

**DEVELOPMENT OF A NATIONAL CLINICAL ASSESSMENT FRAMEWORK
FOR CHILDREN AND YOUNG PEOPLE IN OUT-OF-HOME CARE (OOHC)
A Discussion paper; February 2010**

**SPEECH PATHOLOGY AUSTRALIA
Response to the Nous Group , March 2010**

Background

Speech Pathology Australia welcomes the opportunity to respond to this important initiative and applauds the Child Health and Wellbeing Subcommittee (CHWS) in leading this project aimed at 'supporting the health needs of children and young people in out-of-home care (OOHC)'.

Speech Pathology Australia is the national peak body for speech pathologists in Australia, representing approximately 4,500 members. Speech pathologists are university qualified specialists who provide a variety of services to people with communication and swallowing difficulties that may present across the lifespan. Speech pathologists possess expertise and specialised knowledge and training in normal and delayed/disordered development of speech, language and literacy, and in early childhood socialisation and communication. As such, the profession believes it is ideally placed to provide meaningful input into the development and implementation of a National Clinical Assessment Framework for Children and Young People in Out-Of-Home Care.

Recommendations and General Comments:

Speech Pathology Australia supports the premise that a robust and clear framework for the Clinical Assessment of children and young people in OOHC is an essential element of ensuring that this vulnerable and at risk group have access to coordinated and comprehensive care for their health and social needs.

In-principle support is given to the overall framework including the three tiered approach and the three key domains identified. However further consultation with specialist groups, including speech pathologists, is required to ensure that optimal assessment tools and measures are identified for specific client groups and for different age ranges. It is essential that the relevant health professional is involved in the child's comprehensive and specialist assessment and that any multidisciplinary team approach be sufficiently flexible to draw upon the specialist health professional expertise as required. These points are elaborated below with reference to the consultation questions.

While it is recognised that the focus of this discussion paper is the Assessment Framework which is designed to facilitate early and ongoing detection of problems, it is of concern that the framework does not adequately address steps for ongoing management and services to support the child's physical, developmental, psychosocial needs. It is paramount that there is access to specialised services (involving allied health professionals, including speech pathologists) not only for assessment but ongoing treatment and consultation. The framework needs to clearly identify the 'next steps' with respect to referral to appropriate services.

The discussion paper does outline the barriers in accessing appropriate health care and clearly there are differences across services and jurisdictions. However, there needs to be a clear commitment to providing access and funding pathways to health professionals essential to the individual's needs.





Data supporting the need to identify speech and language impairment in this population

We concur with the reported literature that children and young people in out-of-home care are a highly vulnerable group, at risk of increased physical, developmental, mental and social health needs.

Speech pathology research pertinent to this area confirms that this group of children is indeed at risk of ongoing speech and language development difficulties. Golding (2009) from her review of the literature reports that children in foster and alternative care arrangements will be developmentally delayed in a number of areas, including speech and language. Experiences for these children potentially including abuse, neglect and other harmful situations can result in delayed speech, language and cognitive abilities. The findings of Meltzer et al. (2003) show that speech and language problems are far more likely for children entering OOHC, than for their peers. Culp et al, (1991) confirms this view indicating that children within abused and neglected environments will have language skills that fall from 6 to 9 months behind that of their matched pairs.

Of considerable concern is the data from Nathanson and Tzioumi (2007) [reported on page 29] which shows that, of the children included in their study, 45% of those under 5 years had speech delays and 20% of older children had language delay. These figures are well above the prevalence of speech and language impairment in the general population, where the Australian and international research reports up to 20% of children between 2 and 5 years as having speech and language difficulties (Reilly et al. 2007; Law et al, 2000; Justice, 2010).

Behavioural disorders may indicate undiagnosed communication, learning, literacy and/or attention/concentration problems. A high percentage of children, including toddlers and preschoolers, referred to welfare services have developmental and behavioural needs (Stahmer et al, 2005).

The impact of psychological trauma on language development in children is well recognised, with disorders of multiple delays, communication and social-relatedness identified in children who have been traumatized (Klapper et al., 2007). In particular, emotional neglect has been found to be correlated with poor auditory comprehension and expressive language ability (Allen & Oliver, 1982; .Culp et al., 1991)

The evidence demonstrates that there is a strong relationship between language and mental health problems. Australian research highlights that language problems can lead to emotional and psychological disturbances in adulthood, and correlates with mental health problems and youth offending. (Snow and Powell, 2007). The overlap between emotional and behavioural disorders and language deficits is extremely high and increases with age (Benner et al, 2002), who summarised international research in the area. This research has shown that:

- Out of every seven children with emotional and behavioural disorders, five may have a significant language deficit (71%);
- Out of every seven children with a language disorder, four may have an emotional and behavioural disorder (57%).

