if the child has this ascertainment then services must follow the child. The teacher is responsible for giving a program that meets the child's needs. There must be accessed therapy services. It might not be for individual therapy.

The Hon. Dr A. CHESTERFIELD-EVANS: You call it statement?

Ms DENT: In England they call it statementing, saying what the child's needs are. Ascertainment is ascertaining what the child's needs are at the moment, what the disability is.

CHAIR: And the philosophy is that the service follows the child. You are not talking about segregated education. You are talking about the child who is identified one way or another and who, after that, moves into a mainstream preschool or school.

Ms DENT: It is people working together.

The Hon. Dr A. CHESTERFIELD-EVANS: What is this called in New South Wales, or do we not have it?

Ms DENT: We do not have it.

The Hon. Dr A. CHESTERFIELD-EVANS: Do we go by the seat of our duds, or random chance, or how is it picked up here?

Ms DENT: One of our main suggestions is looking at the adequacy of speech pathology services in New South Wales. Queensland Education has had speech pathologists in the education work force since 1964 because at that stage the Government recognised the importance of oral language and literacy. They are a long way down the path in terms of using the resources and working together. It would be unrealistic to think that we could have exactly the same sort of system quickly or easily. It would cost a lot of money.

Ms BURTON: Speech language has only been in for about three years.

The Hon. Dr A. CHESTERFIELD-EVANS: Ascertainment has been in for only three years?

Ms BURTON: Ascertainment came in for the really obvious low incidence disabilities, like vision, hearing, intellectual and physical impairment maybe seven years ago. The speech pathologists who were employed by Education Queensland lobbied hard for about three years to get speech language impairment recognised as a specific disability. We were very pleased to do that. We are not talking about huge numbers of students.

The Hon. Dr A. CHESTERFIELD-EVANS: What percentage?

Ms BURTON: Many children have speech language impairment going from levels one, two and three, but it is when it gets up to levels four, five or six that the disability is so severe that you have to provide an alternative curriculum for the student because the student cannot keep in touch with his or her peers?

The Hon. I. W. WEST: Where would level six be on the diagram?

Ms BURTON: It is not. It would be in the communication disability area. Level one would-be down to the mild problem. You can have children with an intrinsic disability down at the mild end. The children we are talking about who need a significantly modified or alternative program would be the ones at the end, in the last inch.

The Hon. Dr A. CHESTERFIELD-EVANS: If one were setting up an ascertainment program one would have to know how many people would want to go into it and how to identify those people. You said that it started seven years ago, presumably with other disabilities being assessed, such as motor disabilities or whatever. Speech was added to that process three years ago. You have answered in terms of speech pathology by saying that only the ones who have gone through the process with a level four to level six severity need special treatment, presumably by you individually or these special units. Can we say what percentage of our population needs the ascertainment process, then designate what disabilities they look for so we know what kind of people we would need to administer the ascertainment program, at what age and which department. Can you take me through from the general screening process to the ascertainment process, through the ascertain process and hen to the speech pathology aspect of work?

Ms BURTON: The criteria for putting the child through the process is that their educators have decided that the child needs significant modifications to its program. There might be other children who have problems, but they do not need major modifications to their curriculum. The educators must then decide why the child needs major modifications to its curriculum. Sometimes it is easy because the child has been diagnosed with the hearing or visual impairment, or you can see that the child has the physical impairment. It is more difficult with things like speech language impairment or autistic spectrum disorder because those diagnoses might come later. But the educators have to decide that the child fits the profile of speech language impairment. They would then consult the speech pathologist who visits the school that was employed by Education Queensland and ask the speech pathologist to assess the child.

When the educators have that information and when cognitive assessment has been done to determine whether there is a difference between the non-verbal cognitive level of the performance scales so that up here in the normal range it is 95, but the language levels are down in the 50s and 60s. That is pretty much an open misère to decide that the child has speech language impairment. Then we take that forward and go for formal ascertainment for the child. The child is then guaranteed, irrespective of how much speech pathology service it gets, that the school will provide a significantly modified curriculum during the child's school life. The school will modify the way it teaches, the content if it has to and so on. It is really a contract between the school and the child, because of the disability the school has identified and has taken through the process of ascertainment, that the school will provide an individual education plan tailored to the child. The child will also get help from the speech pathologist the guidance officer or whatever. It is the educators recognising the problem and the educators taking it upstairs

The Hon. Dr A. CHESTERFIELD-EVANS: From the way you have described it, it obviously triggers off a fairly thorough intervention in a kid that pretty obviously has a problem, so it is not screening for everyone. What percentage of kids in Queensland have undergone the ascertainment process?

CHAIR: Can we hone in on the speech language area because the process in New South Wales for children with other severe disabilities is not really any different? The way it works through the bureaucracy might be different.

The Hon. Dr A. CHESTERFIELD-EVANS: But the witness is talking about the ascertainment process as being pretty thorough. Everyone who has a disability goes into it. So in a sense it is an existing model.

CHAIR: Pretty much the same thing happens in New South Wales, but there is a much less co-ordinated and organised response to speech language impairment. I do not know that there is much difference for other disabilities.

Ms DENT: The process in New South Wales is not a smooth process, and it has become less smooth. They have lowered the scores that children have to present with to get a particular diagnosis with a specific language disability, or language impairment. As I said earlier, they need a score of under 70, yet the average rate is 85 to 115,so we have children between 70 and 85 who are not allocated any services. All they have is their classroom teacher and whatever speech pathology services their family can access privately or through the Health Department. But they need a speech pathology assessment every 12 months. That is not provided for within the Department of Education and Training. If the school cannot access that assessment privately or through the local health service, the child does not get any more funding. Funding comes with it, which covers some time for the teachers aid in the classroom and the assumption that a speech pathologist program goes with the child to the school. But that is it. That is where it ends. There is no facility for a program to be implemented or for the teacher to have time with the speech pathologist unless you have two people who are going to work together or you have a speech pathologist who can provide a school service. Yes, there is a recognition that there is funding for children with disabilities in New South Wales schools, but it is a difficult process.

CHAIR: What you have just said falls down if the waiting list for the speech pathologist is so long. Presumably, unless you are pretty well off you cannot get through the hurdle to access the services in the education system.

Ms DENT: The vast majority of speech pathologists in New South Wales are employed by the Department of Health. There is an undersupply in that department, which most people know about. They are generalist positions. They work with all communications issues. In rural areas you might have an 18-month-old child, the next minute the hospital will ring because someone has had a stroke. They are generalist professionals and they are very stretched. Initiatives like Families First which concentrates services on 0 to 5, but the capacity to provide school-age services is very reduced.

The Hon. AMANDA FAZIO: The Committee referred earlier to the fact that, when children go to school, they lose the access that they had to therapists and those who were supporting them earlier. Obviously, that is still a problem with the Department of Health. Is that problem evident in Queensland?

Ms BURTON: If you go to an Education Queensland school which is within the State system a speech pathologist will be given responsibility for your school. The speech pathologist may go to the school at the beginning of the year and 50 children might be referred to him or her. However, only so much time is allocated to the school, and the pathologist can see only 10. Please do not think from what I am saying that, just because there are services in the education department, every child gets the service that they need. They do not. We certainly do not want to talk only about the speech language impairment group, but within that group there has been a significant shift since this formal process of ascertainment has come on line.

