

Dr Brian Gordon

Education and Health Standing Committee

Legislative Assembly

Parliament House

Perth WA 6000



24 November 2011

Dear Dr Gordon,

Please find enclosed a response to each term of reference for the inquiry into improving educational outcomes for Western Australians of all ages. This response constitutes considered input to the inquiry by Therapy Focus – Western Australia's leading provider of therapy to school aged children with disabilities and learning disadvantage.

At Therapy Focus our Purpose is "*Helping Children Grow*". We do this by working with our values of Respect, Inclusion, Courage and Integrity and in so doing we inevitably work with others who are working to a similar end - including education providers.

The response has been prepared from views expressed by members of the Leadership Group of Therapy Focus. The Leadership Group has 11 members with a wealth of experience across business management, education, and the allied health disciplines including Speech Pathology, Occupational Therapy, and Physiotherapy. And these 11 members are responsible for managing 140 staff delivering services to children and young people in Perth homes, schools and community groups on a daily basis.

We trust you will consider this input and give the recommendations, listed for ease of reference on the following page, due credence when forming your own recommendations to Parliament when the inquiry reports in time.

We look forward to the progress of this inquiry and will follow with interest the government's response to its findings.

Yours faithfully,

Matt Burrows

CEO

List of recommendations

Recommendation 1

Therapy Focus recommends that the Western Australian Government mandate that teachers teaching in a WA based curriculum be required to consider any Therapy Service Plan (TSP) when developing an Individual Education Plan (IEP) for any child, and that the IEP have evidence of therapist contact in its development.

Recommendation 2

Schools formally recognise the involvement of educators in therapy activities with both children and their parents/carers, and incentivise further integration of therapy into children's education.

Recommendation 3 (from NDS Policy Paper)

Reform is needed – with an “end-to-end” solution for consumers, which includes awareness and information; support to select the most appropriate item/s of aids and equipment; installation and training; and maintenance and repairs.

Recommendation 4

The government considers technology application to teaching techniques and invests in non-traditional forms to enhance both learning outcomes and social inclusion.

Recommendation 5

Relevant education providers supply families with information about education options for their young child with a disability or developmental delay, early in the child's life.

Recommendation 6

The government ensure that children with disabilities and/or learning disadvantage are supported through their school life and into post school options (equivalent to VET) and transitions between critical years are coordinated between services, ensuring continuity of services to that child by providers external to school.

Recommendation 7

Waitlists should be managed to ensure minimum negative impact on any child's continuity of care and/or learning plan. Oversight of waitlists should be central to the child and independent from any service provider.

Recommendation 8

In all instances where children with disabilities and/or learning disadvantages are engaging with the education sector, the government should facilitate social inclusion programs with defined outcomes for participation and independence for each child.

Recommendation 9

The Department of Education and the Disability Services Commission develop an MOU that specifically details the intent to coordinate the investments in children to achieve development objectives, especially as they transition from childhood education to adult supported care environments.

Recommendation 10

The government should review the agreement to delineate service provision between the Disability Services Commission in the city and the WA Country Health Services in the country.

1. Current and future resourcing of new methods and activities to improve educational outcomes such as e-learning and school partnerships

Evidence-based therapy practice is characterised by the ability of the client to use the therapy intervention to build on their capacity. It requires opportunities for the client to practice (or use) the therapeutic technique in everyday behaviour, to reinforce the physical or cognitive learning and thereby increase the probability that the client will be able to reproduce the desired behaviour or action.

This practice requires clients to be able to “learn everywhere” so that the intervention technique is reinforced as often as possible. This is particularly important for children when attending school as it constitutes a large portion of the child’s waking time as well as represents a place for learning and practicing.

In delivering therapy, the therapist can use a number of modes of service delivery including direct therapy, indirect therapy and consultative therapy and any combination of each.