The research literature shows clearly that the language learning in the early years is rapid, and that this period is crucial for language development. Parent-child interactions form the foundation for positive parent-child relationships and also facilitate speech and language development. Where the parent-child interactions are not optimal, it is clear this can lead to the potential for developmental delays, including speech and language disorders, and mental health problems in the child.

Speech and language disorders have deleterious consequences across the lifespan. Children who enter school with language difficulties are at risk of literacy problems, poor academic achievement, low self esteem, social and behavioural problems and reduced employment options. Oral language competency in the young child is a strong protective measure against negative outcomes in later life. For these reasons it is critical that this population of at-risk children have adequate access to speech pathology assessment and intervention. Speech Pathology consultancy to carers and OOHC workers is also vital so that early detection of speech and language difficulties and monitoring over time can occur, and that strategies can be provided to maximise a child's speech and language development and ultimately enhance their long term outcomes.



Discussion Paper: Consultation questions

1. **Should the Framework identify specific measures that are appropriate for these diverse groups or should all measures identified be appropriate to all population groups? (Page 11)**

There is merit in having some standardisation of primary health screening across all children and young people, which may ensure coverage of all aspects of the child's functioning and capture some useful data of this population over time. However, it needs to be recognised that this group by its nature is not representative of the general population and already is an identified at-risk cohort. Tools that are aimed at general population screening therefore may not be sufficiently sensitive.

It is particularly important that screening tools and comprehensive assessments are applicable to the individual child and tailored for those with special needs such as disability, a culturally and linguistically diverse background (CALD), refugee status and Aboriginal and Torres Strait Islander (ATSI) origin. In particular the screening of speech, language and literacy of these children must be delivered contextually and with appropriate linguistic and cultural sensitivity. Those children from CALD backgrounds, including Aboriginal children, will need to be assessed using different instruments as it cannot be assumed that their exposure to English has been the same as that for children from English speaking backgrounds.

Speech Pathology Australia has developed a position paper in regards to speech pathology practice within a culturally and linguistically diverse society (Speech Pathology Australia, 2009).

An extract from this paper provides this guidance:

"The use of standardised English language tests does not provide fair assessment for clients from culturally and linguistically diverse backgrounds (Fagundes, Haynes, Haak, & Moran, 1998). Decisions regarding assessment procedures should be made with an awareness of cultural biases which may be present in assessment materials or in the assessment context (ASHA, 2004; Fagundes, Haynes, Haak & Moran, 1998)."

While the screening tools suggested in the document are largely carer-reporting questionnaires, the nature of the carer's linguistic background as well as the child's will be important in ensuring validity of results.

Flexibility and professional input as to the best measures to use with individual children is critical.

2. **Are the three key domains for assessments the right areas to focus on? Should mental health be a domain in its own right or continue to be combined with psychosocial health? (Page 11)**

Yes the three domains for assessment are appropriate as areas of focus and should receive equal weighting to ensure comprehensive assessment of all aspects of the child's functioning and development, and to ensure consistency. Speech Pathology Australia is pleased that speech and language is noted as a key area of developmental assessment. Intrinsic in this is the assessment of pre-literacy and literacy skills which has been noted. Not clearly noted is the need to assess social communication (pragmatics) as this can be an indicator of specific problems, such as autism, but may also be reflective of other behavioural and emotional difficulties. The description of areas under 'Speech and Language' needs to be amended as shown below.

With respect to mental health, it is agreed that this fits adequately under the broad heading of Psychosocial assessment.



3. Should the Framework be prescriptive on the areas to be addressed for each assessment or provide guidance on the areas to be addressed and their applicability for the type of assessment being conducted? (Page 13)

It will be useful for the framework to provide guidance on the minimum core areas to be addressed through the primary health checks and more comprehensive health and developmental assessments, however there does need to be the ability for health professionals to utilise their professional expertise and judgement with respect to the appropriate areas to assess given the presentation of an individual child.

Within the current Developmental Domain, the following suggestions are made:

Developmental history

It is known from current longitudinal research into late language emergence and language impairment in children that the factors that are strong predictors include familial history of speech/language disorders and male gender (Reilly et al, 2009; Zubrick & Taylor, 2007) Some studies also have shown early neurobiological growth with suboptimal foetal growth and premature birth as a predictive factor for late language emergence (Zubrick & Taylor, 2007).