Previously, when speech pathologists went into the school they would say, "What about so and so?" The response from the school was, "He has had two years of service. It is somebody else's turn now." They cannot say that any more. They can certainly say, "Yes, all right, he will not get individual speech therapy." They cannot just say, "There is nothing we can do about it." They actually have to provide an appropriate educational program for that speech language-impaired child, which they did not do before. The educational implications rather than the speech pathology implications of ascertainment have been significant for students with a speech language impairment.

The Hon. Dr A. CHESTERFIELD-EVANS: That does not exist in New South Wales?

Ms BURTON: No.

Ms DENT: I will give you an example of the difference. New South Wales has 44 special language units across the State. There is one in Lismore. They take eight children between kindergarten and second class. I am on the review panel for our class in Lismore. Twenty-five children applied for six positions last year. So six children were offered a place. One child did not turn up at the beginning of this year. We did not know where he had gone or what had happened. About two weeks into the term we got a phone call from a speech pathologist from a remote western Queensland town who said, "John turned up at my school. What is the story?" We could send previous assessment reports which stated, "Yes he has a severe language problem. We are recommending placing him in a special language unit."

If he had turned up in a remote New South Wales town the teacher might or might not have recognised that this kindergarten child did not have adequate language skills. The next question that should have been asked was, "Is there a speech pathologist to whom we can refer that child?" Children of school age would probably be on the C priority list. They might sit there for six months before a speech pathologist sets eyes on them. The family to whom I referred earlier did not have the resources to contact us and say, "We are moving. Can we have information that might help service providers in the area where we are moving?" That is a telling example. Because that family moved to a remote Queensland town the service provision for that child was within his education setting. What would have happened if he had gone to a remote New South Wales town?

CHAIR: I refer to Ann's point. A speech pathologist might have 50 children on the list. That child was lucky that the speech pathologist turned up in that remote town that week rather than six weeks or six months later.

Ms DENT: His classroom teacher had the advantage of having a speech pathologist in the system. She knew that, if the kid was not seen by the speech pathologist, she could do some other screening and she knew some of the programs that could be put in place.

Ms BURTON: A critical aspect of that is that if a speech pathologist looked at that child's language skills and thought, "This child is severe enough to go for ascertainment", he or she would assist the school to put that child in the statewide system. The child would be ascertained and for five days a week, six hours a day, the school would be required to give that child a program specifically designed for him. The school could ask the speech pathologist to input resources and information. That does not mean that the speech pathologist will see this child on a regular basis at all. The biggest impact of ascertainment is on education—five days a week in the classroom.

CHAIR: What resources are provided to the classroom teacher to provide that assistance?

Ms BURTON: There is a bit of aide time, which varies between districts. But that might be two or three hours a week. There is also advisory visiting teacher [AVT] support. So we now have AVTs for speech language impairment [SLI]. These are experienced teachers—which speech pathologists are not—who then go around and actually visit the child and the teacher in the classroom. Fortunately, because they are teachers, there is an allocative model. So for every extra 10 SLI students in a district you get another AVT. It does not work for speech pathologists because they are public servants. I am no longer in the public service, but speech pathologists are public servants and not teachers.

So there is no allocative model. Even though it is a good system, we still do not say that, for every 2,500 students, there will be one speech pathologist. If any consideration is given to putting speech pathologists into education in New South Wales, an important benchmark to work towards is to look at the best information available from overseas to determine the ideal professional ratio. You might not be able to start off there, but you could certainly have that as a benchmark.

The Hon. Dr A. CHESTERFIELD-EVANS: What is the difference in the number of speech pathologists for every 1,000 students in Queensland and New South Wales? There appears to be a much better program in place in Queensland, so there must be more troops to run it.

Ms BURTON: In Education Queensland there are about 120 full-time positions.

The Hon. Dr A. CHESTERFIELD-EVANS: In New South Wales is there a corresponding number of practitioners in private practice who fill in through the health system, or in some other way? Perhaps the ratio should relate to population rather than to the number of schoolchildren. Would therapists be better off employed in education than they would be in health? What is the number for each head of population?

Ms DENT: There are a lot more therapists in health in New South Wales than there are in Queensland. Queensland community health services provide services from nought to five because other services are provided once children hit school age.

Ms BURTON: They also service all the private schools.

Ms DENT: The bodies that we represent—both the association and the advisers group—do not recommend that the Government look at shifting speech pathologists from one department to another. The message that we give is that we are a valuable professional group and we are working with children with learning difficulties. You need more of us. We need more of us in education as well as in health.

CHAIR: But that does not mean that you would push to be employed in education? You could be employed in health but still service schools effectively?

Ms DENT: Health therapists are well employed. A huge amount of work can be done that comes into the spectrum of early intervention for learning disabilities in working with children nought to five.

CHAIR: What happened to the 19 children who did not get into the unit at Lismore?

Ms DENT: They did not get in because only six places were available. We were scraping to find children with scores under 70. We really had to do some creative maths for some children.

The Hon. Dr A. CHESTERFIELD-EVANS: So it was 75, or something dreadful like that?

Ms DENT: Yes. They go into mainstream classrooms. They get a report from us and the families might hand on that report. There is an offer of a visit from us and the families might tell the teacher that.

CHAIR: What would happen to those 19 children?

Ms DENT: They do not learn to read; they fail. They fail the basic schools test in year 3, which is the first universal formal assessment of children's academic attainments in New South Wales. If members of the family were resourceful and able to lobby for services for their child and they had access to private therapy they would do that, or they would access public services to see what they can get.

CHAIR: Would the teachers in kindergarten, year 1 and year 2 pick up on that?

Ms DENT: They would. They would make a recommendation that the family refer to us. That might or might not happen. We work closely with teachers. If you took a snapshot of what is going on in New South Wales at the moment with speech pathologists in health and education you would see a lot of terrific grass roots programs in which people are trying to work together. We know schools that have used funds that have been allocated for other areas of their business—funds that they are not meant to access—to purchase speech pathology services for their children if families cannot afford private therapists and there is a gap in that area. A lot of people are working together, but it is not systematic; it is not top down; it is not a smooth process. It depends on individual workers and teachers.

The Hon. AMANDA FAZIO: There might be two children with speech impairment difficulties in the same class and only one child who is getting a teachers aide for two hours a week?

Ms DENT: Exactly. That is right. They could pool the aide time that is available for three children. They could put the children in one class and use that aide time to support the teacher.

The Hon. D. F. MOPPETT: I see a difficulty in the picture that we are painting this morning. We have identified that we need more and higher skilled primary school teachers.

Ms BURTON: Absolutely.

The Hon. D. F. MOPPETT: We need more and higher skilled diagnostic people in the health area. I do not know where those people will come from. There is a shortage of speech therapists and physiotherapists. Positions are unfilled in the New South Wales system. When you get into highly specialised areas people with those skills do not want to work in those areas any longer. They want to go on to an easier and a more financially rewarding lifestyle. They do not want to deal with patients, so to speak. It is an enormous problem. We are setting ourselves the difficult task of finding these people. It is not just a lack of resources. Frankly, I do not believe that that is the issue.

