The New Zealand Psychological Society

Te Rōpū Mātai Hinengaro o Aotearoa

INSTITUTE of EDUCATIONAL and DEVELOPMENTAL PSYCHOLOGY

Submission to the Parliamentary Education and Science Committee for

The Inquiry Into the Identification and Support for Students with the Significant Challenges of Dyslexia, Dyspraxia, and Autism Spectrum Disorders in Primary and Secondary Schools

Prepared

by the

New Zealand Psychological Society

Te Rōpū Mātai Hinengaro o Aotearoa

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About the New Zealand Psychological Society

The New Zealand Psychological Society is the largest professional association for psychologists in New Zealand. It has over 1100 members who apply psychology in a wide range of practical and academic contexts to health, education, young people's services, organisations and corrections. Our collective aim is to improve individual and community wellbeing by disseminating and advancing the rigorous practice of psychology.

Our members are at the forefront of research and innovation in designing systems of support for young people at the margins of our society, their whānau, educators and support agencies.

Educational psychologists and psychologists who work in education are integral to the identification, assessment and ongoing support of children with special needs throughout Aotearoa/New Zealand working across the education, social services and health sectors. A significant number of psychologists are employed by the Ministry of Education. All have a minimum of six years training to post Masterate level and the majority have additional qualifications and experience. They contribute or lead major Ministry initiatives at an organisational level or systems level. This includes whānau/parenting groups and teacher training as well as developing individual community and class room interventions, providing intensive wrap around services for children identified with severe behaviour or significant learning difficulties. Increasingly psychologists are employed in private practice directly by schools and by non-governmental organisations.

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Introduction

1. We are concerned that the short time span for this inquiry has limited the New Zealand Psychological Society (NZPsS) and its Institute of Educational and Developmental Psychology (IEDP) ability to consult our members fully about the many complex and contentious issues that this inquiry raises.

2. The NZPsS and IEDP advocates for an inclusive education system that focuses on the functional needs of a young person. We are cautious about an over-reliance on categorical systems for diagnosis, assessment and intervention.[1]

3. We question the evidence base for the singling out and elevating Dyslexia, Dyspraxia, and Autism Spectrum Disorders (ASD) as meaningful categories for the purpose of this review.

4. Research has indicated that children from as young as seven who live in economically deprived environments are on course for a life of academic, social and emotional failure. It is estimated that 80% of the difference in how well children do in school can be attributed to what happens 'outside the school gates'.[2] Addressing inequity in our country is an essential part of meeting the educational needs of all young people in Aotearoa/New Zealand.

5. We recognise that for some young people and those who care for them, that a diagnosis of a specific condition or learning disorder can provide a sense of identity, comfort and meaning. It can provide a respite from unhelpful descriptions (e.g. unteachable, stupid, unmanageable). For others, it further stigmatises and creates a climate of low expectations for future learning. We favour addressing the underlying cause of these learning difficulties rather than resorting to labels that might pathologise and have unintended consequences.

6. Much of the pressure for assessment and diagnosis of 'named learning difficulties' comes from the needs of the system to ration resources. A minority might gain a successful diagnosis whilst those who were close to the cut-off point, but who would benefit from the same interventions will just miss out. We recommend systems of resource allocation that increase the equitable access to resourcing.

[1] The New Zealand Psychological Society (2015a)
[2] Save the Children, 2013

7. The Ministry of Education's Special Needs Review and Update is reviewing current service systems.[3] One potential model of delivery that has evolved overseas is to constitute local commissioning bodies that buy in the services from psychologists and other providers. We believe that this competitive model will provide perverse incentives for diagnosis and the allocation of additional resources rather than rewarding schools and psychologists for devising successful, local and inclusive solutions.

8. We hope resources will be made available to publicly fund psychologists to support our schools and communities to meet the needs of <u>all</u> young people, including a focus on literacy and other educational needs for those on the margins of our society.

9. There are models of school psychology operating in the country that can provide insights into how educational psychologists can support educational settings in all their processes to better prevent, identify and provide early intervention for learning difficulties, irrespective of cause.