The following excerpt summarises the benefits of direct therapy:

“In general, direct therapy is more effective if:

- it is tailored to the individual’s needs and revised according to progress,
- it is provided in sufficient intensity and duration, as to see a treatment effect,
- it is delivered in natural settings,
- it is designed to promote “generalisation” and “transfer” of skills across settings,
- it is based on functional goals that are set with the person/family in a family-centred manner, and
- it takes account not only of the individual but the person in the environment and the environment in implementation and design.” (Bundy, A. et al; 2008, p26)

Therefore reinforcement of therapy techniques at school represents application in a natural setting (as opposed to being withdrawn from school and attending a clinic of sorts), and allows sufficient intensity and duration to see a treatment effect.

The added benefit of conducting therapy in natural settings like schools is that it enables therapists to interact with people in the client’s life and thereby transfer skills to those people so that they may reinforce the therapy intervention and monitor outcomes. This is the indirect therapy mode and it is most effective for “...skills or functions that require massed practice or repetition...” (Bundy, A. et al; 2008, p37)

A combination of all three modes of therapy will contribute to not only therapeutic outcomes, but also educational outcomes.

“Teachers (consultation partners) also attributed more of the (target) children’s gains to therapy where individualised education plan (IEP) goals

were addressed through collaborative consultation rather than by direct, pull-out services (Dunn, 1990)." (Bundy, A. et al; 2008, p43)

For this reason the congruence of individual therapy plans and individual education plans was examined recently by an evaluation team conducting a mandatory quality management review of the operations of the Therapy Focus West Coast Team. From this examination the following two recommendations were made:

"The Independent Evaluators identified the following Key Priorities for Service Improvement:

Key Priority for Service Improvement 1

Program and Outcome *West Coast SAI in relation to Independence and Participation*

- Outcomes would be enhanced through improved Therapy Focus initiated communication about therapy being provided in schools and through contact at the end of each term to keep goals alive and refreshed.

Key Priority for Service Improvement 2

Program and Outcome *West Coast SAI in relation to Independence and Participation*

- The achievement of family identified goals would be improved through encouraging joint goal setting with family, schools and therapists so that family goals for school are reflected in each student's Individualised Education Programs." (Fynn, N; 2011, p6)

Discussion between the CEO of Therapy Focus and members of the Evaluation Team revealed that without parameters in place, or express delegated authority of therapists to input to IEPs, the second recommendation was aspirational only. This view was confirmed by the Catholic Education Office students with disAbilities team who stressed that IEPs were the ultimate responsibility of school principals and their content was managed by the teachers – not by external parties.

There is an opportunity to improve the integration of therapy and education. The formal mechanical mechanism is to ensure any IEP developed has taken consideration of an existing Therapy Service Plan (TSP), or makes reference for the need for a TSP to be developed.

Recommendation 1

Therapy Focus recommends that the Western Australian Government mandate that teachers teaching in a WA based curriculum be required to consider any TSP when developing an Individual Education Plan (IEP) for any child, and that the IEP have evidence of therapist contact in its development.

A downfall of indirect therapy however is that parents and teachers have often reported a lack of confidence in their skills (or even lack of available time) to perform the intervention and monitor the effects of the intervention. If parents and teachers do not engage in the

therapy intervention then it will be at risk of not achieving the saturation point required for effectiveness.

To mitigate this risk, schools can support educators. Access to ongoing training in therapeutic interventions as well as managing challenging behaviours would be beneficial, as well as encouraging educators to participate in group activities, especially where they involve parents. Schools could formalise the recognition of this involvement for teachers as part of the teacher classification system in the relevant employment agreement.

Further integration of therapy into education will benefit each child's development. Where teachers are reporting on a child's progress they should refer to therapy outcomes that support the child's ability to learn and develop. This will encourage the integration to occur between the professionals involved in a child's life thereby incentivising the preferred behaviour.

Recommendation 2

Schools formally recognise the involvement of teachers in therapy activities with both children and their parents/carers, and incentivise further integration of therapy into children's education.

Schools are responsive to changing learning styles, particularly as they are influenced by changing technologies. The \$60 billion announced in the 2011-12 Commonwealth Budget (http://www.budget.gov.au/2011-12/content/overview/html/overview_33.htm) is testament to this.

To ensure the investments are meeting the objectives of preparing Australian school children to be able to participate in our society and in a globally competitive economy, the government should pay special consideration to disadvantaged students including Indigenous students, as well as students with disabilities and/or learning disadvantage.