Let us take, for example, a child who is presenting to Quambone Public School. That child would require a really switched-on primary education teacher who has had the benefit of world experience and who has come back to Quambone to teach. I can imagine the speech therapist riding to school each day on his bike. It just will not happen. I agree with this idea, but it has to be within the Department of Education and Training, so at least they have a teacher.

Ms BURTON: Speech pathologists working in Education Queensland are lucky. They are based at the schools and they get all the in-service that other educators get. So I suppose that they are specialised workers. Their experience is that, when they go into a classroom to help a teacher deal with a child with speech language impairment, some teachers are so good that they do not really need much help at all. They are already providing for all the individual differences in their classes. They are just brilliant teachers. Some teachers are insecure and lack confidence but, once they have been given information and they are told, "Yes, you can do it", they are fine. They will provide for the individual differences in their students.

Some teachers are unable to vary their program in any way. They have a mental block. They do not have the skills or the motivation to do it. Some extremely important things were said this morning about teacher in-service. I agree with all the things Dr Whiting said about teacher pre-service. I was lecturing to some fourth year students in a tertiary institution in Queensland. I was talking about special education. I said, "how many of you have ever heard of phonological awareness?", which is one of the big things now. Only one person put up his hand. These people, who were about to graduate from university, had four-year bachelor of teaching degrees. I second what Dr Whiting said. It is sort of skills based. Universities no longer do that. It is all education now. They are not allowed to train or teach skills. It all has to be so terribly esoteric.

I think it should be an essential part of every preservice degree that teachers become very knowledgeable about learning differences and that they learn to teach reading. Teachers are not taught to teach reading. In our experience, we ask teachers whether they have been taught to teach reading and they say no.

CHAIR: Does that mean that we must focus on teachers who will teach kindergarten to year 2? There is not much point instructing year 6 teachers on how to teach reading. Must we divide the teachers?

Ms BURTON: Isn't there? If students with individual education plans who are in remedial programs continue right through school, would it not be handy to have a year 6 teacher who was competent in and who knew something about teaching reading? While I concede that special early education people will be the experts, I believe everybody in a primary school classroom should have some competence in teaching reading.

Ms DENT: If we surveyed any parent and asked, "What do you want your children to learn at school and what do they need most to learn at school?", they will answer, "Reading". The business of schools is to teach children literacy. It is not a difficult process to instruct teachers how language develops and how it is learnt. Unless teachers understand the system of learning, they cannot identify where it has broken down and they cannot implement effective programs to fix it. Teachers who know about reading introduce effective programs and they never need to see a speech pathologist or a physiotherapist. An important aspect of this inquiry is to examine the quality and content of preservice training for child care and preschool teachers.

CHAIR: Do you mean that literally: If we train teachers correctly, there will be fewer speech pathologists?

Ms DENT: Yes. Many children have speech communication difficulties because of extrinsic factors such as a lack of exposure to reading and stories in preschool. A lot of classroom teachers will tell you anecdotally that children are coming into schools with fewer oral language skills than children had in the past. Today's children are not getting the enrichment opportunities they need to be ready to learn to read. If teachers do some core screening of essentials skills—there are tools and areas to examine; it is not a huge science—and implement programs based on where children are falling down, that will push them along their literacy learning continuum. The vast majority of those children will then not end up in third class being unable to read. That is the milder end of the scale. As I said, we all want and need to be able to read. Some children get stuck because of poor experience and poor teaching patterns. It is a downward spiral: If you do not get a few essential skills under your belt in kindergarten, you cannot continue your development and you will fail to learn to read.

The Hon. D. F. MOPPETT: I think Dr Whiting referred to contact with primary school teachers. He said that he hoped that those teachers would be the most gifted and inspired because that is the most important period. However, the community and the teaching profession believe that, although that is true of the 7 per cent, the important thing for the 93 per cent is how good secondary school teachers are at teaching children, controlling their behaviour, inspiring them and getting them through the Higher School Certificate. Do people who think, "I am a really gifted teacher; I am the most brilliant person in teacher training" decide to become kindergarten teachers? I do not think so.

Ms BURTON: A friend who is now a guidance officer said, "As a high school teacher, I used to teach my subject; primary school teachers teach children". People usually go into teaching by doing a subject at university and then a Diploma of Education. However, primary school teachers have usually done a Bachelor of Education because they actually wanted to be teachers. There is that natural selection.

Let us look not at the children with severe, intrinsic disabilities but at the wider range of children. I am keen to address your resource concerns—not just where we will find the money but where we will find the people. If those people who are with children all the time can understand normal language development and be comfortable with it, they will be better able to graft literacy onto it. Let us imagine that a child's first word is "cup". The child keeps seeing this object and when he is given this object a series of funny sounds comes out of mum's mouth. The child finally thinks cognitively, "Okay, it is tuh" and then mum gets very excited. That child has learnt an arbitrary representation of that object.

When children go to school and learn to read, the squiggles on the page that say "cup" do not represent the object: they represent the arbitrary oral representation of the cup. The children are two stages removed from the real object. That is very abstract and, if children are not at that cognitive and language level and ready to take on that second level of abstraction, it would be wonderful if teachers know that and know what to do about it before they try to build the walls of the house on a foundation that is not yet constructed. That is where the cross-over is extremely valuable between the speech pathologist and the teacher because the speech pathologist has that knowledge and that ability to look at children in the classroom and to help the teacher with activities and programs that will raise the level not of kids with severe disabilities but of children who come to school with an inadequate language level on which to build this house of literacy.

The Queensland Education Department recently conducted consultation with the community about literacy. I attended a meeting, thinking that I would have to talk about language. However, I did not have to say a word because every teacher who got up to speak said that children are now coming to school with lower oral language levels than in the past. To answer your resource concerns, I think it would be an enormously good investment to make sure that teachers who take on those children in preschool—in my experience, preschool teachers are terrific—have that knowledge, with the help of speech pathologists. That does not mean that speech pathologists must see every child; it is in the programming that early language development knowledge is really important.

The Hon. I. W. WEST: You can teach the teachers.

Ms BURTON: Absolutely; and the parents. Speech pathologists definitely need to see some children individually, but we can make our biggest contribution to kids in other categories by providing resources and information to educators.

CHAIR: And to parents?

Ms BURTON: Yes.

CHAIR: That is the last question we asked Dr Whiting and Dr Twaddell. Do parents play an important role before children go to school?

Ms DENT: Extremely important. They are the main determiners of the quality of a child's interactions. As Dr Whiting said, many parents are sent to parenting programs when they have difficulties with their children. I would like to see a whole-of-community response and approach to providing information to parents about child development. A lot of the time parents do not understand the importance of their interactions with children. They recently conducted an extensive survey in America, which has been published. It found that parents think activities such as computer games, videos and watching television will help children to learn and to read. It also found that parents believed in the use of flashcards with babies.

The Hon. Dr A. CHESTERFIELD-EVANS: Flashcards?

