



Public submission made to the Review to Achieve Educational Excellence in Australian Schools

Submitter: Speech Pathology Australia
Submitting as a: Peak body
State: Vic.

Summary

Speech Pathology Australia is the national peak body for speech pathologists in Australia, representing more than 8300 members. Speech pathologists are university trained allied health professionals who specialise in diagnosing and treating speech, language, communication and swallowing problems, treating communication disorders and swallowing difficulties (dysphagia).

Communication problems encompass difficulties with speaking, hearing, listening, understanding, reading, writing, social skills, and using voice. Communication problems can arise from a range of conditions that may be lifelong (e.g. Down Syndrome or Autism Spectrum Disorder), emerge during early childhood (e.g., stuttering, severe speech sound disorder or Developmental Language Disorder), or during adult years (e.g., traumatic brain injury, stroke, cancers, neurodegenerative disorders such as motor neurone disease) or occur in association with ageing (e.g., dementia, Alzheimer's disease, Parkinson's disease).

Summary of key messages:

- Level of educational attainment is one of the strongest single determinants of health on a population basis and is heavily reliant on language and literacy skills.
- A best practice approach to supporting students with speech, language and communication needs is through a whole school collaborative approach which is multi-tiered.
- Response to intervention (RTI) is an example of this approach that has substantial empirical evidence. This model provides evidence-based classroom instruction for all children and by using a dynamic and ongoing monitoring approach, the RTI model supports the identification of students who are not responding to either Tier 1 or 2 instruction. These students will need increasingly personalised and intensive instruction, while measuring

and monitoring progress in order to make decisions about the need for further intervention.

- The focus for an RTI approach is enhancing the performance of all students, including those with communication needs in the school.
- Monitoring of all students within a RTI framework will measure whole class cohorts and individual student's educational success.

References are available upon request.

Main submission

SUBMISSION QUESTIONS

1. What should educational success for Australian students and schools look like?

Educational success may be reflected in all students accessing and participating in schooling and achieving to their potential.

Monitoring of all students as discussed below in the Response to Intervention framework will measure whole class cohorts and individual's educational success.

2. How could schools funding be used more effectively and efficiently (at the classroom, school or system level) to have a significant impact on learning outcomes for all students including disadvantaged and vulnerable students and academically advanced students?

Students whose only disability is a speech, language or communication disorder (e.g. developmental language disorder, dyslexia, stuttering etc.) are unlikely to be eligible for individual targeted educational funding – but still have functional problems that are known to impact significantly on their educational participation and achievement. Schools and teachers still need to make reasonable adjustments under the Disability Standards to support these students to access and participate in the curriculum. There are no guidelines/information resources available to schools that advise on what are 'reasonable adjustments' for students with communication disability.

An unintended consequence of the provision of targeted individualised funding is that schools perceive that they are "unable" to provide adjustments for students whose disability does not meet jurisdictional criteria for targeted, individualised funding.

A best practice approach to supporting students with speech, language and communication needs is through a whole school collaborative approach which is multi-tiered. This approach is defined as cohesive, collective and collaborative action in and by a school community that has been strategically constructed to improve student learning, behaviour and well-being, and the conditions that support these.

Key features:

- Professionals work together with parents, sharing knowledge and skills to effectively support all students with an integrated approach.
- Professionals know about speech, language and communication, learning, curriculum and the interaction between all of these elements, with an appreciation of the wider social context for students and their families.
- Professionals work together to create an environment that facilitates communication and learning and is adaptable to the needs of students in that environment.
- A range of specialist, well evidenced interventions (tiered interventions) to be planned and delivered by experienced professionals.
- Explicit monitoring by teachers of student learning occurs so that they can make regular judgements about student movement between the whole school approach tiers.

Response to intervention (RTI) is an example of this approach that has substantial empirical evidence. This model provides evidence-based classroom instruction for all children and by using a dynamic and ongoing monitoring approach, the RTI model supports the identification of students who are not responding to this “tier”. These students will need increasingly personalised and intensive instruction, while measuring and monitoring progress in order to make decisions about the need for further intervention.

