To whom it may concern,

Re: **Response to Administrative Appeals Tribunal**
National Disability Insurance Scheme Section

Please find below my responses to the further information requested on xyz date.

Criterion s24(1)(b)

Information has been sought in relation to previous treatments.

I am unable to provide further information around specifically what treatments have been provided in the past by speech pathology. As noted in my assessment report, I saw Client on one extended occasion to complete a comprehensive language assessment, which I believe is an accurate representation of his skills in this area. I have not seen Client for intervention, and comments in my report that allude to previous treatment are references to reflections in other reports. Client accessed specific speech pathology intervention as a younger student through the Department of Education. Further information around this could be requested from this source, including what the treatment entailed, the duration of this treatment and its efficacy, and the reasons for his discharge from that service. He has not accessed ongoing speech pathology support since that time.

Client's recent literacy intervention program was a rigorous synthetic phonics approach, based on the strategies developed by Orton Gillingham. He received weekly 1:1 intervention from January 2020 to March 2021. This intervention ceased when the instructor with whom he was working left our service and we were unable to replace her. Over this time, there was some disruption to service related to COVID-19 lockdowns, compounded by Client's inability to manage telehealth sessions.

Client works with several providers targeting different aspects of his accepted impairments, and the manner in which the finite resources and financial capacity of the family (particularly in relation to his regional location) are distributed has required some consideration by Client and his parents, in order to prioritise those that they believe will have the biggest impact on his functioning. At this stage, speech pathology has not been considered as a priority. It is my understanding that his needs in relation to mental health (psychology) and advocacy for potential NDIS funding have been prioritized. Recently, although this intervention has currently ceased, literacy intervention, further to his diagnosis of SLD was being provided.

With regards to whether there are any other available and appropriate evidence-based interventions that would remedy the impairments, I can speak only to his diagnosis of developmental language disorder (DLD). DLD is internationally recognised as a lifelong disorder with significant lifelong functional impacts, notably in the areas of educational outcomes, employment and mental health. With regards to intervention and use of the term 'remedy', the implication is that there is a treatment available to 'cure' DLD. Speech pathology interventions would seek to ameliorate an individual's ability to develop the skills and strategies needed to successfully function in society and to specifically teach compensations for the skills that may never be effectively internalised. The nature of a lifelong impairment is such that remedying the impairment is unlikely.

The Respondent has requested further information regarding Client's difficulties being remedied, a request that is somewhat confusing given acknowledgement in previous responses that he is accepted to have a disability in a number of spheres. The United Nations Convention on the Rights of Persons with Disabilities defines disability as "long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder a person's full and effective participation in society on an equal basis with others". Given a disability has been identified and acknowledged, the suggestion of a remedy is confusing. Additionally, given a disability has been accepted by the Respondent, and the UN definition alludes to a hindrance in full and effective participation in society, it would seem clear, together with the evidence already provided by Client's providers, as well as the Family Impact statement and his school suspension challenges, that Client is not able to fully, effectively and successfully participate in the community in which he is currently required to operate.

In my original report, I commented on Client's access of 'most' of the accepted interventions for the diagnosed conditions identified. This list included accepted interventions for the full range of his diagnosed conditions, and was not specific to his diagnosis of DLD.

To unpack this further in relation to DLD, Client ha,s over time, accessed ALL interventions that are accepted as evidence-based responses to DLD. To unpack these further, I have re-iterated the list mentioned in my report and commented against each. To be clear, there is only one type of intervention accepted as an evidence based response to DLD, that being targeted language therapy.

