

“ESTABLISHING A SPEECH PATHOLOGY SERVICE TO A TRADITIONALLY HARD TO REACH POPULATION”

This paper describes how a speech pathology service was established for school-aged urban Aboriginal children in Perth, Western Australia. Initially, school staff were not fully aware of the degree of difficulty these children were having in oral Standard Australian English or the link between oral language mastery, academic outcome and social skills within a school environment. An audit provided evidence of the efficacy of the pilot program and regular in-servicing and informal meetings were utilized to keep staff informed of the program aims. There were many challenges posed during the program, the greatest being the demands of the Australian curriculum. The school, however, continues to have speech pathology services delivered to indigenous children to this day.

Lynne Middleton “Talk to Literacy” Thody House, 20 Craig St., Mundaring Western Australia 6073 www.talktoliteracy.com.au

PILOT PROGRAM

The school Principal recognized that the children were not improving in their literacy and numeracy skills due to the ear health program alone. The indigenous Children ranging in age from 5 to 10 years were initially referred by the Medical Officer participating in the Ear Health Program. Two of the children were diagnosed with CAS (Childhood Articulatory Dyspraxia). None of the children had received prior speech pathology intervention.

Figure 1 shows the Receptive Language (Comprehension) results from the children. All but two of the children had comprehension skills below 5 years of age i.e. receptive language skills which were not sufficiently developed to understand the language of the classroom or comprehend a text. 11 of these children are above 7 years which suggests that the curriculum has done little to develop their receptive language skills. All children who received speech pathology intervention improved to some degree so the type of language activities a speech pathologist provides does have an impact on children’s receptive language abilities. Most children had gains of 12 months in their receptive language ages.

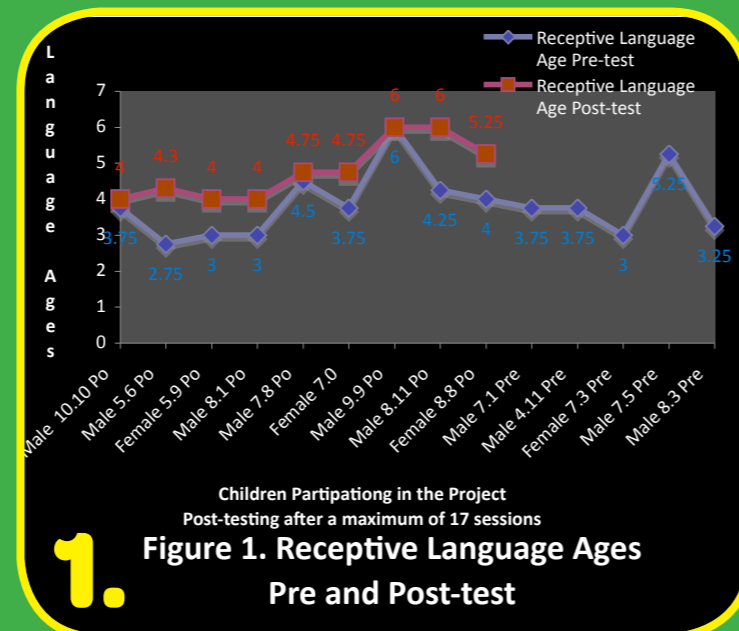
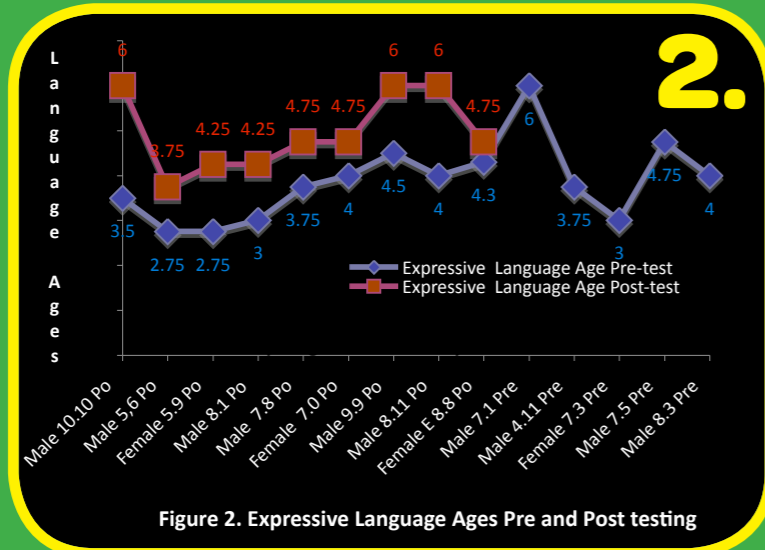


