Educational provision for children with specific speech and language difficulties: Perspectives of speech and language therapy service managers

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ABSTRACT

Background: Children with specific speech and language difficulties (SSLD) pose a challenge to the education system, and to speech and language therapists who support them, as a result of their language needs and associated educational and social-behavioural difficulties. The development of inclusion raises questions regarding appropriate provision, whether the tradition of language units or full inclusion into mainstream schools.

Aims: This study aimed to gather the views of speech and language therapy service managers in England and Wales regarding approaches to service delivery, terminology and decision-making for educational provision, and the use of direct and indirect (consultancy) models of intervention.

Method and Procedures: The present study reports on a national survey of SLT services in England and Wales (129 respondents, 72.1% response rate) and interviews with 39 SLT service managers.

Outcomes and Results: Provision varied by age group with support to children in mainstream common from pre-school to the end of Key Stage 2 (up to 11 years), and to those in designated specialist provision, common at Key Stages 1/2 (age 5 – 11 years) but less prevalent at Key Stages 3/4 (11-16 years). Decision-making regarding provision was influenced by the lack of common terminology, with SSLD and specific language impairment (SLI) the most common, and criteria, including use of the discrepancy model for defining SSLD. Practice was influenced by the difficulties in distinguishing children with SSLD from those with autistic spectrum disorder, and difficulties translating policies into practice.

Conclusions: The implications of the study are discussed with reference to SLT practice, including consultancy models, and the increasingly prevalent policy in local education authorities of inclusion of children with special educational needs.

Introduction

Children with specific speech and language difficulties (SSLD)[5] have a primary language problem, one that is not attributable to intellectual impairment, severe or profound hearing loss or lack of linguistic opportunity (Leonard 1997). Prevalence studies suggest that the numbers of children concerned are substantial, about 5-7% (Law, Boyle, Harris, Harkness, and Nye 1998, Tomblin *et al.* 1997). Their core deficits with language place them at risk of associated literacy difficulties (Botting, Crutchley, and Conti-Ramsden 1998, Dockrell and Lindsay 2004, Stothard, Snowling, Bishop, Chipchase, and Kaplan 1998), poor academic attainments (Snowling, Adams, Bishop, and Stothard 2001) and social-emotional problems (Beitchman, Wilson, Brownlie, Inglis, and Lancee 1996, Fujiki, Brinton and Clarke 2002, Lindsay and Dockrell 2000). This combination of core deficits in the area of language together with increased risk of academic difficulties have implications for support services provided by both speech and language therapy services and the education system, by LEAs and health trusts.

A national scoping study of provision for the full range of children with speech and language difficulties in England and Wales was undertaken by Law *et al*. (2000). This comprised three phases designed to identify existing provision; identify the nature of effective collaboration between education and health partners; and then test these findings with practitioners, policy makers and parents. The study highlighted the importance of working together at several levels, from national policy development, to local policy development and implementation, down to day-to-day

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[5] There are several terms referring to this condition including specific language impairment; our preference is for specific speech and language difficulties. This is one of the issues on which we report in this study.

implementation in schools, clinics and children's homes, but also the wide variation in provision across the country and age groups.

Concerns about the ways to meet the needs of children with SSLD have proved to be a challenge in a number of countries. There are specific concerns about the most appropriate model of service delivery; whether this is working with education or using a consultation model (Hong Kong: Stokes & Yiu 1997; Netherlands: Maas 2000; UK: Law *et al*., 2002; USA: Elksnin 1997). More recently the international move to 'inclusive education' has challenged the appropriateness of special schools and units as models of education for children with special educational needs (Lindsay 2003). Such changes in ideology and policy force a review of the ways to provide effective speech and language therapy for children with different needs within the context of education. (Spain: Montford 2004; UK: McCartney *et al,* 2005; USA: Ruddy and Sapienza 2004.) An important first step is to document current challenges and tensions in meeting the needs of children with SLLD.

Language units are specialist provision within mainstream schools which typically admit children with SSLD from a wider area than the normal catchment area. They have been the major approach to provision for children with SSLD, the focus of the present paper, but there has been no systematic review of provision for this group of children since the national survey conducted on behalf of I CAN[6] by Hutt and Donlan (1987) of provision of language units in England. There had been a growth in the provision from zero (1965) to 200 in 1985. However, Hutt and Donlan expressed concern that provision varied by age groups as there were about half as many units for junior-age children, aged 8-11 years (now Key Stage 2) compared with infants aged 5-7 years (KS1) (349 : 654 respectively) in their sample of 108 of the 200

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[6] I CAN: The National Charity For Children With Speech And Language Difficulties

units, and only 39 pupils in secondary units, and that the teachers had no consistent pattern of specialised training. Furthermore, they highlighted significant variation in the criteria for admissions, the nature and extent of integration, the use of manual signing, and staffing ratios. Establishing the basis of these varying practices is not straightforward as differences may occur for a number of reasons including planned decisions to meet local needs, a result of inadequate identification and assessment, a lack of appropriate facilities, or inadequacies in the matching of needs against facilities (Botting *et al*. 1998, Dockrell and Lindsay 1998). The scoping study (Law *et al* 2000) of provision for children with the full range of speech and language needs identified that units (now often labelled language resources) continued to be a popular form of specialist support, but with a continuing imbalance of resources in favour of younger children (Lindsay *et al* 2002). However, the majority of SLT provision at each age was made to mainstream schools rather than language units.