Medication

There is no medication available to treat DLD. To the best of my knowledge, there is no evidence that research is being conducted in this area, nor any suggestion from any reputable source that there is value in such research

Targeted instruction following evidence-based approaches in each of the learning areas by appropriately qualified educators or allied health professionals

Client accessed speech pathology support in early primary school via the speech pathology service in the Department of Education. The exact nature or duration of this intervention is not known to me, but could be obtained by contacting Learning Services North. Despite this input, his last reported assessment by the Department was reflective of mild language disorder. My own language assessment conducted this year, has demonstrated that this language disorder has become increasingly significant over time. Evidence from researchers in the area of DLD has shown that individuals with DLD will never 'close the gap', will always present with oral language skills less-developed than their peers, will always struggle with the understanding and expression required to conduct communicative exchange for academic, occupational and social fulfillment and will struggle to navigate those exchanges effectively without skilled communication partners and effective compensatory and advocacy strategies. Further targeted intervention will be beneficial for Client in assisting him to effectively advocate for himself and develop compensatory strategies to allow him to manage these situations. Targeted intervention has <u>not</u> been shown to remedy the language difficulties an individual with DLD has. Research evidence has, in fact, shown that that individual will experience challenges in managing language-based interactions for the whole of their life.

Client's DLD and success in managing the intervention context is further complicated by his attention, learning, anxiety and motivation issues that are characteristics of his comorbid conditions.

Specific instruction in compensatory tools and techniques to deal with the ongoing and lifelong impact on low-level literacy and numeracy skills (notably assistive technology)

I am unable to comment on the extent to which Client has accessed significant targeted instruction in his literacy and maths skills. I can confirm that, as with DLD, there is significant empirical evidence to demonstrate that individuals with specific learning disabilities (SLD), of which Client has three, can improve their skills with appropriate intervention, but will continue to struggle with learning and interaction that involves written language or maths.

Psychological therapy, inclusive of counselling as well as specific therapies to target the deficits associated with and compensations for inattention, hyperactivity, and impulsivity (which lie at the base of his behavioural challenges)

I am unable to comment on the extent to which Client has accessed psychological therapy.

Criterion s24(1)(c)

Information has been sought in relation to impairment and functional capacity

Client usually requires assistance from other people to participate in, or to perform tasks or actions required to undertake or participate in activities. (Rule 5.8b)

I have commented extensively on Client's functional capacity in my initial speech pathology assessment and I would refer the Tribunal to these specific examples. These comments were based on observations made during our assessment session, but also derived from reflections of his literacy instructor during frequent informal case conferences. Client worked with this instructor for regular weekly hour-long sessions targeting his literacy skills. He had a good relationship with this provider and a clearer picture of his functioning is likely to be provided by someone with whom he had more frequent and sustained interactions.

It is highly recommended that a functional impact statement is sought from his school. This is the environment in which he is required to effectively function at this point in his life, is the environment in which the interactions and relationships he sustains most closely resemble those that he will encounter in later life, and the environment in which he experiences most challenges.

In the assessment session I had with Client, he struggled to manage his interaction with me independently and was very guarded in the manner in which he accepted communication with me. This is consistent with an individual who expects that successful engagement in communicative exchanges will be challenging. He displayed limited eye contact and poor skills in interacting with me on a social / conversational level, or in the context of the testing framework. He frequently sought assistance from his mother to understand task requirements and would often convey his wants and intentions to her rather than directly to me. Throughout the session, he would indicate that he did not want to be there, that he did not want to complete the activities and that he was not doing any more, that he was leaving. Mother would reiterate the purpose behind our session, and make a request for extended cooperation. Client was not able to negotiate the pace, order of activities, rest time or breaks with me independently and his cooperation was characterised by compliance at the encouragement of his mother only and then sudden refusal to continue. While it was clear that he was reaching his ceiling (in terms of both capability and tolerance) during the testing, he was not able to indicate this verbally and

negotiate a break, but would instead simply announce he wasn't continuing, stand up and look towards his mother to leave. On this occasion, although I am of the understanding that this is not always the case, it was possible to convince Client to continue, but what he would initially agree to do (e.g. let's do 5 more from this activity) was not always what he actually delivered.

