Submission
No 320

INQUIRY INTO THE PROVISION OF EDUCATION TO STUDENTS WITH A DISABILITY OR SPECIAL NEEDS

Organisation: CHI.L.D. Association/LET'S TALK Outreach Services

Name: Ms Tracey Langton

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Inquiry into the provision of education to students with a disability or special needs.

SUMMARY

Specifically regarding children with Language disorders and with reference to the Terms of Reference of this inquiry:
1. The level and adequacy of funding is poor and access is restricted by identification & diagnostic issues
2. Funding allocation models need to include provision for the 'hidden' nature of some disabilities
3 & 4. The focus should be on training and ensuring that the system caters for all learners effectively (rather than place allocations)
5. Poor understanding of Language disorders results in inapproriate support and curriculum modifications aimed at students who may be misdiagnosed with intellectual disability and/or behavioural issues
6. Access to specialist support is restricted by locality, workforce issues & poor information
7. There is limited training available for teachers regarding Language disoders, its implications & the most appropriate support.
8. There are significant long term costs to governments & society along with poor outcomes for individuals with Language disorder who do not recieve approrpiate and early intervention.

Terms of Reference:

1. The nature, level and adequacy of funding for the education of children with a disability.
2. Best practice approaches in determining the allocation of funding to children with a disability, particularly whether allocation should be focused on a student's functioning capacity rather than their disability.
3. The level and adequacy of current special education places within the education system.
4. The adequacy of integrated support services for children with a disability in mainstream settings, such as school classrooms.
5. The provision of a suitable curriculum for intellectually disabled and conduct disordered students.
6. Students and family access to professional support and services, such a speech therapy, occupational therapy, physiotherapy and school counsellors
7. The provision of adequate teacher training, both in terms of pre-service and ongoing professional training
8. Any other related matters.

By the time children start school at age four or five, most of them are fairly well organised. They have sorted, classified and categorised information into the right places in their minds. They can use language to communicate and socialise. They can use language to learn.

There is another group of children who are disorganised and quite overcome by a disorder of language - children who cannot make sense of their world. They are totally distracted by all the information presented to them, so much so that they can appear not to be paying attention or even to be deaf. In fact, they are often paying too much attention to one word or phrase, trying to make sense of it, while the rest of the sentences goes unheeded.

These are children who are lost in space and time. They can't recall the sequences of things, don't know what day, season or year it is, and are confused by *today, yesterday* and *tomorrow.* They muddle *up* with *down, behind* with *in front* and *right* with *left.* They can't visualise their own space or their own body moving in space. They misplace their belongings. They are clumsy, losing their balance. They may not be able to co-ordinate several things at once. Their timing is always off.

The NHS Centre for Reviews and Dissemination suggests that 6 per cent of children will have some kind of speech, language or communication difficulty at some stage of their life. David Hall (1996) suggests that one in every 500 children will have a severe long-term difficulty.

The number of potential cases of children with speech and language impairment is high. A conservative estimate suggests one to two per cent, but well designed studies have suggested seven per cent may have some kind of speech and language impairment.

Not all children with a speech and language impairment will attend a specialist class; a significant number will be in mainstream classes. Many teachers believe that they have steadily increasing numbers of children with some degree of speech and language impairment. This may be so, or we may be getting better at recognising these difficulties. Depending on how it is defined, estimates of the prevalence of speech and language impairment vary between three per cent and 15 per cent of the population.

(Ref: Supporting Children with Speech and Language Impairment and Associated Difficulties, Jill McMinn, Software Publications Pty Ltd, Sydney).

Under the NSW DET guidelines the criteria for disability, the criteria for a Language disability is:

Students must have an assessed receptive or expressive language disorder which is documented within a current speech pathologist's report (in general, the report should be less than 12 months old). The report must include the results of at least one relevant standardised language test that allows for the reporting of both receptive and expressive language skills. At least one of the scales (either receptive or expressive) must indicate a standard score of 70 (second percentile) or less. The report must indicate that the disorder significantly affects communication and diminishes the capacity to achieve academically. There must also be documented evidence of the development and delivery of an intensive learning program assisted by a support teacher, or relevant specialist in the prior-to-school setting in the case of a student entering kindergarten. Difficulties in communication and academic achievement must be the direct result of the disorder.