The focus for a response to intervention approach is enhancing the performance of all students, including those with communication needs in the school.

Response (RtI) to intervention integrates assessment and intervention within a multi-level prevention system to maximise student achievement and to reduce behavioural problems. With RtI, schools use data to identify students at risk for poor learning outcomes, monitor student progress, provide evidence-based interventions and adjust the intensity and nature of those interventions depending on a student’s responsiveness, and identify students with speech, language and communication needs.

Successful RtI programs rely on the integration of systems, data and practices. There needs to be clear systems for collection of data, identification and implementation of support needs; there needs to be clear data-based decisions so data collection occurs that is purposeful and that practices are evidence based and have fidelity.

The leadership of a principal is required and the ability to bring all educators to the same table to share professional development, time, space, money, curriculum and human resources.

RtI offers other benefits as well. It:

- helps identify the contributing factors to a student's poor performance;
- promotes improved instruction through the use of multiple assessments and progress monitoring;
- provides instructionally relevant data and emphasises effective teaching approaches;
- reduces the likelihood of students incorrectly classified as having specific learning disabilities because of difficulties arising from various types of social disadvantage such as social, cultural and/or language differences;
- decreases the number of students inappropriately referred for specialised assessment and intervention.

The general RtI model begins with a tiered approach to quality evidence-based instruction that is effective for the majority of students. General education and intervention specialists provide evidence-based interventions and differentiated instruction to those students who are performing below expected levels of achievement. The RtI approach to intervention requires teachers and specialists to work together as a team to analyse data and design a customised plan for each student who is struggling to learn. It provides opportunities for different professionals to learn from one another and to take that learning into the whole class, small group, and individualised instruction.

An RTI service delivery approach focuses on:

- identifying and supporting the educational support requirements of all students;
- regular monitoring and evaluation of processes;
- matching evidence-based teaching practices/interventions to student educational support requirements.

Tier 1: Support and train teaching staff to deliver high-quality inclusive teaching that helps all students access and participate in the curriculum. It is supported by effective whole-school policies and frameworks. Speech pathologists work across a range of proactive supports. These supports may take the form of collaboration, capability development, problem-solving, interpretation of data and curriculum support. An example of this could include the speech pathologist team teaching with the classroom teacher.

Tier 2: Some students may require additional targeted instruction in aspects of their learning program. This usually takes the form of a time-limited, evidence-based and structured intervention programs in small groups.

Tier 3:

Tier 3 is the provision of intensive, individualised supports for students. This level of support may be for only aspects of, or the whole of one learning area, or may be required across many curriculum areas.

To support the provision of effective supports for students, the speech pathologist may assess the students' speech language and communication needs, to develop an understanding of the impacts of those needs on the students' educational program, and support the school to develop and implement appropriate individualised adjustments. The speech pathologist may, where appropriate, provide direct intervention and/or support the provision of programs through a trained proxy agent (teacher, education support staff).

It is important to understand that each tier builds on the previous one so that all students access universal good teaching. Some students access targeted supports and some of those students receive intensive supports. They are not mutually exclusive and nor are they set in stone as students may move between tiers.

RTI tier Speech pathology roles

Tier 1: All students in the school access and participate in an inclusive curriculum Professional development and coaching for teaching staff to increase knowledge of the links between oral language, literacy and learning.

Collaborating with teachers to develop and implement whole of class or whole-of-school resources and activities that promote oral language competence. Working with teachers to implement and evaluate these.

For children with complex communication needs (CCN); ensuring that there are whole-school approaches in place for continuity of communication systems; that universal teaching strategies are accessible; that skilled communication partners are available throughout the school.

Collaborating with teachers to develop and implement pedagogical strategies that support students with weak communication skills, such as adapting lessons to reduce language complexity, marking important information, or providing elaborations to enhance students' comprehension; visual support, adjustments and accommodations to access and participate in the curriculum.

Input into whole school approaches to screening/identification of children who are struggling and require Tier 2 support.

For children with CCN, collaborating with teachers and other school staff to support access and participation for children, such as providing more time for children to process and respond in class, ensuring that the child and others know of and are able

to access vocabulary to support participation in their learning activity, understanding and providing Aided language stimulation.