These interactions were in a quiet, structured setting with two skilled communication partners (the clinician and Client's mother). Despite this, Client's ability to participate reflected challenges in managing that interaction independently, successfully and such that it was a positive experience. It is therefore expected that participating in interactions in less-than-ideal, unstructured, busy, noisy situations with multiple communication partners (and the possibility of partners who are not sensitive to Client's specific linguistic challenges) will be very difficult.

Reports from others would suggest that Client has a positive relationship and demonstrates a gentle and considerate approach with his younger sister, Sister aged 5 years. Children with DLD frequently prefer the communication style of younger children. The conversational style of younger communication partners tends to be shorter, more superficial and less intense, with simple vocabulary, fewer conversational turns and interactions based on what is happening at that moment in time. Younger children tend to be more self-focussed in their conversations, and less concerned with the complexity or even content of what others say. Our assessment suggested that Client's functional communication skills are commensurate with a 7 year old, which would align with observations around his more successful communicative exchanges with his younger sibling.

It seems unlikely that there would be any suggestion that a 7-year old child would have the functional capacity to interact in a teenage, much less an adult, context / society without requiring assistance *usually* or even *always*. Given this is the functional language capacity suggested in Client's speech pathology assessment, it should be considered that this is the level to which he would be able to manage independently in the community.

Prior to Client beginning private literacy intervention, an initial assessment of his literacy skills was completed. At the time he was aged 12 years and 0 months. His spelling age was identified to be 5 years, 11 months. A reading age was not able to be identified as he was not compliant during assessment. Despite 7 years of exposure to literacy teaching, his literacy level was considered to be commensurate with that of a Prep child. Given his inability at that time to develop skills commensurate with his grade despite a mandated focus in primary school on 'learning to read' specifically, ongoing concerns remain for the future. The UNESCO (1978) definition of a functional level of literacy is as follows:

A person is functionally literate who can engage in all those activities in which literacy is required for effective functioning of his group and community and also for enabling him to

continue to use reading, writing, and calculation for his own and the community's development. UNESCO (1978). *Records of the General Conference. 20th Session* Vol. 1 Paris: UNESCO.

In Australia, it is generally accepted that a functional level of literacy is commensurate with the reading ability of an 11-year-old. Given this, and Client's proposed literacy level, it is clear that his SLD will have an immeasurable functional impact on his ability to successfully engage in the demands of a literate society.

Client's difficulties with successfully independently regulating his behavioural and attentional responses have been discussed in his psychology report, and are consistent with his diagnosis of ADHD, and potential diagnoses of CD and ODD. This means that when he is placed in linguistic and/or literate situations beyond his functional capacity, he will consistently require assistance from others in order to undertake or participate. Given his functional capacity linguistically approximates a 7-year-old and his literacy capacity is not at this level, it can be suggested that there will be frequent situations in which this will occur. When this assistance is not quickly forthcoming, his responses tend to be behaviourally inappropriate. Observations of Client in my own assessment session, and shared observations from other providers demonstrate his challenges in managing his behaviour when this occurs. These dysregulated responses can range from statements that he is "not doing this any more", to physically removing himself from a situation, to more significant verbal and physical responses. My own observations were that he requires assistance from very familiar others, at a very early stage of his frustrations, to manage this dysregulation in a productive way. Other providers, family members and his school could provide further comment as to Client's ability to function in these situations, and the extent of his responses when he feels unable to manage.