Ms DENT: Parents hold up cards with words on them, thinking that will help children learn to read when they get to school. However, parents did not know that playing with their children—rough-house play, playing with them on their lap, reading stories or reciting nursery rhymes—and other person-to-person interaction was needed. Parents are the main shapers of a child's environment in the first 12 months in particular. As children spend more time with carers or teachers, they become influences as well, but parents are the prime and first influence on a child's development.

CHAIR: So if we get everything right between birth and age three, there would be fewer jobs for speech pathologists?

Ms DENT: If we got everything optimal.

Ms BURTON: They would still be needed for hard-core, intrinsic problems. Many learning difficulties are based on language difficulties.

CHAIR: If speech pathologists were to screen all children in reading recovery, they could save you that 10 per cent failure rate.

Ms DENT: Do not wait until the beginning of first class: screen children at the beginning of kindergarten before they get to school.

CHAIR: Speech language impairment must also play a tremendous role in behavioural and other difficulties. It has an effect not just on literacy but on the whole child and how they perceive school: it is a place of failure and incomprehension.

Ms DENT: Longitudinal studies show that children with specific language impairment have a 50 per cent chance of having a psychiatric diagnosis, particularly attention deficit disorder or conduct disorder, depression and mood disorders.

CHAIR: Do we know those things are associated or that there is a causal relationship?

Ms DENT: It is both. They know that it happens. Children who have a psychiatric disorder have a 50 per cent chance of being assessed as having a communication difficulty. We know that children who have communication disorders, have a 50 per cent risk factor of having a mental health disorder compared with their peers. The causal relationship is not understood totally, but we know that those things go together.

The Hon. D. F. MOPPETT: The correlation is very close.

Ms DENT: Yes. In the United States, where they have done specific language impairment studies, children are 50 per cent more likely to drop out of school. As Dr Whiting said, why would children continue to face failure five days a week, 6 hours a day?

Ms BURTON: I suppose that that is the real advantage of an individual education plan. I do not know how teachers can teach children with quite severe problems without such a plan because they would get an incredible sense of failure. If teachers have a plan that has been drawn up with input from them, the student—if he or she is old enough—and from parents, at the end of the semester all those people can congratulate themselves on having met all their goals. It enables the child with the problem to feel genuine success because they have set goals and achieved them.

CHAIR: If children are buried in a class of 25 students or whatever, that is much more difficult.

Ms BURTON: If they are doing exactly the same curriculum, examinations and so on, they will always get a "D". It is a very important support mechanism.

CHAIR: You have given us a great deal to think about. Thank you very much— particularly for travelling so far from St Lucia and Lismore. We did not ask you many prepared questions, but I think we have touched on most issues.

Ms DENT: We appreciate the opportunity to present this information. It has one of our goals for quite some time to get the ear of government on these very important issues. Thank you for allowing us to appear before the Committee.

CHAIR: You have the ear of a mix of members of Parliament and of government. If we have other questions for you in the future—regarding technical matters and so on—I hope we may contact you again.

(The witnesses withdrew)

(Luncheon adjournment)

MARION MOLLY de LEMOS, Senior Research Fellow, Australian Council for Educational Research, Melbourne, affirmed and examined:

CHAIR: You have received a summons from the Committee?

Dr de LEMOS: I had a letter.

CHAIR: Signed by me, the formal one?

Dr de LEMOS: Yes.

CHAIR: And you wish your submission to be included as part of your sworn evidence?

Dr de LEMOS: Yes.

CHAIR: Thank you for not only addressing our questions but for doing so in writing. Do you want to talk to them or do you want to show us some things? We are completely in your hands.

Dr de LEMOS: I am prepared to be guided by whatever is of most interest to you. My idea to clarify the questions for myself was to make a written response to each answer, and I can run through, briefly, the sorts of issues that are covered, and if you have particular issues that you want to focus on, that is fine.

CHAIR: Do you want to make a particular presentation or is that just to illustrate a few things?

Dr de LEMOS: I have a series of transparencies to illustrate various points, and as we come to those points I can use the transparencies to illustrate them. I do not necessarily have to use them all but ones that are of particular interest I can give you a little bit more.

CHAIR: We might need a paper copy later for Hansard.

Dr de LEMOS: Yes, I think you have already.

CHAIR: You have given us a lot of detail here about your research interests.

Dr de LEMOS: For each one I have given the question and then the answer.

CHAIR: I do not know whether we want to ask any more. You have told us so much about your background.

Dr de LEMOS: I can run through what is in them and then you can raise questions as we go along.

CHAIR: Do you want to talk a bit about your most recent research, with particular relevance to our inquiry?

Dr de LEMOS: I actually attached a list of relevant references, because I felt it was important for you to at least get some idea of my background to the area. I have had an interest in early childhood and preschool education going back to 1968, when I first did a review of recent developments in early childhood education. That was at the time when Headstart, early compensatory education, became very much in. I was very much involved in the area from then onwards. I have done some studies. As a result of that review I was interested in issues relating to preschool education, enrolments in preschool education in Australia. So, I have done a number of studies in that area. My interest has been more on the implications in terms of schooling and subsequent achievement. So, my focus of interest has been the early years of schooling and conceptual development and how experience affects later developments.

I am currently working on a study, curriculum and organisation in the early years of school, which has involved looking at children from the pre-year 1 to the year 2 level and at literacy and numeracy development in relation to age curriculum, teacher expectation, and so on. I also recently completed a study in Victoria on the effects of multiage grouping in the first three years of schooling. So I do have an interest in the early years of schooling. That is my main area of interest.

I have also worked in the disabilities area. I should mention it because I think it is relevant. I did a study of educational provision to students with a disability. It was a Commonwealth-funded project from 1992 to 1994. My background is in psychology. I have done a lot of work on development of psychological and educational tests, so I have a background of testing as well.

CHAIR: When you use the phrase "early years of schooling" are you usually talking about kindergarten to year 2?

Dr de LEMOS: That is what I usually think of in terms of the early years of schooling, yes.

CHAIR: The other thing I particularly noted in your answer to question 1, what did you conclude about the age of entry to school?

Dr de LEMOS: In all the studies I have done, and my research on this goes back quite long way and I have also looked at the literature, there was no evidence indicating that early entry to school has any disadvantage. What differences occur on entry to school tend to wash out after the first two or three years of schooling. So, there is no long-term effect, if you like, of early entry to school and no long-term effect of relative age and grade. In fact, most usually when you look at relative age and grade, it is the older children who do less well than the younger children. There are reasons for that, because sometimes they are the ones who had been retained or entry to school has been deferred because they are not quite as advanced.

CHAIR: Does your study on entry to school cover or have any implications on whether or not all children should have a year's preschool, for instance?

Dr de LEMOS: I am not sure that they are directly related. I think the point is the older the children are when they start school probably the more need there is to have a program for them in the year prior to entry to school.

CHAIR: So, whether they go to preschool at 4 or start school at four and a half, does not make much difference?

Dr de LEMOS: Yes and no. I think they are different programs. I think the focus of the preschool program is much more on play-centered things, and for some children a more structured program is more helpful, particularly children whose home background does not provide them with that. Very often I suspect the traditional, socially-focused preschool program meets the needs of middle-class children. I am not sure that it meets the needs of less advantaged children as well. It sort of complements the experience children have at home, the social focus, because they get a lot of learning through the parents that the children from disadvantaged homes do not necessarily get. That sort of evidence goes back to the late 1960s and 1970s.