In facilitating the inclusion of these students into the general school population, the government, as well as the schools, should consider the application of technology to enhance teaching techniques. iPads and iPods presently are showing real value to children with disabilities, both in their functionality and in their social acceptability. They are resource aids that are accepted as mainstream technology, rather than particularly "special" equipment for individuals with disabilities..

With technology moving so quickly, it is difficult to prescribe the different types of technological aids that are eligible for government subsidy. The iPad for example is not eligible for funding under the WA Government's Community Aides and Equipment Program (CAEP) as this program funds only basic and essential equipment. CAEP does not fund equipment that is solely for use at school as this need is expected to be met by the school. The challenge for government is to be responsive to technological change, and not exclusive.

Recommendation 3 (from NDS Policy Paper Baker, K. A. Philippa; 2011, p8)

Reform is needed – with an “end-to-end” solution for consumers, which includes awareness and information; support to select the most appropriate

item/s of aids and equipment; installation and training; and maintenance and repairs.

Other forms of technology also assist with learning, including for example “You Tube” and the broader social networking phenomenon. Where children have issues with sociability, technology may assist in providing a supportive environment for individuals who are challenged by face-to-face social communication.

Recommendation 4

The government considers technology application to teaching techniques and invests in non-traditional forms to enhance both learning outcomes and social inclusion.

Technology should also be considered in all aspects of communication between children, their parents/carers, teachers and therapists. As with health and the implementation of Personally Controlled Electronic Health Records (PCHER), a student’s web-based portal for records, access to services, enrolments, IEPs and TSPs etc, would be beneficial. It could also then be integrated across sectors.

2. Factors influencing positive or negative childhood development from birth to year 12

The primary issue facing children with disabilities and/or learning disadvantage is timely diagnosis and subsequent access to therapeutic and support services as an early intervention (ie in the 0-5 year range). The more efficient this process is, the more effective the intervention will be and the more dramatic the improvement in a child’s response to the therapy.

A major factor beyond the diagnosis and admittance to a therapy service is the management of transition points in a child’s life. The transition from early intervention to school age therapy (5-6 years), the transition from primary to secondary school (11-12 years) and the transition from school to post-school (17-18 years) are critical points requiring seamless transition. However in reality they are poorly managed.

Children in WA who are granted a place with a service providing early childhood intervention services, such as Therapy Focus, are not guaranteed a service when they transition to school age. They must reapply at that point. Likewise children who access services at school age finish their schooling and not only face the challenges of all other children at that point in their lives, but also lose the support and potential that access to therapy offers.

This year, Therapy Focus hosted two of four sessions facilitated by Early Childhood Intervention Australia (ECIA) Western Australia, to provide parents of young children with special needs, with information about the options open to them for education. ECIA invited speakers from all education sectors, as well as the Equal Opportunity Commission, home schooling representatives and parent speakers to present.

There is such strong interest in this topic and such demand from families who are grappling to try and understand what is out there in education for their young child with a disability. Often their relationship with their Local Area Coordinator (LAC) is very new, or they don't yet have one, and they are struggling to find out what is available to them, for example – playgroups, child-care, pre-kindy programs, kindy, pre-primary, and all with what type of inclusion support, whether it be a mainstream education environment, specialised setting such as a Language Development Centre, Education Support School, Centre or Unit. ECIA WA developed a booklet "Starting School" some years ago with WA-specific information which now requires update, particularly with pre-primary being compulsory now in the future.

Recommendation 5

Relevant education providers supply families with information about education options for their young child with a disability or developmental delay, early in the child's life.

It should be incumbent upon the education sector, particularly the Department of Education, to proactively seek out parents of young children with disability and developmental delay, to provide them with information about their options. Currently it is left up to not-for-profit organisations such as ECIA (WA), Statewide Specialist Services in DSC (who in fact initiated these sessions for parents a few years ago), LACs where they are in place, and individual families themselves, rather than the sector, especially the government provider of education, providing this information.