In the case of children with Language disability, there are a number of funding factors:

1. Before a child is identified with a Language disability, there are a number of 'stages' the school staff, allied health professionals, parents and the child need to be involved in.

a) Recognition of the disability: There is a wide range of problems experienced by a significant number of children in the education system. Teachers and specialists within educational settings need to have an awareness of these problems and the test instruments which would best identify specifically the type and extent of the disability. Many of the children who have a language issue present behaviourally, in the mainstream classroom, in two ways. There is the child who is disruptive - their frustration with not understanding what they are asked to do and/or their frustration at not being able to express their knowledge about a concept, may manifest itself as 'referred pain' in the guise of inappropriate behaviour. The second group of children include those who work diligently on tasks, may complete sections of work which they have copied from others, create a visually appealing piece of work or may sit quietly in the classroom hoping that the teacher does not 'see' them or call on them to contribute to the lesson – they attempt, often successfully, to fly under the radar. As speech language impairment of language disorder is a disability of 'exclusion' (i.e. other reasons for a

child's learning difficulties need to be eliminated before considering language impairment), considerable time is required for children and parents to move through the identification process. Additionally, teacher training ill prepares teachers to recognise the indicators for Language disorders, let alone providing with them with the knowledge and skills for adequately and appropriately supporting these children. At the end of the day, with so many hurdles to accurate diagnosis, some educators believe that children with Language disorders are actually not recognised or supported in the NSW education system.

b) Ability to 'read' standardised assessments: The criteria for identification of children with a Language disability, while appearing to be descriptive, is open to some interpretation. While the disability criteria for funding provide a prescriptive standard score of 70 on a language assessment instrument, there is sound evidence-based argument for children who test above that score to warrant the support given to them by the classification of Language disability. Other test instruments or data-gathering may provide additional support for children to obtain this classification. The presentation of the argument that will "indicate that the disorder significantly affects communication and diminishes the capacity to achieve academically" is objectively given from the assessor and/or the person collating the data. Dependent on their skill level and knowledge of the diagnostic specialists and education-based case managers, a strong or weak case for Language disorder may be provided for the same child.

c) Level of support: For some children in various settings through out the state the level and type of support given reflects directly on the *documented evidence of the development and delivery of an intensive learning program assisted by a support teacher, or relevant specialist in the prior-to-school setting in the case of a student entering kindergarten.* Where there is limited or no access to professionals, especially Speech and Language Pathologists and Occupational Therapists, the documentation of a developed and delivered program can be non-existent or 'flimsy' at best. Compounding this issue is that staff who are employed in more rural, isolated or less desirable locations are usually young graduates, who have limited life experiences and have a tenure in the area for 1, 2 or at best 3 years. The turnover of staff may delay the diagnosis of the condition, as with the employment of each new staff member the documented evidence process may start from the beginning and as a result children can go through the process 2 or 3 or more times without a definitive outcome. In some cases, children have been waiting up 3 or 4 years or more for this process to be completed and are today still not recognised under the category of Language disability.

2. The above funding allocations for staff and professional development applies to identification of children with the disability. Once a disability category has been obtained, appropriate support for the child becomes the next challenge for parents and school staff.

As a result of a shortage of Speech and Language Pathologistss and additional allied health professionals, particularly in rural, isolated or less desirable locations, providing a program that meets the needs of the individual child is challenging and falls on the shoulders of school staff. While the concept of an inclusive curriculum would appear to provide benefits to children, holistically, the level of support required to enact the inclusive curriculum concept is high and has never been fully supported finaincially. Over time, the objective has been eroded as the value of the concept and ultimately of the children it 'supports' is seen to be an increasing financial burden to schools and the department.

The problem is two-fold. The problem is two fold. The teachers who take on the role of working with students with a disability may have limited or no experience in the area of working with children who have a disability. Added to this is the concept that teachers need to have knowledge of the whole spectrum of disabilities including Language, Physical (in all its forms), Intellectual, Hearing, Vision, Deaf/Blind, Mental Health and Autism. While teachers

may, in metropolitan settings, train in one or more of these disabilities, many must develop their skills through 'on the job training'. Without the intimate knowledge of:

- the signs of the condition;
- criteria for diagnosis;
- appropriate diagnostic tools;
- data gathering techniques that are reflective of the disability;
- being able to read assessment scores and summaries;
- developing, delivering and evaluating programs;
- knowledge of appropriate strategies and resources and in particular an specialised knowledge of speech and language and occupational therapy and well as an educational knowledge that need to work in tangent to provide appropriate support.
- and being able to complete the process for review,

children are not being recognised, are misdiagnosed and/or removed from a disability classification.