The UK education system has been the subject of many changes since the Hutt and Donlan review, following legislation (Education Reform Act 1988, Special Educational Needs and Disability Act (SENDA) 2001); and various initiatives of the Labour Government (Green Paper: DfEE 1997, SEN Action Plan: DfEE 1998, and the present Strategy for SEN: DfES 2004). These changes in education have been paralled by the reorganisation of local educational authorities (LEAs) and the NHS, and developments in professional and administrative practice by LEAs and health trusts. The implications arising from legal interventions, including judicial reviews, have also had important impacts on policy and practice (Royal College of Speech and Language Therapists (RCSLT) 1999). Consideration of educational provision for children with any special educational needs (SEN) must take account of the development towards a more inclusive system of education embedded in this

legislation and guidance and the enhanced involvement of parents in partnership with professionals (DfES 2001; RCSLT 1996; www.talkingpoint.org.uk). Although the principle of inclusion is generally supported, there is concern that provision may be 'inclusive' but not meet the children's needs, with practice being driven by the rights of children to be included, rather than by evidence of efficacy (Lindsay 2003). Teachers may feel unprepared by lack of training and support (Dockrell and Lindsay 2001), a cause of much concern for parents (Lindsay and Dockrell 2004).

Speech and Language therapists (SLTs) are central to the comprehensive support of children with SSLD. Models of SLT support are changing with moves away from clinic-based services to school-based provision (Law *et al*. 2000), a development largely driven by the profession (van der Gaag 1996). School-based practice is not synonymous with, but may be seen as a pre-requisite for, another key development in SLT practice, namely the consultation model where the SLT advises another professional (e.g. a teacher or either a teaching or SLT assistant) on the assessment of needs and intervention. In this case, intervention is indirect rather than direct. Consultancy rather than direct treatment has been promoted as more cost-effective, increasing the numbers of children for whom the SLT can provide support, and also as an appropriate vehicle for multi-disciplinary practice where the strengths of different professionals may be combined such that the whole is greater than the sum of the parts. Consultancy can be effective if interventions are developed that address both speech and language and also the wider educational needs of the children, and empower staff to implement programmes (Hirst and Britton 1998). However, concerns about consultancy are also evident (Law *et al*. 2002). For example, practitioners themselves point to a lack of evidence for the comparative efficiency of provision in education and health settings (Law *et al* 2000) and parents

in that study expressed concerns that this development is for cost-cutting rather than professional reasons (Band *et al* 2002).

There is a general consensus that the population of children with SSLD is heterogeneous (Conti- Ramsden, Crutchley and Botting 1997, Rapin and Allen 1983) - despite the common clinical criteria that are often used to identify the children. This can make accurate identification of children with SSLD problematic and results in a variation of needs in an educational context. To some extend this reflects the children's associated difficulties (Botting, Conti-Ramsden and Crutchley 1998, Dockrell and Lindsay 2000) but is also dependent on age and the context in which identification takes place.

The focus of the present research was the provision made for children with SSLD in England and Wales in the context of legislative changes, the development of inclusive education and changes in SLT practice. The overlap with autistic spectrum disorder (ASD) required that the inter-relationship between these two categories also be explored. This had become increasingly important given the apparent increase in the number of children diagnosed with ASD (Charman 2002, Charman and Baird 2002). This paper reports the views of SLT managers derived from a national survey and individual interviews with respect to a) the range of provision made, b) decision-making regarding diagnosis and provision and c) service delivery. Although the study was undertaken in the UK, the issues addressed are common to many other countries subject to similar political and professional developments. Thus, a detailed analysis of the UK context provides a case study to identify current barriers and opportunities in meeting the needs of children with SSLD.

Methods

The study was carried out in England and Wales and built upon earlier research which investigated services for children with speech and language needs of all types (Law *et al* 2000, Lindsay *et al* 2002).

Sample

The three samples investigated were LEAs, SLT services, and schools. A 2-stage process comprised national questionnaires to all LEAs and SLT services, followed by interviews with a sample of each and with a sample of schools which provided for children with SSLD. The present paper reports the findings of SLT services.

A questionnaire was sent to the head of the SLT service in all health trusts understood to have a paediatric SLT service (n = 179). A total of 129 completed questionnaires were returned, including 5 from Wales, a response rate of 72%. The majority of respondents indicated their specific role within the Health or Education Service. Ninety-seven held basically a managerial role within the SLT service, with a further eight indicating that they were the 'Paediatric co-ordinator' and one classed their post as 'Co-ordinator of mainstream support and resource bases'. Three respondents detailed their job title as 'Head of Education (learner support)'. The remaining 18 respondents were speech and language therapists, but did not indicate the nature of their managerial role.