Furthermore, in Victoria the Department of Education and Early Childhood Development has been particularly successful at reform of early childhood intervention services, and have commissioned reports (see <http://www.eduweb.vic.gov.au/edulibrary/public/earlychildhood/intervention/ecislitreview.pdf>) to substantiate the assumptions of best practice. The confusion created by having separate ministries and departments of Education, Health and Disability in Western Australia can have a negative impact on what could be effective collaboration. A similar department that integrated education and childhood development would be much welcomed and may see a reduction in the amount of silo working that does go on in WA.

Recommendation 6

The government ensure that children with disabilities and/or learning disadvantage are supported through their school life and into post school options (equivalent to VET) and transitions between critical years are coordinated between services, ensuring continuity of services to that child by providers external to school.

Where a child does face a lapse in the continuity of a service – whether therapeutic, health care, or education - an avenue should be available for it to be managed. Whilst waitlists are a normal and accepted way of managing people accessing services, it should be noted that extended periods on a waitlist are not only disruptive to a child's therapeutic care, but are also negative to the child's perception of the value of therapeutic care, and also on the family (and possibly teacher's) commitment to participating in the therapy.

Recommendation 7

Waitlists should be managed to ensure minimum negative impact on any child's continuity of care and/or learning plan. Oversight of waitlists should be central to the child and independent from any service provider.

In all instances where children with disabilities and/or learning disadvantage are engaging with the education sector, the government should facilitate social inclusion programs. Not only are there benefits for the society more generally, with increased understanding of individuals' circumstances and therefore a higher acceptance of differences, but also a direct benefit to health outcomes for the child with a disability (Baker, K. A. Philippa; 2011).

Recommendation 8

In all instances where children with disabilities and/or learning disadvantages are engaging with the education sector, the government should facilitate social inclusion programs with defined outcomes for participation and independence for each child.

Just as therapy conducted in a child's natural settings is most beneficial for lasting outcomes, so too the schooling, where possible, should be conducted in a mainstream sense. Except in exceptional cases, children will grow when able to interact with mainstream students. Therefore removal of children from a mainstream environment should be the exception, not the norm.

3. Facilitating greater opportunities to engage all students in year 11 and 12

Whilst all therapy is aimed at building on the capacity of every child so that they may live life to their full potential, disabilities are such that some children will never live a life with full participation in society. Some children will transition from schooling to group home or other care arrangement – supported accommodation or otherwise.

The transition from the education period of life to the "wide world" is intimidating for almost everyone. With disabilities it adds to the complexities. The better the transition is coordinated, the less disruptive the transition to the young person's life and to the family that cares for that young person (Davis, J. et al; 2011). This is a matter critical for the Department of Education and Disability Service Commission to work together on.

Recommendation 9

The Department of Education and the Disability Services Commission develop an MOU that specifically details the intent to coordinate the investments in children to achieve development objectives, especially as they transition from childhood education to adult supported care environments.

Post school options are essential during this period. Investments in post-school option experiences, such as bus trips to different providers of alternatives to employment, would be beneficial for children with a disability in years 11 and 12.

Actually building the capacity and confidence of business to provide real employment opportunities for people with a disability should be the ultimate aim and is the lead priority for NDS WA going into the 2012-13 budget process.

4. Improving access and opportunities for adult learning in regional and remote WA

The service provision for therapy for children with disabilities differs from the metropolitan region to the country. The services that children access are very different in both scenarios, with city services a professional disability service and country services more an “add on” to broad allied health hospital inpatient and outpatient services. Not only are the services therefore different in design to the city, but the clinicians working in the sector may be different in their approach and motivation. They may work in a medical model as opposed to a family-centred model – working as clinicians as opposed to therapists.

Recommendation 10

The government should review the agreement to delineate service provision between the Disability Services Commission in the city and the WA Country Health Services in the country.

Suggest input is sought from industry and from regionally based adult education providers including the regional TAFE Colleges.

5. Foetal Alcohol Syndrome: prevalence, prevention, identification, funding and treatment to improve education, social and economic outcomes

Nil comment to input.

Suggest input is sought from the Telethon Institute for Child Health and other providers with specific knowledge on the matter including Nindilingarri Cultural Health Service, Kimberley Aboriginal Health Services Council, and Boab Health Services for example.

References

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