Inclusion

10. The Ministry of Education has expressed a high aspiration to produce "a world class inclusive education system that was intended to provide learning opportunities of equal quality to all students."[4] Special Education 2000 was an explicit attempt to move away from categorising children and focus on need. The return to categorical subgroups is a retrograde step.

11. There is a risk that groups that are more organised and well-resourced will have more influence and capture more resources.

    A review of children with special educational needs found:

    > *There is no special pedagogy for special education with all its labelled disabilities (Lewis and Norwich (2000). Categories are often devised or promulgated for funding purposes. As Rapoport indicates "I'll call a kid a zebra if it will get him the educational services I think he needs."*[5]

    The NZPsS submission on NCEA Special Assessment Conditions documents our concerns about the inequitable access children have to psychologists and therefore the unfair advantage for those who can afford to pay for assessment.[6]

12. Successful inclusion is evident in many schools, supported by teaching excellence and professional communities incorporating educational psychologists, as well as

[3] Ministry of Education (2014)
[4] Massey University College of Education (1999) p5
[5] Cited in Liu, King & Bearman (2010) p10
[6] The New Zealand Psychological Society. (2013) p1 para 7

deliberate collaboration with families and community. Processes for successful inclusion, that is, sustainable learning and responsive teaching, are based on considerable evidence from research and practice both nationally and internationally.[7]

Diagnosis and Categorical Systems

13. Psychologists have documented the limitations and dangers of diagnostic and categorical systems related to the recent revision of DSM-5[8]. There may be a few diagnostic categories that have a sound evidential basis e.g. vision and hearing for which there is a specific pedagogy.[9] However, even when a differential diagnosis can be established so as to inform an intervention it may obscure the individual needs and the cultural context in which the young person resides.

14. Dyslexia is no longer a useful diagnosis to discriminate a group of students from other poor readers. A recent comprehensive review of the literature evaluated claims made about phonological awareness, rapid naming, short term and working memory, auditory and speech processing, visual processing, magnocellular, psychomotor problems, scotopic sensitivity, attentional shifting, visual attention and abnormal crowding. There is no convincing evidence that dyslexia can be reliably diagnosed so as to distinguish this group from other poor readers. There is no evidence that those described as dyslexic require different interventions from other persistent, poor readers (e.g. multi-sensory approaches).[10] Some of our members hold a contrary view and there is not a consensus about the value of a dyslexia diagnosis.

15. There is an increasing consensus that dyslexia can no longer be diagnosed by seeking a discrepancy between a child's intelligence (IQ) and their reading level i.e. able and less able children are found to have difficulties decoding words on a page.

16. There is some evidence suggesting a biological and hereditary link to children struggling with reading. However, at present, there are currently no neurological or genetic markers that would separate a dyslexic student from an otherwise poor reader.[11]

17. There appears to be a greater consensus about the utility of the term Autism Spectrum Disorder (ASD). However, the NZPsS has documented some of the difficulties of determining differential diagnosis from other common difficulties that

[7] Graham, Berman & Bellert (2015); Carrington & MacArthur (2012)
[8] The New Zealand Psychological Society (2014); Division of Clinical Psychology (2013)
[9] Brown (2010)
[10] Elliott and Grigorenko (2014)
[11] Elliott and Grigorenko (2014)

are known to coexist with ASD in a consultation document updating the New Zealand ASD Guidelines.[12]

18. Various social factors that go beyond the individual child have a strong impact on gaining a formal diagnosis, for example, a child living close to a child previously diagnosed with autism is more likely to be diagnosed with autism.[13] A Ministry of Health survey indicates a wide variation in prevalence rates of ASD in Aotearoa/New Zealand e.g. Taranaki at 3.3% of the population (confidence level 1.6% to 5.9%) compared to the West Coast at 0.0% (confidence level 0.0–2.4%).[14] It is possible that there are no or few children with ASD on the West Coast but more likely that they have gone undiagnosed due to the lack of available professionals. Further research might determine if children in Taranaki have their needs met and achieve better outcomes as a result of diagnosis than those that go undiagnosed on the West Coast.