Greater detail was collected through in-depth interviews. We aimed to sample 1/3rd of all respondents to provide a representative sample. Thus a random sample of 40 SLT departments was taken by selecting every third response from the returned set of questionnaires for follow-up interviews, with the person who had completed the questionnaire. This occurred in all but one case; 39 were interviewed with one unable to give the time needed.

Measures

The questionnaire and interview were designed by the research team, which included an experienced SLT (BL), and piloted on a small number of appropriate professionals including an advisor for special educational needs, education officer for I-CAN, and an LEA education officer (SEN), resulting in modifications to clarify issues concerning ASD. The questionnaire aimed to establish current levels of provision for children with SSLD, location of provision, criteria for placement and approach to service delivery. Copies of the questionnaire are available from the first author. The interview schedule was semi-structured, designed to produce both comparable data on key elements and allow an exploration of respondents' views, with open-ended questions followed by prompts if needed about the rationale that underpinned service delivery and the difficulties, barriers and problems that existed. Interviews were conducted by phone by the team's SLT (BL), and typically lasted about 30 minutes.

Results

Criteria for admission to SSLD provision

In the present section we report the responses to the questionnaire. In all cases percentages are reported on the basis of the total sample of respondents ($N = 129$). Use of specific admissions criteria was reported by 82% of respondents to the questionnaire, with 70% reporting that these criteria were agreed service policy. Respondents were invited to specify the criteria; of those that did, the most common criterion (46% of respondents) specified a discrepancy between the child's language and non-verbal cognitive ability. The only other sizeable criterion (14% of respondents) specified a statement of SEN awarded/pending or at least at level 3 on the 1994 Code of Practice stages of assessment.

Approach to Service Delivery

The overall distribution of time between direct and indirect interventions was slightly in favour of the former (direct: *M* = 54% *SD* = 25%; indirect: *M* = 46% *SD* = 25%). The 11 respondents (9%) providing separate answers for special and mainstream all indicated a smaller proportion of direct intervention in the latter: an average 80% direct intervention in special and language units, 42% mainstream. Seventy nine of the 129 respondents reported changes in service delivery underway, primarily moves towards a more consultancy-based approach (14% of total sample but 22% of those indicating changes) with more indirect intervention (19% and 30% respectively).

Provision

Pre-school

[Figure 1 about here]

Ninety one respondents (71%) reported there was SLT support to pre-school educational settings. The majority of these reported providing a service to children attending mainstream nurseries and other pre-school settings: 89% of these 91, but 63% of the total 129 respondents (Figure 1). Many services (38%) made provision to designated special provision (units/integrated resources) within mainstream pre-school provision, particularly to LEA nurseries, but also to those provided jointly by LEA/social services (6%) and LEA/voluntary body (8%); 8% also made provision to designated LEA special nursery school provision. The modal numbers of facilities supported by each service making provision was one nursery school for SSLD and two SSLD units in nurseries. There was variation in provision to LEA nursery units with two thirds (68%) of those providing a service supporting a single unit, and the others supporting between two and six. The most common number of children

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supported was 10 in both LEA nursery schools and units, with more variation in the other provision, between five (the four LEA/social service units) and 25 (the LEA/social services nursery schools).

Reception to post-16

In reception/KS1 and KS2 four out of five services supported mainstream schools (80% and 81% respectively). Support for secondary schools was lower (60% of services), but coverage by those services was typically for all schools. However, at post-16 just 9% of services reported covering mainstream schools.

Very few respondents reported an SLT service to special schools specifically for children with SSLD (between 3 and 5% across the age range), reflecting the small number of such schools and their typically employing their own SLT. Where a service was provided it was most commonly to a single school. However, most services (84%) made provision to Units/Integrated Resources for children with SSLD at reception/KS1, most typically to a single Unit/IR for 10 pupils (60% of services that made provision). Provision at KS2 was similar (73% of services), most commonly a single Unit/IR for 10 pupils.

Only 26% of services reported making provision to Language Units/IRs at KS 3/4 reflecting the small number of LEAs offering this provision, with 83% of these serving a single unit (range 1-2). The modal size of Unit/IR was again 10 but the mean of 17 indicates many were larger. Provision post-16 reduced still further to just 4% of services, each providing to a single Language Unit/IR for very few pupils ($M =$ 3).

Only a minority of SLT managers provided a service to children with SSLD in other forms of special Units/Integrated Resources, with a reduction from 21% of services at reception/KS1 to just 5% at post-16. Provision, where made, was most

commonly to one Unit/IR. The mean number of Units was two at reception/KS1 and KS2, and one at KS3/4 and post-16. The numbers of pupils generally reduced over the key stages: reception/KS1 $M = 23$, $SD = 26$; KS2 $M = 14$, $SD = 9$; KS3/4 $M = 18$, $SD = 19$; post-16 $M = 10$, $SD = 7$. About half of the services supported pupils with SSLD attending schools for children with moderate learning difficulties (MLD): Reception/KS1: 55%; KS2: 48%; KS3/4: 55%, dropping to 9% at post-16. A smaller proportion of services supported children with SSLD in other types of special schools: Reception/KS1: 35%; KS2: 29%; KS3/4: 28%, also reducing post-16, to 9%.