CHAIR: So, children from the more disadvantaged homes need a more formal—

Dr de LEMOS: —a more structured and more focused program.

CHAIR: To catch up?

Dr de LEMOS: To catch up.

CHAIR: We have our question and a very long and detailed answer about schools in New South Wales and the use of assessment.

Dr de LEMOS: I suspect the short answer to that is, without knowing what tests are being used I cannot answer the question. What I can say is that the conventional way of identifying learning difficulties is through the use of a standardised test, such as the WISC-III or the Stanford-Binet. I think the WISC-III is more commonly used. That is the Weschler intelligence scale for children. You use the measure of intelligence together with the measure of educational achievement. If there is a discrepancy between the score on the intelligence test and the score on the educational test, we are talking in terms of a specific learning difficulty. In other words, if the child is of average or above average intelligence but is having problems with learning, it is assumed there is a specific learning difficulty associated with brain dysfunction. If they are scoring low on both the intelligence and educational measures, the assumption is they are low ability children at the lower end and the educational or learning difficulty is associated with a low level of general ability.

There is a tendency to make that distinction between the specific learning difficulty and the general learning difficulty.

CHAIR: Would that implicit definition be broadly accepted as defining specific learning difficulties?

Dr de LEMOS: I think it is broadly accepted, especially by psychologists who usually assess children. That is one of the transparencies I have brought with me. There are two problems with that, one is that the individually administered intelligence tests is very time-consuming to administer. It becomes a very costly process. The other problem is that their definition tends to involve the average intelligence on the intelligence test, and those two years or more behind on the educational measure. The problem with being two years or more behind means different things at different ages, and it also depends on the validity of the test being used.

It is a valid method, but at the same time there might be a more cost-effective way. I have worked with a set of data which uses scores on a measure of reading and a measure of maths. By combining those scores I can identify kids in different categories. Those categories relate very much to the different learning difficulty categories. If you read the literature you would know that there are huge differences in the estimates of the numbers of kids with learning difficulties. That is a way of classifying children, on the basis of two standardised measures of reading and maths and looking at where they fall in relation to the two tests.

Children can then be classified. The cut-off points are scores of less than 90 on both reading and maths, when referring to a test which has a means of 100 and a standard deviation of 15. The scores on the two tests are comparable, with less than 80 on both, and less than 70 on both. When using an intelligence test a score of less than 70 is normally considered to be the criterion for intellectual disability. On a test of intelligence a child scoring below 70 would be identified as having an intellectual disability. That is a way of combining the scores on the reading and the maths and getting classification in which you can identify kids. This is very consistent, although there is some variability.

CHAIR: This morning Dr Whiting preferred to use the term "learning disability" rather than "learning difficulty", which I gather is the American tendency.

Dr de LEMOS: The Americans talk about learning disability and under the American system children with a learning disability are entitled to funding under their funding for children with a disability. In the Australian situation, funding under the special education program is for children with an identified disability only. A learning difficulty does not entitle a child to funding under that program. The term "learning disability" is confusing. I prefer the term more commonly used in Australia to be "learning difficulty", and that is, of course, either a specific or a general learning difficulty.

The use of the term "disability" has a level of confusion. I have used the term "learning disability" to indicate the severe cases, because I suspect that if you look at those you are getting into something which is more than just a learning difficulty. It is something that requires support, when looking at that lower 1 per cent.

CHAIR: Would that classification be broadly acceptable?

Dr de LEMOS: Well, it is kind of new.

The Hon. Dr A. CHESTERFIELD-EVANS: Is it your classification?

Dr de LEMOS: It is my own. It is based on the same principle as identifying students with an intellectual disability. A lot of people now use a measure of adaptive behaviour and a measure of intelligence. This follows exactly that model for identifying educational or learning difficulties as against intellectual disabilities. In a sense it is the same model, but with intellectual disability you are concerned only with that lower group, because they are the only ones that fall into the category of having a disability.

CHAIR: Where does this classification fit children whose major difficulties may be behavioural and who may score badly because of that?

Dr de LEMOS: The same model can be applied, and has been applied, to a measure of behavioural difficulty together with a measure of learning difficulty. You can probably then get the same sort of classification, if you like, with a kid who has either a behavioural difficulty and not a learning difficulty, or a learning difficulty and not a behavioural one, and when they have both. I think you can apply the same model to that group of children. In fact, I could probably do it on some of the data I have. Although that is a theoretical model I have applied it to a set of data and I am getting different results from different sets of data in terms of the proportion of kids who are classified at different levels.

The reason I did that was because there was so much confusion and disagreement about the proportion of kids have learning difficulties. There would be estimates varying from 3 per cent to 30 per cent. That did not make sense to me, so it seems that you need to get a fairly clear definition of what you mean by a learning difficulty. That could be applied in any context. It depends on having available standardised norm reference tests with the normal distribution of schools and up-to-date norms.

CHAIR: What does that tell us?

Dr de LEMOS: If you look at the total at risk, it shows 30 per cent. The first level, the lower achiever in reading and maths, is 8 to 12 per cent. If there is a low achiever in reading only, that varies a bit across different studies, at about 3 to 8 per cent. If there is a low achiever in maths only, that is similar. With learning difficulties, the low achiever, it is 80 to 90 per cent. The learning difficulty is 70 to 80 and learning disability is less than 70. Those results tend to agree reasonably well with predicted results on the basis of the classification. The value is that you get consistent results. This is not a question of different criterion, different tests, different definitions, different understandings, of what a learning difficulty actually is.

The Hon. D. F. MOPPETT: I may have missed something in the presentation of other witnesses, but you seemed to have expanded the potential group that we are interested in. This morning we heard about 7 per cent.

Dr de LEMOS: It depends. The low achievers may or may not be at risk and you may need to monitor them. Probably the children of concern are in the 6 per cent moderate, the 3 per cent severe. The others are the lower end of the norm. You are particularly interested in children who have a difficulty in one area but not another. That is where you would expect that something funny is going on which needs to be looked at. If the child is low in both we are probably looking at a low level of ability.

CHAIR: If someone uses the term "children achieving a functional level of literacy", where do they come on this scale?

Dr de LEMOS: That is moving into a different area. How do you define a functional level of literacy? Usually it is an average. The American average was grade 5 and they have put it up to grade 8. That is a criterion reference, and it depends on how you define it. It is a continuous thing, where do you set the cut-off?

CHAIR: I asked you that question because I am not quite sure what scores less than 90 mean.

Dr de LEMOS: This is based on a normal distribution, and is taken at every age level. It is age related, and would be applicable at every age. Children who are scoring more than two standard deviations below the mean are usually seen as being outside the normal range.

CHAIR: You are up to one standard deviation by looking at the 33 per cent, are you not?

Dr de LEMOS: Yes.

The Hon. Dr A. CHESTERFIELD-EVANS: That means 33 per cent on one half of the curve.

Dr de LEMOS: I have used a cut-off point of 90. You can use 85, but 90 was the measure that most psychologists used when defining what is average to above average. In a sense I used the traditional or conventional definition of what was average to above average, and I went from there.