19. There is an increasing heterogeneity and diagnostic expansion of those defined as being on the autism spectrum. There are arguably more differences within the ASD population than there are between the ASD population and the so called 'normal' population. A description of ASD can mean anything from a young person mute, rocking in a corner and flicking their fingers to a highly competent young person in a secondary school that excels in mathematics but refuses to make a written recording of their findings. Their unique functional needs will be more relevant in devising an intervention rather than the diagnosis.

20. The evolving nature of these diagnostic categories illustrates the relative temporal nature and malleability of these categories e.g., the removal of Asperger Syndrome from DSM-5 and creation of other categories such as Social (Pragmatic) Communication Disorder which might remove or include young people formerly diagnosed as being along the autistic spectrum.

21. Diagnosis will not always lead to better outcomes for young people. A Norwegian study found those diagnosed with dyslexia (difficulty with word decoding) at 10 years of age continued to have reading difficulties at 23 years of age.[15] A review of children with special needs found that a child's primary or secondary diagnosis did not moderate outcomes i.e. the child's "syndrome" (and the cluster of behaviours associated with that syndrome) was of less significance to the success of an intervention than the nature of the observed behaviour.

22. The initial conceptualisation and much of the current research base for dyslexia, dyspraxia, and autism spectrum disorders have come from overseas. Alternative models in Aotearoa/New Zealand might embody the relational principles set out in Te Tiriti o Waitangi and broader concepts of hauora/well-being. Within a Māori context, there is rarely a binary of special education versus normal education. These

[12] The New Zealand Psychological Society. (2015b).
[13] Liu, King and Bearman (2010).
[14] Ministry of Health. (2014)
[15] Undheim (2009)

children belong to their community regardless of their need. Therefore their needs should be examined within their immediate and wider whānau.[16]

Assessment

23. One response to this heterogeneity and variable prevalence rates is to call for tighter criteria for categorial diagnosis and an increase in qualified diagnosticians to carry out assessment. We would argue that this is unrealistic. The diagnostic criteria for these categories may at best provide a loose guide to further intervention that requires careful interpretation by professionals within the situation that the learning takes place.
24. It is estimated that up to one half of the costs associated with educating a child with special education needs is taken up with the identification processes.[17]We favour low cost, locally devised systems of assessment where the bulk of funding is prioritised to focus on evidence based interventions for the functional needs of children.

25. The words 'dyslexia' or 'reading difficulties' do matter as they have an impact on teachers' beliefs about the immutability of the child's learning capacity and the view of their effectiveness as teachers. We need to be mindful that assessments and diagnosis can lead to low expectations and can potentially limit a child's progress.[18]

26. The shortcomings of static and standardised forms of assessments are well documented.[19]As psychologists we are required to maintain high administration and interpretation standards for testing, as specified in our Code of Ethics and the New Zealand Psychologists Board guidelines, "The Use of Psychometric Tests".[20]

27. We have concerns about the use of screening assessments that have poor psychometric properties that are administered by those who are not suitably qualified and who make unjustifiable claims about the needs of young people. Any screening programme at an early age may risk creating the belief that a young person cannot learn.

28. If we ignore the concerns about the constructs of dyslexia, dyspraxia, and ASD as discussed above, there is a dearth of assessment tools designed in Aotearoa/New Zealand with suitable New Zealand norms. As a result extreme caution must be taken when interpreting any standardised assessment that has been devised overseas, with a different population in mind.[21]

[16] Macfarlane et al (2014)
[17] Cited Coleman (2010)
[18] Gibbs and Elliott (2015).
[19] Stobart (2008)
[20] New Zealand Psychologists Board (2013)
[21] The New Zealand Psychological Society. (2015b)

29. Curriculum based assessment and dynamic assessment might generate more practically valid information that is linked to the child's curriculum and provide more information about the child's learning potential using an `assess-intervene-assess' method that will be of more relevance to educators.[22]

30. No standardised assessment can replace high quality professional observation, assessment, problem analysis/case conceptualisation and the formulation of an appropriate intervention. The relative merits of current assessment materials for ASD are discussed in advice given to a review of Autism Spectrum Disorder Diagnostic Instruments.[23]

Intervention

31. Psychologists are unique in that they employ the wide systemic and theoretical base of psychology to generate solutions to problems. This sets psychologists apart from other practitioners who might also use '*common* sense' ideas or other technical skills such as behaviour management and reading assessment.[24]

32. Psychologists are often seen as the bridge across the boundaries of health, education, social services, non-governmental organisations and the wider communities.[25] For example, most educational psychologists would observe the functional behaviour of a child with ASD across different settings and help to devise strategies that would generalise accordingly.