Terminology

The remaining sections report the results of interviews with the 39 SLT managers. Given the size of this sample, data are presented as absolute numbers of respondents not percentages.

Interviewees were asked about the term used for children, whether it was 'specific speech and language difficulties' as used in the study, or an alternative. It is evident from Table 1 that there are a wide variety of terms used for this group of children among the SLT community. The most prevalent was specific language impairment (SLI) and specific speech and language difficulties (SSLD), but a total of 10 single terms were reported and a further seven interviewees reported using two or more terms. The problems indicated by this wide range were summed up by one SLT respondent who annotated the questionnaire: 'Is there any way we could agree nationally as to what we call this group of children? SLI, SSLD, SpLCD etc. There's too many terms around to help understanding and planning'.

[Table 1 about here]

Only 24 of the 39 interviewees stated there was an agreed definition of the chosen term within their own service and, when asked to provide it, some were

suggested to be only approximations of the definition, e.g.: 'Don't know…. without any learning difficulties…. excludes ASD'. Four components of the definition were offered approximately equally by interviewees: primary speech and language problems (12), cognitive skills in the average range (11), no other causes (10: which overlaps with the problems being primary), and a verbal/non-verbal discrepancy whether stated explicitly or implied (8).

Decision-making regarding educational provision

Specialist language provision

The terms used for designated special provision in mainstream schools varied, the most popular being 'language unit' (26 interviewees). The only others with more than a single reference were 'language resource base' and 'language resource' (4 each). In some cases, but not all, different terms indicated different models. As shown in Table 2 the most frequent criterion for entry to the specialist provision referred to the child having 'speech and language difficulties as primary disorder' but not all specified this must be in the absence of other difficulties: 'Does *not* exclude if behaviour problems, hearing impaired etc'. The discrepancy criterion might specify a 'significant discrepancy between verbal and non verbal abilities with evidence of potential for age appropriate functioning in non verbal areas', or nonverbal ability within the normal range.

[Table 2 about here]

Another criterion referred to the need for a type of SLT or teaching provision: 'If needs small group, intensive language therapy delivered by SLT'. Severity of speech and language difficulties could be based on a specific test cut-off, '-2 SD or 1-5 percentile rank on standardised test if used'; age discrepancy, 'Significant gap between what a child of that age would normally be expected to function at – one to

one and a half years behind'; or a general judgement, 'Clinical profile of child -
identifies needs intensive therapy'. The statement of SEN, as a criterion, was relevant
typically if it proposed a diagnostic category or specialist support: 'Statement to
indicate SLI'. Educational factors were also specified: 'Language impairment stops
from accessing the curriculum but could cope with mainstream academically'. About
20% (8/39) of interviewees either did not know what the criteria were: 'How the LEA
make the decisions is unknown to us' or 'I am trying to get hold of the document they
work from but can't': or reported that there were no criteria.

[Table 3 here}

Interviewees mentioned other factors which could influence decisions
regarding provision, as shown in Table 3. Parents may be concerned about travel or
express their preference for different provision: 'Parents adamant they want
mainstream or want unit when the other has been recommended'. Interviewees were
concerned some parents might be misled by teachers: 'Class teacher says the pupil has
been fine (in mainstream) …difficult for teachers to understand SLI'. Some
interviewees were concerned about differential power of parents: 'Children with
pushy parents or well informed parents get the provision. My concern is that there are
others who are unsupported and the children drift into inappropriate provision'.

Lack of provision, mentioned by over half the interviewees, could lead to
inappropriate placements: 'Older pupils may go to MLD school as they can't cope in
mainstream …no other provision… really shouldn't be there'. Provision might
depend upon the child having a statement, but they might disagree with the LEA's
view: 'SLT may identify appropriate child but does not meet the stringent
statementing side'. There were also suggestions of a lack of consistency, 'Pupils are
placed depending on who happens to meet them and who happens to do the

paperwork' or the promotion of inclusion: 'Big push for inclusion; those with mild or moderate difficulties placed in mainstream even if meet the SLI criteria. Places a big stress on our service'.

Some SLT managers had concerns about lack of knowledge among educational psychologists (EPs): 'Occasionally some who don't think that SSLD exists!' or teachers, even those in language units:

'Teacher from language unit is involved in the assessment. Doesn't have sufficient skills or knowledge or level of experience. The criteria around the placement are grey. She looks at a child and thinks she can do something for him or her, but we may think that the child is not different from many others in mainstream.'