Speech and Language section - to be amended to:

Speech, Language and Communication

Speech/articulation
Expressive and Receptive (Comprehension) language
Pre-literacy skills
Literacy skills
Social communication (pragmatic language)

4. Does the tiered approach provide the right structure for assessments? What other models can be identified? (Page 15)

The proposed tiered approach of the framework is supported, however there needs to be some clarification around the Comprehensive Health and Developmental Assessment and the Specific Health Assessments. From a speech, language and literacy perspective, it is critical that more detailed assessment is performed by a speech pathologist. This is presumed to be the case for the Specific Health Assessments with speech pathologists listed among the specialists to whom the child may be referred, however we contend that speech pathologists should be part of the multidisciplinary teams involved at the level of Comprehensive Health and Developmental Assessments. Indicators at the Primary Health Check level could be considered for the inclusion of speech pathology at the second tier.

5. How frequently should repeat assessments be conducted? Should the Framework including specific timings or should the implementation of the Framework be flexible to allow practitioners to determine the need and timing of assessment on a case by case basis? (Page 17)

There should be minimum benchmarks in terms of the timing of assessments at each of the tiers of the framework. Flexibility should be allowed for professionals to determine more frequent repeat assessments where their judgement would suggest this is necessary. While it is generally agreed that more frequent assessments would occur in the younger years, specific assessment should occur at certain transition points, not just in terms of the child's care situation, but also along the developmental pathway. For example transition to school can be a period when higher demands socially and academically are placed on the child, and subsequently specific problems may become apparent or exacerbated at this time. Transition to secondary schooling is also a crucial period.



Of further note are the findings of the Early Language in Victoria Study (Reilly et al, retrieved 2009) which shows that of the cohort of children who have language difficulties at 4 years, 50% were not identified with language difficulties at 2 years. This highlights the importance of repeat assessments at later years even where speech and language problems may not have been detected in a child's first two years.

6. Should the Framework be prescriptive on the tools to be used for each assessment or provide guidance on the range of tools available and their applicability for this group? (Page 21)

It is recommended that while there may be a minimum standardised battery of screening tests prescribed at the Primary Health Check level, for the level of Comprehensive Health and Developmental Assessment and the Specific Health Assessments there may be suggested assessment tools but allowance should be made for specialised professionals to select the appropriate assessment and measures for that child's presentation. This allows for professional judgement and should not be limited to a single tool for each domain as indicators may be identified that require more comprehensive assessment.

It is noted that the list of developmental screening tools mostly include a communication (speech or language) component. The ones listed do differ in depth and length of questions with regard to language development. One language screening tool to be considered for inclusion in this list is the MacArthur Bates Communicative Development Inventories which is a more extensive vocabulary tool. This tool has been noted as part of the Clinical Practice Guidelines for early intervention communication assessment tools (New York State Department of Health, 1999).

It is noted also that the tools suggested are all based on parent/carer reporting. Despite their validity, these tools will not replicate more detailed assessment and observations by health professionals. One further tool in the area of language development for consideration is the Communication and Symbolic Behaviour Scales (CSBS). This tool includes a section for observation by the clinician and therefore is enhanced by professional expertise and opinion. While this test has often been used as a screen for early signs of autism, it is not restricted to this population.

It is noted also that the screening tools suggested focus on the very young child, and tests suitable to the older child should be suggested by the relevant professionals.

7. Should the Framework be prescriptive on which clinician, health professional or health worker should undertake the assessments or be more flexible? (Page 22)

It is essential that the most appropriate health professional relevant to the child's needs is available to undertake detailed assessment. Where a multidisciplinary team approach is employed, it needs to be ensured that clinicians operate within their level of competence and scope of practice. A full complement of specialists, including speech pathologists, needs to be available to be part of multidisciplinary teams dependent on the child's needs.

8. How should the results of the assessments and any follow up care be documented? The framework proposes preparation of a health plan for each child or young person entering out of home care. (Page 24)

Speech Pathology Australia strongly agrees that assessment findings and recommendations of the professionals involved need to be translated into a coordinated and documented health plan for each child and young person. The health record needs to be available to the various professionals involved in the child's management and where appropriate be transferable across agencies and services. The health plan should document the child's specific identified problems and needs and the recommended services for ongoing management. A workable communication pathway for communication of the health plan to relevant stakeholders will be crucial to the success of the plan. The pathway and funding for specific treatment needs to be identified to ensure the child receives the care and services he/she requires.