33. Psychologists have been part of teams that have facilitated some remarkable inclusive practices with teachers, parents, extended whānau and other educators. For example the joint Ministry of Education and Ministry of Health, TIPs for Autism delivers practical advice alongside the expertise of those who know the young person to focus on proactive rather than reactive strategies.[26]

34. Psychologists might be one of the professionals who can contribute to Initial teacher training, so teachers feel equipped to work with a diverse range of learners.[27]

35. Psychologists have developed Teacher Support Teams to help teachers address a range of specific concerns in schools which have been evaluated as successful.[28]

36. We favour placing the highest qualified teachers and other professionals, alongside the young people with the greatest need. Untrained teacher aides may be of limited

[22] Berman& Graham, 2002; Elliott, Grigorenko & Resing, 2010; Mentis, Dunn-Bernstein, Mentis & Skuy, 2009,; Lidz, C. (1997).
[23] NZPsS and NZCCP (2010)
[24] Management Advisory Service (1989 p6); Mitchell (2010) p206
[25] Farrell et al 2006
[26] Mells (2014)
[27] Graham, Berman & Bellert, (2015)
[28] Norwich and Daniels (2013), Woodward (2015).

educational value and in certain situations may 'disable' students.[29] Furthermore, there may be hidden management costs to ensure the effectiveness of teacher aides.

37. Children and young people with ASD, like many others, can be sensitive to environmental triggers in a high stimulus environment which will require careful assessment, planning and intervention.

38. Young people with a special educational need can be prone to bullying, externalising behaviours (e.g. hitting out) and internalising behaviours (e g. self-harm). Psychologists can help in devising suitable preventative systems and where necessary assist in supporting those with the day to day care of these young people.

39. Educational psychologists are trained to question evidence, to be rigorous and systematic. We are able to offer professional advice to schools about educational packages that have questionable evidence e.g. versions of Brain Gym, Irlen lenses etc.

40. We need research that will monitor the effectiveness of intervention programmes so we do not overly rely on academic and overseas research. Many academic studies have narrow exclusion criteria, so programmes fail to be evaluated on the type of children in our schools i.e. those who have multiple and complex difficulties

    We need locally designed research that can tease out what teaching strategies work best for different young people. For example, Reading Recovery (RR) is successful in helping up to 80% of young people who are struggling with reading in the in short to medium term. What type of programme is required for the remaining 20%? If RR often fails to meet the needs of Māori/Pasifika students how should these programmes be redesigned?[30] Educational psychologists are well placed to carry applied research that might modify or develop more effective programmes to meet the needs of all young people with persistent reading difficulties.

    Other local interventions are available that have contemporary evidence base and continue to gather evidence of their efficacy, e.g. in an Auckland primary school Iversen's Quick60 literacy, three tiered programme has resulted in 51% of students reading at, or above national standards, where historically only 5-7% of students were reading at, or above national standards.

41. Many everyday interventions are just 'good ideas' that may have good face value but lack the relevant evidence for effectiveness and/or clarify which parts of the

[29] Webster and Blatchford (2014); Kearney (2009).
[30] Tunmer et al (2013)

intervention are essential and which parts are unnecessary. For example, Social Stories, [31] Circle of Friends,[32] and the use of peers.[33]

42. Psychologists are well positioned to assist with the identified translation gap between the type of knowledge and practices recommended by researchers and professionals versus the stated priorities young people and their communities.[34]We are one group of the cultural and relational specialists that acknowledge the expertise and knowledge of our clients, seeking and responding to their needs.[35]

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[31] Styles (2011
[32] Frederickson, Warren and Turner (2005)
[33] Chan et al (2009)
[34] Pellicano (2014)
[35] Berryman (2014); Todd Hobbs and Taylor (2000)

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