There could be conflicts between professionals' judgments and issues of power: 'Very personality-driven, depending on EP: seems arbitrary. EPs have disproportionate amount of input'. The present make up of the group might be a factor, 'If two already with behavioural difficulties, unlikely to take another' or the purpose of the provision, 'The units are very specific, one is for 'speech' another for 'receptive difficulties'.

Mainstream

The criteria for mainstream placement were generally not very explicit: only one interviewee referred to a specific profile of children appropriate for their mainstream service. The two main types of criteria referred either to needs or the ability of the child to cope in mainstream. Children might be able to 'cope' in mainstream because their problems were less severe, or they had attended a Unit, or were now improved sufficiently and could receive appropriate SLT support. This, of course, raises the question of whether coping consists of attending, participating and

successfully negotiating the demands of mainstream education or only attending a

school without having specific educational needs met.

Moderate learning difficulties

Nineteen interviewees reported using provision for children with moderate

learning difficulties (MLD) for children with SSLD. Twelve had criteria comprising a

general statement that the child would have general learning difficulties and

additional language difficulties. 'Clinical profile shows child has learning difficulties

– cognitive levels are low, as well as SLI'. Six interviewees stated there were no

specific criteria, or that placements were a result of a lack of alternatives. 'LEA place

pupils with SSLD who have severe language impairment, more complex needs, and

who don't fit the criteria for the language school or unit'.

Lack of resources

Almost all (34) interviewees reported a lack of specialist provision with

particular concern about secondary (KS3/4), **'**Enormous problems at secondary level-

need a secondary unit'. Others referred to the impact of inclusion:

> 'There are enough places at school age – recently not filled not because there
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> aren't the children because of inclusion drive. I feel they can't be supported as
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> well as they could be in (language unit).'

> However, some supported inclusion: 'I would like a centre of excellence in

every school - have small groups and integrate naturally into the school' even if

concerned about current mismatches: 'Some children's needs are between mainstream

and resource models - we don't really address their needs properly'.

Placement process

Inter-agency collaboration

The status attributed SLT advice and involvement in the LEA's SEN decision-making panel varied. In some cases panels were based on equality of esteem: 'It's policy that each professional or parent has equal status and no-one's advice is more influential'. The absence of an SLT representative could be problematic: 'Last year there was no SLT manager on the panel. They overturned recommendations and accepted three autistic children into the Language Resource Base'. Educational psychologists and SLTs could be a powerful joint force: 'Quite a lot of weight attached to what we (EP and SLT) suggest' while in other cases these two powerful influences could be in conflict: 'Our recommendation is less influential because of EP on panel'. Good relationships and collaboration was seen as a means of optimising the process. Overall, interviewees rated the status attributed to their advice medium to high, particularly when SLTs sat on the panel. Where perceived status was low, discontent was evident:

> 'There is ongoing discourse between the LEA and SLT at the moment. LEA are not happy with the SLT statement advice. LEA want 'resource led' advice. However there are no special schools left in the borough – because of inclusion. Provision the SLT may want to advise is not available - LEA want the SLT to recommend from what is available.'

Effectiveness

Interviewees' judgements of effectiveness of the decision-making process were generally positive with 29 rating it either very effective (8), effective (12) or reasonably effective (9) and only 8 regarding it as either not very effective (4) or not effective at all (4).

'Outcomes are good, yes [if appropriately placed]. We did an audit and found many pupils with significant impairment and statemented who got a specialist package were no longer statemented in Y6.'

However, most (27) managers described negative aspects of the process. A third (12) were concerned about inappropriate placements and lack of SLT input into the decision; two with 'parent power'; seven with the statutory assessment and statementing processes including time taken; and six reported conflicts with EPs or teachers:

'LEA does not adhere to the admissions criteria, has altered the operational policy and has not showed or discussed this with SLT. It used to be joint decision, not now -.controlled entirely by education.'

Overlap between SSLD and ASD

ASD provision and influence on SSLD

About half (19) of the respondents reported that separate specialist provision was made for children with ASD, while 18 reported varying degrees of overlap with provision for children with SSLD (Table 4). Of the managers who reported a need separate provision, almost half gave no rationale, while a third argued the children's needs were different: 'SLI benefit from intensive SLT, this is cost effective long-term, whereas ASD have behaviour issues and need protection' and because of the substantial growth in ASD numbers, 'New ASD provision because LEA is concerned ASD are 'coming out of the woodwork'. Where respondents indicated overlap between SSLD/ASD provision the most frequent explanation was the commonality of needs and unclear boundaries; some attributed this to problems with differential diagnosis:

[Table 4 here]

'There is a grey area for those not suitable for special ASD placement and who are suggested for the language provision. We try to ring-fence the language provision for SSLD not long-term ASD. Sometimes it is not clear whether a pupil has SSLD or ASD, so stays for a year.'