9. How should implementation of the Framework be monitored and evaluated? (Page 25)

There needs to be performance indicators and auditing to ensure that the framework is implemented, consistent with the prescribed standards and timing benchmarks. Measures need to be included that evaluate whether the required services and follow up are received by the child. Measures should not only be process based but address children's outcomes. Longitudinal research needs to be incorporated to measure the framework's effectiveness in meeting the objectives of ensuring children in OOHC are safe and well.

In summary

Speech Pathology Australia provides its in-principle support for the National Clinical Framework for Children and Young People in Out-of-Home Care. Specific comment and recommendations have been made against the consultation questions.

Speech Pathology Australia would welcome further consultation on this important framework, and as appropriate, can assist in identifying speech pathologists with particular expertise in this area to provide specialist input.

As has been stated, this framework has the potential to provide a comprehensive and consistent approach to ensure that children in OOHC are identified with respect to their specific needs and ongoing management. It is essential that the care planning for the individual child and young person addresses what services are required to support them in achieving their optimal development and long term outcome.

For further information contact:

Gail Mulcair
Chief Executive Officer
Speech Pathology Australia
19 March 2010

2nd Floor, 11 – 19 Bank Place, Melbourne Vic 3000
Telephone: 03 9642 4899 Fax: 03 9642 4922
Email: gmulcair@speechpathologyaustralia.org.au



References

- Allen, R., & Oliver, J. (1982). Effects of Child Maltreatment on Language Development. *Child Abuse and Neglect*, 6 (3), 299-305.
- Benner, G. J., Nelson, J. R., & Epstein, M. H. (2002). Language skills of children with EBD: A literature review. *Journal of Emotional and Behavioural Disorders*, 10(1), 43-56.
- Culp, R. E., Watkins, R. V., Lawrence, H., Letts, D., Kelly, D. J., & Rice, M. L. (1991). Maltreated children's language and speech development: Abused, neglected, and abused and neglected. *First Language*, 11(33), 377-389.
- Golding, S. (2009). *Speech and language development: Knowledge, beliefs and experiences of foster carers*. Honours Thesis. Curtin University of Technology.
- Justice, L.M. (2010) *Communication sciences and disorders. A contemporary perspective*.
- Klapper, S., Plummer, N., & Harmon. (2007). Diagnostic and treatment issues in cases of childhood trauma. In, Joy. D.Osofsky (Ed.).*Young Children and Trauma: Intervention and Treatment*. The Guilford Press.NY.
- Law, J., Boyle, J., Harris, F., Harkness, A., & Nye, C. (2000). Prevalence and natural history of primary speech and language delay: findings from a systematic review of the literature. *International Journal of Language & Communication Disorders*, 35(2), 165-188.
- Meltzer H., Corbin T., Gatwards R. and Ford T. (2003) *The mental health of young people looked after by local authorities in England*. London; The Stationery Office.
- Nathanson, D & Tzioumi, (2007), Health Needs of Australian Children in out-of-home care. *Journal of Paediatrics and Child Health*, 43, 665-669.
- Reilly, S., Wake, M., Bavin, E. L., Prior, M., Williams, J., Bretherton, L., et al. (2007). Predicting language at age 2 years: A prospective community study. *Pediatrics*, 120(6), 1441-1449.
- Reilly, S., Bavin E., Bretherton, L., Conway, L., Eadie, P., Cini, E., Prior, M., Ukoumunne, O. & Wake, M. (2009). The Early Language In Victoria Study (ELVS): A prospective longitudinal study of communication skills and comprehensive vocabulary development at 8, 12 and 24 months. *International Journal of Speech Language Pathology*; 11 (5): 344 – 357.
- Speech Pathology Australia. (2009). *Working in a Culturally and Linguistically Diverse Society Position Paper*. Melbourne: Speech Pathology Australia.
- Snow, P. C. & Powell., M.B. (2008). Oral language competence, social skills, and high risk boys: What are juvenile offenders trying to tell us? *Children and Society*, 22, 16-28.
- Stahmer, A. C., Leslie, L. K., Hurlburt, M., Barth, R.D., Webb., M.B. & Landsverk., J. et al. (2005). Developmental and behavioral needs and service for young children in child welfare. *Pediatrics*, 116 (4), 891-900.
- Taylor, C & Zubrick, S. (2009). Predicting children's speech, language and reading impairment over time. *International Journal of Speech Language Pathology*; 11 (5): 341 - 343