The Hon. Dr A. CHESTERFIELD-EVANS: This morning we heard evidence that the Government was only resourcing 3 per cent. From memory the Committee was told that below 70 was being resourced but they wanted below 80 to be resourced.

CHAIR: The 70 to 85 was in relation to speech pathologists.

Dr de LEMOS: The best system is a flexible, continuous one. The Danish system ranges within a classroom down to your residential special school and according to the need of the student they are given the required resources. Different levels of resources are required for different levels of disability. The ones that have resources are for students who fit the criterion of a disability as defined by the Commonwealth or State governments. My data was certainly back in 1992 and that was essentially 2 per cent which included not only those with intellectual disability, although most in that category are intellectually disabled, but also those with hearing, vision, motor, physical, emotional and social disabilities. That category of students with a disability covers a whole lot of other areas.

CHAIR: Why do you suggest it is difficult to accurately identify children in preschool years who may subsequently be at risk of learning difficulties? Does that mean that there is no need to improve existing systems for early identification of learning difficulties?

Dr de LEMOS: I have some data relating to accuracy of prediction. One of the problems in early identification of children who are likely to have learning difficulties is that your preschool measures are usually measuring something rather different to what is being measured at the later age. They are more dependent on development which is more dependent on underlying maturational processes whereas the measures of achievement tend to be more dependent on a general ability factor which is a speed of processing factor. In a sense your early measures are measuring something rather different to your later measures. The idea that it is difficult to predict on the basis of measures of later preschool difficulties, I have actually picked out some data from the study of multiple age grouping in Victoria where I followed a group of children from prep through to year 3. I used the lower end of the scale to identify children who were at risk. I had 85:15 so I took the lowest 15 per cent on the various measures that I was using. I only included in that study the children for whom I had measures for all the four years of the study. Of the 726 children there were 80 who were identified at risk at prep level which was 11 per cent at the time.

The Hon. Dr A. CHESTERFIELD-EVANS: What is prep level?

Dr de LEMOS: It is the equivalent of kindergarten in Victoria.

The Hon. Dr A. CHESTERFIELD-EVANS: What age is that?

Dr de LEMOS: That is five years of age. Of those identified at prep level, this particular group of children were followed through, only 45 per cent of them were still at risk in year 1, 36 per cent in year 2 and 49 per cent in year 3. On the basis of your measure at the prep level, and for that service I used the AGS early screening profile which is a well-established American screening instrument, at years 1, 2 and 3 levels that was based on measures of reading.

The Hon. Dr A. CHESTERFIELD-EVANS: How many people in year 3 were at risk who were not at the start?

Dr de LEMOS: I am glad you asked the question. I had 101 that were identified as at risk in year 3 and were 14 per cent of the sample. Of that group 50 per cent had been identified the previous year, 49 per cent had been identified in year 1, 39 per cent in prep.

The Hon. Dr A. CHESTERFIELD-EVANS: You have only got a 40 per cent pick up rate in prep of the problems that are going to come later?

Dr de LEMOS: Yes. This transparency shows consistency. Of the 726 children, 213 were identified as at risk on at least one of the measures over the four years of the study. Of that total there were 54 per cent who were only identified in one of the four years of the study as being at risk. There were 25 per cent who were identified on two measures, 14 per cent identified on three measures and only 8 per cent who were identified right through as being at risk.

The Hon. Dr A. CHESTERFIELD-EVANS: That is on all four measures?

Dr de LEMOS: Yes, over four years on all four tests.

The Hon. Dr A. CHESTERFIELD-EVANS: Is there more consistency at the lower end of the scale? You have taken the bottom 15 per cent which means that the top few per cent of your 15 per cent lead into the normal pretty well actually.

Dr de LEMOS: Yes. I have some data from the United States of America on the Gazelle school reading test which is one of the most widely used to have there. They use different cut-off points. Those identified on the measure who subsequently fail, and there your prediction is somewhat better the stricter the cut-off point, the less stricter the cut-off you are getting more children at a higher level for your cut-off point. The retrospective prediction of those who later failed, what per cent have been identified, 47 per cent at the lower cut-off. There are a higher number identified at risk the higher the thing. At that stage so many have been identified at risk and you are going to include those who were rigidly identified. You are identifying a large number of children who are going to be at risk. A lot of those may not be at risk that when you finally use your criterion measure you have a small number, as though most of those at that level will have been identified as a risk.

The Hon. Dr A. CHESTERFIELD-EVANS: Presumably at some level you have enough to make the screening test cost effective in that it is not much good testing 100 kids to get 0.5 per cent because you have tested 99.5 and they did not need it. If you tested and got 5 per cent, you are pretty sure you have got an 88 per cent chance for example that they will be a problem later, the amount you would save by identifying that 5 per cent earlier would pay easily for the screening of the other 95 would it not? At what point is it reliable enough? It is a question of balancing the age of the most troubled in the services?

Dr de LEMOS: I can see what you are saying but then the point is once you have identified them what would you do about them? Will identifying them have a benefit? How do you calculate the benefit?

The Hon. Dr A. CHESTERFIELD-EVANS: The groups who have given the Committee evidence generally lobby for resources for a child development aspect whether it be that their learning or physical difficulties were not picked up or their social problems with their families were not picked up which leads to behavioural difficulties in the presence of what you might define as intellectual performance. I suppose you look at it from the perspective of reading and writing tests rather than behavioural or family problems or physical disabilities. Our point of view is to do a thorough screening. When is it done? What is the pick up rate? What is its cost benefit analysis in all the areas which might cost you more money if you do not do something preventive early?

Dr de LEMOS: That makes the assumption that if you do something preventative early the problem will be eliminated.

The Hon. Dr A. CHESTERFIELD-EVANS: Or eliminate enough of it to make it cost-effective to do the intervention.

Dr de LEMOS: I suspect there are two answers to that. One is that most children who have severe difficulties, in a sense that is almost self-evident and they are picked up because it is obvious that they are performing at a low level.

The Hon. Dr A. CHESTERFIELD-EVANS: The Committee gets a lot of evidence the other way which means that the failures make the noise. It is hard for the Committee to decide whether the failures make the noise or whether there is a huge problem of people not getting picked up. It is difficult to try to make decisions about resource allocations to sort out these things.

Dr de LEMOS: I have been looking at data from two American studies that have been widely quoted in favour of early identification and intervention. They dealt with very low socio-economic or low birth rate children. This one is low socio-economic.

CHAIR: You have moved onto our question seven?

Dr de LEMOS: Yes. I thought it was relevant at this point. There was this view that if you identify early and intervene you will have dramatic results. In fact, the evidence does not show that. This is evidence on the Abecadarian project which has been very widely quoted in the literature. The IQ gains of the experimental group at age 18 to 54 months seem to be very dramatic. Here again you have to remember that you are probably measuring different things: development versus ability. At 5 to 8 years your gain is only about 3 to 8 points on different measures; 12 years your gain is 6.5 points; at 15 years your gain is 4.6 points on an IQ measure. They are still below average. These are all around 89/90 . They are on that low ability level. These had very intensive intervention from four months old full-day care until they went to school. At 15 years old the only difference between the experimental and the controlled group was 4.6 points of IQ which from an educational point of view would make very little difference to performance and their outcomes.