A quarter of the interviewees were concerned about a 'lack of ASD unit places' or that 'in mainstream they either sink or swim, no special provision' owing to 'resource problem and enormous pressure on class teachers expected to manage with whole range of difficulties'. There could also be a lack of SLT support in mainstream: 'LEA's setting up new ASD provision currently, without our involvement. We have explained they can't expect SLT just to follow'. Finally, training was stressed: 'SLTs and staff in education are aware of the difficulties but don't know what to do…training issue'.

Differential diagnosis

A third (13) reported problems with differential diagnosis of SSLD and ASD, one being a perceived change in diagnostic practice:

'Paediatricians are now more confident and quicker to give a [ASD] diagnosis, but in some cases the SLT hotly disputes it. Once a child has the ASD label the parent can get anxious and want specific programmes.'

This could be compounded by a lack of multi-disciplinary perspective: 'The consultant psychiatrist diagnoses ASD. It is not multidisciplinary. They make the diagnosis and we have to adapt'. The specific input of SLTs into assessment of ASD was not just a question of inter-professional rivalry, but of their particular contribution:

'I have a concern that because some mature out of the early features and then there is a query as to whether it is ASD or communication or language diagnosis. It would be good to have SLT input into the diagnosis.'

In addition, some interviewees questioned whether there was also an issue of provision: 'A label of autism or learning disability has been withheld so that the child can get into the unit' or the need to take account of parents' feelings. The specific problems of assessing young children and making a clear differential diagnosis were also seen as central

Changes in the perceived incidence of children with ASD

Almost all the SLT managers (38) reported an increase in numbers of children with ASD, often substantial: 'yes dramatically up… it has increased 4 fold'. One provided a long-term perspective: '32 years ago in my first year I saw one child with ASD, now it's one a week!' However, the increase was also linked to the inclusion of lesser severity: 'More higher-level ASD not classic autism' and 'severity is going down, more with very mild and Asperger's'.

Interviewees offered a number of reasons for this increase. A quarter (9) suggested a real increase in incidence while others postulated changes in diagnostic practice: 'Those ASD now were previously categorised as receptive language problems' while a further nine were unsure of the reason. Hence, there was dispute whether this was a true increase, a reflection of changes in professional practice including different diagnostic protocols with ASD rather than autism, or a combination of factors.

Direct versus indirect intervention

Managers were frequently reluctant and had great difficulty discussing the balance between direct and indirect intervention time in mainstream and special

language provision settings. Practices varied amongst clinicians and schools and Managers/SLTs were not always aware of the exact nature of SLT provision in particular provision. Interpretation of 'direct' and 'indirect' intervention was also problematic. However, on average, interviewees reported more direct intervention in special than mainstream schools: 70% of the time in special provision was allocated to direct intervention but only 40% of the time in mainstream. This is similar to the 80%, 42% reported in Law *et al*., 2000). Those reporting a greater percentage of direct work mentioned its importance for effective intervention: 'High percentage of direct for the SLI group compared to other groups because we see us making the most changes with the child because of the nonverbal cognitive ability being OK'. However, funding was also a factor, distorting provision:

'Higher direct than indirect because our trust doesn't allow higher indirect. It only looks at waiting times and contacts. We need contact numbers [to be high] or we don't get more funding. It's the health model.'

A third reason was that: 'Focus is always hands on. It is a historical traditional language unit model – works well for unit staff involved'. Individual direct work was also viewed by some as inherently superior. Where there was more indirect work in mainstream, interviewees often referred to limited resources determining practice: 'Level of resources, in mainstream: 4 SLTs for about 700 children. We are prioritising those in special provision' and 'In mainstream now lucky if SLT visits once a half term to set up programmes'.

Most interviewees reported a move, which they supported, to increase indirect work by SLTs. Reasons for this change included the practical, especially SLT time per se or limitations owing to vacancies or recommendations attributed to the scoping study (Law *et al*. 2000). Nevertheless, interviewees raised several concerns about the

development of more indirect work, or a 'consultative model'. These included monitoring and the need for expertise and clarity of responsibility: 'More indirect should be more effective, *but* we need to be sure that we are clear what we are asking others to do'. Parents were not always in favour: 'A lot of resistance from parents- they feel 1:1 SLT is the solution'. There was a need for more resources and training, and concerns that indirect intervention could lead to an increase in work: 'Referral rate increased by 30% following focus group with mainstream teachers', and: 'In education- the more we do the more they want. Need to look at how sustainable it is'.

Discussion

In order to optimise the contribution of SLTs in the educational provision of children with SSLD it is necessary to address their involvement at three levels: national policy, local policy and practice. The present study considers the latter two levels: translation of national policy into local policy and framework for implementation at the level of LEA and health trust; and practice at the level of individual SLTs working with educationists and parents... The findings will be considered with reference to two main issues: decision-making regarding provision for children with SSLD and the nature of SLT intervention.

Decision-making

The national survey indicated most services support children with SSLD in mainstream, with specialist provision being largely in the form of language units/integrated resources. However, some children, particularly as they moved to secondary school, were supported in MLD schools. Central to the issue of decision-making is the delineation of the children appropriate for particular provision or intervention. The general approach, both in the research literature and in practice, has been based on a discrepancy between language and non-verbal cognitive ability.