I have commented extensively on the functional impacts to Client associated with his DLD in my initial speech pathology assessment report. I would draw the Tribunal's attention to these points, and for ease of access have re-inserted these points here:

The impact of Developmental Language Disorder alone on Client's day-to-day life is extensive. Some examples of this impact include:

In the academic context:

- *Difficulty following instructions in the classroom in the same time frame as peers which makes it appear that he is delaying or being difficult*
- *Difficulty formulating responses, questions, and requests in a suitable time frame*

· *A lack of confidence and skill in advocating for himself, even in the simplest form of requesting clarification when he has not understood, or asking for time to process what has been said*

· *Difficulty processing and retaining the information presented to either understand what is expected of him, or the information he is required to learn, when this information is presented verbally*

· *Immense difficulty transferring and representing any of his thoughts in written format, which is the format expected in the high school context*

In the social context:

· *Difficulty understanding the extended stories that make up conversational language*

· *Difficulty understanding the nuances, slang and inference that form part of teenage language culture, meaning he will not always understand exactly what peers are saying.*

· *A tendency to understand and respond to things as if they were meant literally (without understanding the additional contributions to meaning made by non-verbal cues (e.g. intonation, vocal tone and volume, sarcasm, winking, personal distance)*

· *Attempts to use, but ineffective carry of, teenage language, such that his attempts set him apart as a 'try-hard'*

· *Difficulty understanding when peers are genuinely inviting him to be part of a social context, rather than involving him in order to 'set him up' for inappropriate or embarrassing behaviour (there is evidence to suggest this is already occurring, with peers 'baiting' Client to anger him and then leaving him to be disciplined)*

· *A tendency to either avoid interactions or dictate the terms (particularly with adults) because while he does this, he increases his likelihood of understanding the language that is used and end things when it becomes harder to manage*

In contexts involving challenging behaviours

· *Difficulties understanding expectations of him in terms of behaviour in various contexts*

· *Difficulties explaining what he has understood and therefore why he has behaved in the way that he has*

- *A lack of insight and ability to predict what the likely outcome of a given course of action will be, before embarking on the course (or reacting to something)*
- *Difficulties identifying alternate course of action when on a path that will likely lead to trouble*
- *Difficulty with the appropriate vocabulary and language to identify how he is feeling, why he is feeling that way and what he needs in order to feel better*
- *A tendency to give conflicting 'messages' about what is happening and what he wants to happen (often so that it looks like defiance and difficult behaviour are Client's preferred choices, when this is not the case)*
- *Poor negotiation and compromise skills which mean he feels unable to impact what is happening and how it will end, even when there is the possibility that he could*
- *A tendency to sudden statements of what he will and won't do*
- *Inability to convey the consideration he may feel for others, and difficulty interpreting messages he is being given that someone is 'on his side', which gives the impression of a child who does not want or value help*

I am unable to comment further regarding the specific functional impacts of Client's DLD because of the limited time I have spent with him. There is extensive anecdotal and empirical evidence that can be accessed that considers the impacts of DLD of those whom it impacts. While the exact nature of these impacts will vary between individuals and their comorbid diagnoses (of which Client has many), the impacts are many, significant and lifelong.

I would draw the Tribunal's attention to a well-resourced and respected website used by speech pathologists for further information https://thedldproject.com/

Additionally, I have attached as a separate document, but also include the link here (https://drive.google.com/file/d/12O47Uc7Gt6-Ce4vpppnB_fyoGb57DNZ8/view?usp=sharing), to our own national association, Speech Pathology Australia's policy brief on the nature and impact of Developmental Language Disorder.

I would implore that the Tribunal consider highly the Family Impact Statement provided by Client's mother, Mother Surname, for a detailed and contemporaneous reflection on the reality of life for this young man. I am not aware whether a similar Impact Statement has been sought

from Client's school, Scottsdale High School, but would implore that this is requested, if it has not already been.

From a functional perspective, one must consider that communication is a life skill, if not the most significant life skill, and certainly one from which most of us derive significant pleasure. Without the ability to effectively navigate communicative situations and with the knowledge that these situations will always be difficult (as is clearly the case for Client when he is with unfamiliar communication partners), it can easily be understood why individuals with DLD are well represented in the justice system, and that the link between DLD and mental health issues is clearly established. Both of these paths, are paths with which Client has already (at the age of 13 years) had some experience.