Due to increasing work demands, allied health professionals are limited to the diagnostic process and are finding themselves completing more and more assessments, with little time given to work with teachers to provide a program that meets the needs of the child. This problem impacts on the type of program that is ultimately developed by teachers who may have limited or no knowledge of the disability and/or limited or no time to prepare a program that meets the child's needs.

As a result of the shortage of allied professionals another set of problems arise. Schools and the professionals, in an ideal situation, would work in tandem to provide a program to support these children (such as the programs provided at The Glenleighden School in Brisbane). However, the usual program would include the employment of support staff (i.e. teacher aides) to develop, deliver and assess programs to assist children with a disability. In most cases there is generally a lack of professional development to support their work or lack of knowledge and experience as teacher aides are generally employed from the community, and may not necessarily have qualifications to support these programs. Again, it is generally a case of 'learning on the job'.

Teacher aides are supporting children in the classroom and on a one-on-one basis with little to no understanding of the issues faced by the child and the appropriate strategies to help them access the curriculum. Innately, teachers and teacher aides are using strategies that do assist the child to learn, but more often than not this is a 'hit and miss' experience based on what they have at their disposal and what they have learned as a parent or educator.

Additionally, while many teachers who work in the disability area value their children, many teachers in the mainstream classroom setting, find it difficult to understand their role in the education of <u>all</u> children. For some, and most particularly in high school settings, teachers do not believe that they are required to teach children who have a disability. "These children should be taught in units or special schools" is an example of conversations carried out in staff rooms every day. To change this culture, one must change people's values. For many teachers this is a belief that was cultivated early in their careers, and while departmental policy may have changed to an inclusive education model, the process of change could best be described as 'poor'. As a result, what is 'policy' by the department is not being carried out, or there is a passive resistant environment in all levels of the department and across all sectors of education.

The 'shortage' of allied health professionals comes about as a result of three issues:

a) numbers of graduates and the desirability of locations afforded them as a result of low numbers

b) working conditions – in most cases, while the number of cases is smaller than in metropolitan areas, the distances to travel between centres can be extensive and the range of cases wide. In a metropolitan setting you may be based in one setting and specialise in adult, school-aged children or pre-school children cases. In rural areas, the expectation is that you travel long distances, often by yourself, and address cases across a broad spectrum of issues. Coupled with this is the lack of collegial support - there is not someone down the hallway with whom you could have a conversation and get advice.

c) Remuneration – wages based on experience and level of qualification is low. Graduates are now in a position to take up private practice, either working in an established firm or working for themselves, and are acquiring better wages than what the public sector can provide.

Parents, who are frustrated with the system and who want the best for their child become increasingly distraught and find alternative options for their child. This may include speech and language therapy, occupational therapy, psychological counselling and educational tutoring. All of these options can be expensive and add an additional burden, both financially and emotionally, to the parent/s, who is/are already grieving about the loss of a child's potential life and having to make a mindset change to accept what is possible now.

If additional support is provided by the parent, communication between the support groups can be limited or none existent and as a result, unintentionally, people may be working at cross purposes. Children may left confused, frustrated and more isolated than before.

3. Once a child has been identified with a disability, there is a review process. Again, professionals from the health and educational sectors must go through the process with parents and children to determine whether the child continues to meet the criteria. This can be expensive for the parent, overwhelming for the child, time consuming for the school staff and challenging for health professionals, particularly those who are young and have not experienced the process in the past. A particular challenge for children with Language disability and their families is that the 'diagnosis' is expected to be reviewed again and again, with further time and resources being put into assessment and proving the child requires support rather than the actual provision of support.

4. Post school options for children with a language disability is an area of ongoing research. What happens to these children? Do they become a productive member of our society? Alarmingly and sadly, there is evidence to suggest that children who did not receive the support they needed find themselves incarcerated as juveniles and/or adults. (See the attached article for further details).