While the majority of managers in the national survey had specific criteria for admission to specialist language provision for children with SSLD, fewer than half specified the need for a discrepancy. Nonetheless, many considered this an indicator of likely response to therapy. Furthermore, although the present study has no objective data on this, anecdotal evidence suggests that practitioners may not require the precision defining discrepancies that researchers consider necessary and so, even if a discrepancy criterion is specified, interpretation may vary.

The interviews also indicated substantial variation in the terminology used to delineate the population. The most common term in the research literature has been 'specific language impairment' but 'specific speech and language difficulties' has also been used, especially by those working in an educational setting. This reflects the preference in the UK for the behaviourally-based term 'difficulties' compared with 'impairment', which was central to UK legislation on SEN since the Warnock Report (Department for Education and Science 1978) and Education Act 1981. The use of a needs-based approach is now a feature of educational decision-making (Department for Education and Skills 2001) and is reflected in the recent code of practice which refers to communication needs (DfES, 2001: para 7.55). This is in contrast to the main approach reported by the SLT managers which may be described as 'diagnostic', matching individual children against criteria for SSLD, in order to determine suitability for provision.

Tensions between these two approaches to decision-making are evident in the discussions regarding children with ASD. There was a general perception that numbers had increased, putting a strain on the services not only by increase in workload, but also because of contested views regarding appropriate educational provision. Underlying these tensions was concern about differential diagnosis, the

basis of which many interviewees considered had changed over the recent past. A number of children with ASD, it was argued, would previously have been considered to have language difficulties as their primary problem, probably referred to as semantic-pragmatic disorder (Boucher 1998). This view is supported by recent research which has highlighted the overlap between autistic spectrum and pragmatic difficulties (Bishop and Norbury 2002, Geurts *et al.* 2004). Furthermore, in a study of children previously attending language units at age 7 years, and previously referred to as having specific language impairment, the majority (67%) were found at age 11 years to show pragmatic difficulties (Botting 2004).

SLT intervention

The nature of SLT intervention with children with SSLD was related to two main factors namely the location of the child, whether in mainstream or in specialist language units/integrated resources, and models of practice, contrasting direct v indirect intervention mediated by age of child. The majority of services provided SLT support to children in mainstream schools during the primary phase reducing at secondary (KS3/4). A similar proportion supported language units/resources at reception/KS1/2 but only a quarter made this provision at KS3/4, reflecting the relative lack secondary units/resources. In general it was suggested that children in the specialist provision would have more severe or comorbid difficulties and hence greater needs. This was linked to a need for direct intervention, requiring the specialist 'hands-on' skills of the SLT. In mainstream, by contrast, the children were seen as having less severe problems and so indirect intervention was possible and appropriate.

This study has supported the view that there has been an increasing shift to indirect work with children with SSLD, characterised by SLTs providing a

consultative support service to teachers, teaching assistants or SLT assistants, and indeed to parents (McCartney 2002; Law et al 2002). The pattern of service varies but interviewees suggested that more direct work with children by SLTs occurred in special than mainstream settings. This variation was frequently ascribed to planned differences based upon the needs of the children, but raises questions regarding the development of a more inclusive system that reflects the changing developmental needs of children with SSLD. If a greater proportion of children with more severe forms of SSLD are supported in mainstream, the balance of consultancy and direct intervention will require reanalysis to consider the relative efficacy of the two approaches for the populations served. This shift from direct work in clinics to direct work in schools, and then a further development to indirect work (consultation) in schools reflects a similar pattern of the development of professional practice undertaken by educational psychologists (EPs) in the 1970s and 1980s (Gillham 1978, Lindsay and Miller 1991). As with educational psychology, initial development of indirect work will require careful appraisal to ensure that its apparent benefits do indeed occur, and also that the necessity of highly skilled interventions are indeed delivered by appropriately experienced professionals where necessary (Law *et al*. 2002). Otherwise, teachers may be disillusioned by what they see as insufficient support to allow them to develop necessary knowledge and skills (Dockrell and Lindsay 2001) and parents may be disenchanted by services they perceive as inadequate and designed to cut costs (Band *et al.* 2002, Lindsay and Dockrell 2004).

Furthermore, the development of models of practice must be ecologically valid, that is they must be fit for the purpose, in this case within educational settings. Practice must be based on an analysis of child needs and on negotiated intervention. The former also requires understanding of the characteristics of many different

schools and curricular demands; a more challenging task than working within a single language unit. The necessity, therefore, is to develop effective models of collaboration, based on mutual respect of differential expertise, with both complementary and integrated delivery of support provided in a cost-effective manner. This model goes beyond that of consultancy, which may be seen as a reduction in expert support for children, by parents for example (Band *et al*. 2002), to a model of integrated collaboration.