Tier 2: Focused support for students who need additional supports to access general instruction Collaborative development of programs for classes or small groups of students to enhance skill development in specific areas, such as phonological awareness or narrative skills.

Support for evaluating the outcomes of the above, including monitoring students to determine if they are responding to this level of support and identifying students who need to move to Tier 3.

Tier 3: Individual intervention and support

Comprehensive assessment, diagnosis, applications for funding (where appropriate) to support educational programing for individual students.

Working with teachers and parents to individually plan and implement programs to develop specific communication skills and competencies. Delivery may be by the speech pathologist or through an aide, teacher, or trained assistant.

Individual programing to support children to access curriculum in the classroom. For example developing activities that target specific skills or allow children to use existing skills within age-appropriate curriculum.

Targeted feedback and training for teachers regarding strategies that will support learning for an identified child.

Monitoring student outcomes to determine if more or less intensive support is needed by using objective information to determine if students are meeting goals.

Response to Intervention and Literacy

The RtI model offers an alternative to the discrepancy model and takes an evidence-based approach to determining who should qualify for intervention and when. It is also predicated on the fact that any intervention provided must be of the highest quality/based on the best available evidence. For the RtI to be successfully implemented, a whole-school adoption is required.

RTI tier Speech pathology roles

Tier 1: All students in the school access and participate in an inclusive curriculum Evidence-based classroom instruction in conventional literacy is provided to all students. For students who are commencing formal reading instruction, systematic synthetic phonics instruction has consistently been shown to be more effective compared to alternate methods of teaching such as analytic phonics or the three cueing system. Speech pathologists may engage in observation of students, discussions with classroom teachers, implementation of systematic synthetic phonics instruction with a teacher in a class, and possibly screening, to identify children who

are not responding adequately at Tier 1. It is these students who would then be provided with Tier 2 intervention in the area or areas of need identified.

Tier 2: Focused support for students who need additional supports to access general instruction. Involves additional targeted intervention, for example a focus on phonemic awareness, phonics, oral language competencies and/or speech sound errors which usually lasts for about 10-20 weeks, in addition to mainstream classroom instruction for those students who have not responded adequately or completely to Tier 1. Tier 2 intervention is provided in small groups and may be delivered by classroom teachers, specialists and even by well-trained volunteers (with substantial coaching and support provided). The intervention should target specific skill areas as needed, such as phonemic awareness, decoding, and grapheme-phoneme correspondences. Intervention can also target oral language competencies and comprehension-related reading skills. Tier 2 intervention is typically delivered in either the classroom or as a withdrawal group.

Speech pathologists are well-equipped to deliver this level of intervention directly or using indirect consultative methods whereby classroom teachers or others become the agents of the intervention. It is critically important to collaborate with the classroom teacher rather than working in isolation as the more co-constructed the intervention goals are, the better for the student. Given the overwhelming evidence that children who present with reading difficulty at an early age will not meet year-level expectations without additional support, it is important that Tier 2 intervention commences in a timely manner in order to maximise a student's literacy growth.

Tier 3: Individual intervention and support

A small proportion of students will inevitably have more severe difficulties learning to read and spell. These students require Tier 3 intervention which is more individualised and typically lasts for extended periods of time. These students should receive evidence-based Tier 3 intervention in order for optimal language and literacy gains to be realised. Tier 3 intervention is more individualised to the student's needs and is delivered one-to-one or perhaps in a smaller group with other students who have similar intervention goals and importantly, should be provided with greater intensity. For many students, the activities and strategies are similar to Tier 2 however there is:

- increased frequency of sessions per week,
- increased length of sessions,
- increased duration of the intervention from start to finish, and
- increased instructor expertise.

3. How can system enablers such as targets and standards, qualifications and accreditation, regulation and registration, quality assurance measures and

transparency and accountability provisions be improved to help drive educational achievement and success and support effective monitoring, reporting and application of investment?