Special Populations: Prison Populations - 2004 Edition

Studies of the relationship between communication disorders and delinquency, violence, and incarceration date back to the 1920s. In the years that followed, a limited number of investigators continued to explore this relationship. What has generally been found in the literature is that there is a high level of speech, language, and hearing impairments, as well as learning disorders, present in the juvenile detention and state prison populations (1). The

relative lack of attention to this topic may have several causes, including lack of awareness of the fundamental importance of adequate communication skills, general societal disinterest in the welfare of incarcerated persons, and a paucity of funding sources for further research (2).

General Demographics

- Although representing a small proportion of the general United States population, individuals incarcerated in correctional institutions represent a neglected group with respect to receiving speech, language, and hearing services (3).
- Some relationships have been implied between the presence of communication disorders and other variables, such as I.Q. and cultural or economic deprivation in the prison population (4).
- Prevalence data on specific communication disorders varies widely within available sample studies. One factor that may contribute to this variation is limited diagnostic capability of the screening measures. For example, different criteria for defining an impairment and differences in conducting screenings could contribute to the variability (4).
- Although the reported incidence of speech, language, and hearing impairments among adult male prisoners is significantly higher than that for the general population, very little research concerning the occurrence of communication disorders among female prison inmates has been published (5).
- It is clear that more research is needed to understand the impact of disability on delinquent behavior. A number of hypothesized relationships exist but empirical evidence is scarce (6).

Speech/Language/Voice Disorders

- The prevalences for articulation and fluency disorders are comparable to prevalence figures in the general population (8).
- While few studies have investigated the language abilities in prison populations, one study suggests that the incidence of deficient language skills is considerably greater in that population than in noninstitutionalized adult groups. The results of this study indicate a considerable potential deficiency of receptive vocabulary skills (7).
- According to one study, the incidence of language and communication problems among female juvenile delinquents is approximately three times the figures cited for adolescents in the general population (9).
- A high prevalence rate of voice disorders among offender populations has been reported in the literature (8, 10). This may be attributed, in part, to the interaction of a variety of factors such as chronic upper respiratory infection, allergy, smoking, and substance abuse (11).
- A typical vocal pattern noted in studies of the prison population included excessive breathiness, perceived lowered pitch, excessive vocal tension, throat clearing, and coughing. Of individuals identified with abnormal vocal quality in one study, almost 66% were noted to have physical characteristics of vocal abuse (e.g., swelling, inflammation, nodules, or polyps) (4, 8).

Hearing Disorders

- The majority of studies report the incidence of hearing loss in prisoners to be approximately 30% (2).
- Variability in reported incidence ranges may be attributed to the limited nature of screening measures and different assessment criteria used in various studies. Other factors may include testing environment, sensory distraction, ambient noise, and hearing screening levels (11).
- The type and degree of hearing loss found in prison populations is diverse, with middle ear abnormalities yielding the highest incidence, followed by sensory and nonorganic hearing loss (11).
- One explanation for the high incidence of hearing loss among inmates is that early loss can cause poor language skills, frustration, academic problems, and inadequate social skills. These in turn may lead to school drop out, juvenile delinquency, and eventual criminal behavior (14).
- Research designs for further study of hearing disorders in offender populations might address various subgroups within the populations (e.g., juveniles, females, federal penitentiary inmates) in order to specify the nature and etiologies of hearing problems in the prison population and the contribution of hearing loss to offender behavior and substance abuse (15).

Learning Disabilities/Literacy

- The relationship between learning disability and juvenile delinquency has been more closely examined than that between communication disorders and violence. However, learning disabilities and communication disorders are closely intertwined; thus the numerous studies of learning disability in juveniles are pertinent to communication disorders. Many individuals diagnosed with learning disabilities have one or more communication disorders (2).
- Approximately 80% of prison inmates are reported to be functionally illiterate (12).
- Although recent studies have focused on reading and writing disabilities among inmates in prisons and juvenile institutions, little attention has been paid to different types of reading and writing difficulties (13).

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*Compiled by Andrea Castrogiovanni * American Speech-Language-Hearing Association * 2200 Research Boulevard, Rockville, MD 20850 * acastrogiovanni@asha.org*