These data reflect the perceptions of practitioners working across the UK and thereby provide an important backdrop for understanding practice. There is a clear consensus about shifts in practice, levels of need and distribution of services. The extent to which these perceptions are mirrored by actual policy and practice requires further evaluation.

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Table 1   Terms used by SLT services

Terms used where only one was identified	n
Specific Language Impairment	13
Specific Speech and Language Difficulties	9
Specific Speech and Language Difficulties - delay or disorder	1
Specific Speech and Language Difficulties -disorder not delay	1
Language Disorder	3
Specific Speech and Language Disorder	1
Specific Language Disorder	1
Specific Speech and Language Impairment	1
Specific Language Difficulties	1
Specific Communication Difficulties	1
Total	32

Terms used where two or more terms were identified	
Specific Speech and Language Difficulties and Specific Language Impairment	3
Specific Speech and Language Difficulties and Language Disorder	1
Specific Speech and Language Difficulties or Specific Language Disorder	1
Specific Speech and Language Impairment and variety of other terms	1
Mixture of terms used	1
Total	7

N= 39

Table 2   Criteria for entry to special language provision.

Criteria	n
Primary speech/ language	22
Non verbal discrepancy	17
Type of SLT or teaching provision	10
Speech and language severity	11
Speech and language profile	8
Don't know or no LEA criteria	8
Statement	8
Prior SLT input	7
Other	7
Educational considerations	6
SLI	5
Age	5
Parent consent/ choice	3
Signing	2
Social Considerations	2

Note: Managers (n = 39) could offer more than one criterion

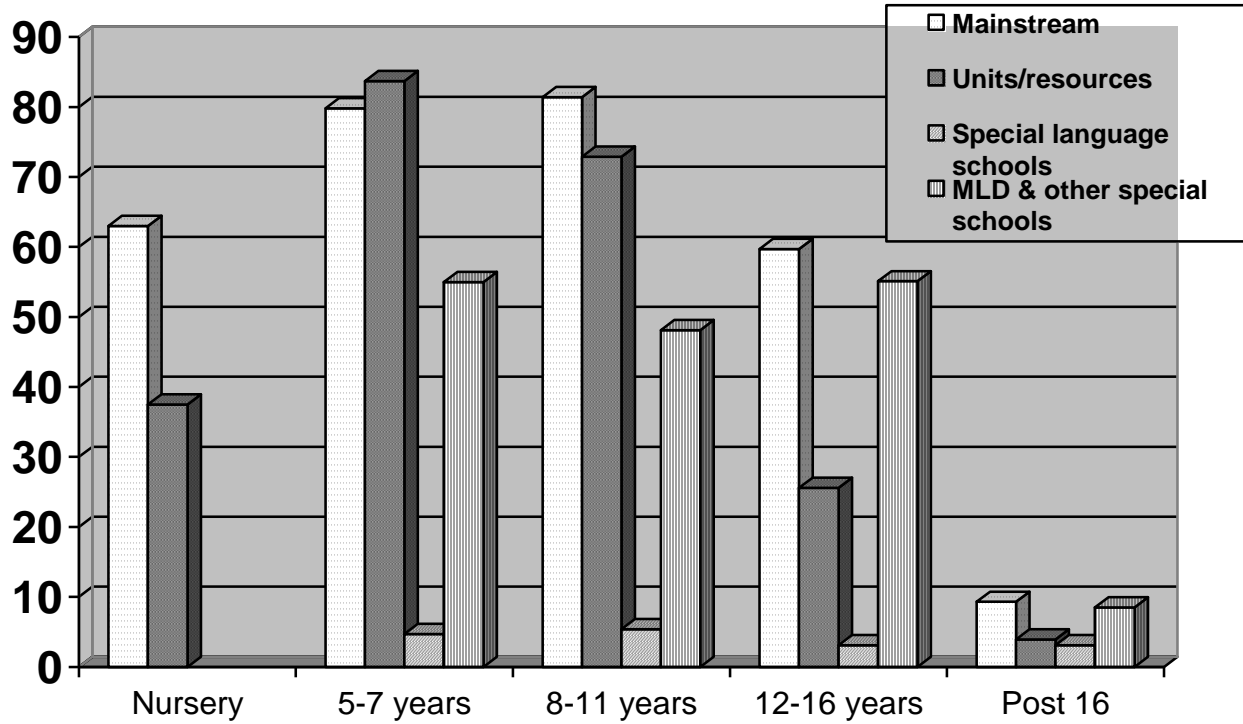Table 3   Other factors influencing decisions about provision.

Factors	n managers
Parental factors	30
Places and funding	19
Professional factors	7
ASD and MLD	7
Statement or system	6
Population factors	5
Child and time factors	4
Support available	3
Lack other resources	3
None	1

n = 36

Table 4   Placement of children with ASD pupils in special provision

	n trusts
Separate special provision for ASD	19
No special ASD provision, some in special language provision	5
Some in separate ASD, some in language provision	13
No special ASD or language provisions	2

n = 39

Figure 1. Speech and language therapy provision for children with SSLD in England and Wales (% of services).