Figure 2 shows the Expressive Language results from the children. Most children improved at least 12 months in their expressive language abilities and some children improved as much as 2 years. Child H gained confidence in speaking and reduced his reliance on pointing and gestures as he began to realize people understood him. In three cases, the 17 treatment sessions were able to lift the children’s oral language abilities to 6 years so they had reached the level required for entry to the Education curriculum. These results were really encouraging and the school administration were keen to continue the programme. The authors were encouraged by the work of Gillam et. al. 2008 which reported on the efficacy of intensive intervention so the 2010 version of the programme targeted the Pre-Primary year 1 cohort. The teachers and the principal had noted significant language delays in children right across the school and frequently enquired about the selection process for these Phase 1 children. Clearly hearing issues alone could not account for the prevalence of language impairment seen in these children so the staff were keen to widen the scope of the program to include all children.



THE LEVEL PLAYING FIELD PROGRAM WAS DESIGNED TO ACHIEVE THE FOLLOWING AIMS:

1. Successful academic achievement in mainstream Australian schools is measured in Standard Australian English (SAE) using NAPLAN (the standardised national and numeracy assessment). The performance of indigenous children on NAPLAN has been significantly poorer than their non-indigenous peers. The primary aim of the program was to improve oral language competency in SAE which, in turn would enable better literacy and numeracy outcomes in these children. A certain level of oral language mastery is assumed at school entry and the curriculum does not address the establishment of good oral language skills prior to the introduction of literacy.
2. To assess the oral language competence in Standard Australian English (the language of education) using the same standardised assessment tools as their non-indigenous peers.
3. To provide intervention in a “culturally sensitive” environment.
4. To promote the development of auditory perceptual skills.

EXPANDED PROGRAM

The program was expanded in 2010 to 0.5 Speech Pathologists working with the children in the Pre-Primary class on a daily basis for 20 weeks. This time the school agreed to pay for speech pathology services as they could see the benefit. One of the key elements to continued funding was ongoing education of staff with regard to what oral language entailed, how this was different for speech and how certain behaviours may be a result of communication impairment as opposed to oppositional/defiant behaviour. Once staff had the knowledge of what to look for they were more accurate in their reporting with regard to changes in the communication abilities of these children.