The Hon. Dr A. CHESTERFIELD-EVANS: If you are saying the tests are unreliable at four months, all you are saying is that they are from a poor family. When you say high amount of intervention, are you saying nutritionally there was a huge change?

Dr de LEMOS: My understanding was that the intervention was mainly on the cognitive aspects.

The Hon. D. F. MOPPETT: In any case, it was a control group.

Dr de LEMOS: It was a control group.

The Hon. Dr A. CHESTERFIELD-EVANS: You cannot really define children as being of low IQ at the age of four months, surely? I am not an expert on child assessment, but I would have thought at four months you are basically defining them by their socioeconomic group or the parents' intelligence; you are not saying, "Gee, that's a bright four-month-old, that's a dumb four-month-old?"

Dr de LEMOS: They use measures of development. I have not looked at it in detail and I would have to check those measures. That was one of my questions: what were they using. This is what they report: all of the children were drawn from lower socioeconomic backgrounds and were randomly assigned to a control group and experimental group. This is the difference between control and experimental groups.

The Hon. Dr A. CHESTERFIELD-EVANS: Surely it depends on what they did? This is a case where you would have to look at the methodology. The Committee heard from a fellow whose name escapes me.

CHAIR: Professor Perry.

The Hon. Dr A. CHESTERFIELD-EVANS: He measured brain circumference and was saying that the growth rate of the brain is hugely greater the younger you are. In that case it could easily be a nutritional thing and you can do all the cognitive work in the world and you would be better to stick a bottle in their mouth. What I am saying is that the intervention would need to be looked broadly.

CHAIR: There is other detail in the written answers. These are things we can consider later.

Dr de LEMOS: My point basically is that two studies have been widely quoted. The arguments in favour of early intervention are based on two United States of America studies. The outcomes simply do not justify what has been put. That is the point I am making. These are the studies on which the arguments are based.

The Hon. Dr A. CHESTERFIELD-EVANS: Effectively you are now putting forward a null study, the one you are saying is only 4.8 per cent is a null study, are you not? It does not really show a significant difference?

Dr de LEMOS: It is not sufficient, no.

The Hon. Dr A. CHESTERFIELD-EVANS: Was that used as an argument for or against?

Dr de LEMOS: It is one of the main studies used as an argument in favour of early intervention, in the literature. I can certainly pass on the literature. The finding from the studies is the effect of maternal IQ. Maternal IQ can work in both ways: either as a genetic or environmental factor. The problem is that a lot of programs are focused on parent education; it is the parents with the higher IQ who respond better. You are not really targeting the children who are most in need, who would be the children whose parents are less able to provide them with the kinds of experience they need. There is a lot more on this. I can certainly provide you with more details.

The Hon. D. F. MOPPETT: This is one of the most profound pieces of evidence the Committee has heard. The rest has simply said the key to normalising everyone is to get at them earlier and put in more resources. You have challenged that.

Dr de LEMOS: I have some articles I am sure you will be interested in, but the argument is that the link between brain research and educational implications is just not there.

CHAIR: This morning the Committee heard from speech pathologists. How does what you say relate to the sorts of things they told us about testing with speech and language performance, which seems to be related to later learning difficulties and may also relate to developmental failures of a child? Nevertheless, things like that can be measured fairly early; parents pick up those things fairly early.

Dr de LEMOS: One of the positions I would argue is a model of ongoing monitoring and support rather than a model of early identification and intervention. You have to have your ongoing monitoring and support. When the difficulty is there you provide resources to support it. But you do not try to predict which kids are going to have difficulties and which are not, because you do not really know. The argument is to identify. When you have identified the problem you provide the support necessary. That is an alternative.

CHAIR: Will it be clear what support is necessary?

Dr de LEMOS: I would think so, yes. It depends on what you are looking at. There are educational problems, behavioural problems, probably nutritional and other social problems, but I feel it would be possible to identify what the problem is and provide resources.

CHAIR: Is that the case if the child is only two or three years of age as distinct from a school-age child?

Dr de LEMOS: Yes. You can provide support all along the way. It is not a question of if you do not provide the support early the child is lost. There is not the evidence to support that.

CHAIR: Question 4 was about the preparation and training of teachers. Question 5 is: Should we make a distinction between "parent education" in the prior-to-school years?

Dr de LEMOS: Basically in my answer I have said that I think it is unrealistic to expect all teachers to be able to identify and support children with learning difficulties in the classroom. They need the support of specialised teachers. I would envisage a system whereby you have like a support team that provides support for the classroom teacher. So, the child might be in the classroom setting but supported by somebody who has training in that area. It is a question of providing appropriate support for the teacher.

CHAIR: Would that be done as a squad that goes from school to school or within a school if it is of a certain size?

Dr de LEMOS: If it is a large enough school I would expect there to be a resource centre within the school. For smaller schools I would expect a regional person. I think it is a model that has been adopted in the past. I am not sure in New South Wales; it is a model that tended not so much to be discarded but run down so that schools no longer have the sort of support they used to have from guidance officers or the support centres.

The Hon. D. F. MOPPETT: Or inspectors?

Dr de LEMOS: Inspectors are slightly different.

CHAIR: Would you see those teams as being made up of non-teaching people like guidance officers or speech pathologists, psychologists, counsellors?

Dr de LEMOS: I would think they would be a multidisciplinary team: You would have your teachers; teachers who have specialist training for children with learning difficulties, used to be remedial teachers but they probably use other terms now; and specialists in speech pathology and psychologists to assess. I would see it as a multidisciplinary team.

CHAIR: You wanted to address other questions further because you have transparencies to show the Committee. The next was whether we should make a distinction between care and education in preschool?

Dr de LEMOS: I do argue for making a distinction and I recognise there is both care and education prior to school and at school level. You have your before and after school, but it seems to me that it is necessary to make a distinction. I see the care of children as the responsibility of the parents and not something that should be provided free to all children whereas education is the public responsibility. In order to eliminate disadvantage you need to have that education, whether it be preschool or school education, free and publicly funded. I have some data which indicates there is a difference in access; where the preschool is attached to the school as part of the education system as against where it is run under a separate authority.

CHAIR: Taking up the point you made before about the differences in social class, if preschool is to be widely available should it be compulsory if the State is going to provide it, given the people who will use it?

Dr de LEMOS: If you make it free and publicly available you do not necessarily have to make it compulsory.

The Hon. Dr A. CHESTERFIELD-EVANS: You are using models that are academic in older kids and extrapolating downwards?

Dr de LEMOS: How do you mean?

The Hon. Dr A. CHESTERFIELD-EVANS: You are saying the tools that measure the very young are not reliable in their correlation with others?

Dr de LEMOS: It is not so much they are not reliable. I think I am measuring a somewhat different aspect of behaviour. I think there is a distinction.

The Hon. Dr A. CHESTERFIELD-EVANS: If that study you are showing us is valid, that it does not make much difference, the corollary of that would be that preschool education does not matter much either, is that right?

Dr de LEMOS: Yes.

The Hon. Dr A. CHESTERFIELD-EVANS: You are saying intervention does not make any difference between a control group or experimental group. By that logic, preschool would not make much difference either?