- Systemic incentives to encourage teacher education programs to share relevant subjects with speech pathology students
- Quality assurance of preservice teacher education:
 - o to ensure teachers have a good grasp of phonological and phonemic awareness supporting their teaching of systematic synthetic phonics
 - o to ensure that educators can critically read and develop evidence-based teaching practices
- - early identification of students with speech, language and communication needs is essential to improve a school's monitoring
- - Increased public reporting and accountability of schools, support for kids with disability.
- - Inclusivity measures to schools as per My School website

National Unique Student Identifiers, assigned in early childhood education (pre-school/kindergarten) and then following that child through their primary, secondary and even tertiary education.

Given the importance of the early years on child developmental, education, health and wellbeing outcomes, it is critical that a way to 'track' children's outcomes is initiated as early in their lives as possible. In an educational environment, this might best be achieved at the universal preschool/kindergarten year as the first 'entry point' into formalised education. If a Unique Student Identifier is to be implemented, this is the time at which it would be of most value to be assigned to all children.

Unique Student Identifiers may offer considerable value for the most vulnerable of students (including those who are 'transient' and move schools multiple times) and for students with disability (specifically during key transition points that are known to influence their educational experiences such as kindergarten to school and primary to secondary school. Unique Student Identifiers may assist in ensuring continuity of important information about the student between schools and educators to assist the incoming school to best meet the needs of that student. It may also offer efficiencies in reducing duplication of testing (for example, repeated speech pathology assessments) if this information 'follows' the student from one school to another. Whilst it is acknowledged that for some students, the 'following' of information about their education from one school to another might raise concerns (for example, information about suspensions and expulsions) and restrict their capacity to 'start afresh', the value in continuity and integrity of educational

information may be of significant value to help improve the educational experiences of the student. A balance would need to be struck with appropriate privacy and confidentiality safeguards in place.

Whilst data linkage processes provide an avenue for longitudinal data analysis and linkage with other non-educational datasets, this is currently complicated by state/jurisdictional comparability problems. The use of educational data to track outcomes for students longitudinally, and particularly for cohorts of children through a Unique Student Identifier is likely to both facilitate improved research and analysis and provide cost savings through the streamlining of administrative and research processes. Of course, appropriate privacy and confidentiality arrangements will need to be put in place.

It is probable that data linkage processes with non-health data sets (e.g. NDIS, maternal and child health) could also be streamlined if educational unit data was identified through a Unique Student Identifier. The existence of Unique Student Identifiers would allow for RCT or other high quality evidence studies to be undertaken to examine the effect of speech pathology or literacy interventions on student outcomes that factor in any confounding effects of non-education based supports also being provided to these students through non-education sector supports.

The NCCD (Nationally Consistent Collection of Data) may provide a useful basis for a needs-based funding system, however it has limited sensitivity in data collection. Linking funding to the NCCD may be acceptable in large schools that can accommodate economies of scale in the purchase of adjustments or additional supports for multiple students, but smaller schools or those in rural areas may have difficulty implementing appropriate adjustments (even with adequate funding) due to a range of contextual issues (such as limited purchasing power, limited access to speech pathology services, limited teacher and principal experience and knowledge regarding disability support).

The NCCD provides an opportunity to 'link' the advice/information and guidance for Principals to their routine collection of information about their students – to help support Principals and teachers to make informed, evidence based decisions about supports for their students with disability, including provision of speech pathology services. Advice and information for Principals is essential in order for Principals and teachers to meet their legislative obligations under the Disability Standards for Education.

Speech, language and communication impairments meet the definition of disability as prescribed in the Commonwealth Disability Discrimination Act, 1992 and in the subsidiary legislation of the Disability Standards for Education, 2005. Importantly, speech, language, communication and swallowing impairments would almost always

mean that the student met the criteria for 'disability' used by the NCCD that requires a functional impact at school (for example monitoring or differentiation in the classroom, or a supplementary or higher level of adjustment).

4. Are there any new or emerging areas for action which could lead to large gains in student improvement that need further development or testing?

Please see section above regarding Response to Intervention framework.

5. Are there barriers to implementing these improvements?

The following points are possible barriers to implementing these improvements:

- Leadership and commitment,
- Principal knowledge/funding,
- Parents' expectations of specialised support (1:1 model),
- Teacher knowledge and underlying community beliefs.