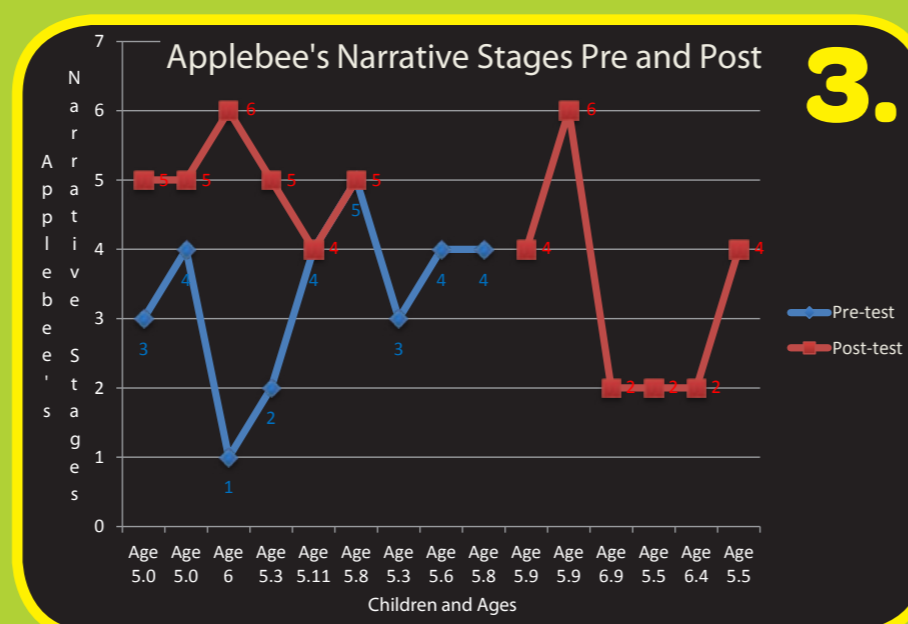


Figure 3 illustrates the Applebee Stage of Oral Narrative Development for the Children pre and post test. Interestingly, Applebee's Stages address structure more than content. Some improvement was seen in content for some of the children in the study but most children were still giving a very brief narrative account by the end of the intervention stage.

RECOMMENDATIONS

In Western Australia intense lobbying by Speech Pathologists is required to ensure the message that poor communication skills impact significantly on health and educational outcomes is understood. Speech Pathologists must continue to present the evidence with regard to the link between oral language abilities and academic failure and continue to evaluate effective programs to ensure funding for oral language intervention continues. As a result of this program, Speech Pathology services continue in the school to this day.

WHAT WORKED:

The staff understood that a speech pathologist could improve the communicative abilities of children in the school. They also understood communication depended upon more than just improved hearing. Behavioural improvements were noted in children whose oral narrative abilities had improved. These children were able to say what had happened when asked to give their side of the story after an argument in the playground. The individual phonology sessions could be seen to be of benefit by all the staff at the school when they spoke with the children participating in the playground.

WHAT DIDN'T WORK AS WELL AS WE HAD HOPED:

Because of the demands of the Curriculum, staff felt very pressured to work on literacy skills. It was difficult for school staff to see the necessity to work so intensively on an oral level and they found this quite difficult. The teachers asked if they could be allowed to observe the speech pathologist more should the program continue in its current form. The allocated groups would have been able to accomplish more if they were smaller and the educational assistant had been allocated children to form an additional group. Some children (the children with a need to teach rather than learn) needed individual rather than a group approach. Some children did not attend school regularly and therefore did not gain the maximum benefit from the program so liaising more with parents about the importance of the program would be good. A truancy officer might also be an option to improve school attendance. The children were bussed in and parents rarely attend school functions so contact with parents was complicated. We were unable to influence the Department of Education to address the oral language needs of all Indigenous Children in Western Australia. Staff who had worked in isolated country areas with a high Indigenous Population stated they noted the same oral language difficulties in urban Indigenous Children as they had seen in the children of rural and remote communities.