Dr de LEMOS: Yes. In a sense this transparency will answer those questions. The one at the bottom is the most relevant. When you are looking at the impact of preschool education, that can reduce rates of early school failure. They are more effective with disadvantaged than advantaged children. They cannot on their own solve the problem. They cannot overcome other forms of disadvantage. Providing substandard programs to disadvantaged children is unlikely to change their lives. The bottom line is the most important: the fact that most positive outcomes have been found in countries with the national policy of providing preschool services to all children and a tradition of ensuring the quality of those services through enforceable regulations. It is the quality of the education system from preschool level right through that is important.

The Hon. Dr A. CHESTERFIELD-EVANS: That is right, the bottom paragraph is the guts of it.

Dr de LEMOS: I think that is the critical thing.

The Hon. D. F. MOPPETT: Would that imply that in those countries the accent has moved very much from the social to the educational aspect of preschool service rather than just being a place where children learn to socialise and get ready for school?

Dr de LEMOS: The push is moving more towards recognition of the importance of cognitive preparation or developing the skills necessary for subsequent learning. That is more important to the lower socioeconomic than the middle class because they get it at home anyway.

CHAIR: You have summed up that point in your answers referring to the data from the ACR study on curriculum and organisation in the early months of school in which you say something very similar to that but in relation to Australian States.

Dr de LEMOS: Yes.

CHAIR: Those that provide preschool education as part of a publicly funded education system have the highest rates of preschool attendance and the least discrimination.

Dr de LEMOS: Yes. This is a sample study. It is not census data. Dividing the sample into those States where the preschool is attached to the education system as against those attached to the Department of Community Services and are separate. Then looking within each of those categories at the background of children, this was a teacher rating if you like, whether it had high or low literacy support.

The critical set of figures is the one in the second last column with the total number of children who had not attended any form of preschool where it was attached to an education department. The difference between those who came from a high-literacy support home and low-literacy support home is 3.5 versus 7.4. In the other case, where the preschool is not attached to the school, there was a much bigger difference. Some 6 per cent of those with high-home support had not been to preschool as compared to 17 per cent from the disadvantaged.

The Hon. Dr A. CHESTERFIELD-EVANS: In my other life I was on the committee that considered socialisation as a preventative measure to going to gaol. It was interesting to note that they were very much pro the socialisation of children with role models. They wanted to do that at a very young age. They said that preschool is about the most important schooling you can have in the sense that socialisation with the other kids allows you to develop self-confidence and interpersonal skills that will be critical. Will that be picked up in the data you are looking at? Could they be non-socialised yet still do quite well in the indices that you are measuring?

Dr de LEMOS: You have the socialisation aspects of preschool and you have the cognitive development ones. I can see no reason why you do not have both together.

The Hon. Dr A. CHESTERFIELD-EVANS: I am sure you would have both together if you had a decent preschool. But there are two different reasons, from our point of view, why you might put a lot of money into a preschool program in your country and the two are cumulative, presumably.

Dr de LEMOS: I would have to look at the evidence in terms of the social effects on social behaviour. In terms of long-term effects it may be more difficult to pick up the effects, but in terms of short-term effects it is certainly the case that children going to preschool are better prepared for the school environment and adapting to the expectations of the school environment.

The Hon. AMANDA FAZIO: Previously you referred to early intervention. Would you support early intervention in terms of speech therapy and occupational therapy, which is essential for some children to allow them to get the most benefit out of their early years of education?

Dr de LEMOS: Two things that are most important to screen for in young children are hearing and visual problems because if they have those sorts of problems they will not benefit from the environment. Children who have marked disabilities in speech, yes, they need support. But I would regard hearing and sight as the two things you need to check for.

CHAIR: We are running out of time, because we have asked you so many questions.

Dr de LEMOS: I know that we are running out of time, but I wonder whether you want the information on the enrolments, which seemed to me to be an issue.

CHAIR: Yes, the preschool. I was going to move on to that. We have been given such conflicting statements, but I think you are in a position to clarify some of them.

Dr de LEMOS: This set of figures is from the latest report on government services. This set of figures is the total number of children in government-funded or provided child care from 0 to 5 years; it is the top level figures. You can see from that that New South Wales has the highest proportion of children in some form of funded child care in the 0 to 5 age group.

CHAIR: It is a difference. We are not doing very well, nationally, are we? It is pretty hopeless. How does that compare with your standards? The 31 per cent as a nation is pretty dreadful, is it not?

Dr de LEMOS: Our figures are much lower than OECD figures. Countries like France, Belgium and the Scandinavian countries have a very high proportion of kids in some form of early childhood program.

CHAIR: That is childcare, and when you add preschool—

Dr de LEMOS: These are the figures that I thought you would be particularly interested in because of the debate about participation rates in New South Wales. The real problem is that in the past children in preschools attached to childcare centres were not included. But once you include children in preschool programs within a child care centre, New South Wales comes out much the same as the other States, and that solves one of the problems I had in my study where my figures were very different from the figures in discussion paper brought out by the Australian Education Union.

The Hon. Dr A. CHESTERFIELD-EVANS: New South Wales caught up only very recently?

Dr de LEMOS: It is not that it has caught up, but it has changed the way in which it has counted. It is a problem with accounting. Previously they did not include those in preschool programs in day care centres.

CHAIR: Some people have suggested that on average children in New South Wales start school a little earlier than in other States and that affects the figures; there are more 4½-year-old children there.

Dr de LEMOS: I do not think that has any affect on the figures. This is the cost, and that is based on hourly rates from the report on government services. If you convert the hourly rates, assuming 10 hours a week for 40 weeks a year, that is the difference in the cost between the different States.

The Hon. Dr A. CHESTERFIELD-EVANS: They get good value for money in Queensland.

Dr de LEMOS: In Queensland if the preschool is provided by the State it is free. Preschools attached to schools are free. If children go to community-based preschools they pay $7.80. But most children in Queensland, about 80 per cent or more, the preschool is attached to schools. Many of the States do not talk about fees but they refer to voluntary contributions, which are very low.

CHAIR: We raised with both Dr Whiting and Dr Twaddell this morning the move in most States away from infants departments and specially trained infants teachers, and a real division between the infants and the primary. I would like your comments on the record in that regard.

Dr de LEMOS: As I said in my written comments, I do not know of any research evidence on this subject but in principle it would seem to make a lot of sense to have your early primary in a separate unit to the rest of the primary. Victoria used to have what they called the Trained Infants Teachers Certificate, I do not know whether you have the same here. Even today we hear comments about the values of that training, the specialisation of the teachers, the fact that they had a better understanding of early childhood development, they had a better understanding of teaching techniques, and it provided them with a career structure which otherwise they lost in the system. I would certainly support it in principle, but whether the evidence is there to support it is another issue.

CHAIR: As you have given so much detail in your written submission, would you have any objections if we were to attach it to the transcript so that it is clear to people who do not have it that we were building on some of that information in the questions we asked of you?

Dr de LEMOS: Yes, certainly.

CHAIR: And the transparencies?

Dr de LEMOS: The transparencies were not prepared with that in mind because I note all the necessary sources and references on them. I would normally put all the relevant references on that kind of material.

(The witness retired.)