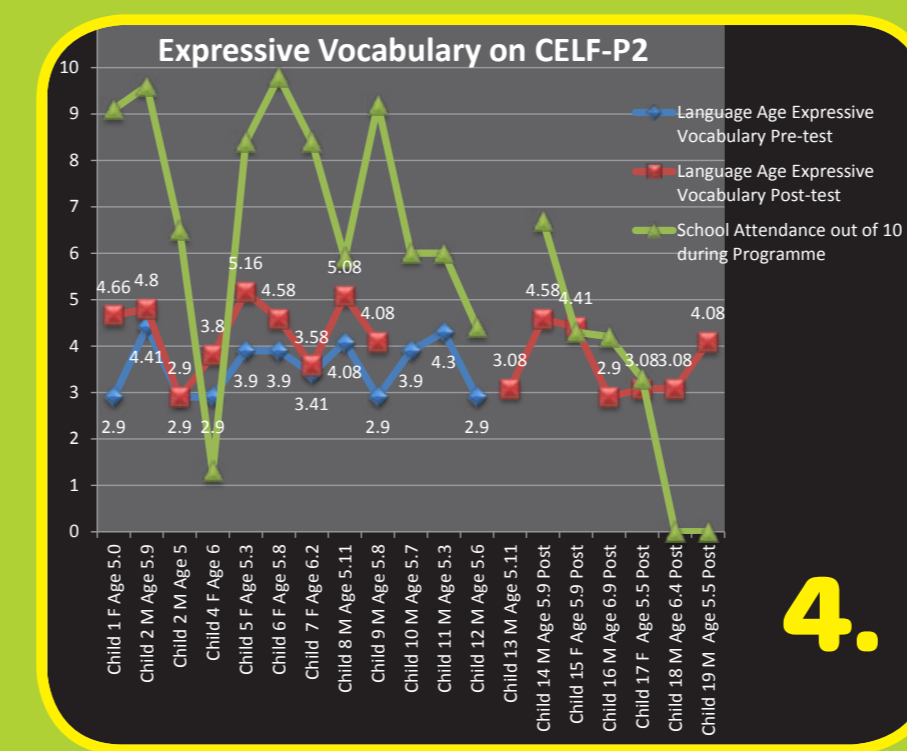


Figure 4 shows the Language Age results from the Expressive Vocabulary Subtest of the CELF-P2 along with their attendance record. Those children who attended an average of 9 days a fortnight, would score 9 for attendance on this graph. Those averaging only one day a fortnight would only obtain a score of 1 for attendance.

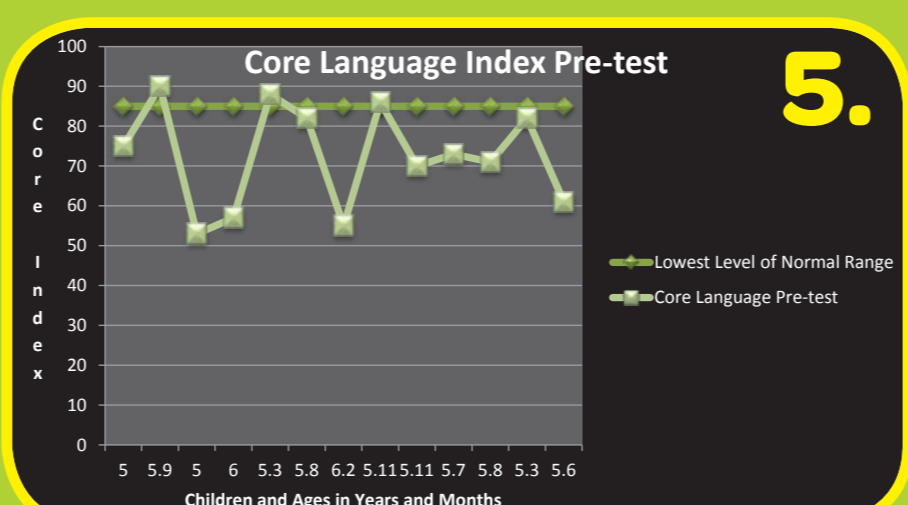


Figure 5 Core Language Scaled Scores for the 12 Children who underwent pre-testing. Average range scores are above 85. Below average scores range from 71 to 85 and scores in the severe range are below 70.

ACKNOWLEDGEMENTS

The author gratefully acknowledges the assistance of Bernie O'Hara, Clare Snedden, Ash-Leigh Evans and Denise Powdrill in the implementation of this program. Their support, suggestions and support with the practical implementation was invaluable.

REFERENCES

Cirrin, I and Gillam, R.B. (2008) Language intervention practiced with school-aged children with spoken language impairments: A systematic review. *Language, Speech and Hearing Services in Schools*, 39, (1), (supplement) S110-S137.
 Gillam, R.B., Loeb, D.F., Hoffman, L.M., Bohman, T., Champlin, C., Thibodean, L., et al. (2008). The Efficacy of Fast Forward Language Intervention in School-Age Children with Language Impairment: A Randomized Controlled Trial. *Journal of Speech, Language, and Hearing Research*, 51, 97-119.
 McLeod, S and Threats, T. (2007) The ICF-CY and children with communication disabilities. *International Journal of Speech-Language Pathology*, 10, 92-109.
 Ngarritjan-Kessarar, T (1994) Talking Properly with Aboriginal Parents. in Harris, S and Malin, M Aboriginal Children in urban classrooms. Social Science Press pp 117-123.
 Snow, P. (2009) Child maltreatment, mental health and oral language competence: Inviting speech-language pathology to the prevention table. *International Journal of Speech-Language Pathology*, 11, 95-103.
 Wiig, E.H, Secord, W.A., and Semel, E 2004. *Clinical Evaluation of Language Fundamentals Preschool- Second Edition*. NCS PEARSON INC., SYDNEY AUSTRALIA.